OVERVIEW REPORT

DOMESTIC HOMICIDE REVIEW

in respect of

VICTIM 3 - 2014
Deceased November 2014
Age 20 years

Chris Few
November 2015

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INTRODUCTION

1.1 Domestic Homicide Reviews were introduced by the Domestic Violence, Crime and Victims Act (2004), section 9.

1.2 A duty on a relevant Community Safety Partnership to undertake Domestic Homicide Reviews was implemented by the Home Office through statutory guidance in April 2011. The 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' was updated in August 2013 and that revision provided the framework within which this Review was conducted[1].

1.3 A Domestic Homicide Review (DHR) is defined[2] as:

A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:-

- a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

1.4 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.5 DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts. They are also not specifically part of any disciplinary enquiry or process; or part of the process for managing operational responses to the safeguarding or other needs of individuals. These are the responsibility of agencies working within existing policies and procedural frameworks.

[1] www.homeoffice.gov.uk.
[2] Domestic Violence, Crime and Victims Act (2004), section 9 (1).

2 Summary of Circumstances Leading to the Review

2.1 The victim (X) and perpetrator (Y) began an intimate relationship in April/May 2014 but did not at any point live together.

2.2 In November 2014 Y visited the address which X shared with other students, entered her bedroom and stabbed her numerous times with a knife that he had brought with him. X escaped from her bedroom but collapsed and died shortly afterwards on the pavement outside her home address.

2.3 Y was arrested nearby and subsequently charged with murder of X.

2.4 On 1 December 2014 a Scoping Panel convened on behalf of the Stoke-on-Trent Responsible Authorities Group considered the circumstances of the case and concluded that the criteria for conducting a Domestic Homicide Review were met. A recommendation to commission a Domestic Homicide Review was endorsed by the Chair of the Responsible Authorities Group on 12 December 2014.

2.5 In 2015 Y pleaded guilty to the murder of X. He was subsequently sentenced to life imprisonment.

3 Terms of Reference

3.1 The full Terms of Reference for this Review are at Appendix A. The following is a summary of the key points.

3.2 For X the Review considered in detail the period from September 2013 until the date of her death, to cover the period that she was living in Stoke-on-Trent. In respect of Y the Review considered in detail the period from October 2010, when he was released on licence from prison to live in Stoke-on-Trent, until the date of X's death. Summary information regarding significant events outside of this period was also considered.

3.3 The focus of the Review was on the following individuals:

Name	X	Y
Relationship	Victim	Perpetrator
Age	20	68
Gender	Female	Male
Ethnicity	Asian	White British

3.4 In addition to the general areas for consideration outlined in the statutory guidance the Review specifically considered the management of Y as a registered sex offender released from prison on licence.

4 Review Panel Chair and Independent Overview Report Author

4.1 The Review Panel was chaired and this report of the Review was written by Chris Few, an Independent Consultant. Mr Few has chaired review panels and written overview reports on behalf of numerous Community Safety Partnerships, Local Safeguarding Children Boards and Local Authorities in connection with Domestic Homicide Reviews and Serious Case Reviews[3]. He has no professional connection with any of the agencies and professionals involved in the events considered by this Review.

5 Review Panel Members

5.1 The Review Panel comprised the following post holders:

- Domestic Abuse Service Manager (as an advisor to the Panel)
  Arch
- Service Manager
  Heantun Housing Association
- Head of Staffordshire and Stoke-on-Trent
  National Probation Service
- Lead Nurse Adult Safeguarding
  North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups
  (On behalf of NHS England)
- Senior Investigating Officer
  Staffordshire Police
- Detective Sergeant
  Investigative Services Policy, Review and Development Unit
  Staffordshire Police
- Academic Registrar and Director of the Student Experience
  Staffordshire University
- Personal Crime Programme Lead
  Stoke-on-Trent City Council
- Lead Nurse Adult Safeguarding
  University Hospitals of North Midlands NHS Trust

6 Review Process

6.1 The Review Panel met on one occasion in March 2015 to consider contributions to and emerging findings of the Review.

6.2 Completion of the Review was delayed as a result of attempts by the Police to interview Y on behalf of the Review Panel subsequent to his conviction and consequently in submission of their report to the Review Panel.

[3] Under the Children Act (2004) and its associated statutory guidance.

6.3 This Overview Report was endorsed by the Review Panel on 1 December 2015 and forwarded to the Chair of the Stoke-on-Trent Responsible Authorities Group. It was presented to and endorsed by the Responsible Authorities Group on 2 February 2016.

7 Contributions to the Review

7.1 Requests to confirm the extent of their involvement with the subjects of this Review were sent to all statutory and voluntary agencies in Stoke-on-Trent and Staffordshire who may potentially have had such involvement. This scoping process was used as the basis for more targeted requests for Management Review and Summary Information Reports.

7.2 Management Review and Summary Information Reports were submitted by:

- Heantun Housing Association
- NHS England (Primary Care Services)
- National Probation Service
- Staffordshire Police
- Staffordshire University
- University Hospitals of North Midlands NHS Trust)
- West Midlands Ambulance Service NHS Trust

7.3 Other sources of information accessed to inform the Review included:

- An overview of domestic violence and abuse services in Stoke-on-Trent prepared by the City Council Personal Crime Programme Lead
- Email correspondence from Stoke-on-Trent City Council Grounds and Parks
- Association of Chief Police Officers (ACPO) 2010 Guidance on Protecting the Public: Managing Sexual and Violent Offenders

8 Parallel Processes

8.1 The criminal investigation into the murder of X was conducted in parallel with this Review. In 2015 Y pleaded guilty to murder and was subsequently sentenced to life imprisonment.

8.2 HM Coroner for Stoke-on-Trent and North Staffordshire opened and adjourned an inquest pending the outcome of the criminal prosecution. Consequent to Y's conviction the inquest was not resumed.

8.3 Both Staffordshire Police and the National Probation service conducted reviews of their involvement with Y on behalf of the National Offender Management Service (NOMS). That work informed the contribution of the agencies to this Review.

9 Family Engagement

9.1 Members of X's family were advised of the Review at its outset. No response was received to written invitations to contribute to the Review and family members have not engaged with attempts to establish personal contact with them.

9.2 Y was also informed of the Review at its outset. He was invited to contribute and asked for consent to access his primary care medical records. He declined in both respects. A further

approach was made to Y inviting him to contribute to the Review subsequent to his conviction. He again declined to do so.

9.3 Members of X's family were offered sight of this report on its completion and prior to its submission to the Home Office.

SUMMARY AND ANALYSIS OF EVENTS

10 Background of X

10.1 X was born in Pakistan of British Asian heritage. Her father became estranged from her family when X was born and is believed to be living abroad. Her mother lives in Pakistan. In the UK X had an older brother and an uncle.

10.2 X spent her early life in London before moving to the Midlands and then the North West of England.

10.3 In September 2013 X started a 3 year degree course at Staffordshire University.

10.4 X was initially allocated University accommodation but within two weeks moved into a privately rented house which she shared with three other students. The University informed the Review that this is not unusual as some students do not find that living in halls of residence suits them and would not raise any concerns.

10.5 X had a self-contained room on the first floor of the address and remained living there until the date of her death.

10.6 X is described as a hardworking student who was suited to University life and was progressing well. She regularly attended lectures and tutorials and passed her first year examinations in May 2014.

10.7 In her first year at University X made her personal tutor aware that occasionally she had to sort out problems for her brother who lived alone but otherwise mentioned no issues regarding her personal life.

10.8 Around April 2014 X's personal tutor was cycling along the canal towpath in Stoke-on-Trent when he passed X, who was talking to a man. He spoke to X but she ignored him. When the tutor next met with X he asked her who the man was but found that she was evasive and did not answer the question. The description of the man seen with X is consistent with that of Y.

10.9 X twice attended the University Hospital of North Midlands Emergency Department in February and March 2014 with minor injuries sustained by respectively standing on broken glass and slipping whilst cutting vegetables. There is nothing to suggest that these injuries were in any way connected with Y.

10.10 X had no other contact with any agency in Stoke-on-Trent prior to her death.

11 Background of Y

11.1 In 2002 Y (then aged 56) indecently assaulted the 14 year old daughter of a neighbour whom he had groomed whilst she was doing a paper round. He touched her sexually and suggested that they have intercourse.

11.2 Y pleaded guilty to these offences but absconded whilst on bail for pre-sentence reports. A warrant was issued for his arrest.

11.3 Y remained on the run until arrested in 2009. In March of that year he appeared at Stafford Crown Court and was sentenced to 30 months imprisonment followed by an extended licence period of 72 months.

11.4 Y did not undertake a Sex Offender Treatment Programme whilst in prison.

12 Management of Y as a Registered Sex Offender on Licence

12.1 In October 2010 Y was released from prison on licence and moved into Approved Premises (hostel) accommodation run by the Staffordshire and West Midlands Probation Trust[4] in Stoke-on-Trent. The licence was due to expire in July 2017.

12.2 The Multi-Agency Public Protection Arrangements (MAPPA) framework within which Y was managed following is release from prison is described in Appendix B.

12.3 Y was managed as a Category 1 offender (Registered Sex Offender) at MAPPA Level 1 throughout the period under review. As Y was subject to licence conditions until July 2017 the lead agency in his management was the Probation Service. During this period Y had two allocated Offender Managers, the changeover occurring when Y moved from the hostel to private rented accommodation in June 2011(see below).

12.4 The Staffordshire Police Violent and Sex Offender Management (VSOM) team was also involved in the management of Y as he was subject to sex offender notification requirements. His allocated Risk Assessor remained the same throughout his time in the community and home visits were always conducted by this Officer, accompanied by other members of the VSOM team who varied due to other operational demands and staff capacity within the team.

12.5 In June 2011 Y moved into privately rented accommodation with the assistance of Heantun Housing Association. That organisation subsequently provided Y with support from an experienced caseworker who conducted visits at first weekly and eventually reducing to monthly. Support for Y was due to end in June 2013 but was extended at his request as in June 2013 he moved to a new privately rented flat. It thereafter continued until April 2014. The overall support plan was reviewed each six months.

12.6 Throughout the period under review there is evidence of effective liaison and collaborative working between the Probation Service Offender Manager, the Police Risk Assessor and the Heantun Housing Association caseworker. This included regular sharing of information and three way meetings with Y involving the Probation Service and Police or Housing Association staff.

12.7 It also included the provision of reports by the Heantun Housing Association caseworker to the Police and Probation Service on each contact with Y. In March 2012 an issue was identified by Heantun Housing Association with the electronic transmission of these contact reports to the Police. This was attributable to the firewall of the Police IT system and was resolved through use by Heantun Housing Association of the criminal justice secure network for such communication.

[4] In 2014 the responsibilities of this Trust in respect of MAPPA offenders transferred to one of its successor organisations, the National Probation Service. Throughout the remainder of this report these organisations are referred to as the Probation Service.

12.8 **Probation Service**

12.9 On release from custody Y was assessed by the Probation Service as posing a high risk of harm to children, medium risk to a known adult (the victim of the index offence) and a low risk to public and staff.

12.10 The Probation Service risk assessment was reviewed in line with national and local policy standards and guidance until 2012 (see 12.18). The conclusions reached on risk levels and identified risk factors within the OASys[5] assessments were supported by the evidence and compliant with risk of harm guidance, local policies and national standards. They clearly identified who was at risk and the nature of the risk. Assessments drew upon the information contained in previous assessments.

12.11 Y's licence had six standard conditions and a comprehensive list of fourteen additional licence requirements, covering unsupervised contact with children or play areas, no contact with his victim including an exclusion zone, to undertake work on sexual offending and alcohol use. There was also a condition for Y to disclose any developing relationships with women.

12.12 A thorough Risk Management Plan was compiled which outlined the work Y must do to address his risk factors whilst in the community. The plan was completed within national standard timescales. The plan clearly identified his licence conditions, factors linked to his risk of harm, how they would be managed and the other agencies involved in the management of risk, including names and contact details. It is clear from the plan how the Offender Manager and others would manage the risk presented by Y.

12.13 In November 2010 and April 2011 Y undertook polygraph testing as part of a Probation Service pilot scheme for sex offenders being managed in the community. His responses to questioning about contact with children and his earlier victim were satisfactory. A further polygraph test in October 2011 was cancelled owing to Y's ill health and was not re-scheduled as the pilot programme came to an end. Following a positive evaluation of the pilot, use of polygraph testing for sex offenders managed in the community was recommenced nationally on 1 January 2014 and included as a licence condition for offenders released after that date. Failing a polygraph test is not of itself a ground for intervention but forms part of the information base triangulated with other sources. Refusal to undergo a polygraph test is dealt with as a breach of licence conditions. The Probation Service informed the Review that for polygraph testing to be reinstated as part of Y's licence conditions he would have had to be assessed as high risk and on the basis of the information known at the time this would not have been justified.

12.14 During 2010-11, Y also undertook work on the issues identified as linked to his offending behaviour, including the completion of the Community Sex Offender Groupwork (CSOG) programme and victim awareness courses.

12.15 Although alcohol use was an identified risk factor for Y this was the subject of monitoring rather than being proactively addressed, on the basis that there was no evidence of current alcohol use. The Probation Service identified to the Review that proactive work on addressing previous alcohol misuse should have been undertaken to aid relapse prevention, despite the absence of current alcohol use. They made an appropriate recommendation in this regard.

[5] OASys is a system used by the Probation Service for undertaking and recording all formal risk assessments and sentence plans

12.16 In March 2012 Y's risk levels were reduced from high to medium risk of harm to children and low risk of harm to public, known adults and staff. The reduction in risk was well evidenced and supported by the completion of accredited programmes, discussion with the other agencies, compliance with Probation Service supervision and licence conditions and there being no evidence of further offending. The reduction was given oversight by a Senior Probation Officer and a senior manager and the rationale for it was fully recorded.

12.17 Risk reviews were undertaken by a Senior Probation Officer on a 3 monthly basis whilst Y was viewed a posing a high risk to children and every six months after the assessed risk was reduced medium.

12.18 Y's documented (OASys) risk assessment was not reviewed in line with local guidance in 2013 or 2014. It has been established that the 2013 OASys assessment was 'guillotined' as incomplete and therefore updated information was lost. This happened as the assessment was open for 45 days without being signed and finalised. The March 2012 risk assessment therefore remained in place for the remainder of the period under review.

12.19 It is unclear why a back-up reminder system failed to flag up that the risk assessment had not been finalised and the Probation Service made an appropriate recommendation for review of this system to ensure that it is effective.

12.20 The Probation Service also made an appropriate recommendation for review of this staff member's caseload to ensure that all risk assessments are up to date.

12.21 Notwithstanding the procedural non-compliance, the Probation Service confirmed to the Review Panel that all relevant risk information was contained within the 2012 risk assessment and that no significant risk factors were missed by the failure to update it.

12.22 Y had contact with the Probation Service at least once per week following from his release from custody until the point at which his risk was reduced to medium in March 2012. His contact levels were then reduced to fortnightly. A further reduction to monthly contact was made in November 2012. These levels of contact are in line with national standards and local policy and guidance. During his 4 years on licence, Y missed 4 of 111 appointments with his Offender Manager and each of these was acceptable due to health issues.

12.23 With the exception of a more proactive approach to relapse prevention in respect of alcohol misuse and the procedural compliance issue detailed at 12.18 above, Y's Risk Management Plan objectives were appropriately managed and the overall sentence plan was implemented effectively. There is evidence of regular and appropriate management oversight throughout the case records and both Offender Managers were observed undertaking supervision sessions with Y.

12.24 **Police**

12.25 Throughout the period under review the Police RM2000 risk classification[6] combined with the dynamic risk assessment remained the same, with Y graded overall as posing a medium risk. The risk assessment was regularly reviewed in accordance with local policy.

12.26 Y was visited by his Police Risk Assessor on the day of his release, just after his arrival at the approved premises. The Police report highlighted this 'meet and greet' strategy as good practice; demonstrating to the offender that he is going to be positively and robustly managed but also that he is going to be supported at a time where he is likely to feel

[6] See Appendix B

particularly vulnerable. It was however identified that the visit would have been more beneficial if it had taken place after Y had met with his Offender Manager to have his licence conditions explained to him and had completed his induction process at the Approved Premises.

12.27 The Police advised the Review Panel that the 'meet and greet' strategy is considered in each case and occurs when professional judgement deems it necessary and proportionate, taking into account the level of risk that the individual poses and the amount of support that they will require.

12.28 Y was thereafter visited regularly by his Police Risk Assessor, in parallel with the Probation Service Offender Manager contacts, with at least one and up to three visits between each six monthly level 1 MAPPA review. There is evidence that these visits were used to explore Y's lifestyle and daily activities. There are also examples of effective intervention to ensure that the risks associated with that activity were properly managed, for example through contact and information sharing with a church that Y wished to attend and arranging that he would only attend services at which children would not be present.

12.29 The Police report highlighted that although Y's record on ViSOR[7] had been updated in a timely manner and all of the required information had been inputted into the system the information may have been enhanced by a more comprehensive recording of the detailed conversations that had clearly taken place between Y and the Risk Assessor.

12.30 The Police report also identified that the 'appearance' field was not completed and kept up to date within Y's ViSOR record. This issue is particularly pertinent in relation to Y who significantly changed his appearance in the summer of 2014 (see 13.28). The Police report made an appropriate recommendation regarding ViSOR recording practice.

12.31 With the exception of these two issues, the risk assessment and supervision of Y as a Registered Sex Offender was in accordance with national and local guidance.

13 Issues during the Management of Y as a Registered Sex Offender on Licence

13.1 Y was noted by all of the professionals involved in his supervision to be a socially isolated person who had minimal contact with his family and little in the way of interests other than going for walks and visiting the library. Throughout the period under review he presented as compliant.

13.2 Fishing

13.3 In July 2011 Y asked his Offender Manager if he was allowed to go fishing on the canal in Stoke-on-Trent. This was discussed with the Police Risk Assessor and agreed to, with a stipulation that he should only do so on weekdays when children were in school and that this would be monitored. It was considered that Y had recently completed his CSOG programme and that this had included work on dealing with risky situations should children frequent the towpath whilst he was there.

13.4 There is no indication that either the Offender Manager or the Risk Assessor explored this activity and Y's motivation in depth or that the activity was monitored. It should have been

[7] ViSOR is a national IT system used by agencies for the management of people who pose a serious risk of harm to the public.

recognised as an activity which, notwithstanding the restriction on when it took place and his CSOG programme, may have brought Y into contact with children, afforded him a means of attracting their attention and thereby increased the risk of him re-offending.

13.5 **Allotment**

13.6 In October 2011 Stoke-on-Trent City Council granted Y the tenancy of an allotment adjacent to and with direct access from the canal towpath in Stoke-on-Trent, on which there were two sheds.

13.7 During the period that Y had the allotment he visited but made no effort to cultivate it. Y did not pay the rent due for the allotment and his tenancy was terminated by the Council in March 2012.

13.8 Both the Risk Assessor and the Offender Manager were aware of this tenancy and that Y was spending time at the allotment. It was mentioned by Y during visits by both professionals but there is no indication that either visited the allotment, was aware that Y had access to sheds there or explored in depth the use that Y was making of it.

13.9 The allotment and its location adjacent to the canal towpath where Y had opportunity to engage with passers-by should have been recognised as providing Y with a venue where he might re-offend away from the scrutiny that would be present at his home address.

13.10 **Neighbour's dog**

13.11 In February 2012 Y informed his Offender Manager that he was taking his neighbour's dog with him on walks along the canal towpath. He was noted to be fully aware of risk issues but advised to distance himself before he got too attached to the dog as his flat had a "no pets" policy and the dog would have to go when the landlord found out. Notwithstanding this advice and Y informing the Offender Manager in March 2012 that he had curtailed looking after it, the dog was present when the Risk Assessor visited in August 2012 and it appeared that Y was looking after it a lot.

13.12 There is no indication that consideration was given to the potential for Y to use the dog as a prop with which to engage children, or adults, in conversation.

13.13 **Deterioration in Y's self-care**

13.14 In June 2013 Y moved to a new flat. He was visited shortly afterwards by his Risk Assessor to whom Y complained about aspects of his accommodation.

13.15 He was noted to have a low mood. This was also commented on during the following visits by the Risk Assessor and in February 2014 Y's kitchen was noted to be very dirty, a significant change to the manner in which Y had previously kept his home.

13.16 During this period Y's Offender Manager and Heantun Housing Association case worker also noted Y's dissatisfaction with the flat and his deteriorating mood. Both had urged him to seek alternative accommodation but recorded that Y seemed to have little appetite for this.

13.17 It was noted that Y was undergoing investigations for an illness which he believed might be bowel cancer and reasonably speculated that this was a factor in Y's presentation. Y was subsequently diagnosed in July 2014 as suffering from Crohn's Disease[8].

13.18 **Relationship between X and Y**

13.19 Information gathered as part of the homicide investigation suggests that X and Y met on the canal towpath in Stoke-on-Trent in April or May 2014. They initially met up for walks as friends and had lunch together but the relationship soon developed into one of intimacy as evidenced by X's housemates.

13.20 Both X and Y appear to have been keen letter writers and kept up two-way correspondence. The tone and content of the letters suggests that both parties were engaging in a fantasy relationship where X would refer to Y as "Daddy".

13.21 There is evidence that Y had bought a number of items, some expensive, for X, such as a laptop and clothing. Y was unemployed but when searching his house after the death of X the Police discovered large sums in cash hidden in various places. The source of this has not been confirmed but it is believed that he had received money from the estate of his mother.

13.22 When Y's relationship with X started he should have disclosed it to his Offender Manager in accordance with his licence conditions but did not do so. The relationship was not otherwise brought to the attention of the professionals supervising Y. When X's house mates became aware of the relationship and when X's personal tutor saw her with a man who may have been Y in April 2014 they thought it a bit strange but there was no reason for them to have considered bringing this to the attention of any agency.

13.23 Throughout the period under review many of the contact records completed by both the Offender Manager and Risk Assessor state that Y was asked about new relationships. On each occasion he responded that there were none and nothing was evident at his address which might suggest there was a relationship.

13.24 The only occasion on which Y acknowledged a desire to be in a relationship was in March 2012 when he also stated that he felt his ill health was preventing him from starting one. It would have been good practice to explore in depth Y's wishes and intentions at that time.

13.25 The Review Panel noted that even if the relationship had been disclosed, X was 20 years old and had no children or direct access to children, which would have been the concerns under MAPPA arrangements. There would not therefore have been any grounds to disclose Y's offending history to X and exploring the nature of their relationship with X would not have been possible without doing so. This would not however have obviated the potential to explore the nature of the relationship directly with Y.

13.26 **Y's perspective on the Muslim Community**

13.27 In June 2014 Y informed his Offender Manager that he often spent time in an area of Stoke-on-Trent with a significant Muslim population as he liked the Muslim Community. There is no indication that this statement, which seems rather odd to make without the benefit of hindsight knowledge that Y had commenced his relationship with X, was explored with Y.

[8] Crohn's disease is a long-term condition that causes inflammation of the lining of the digestive system.

13.28 **Change in Y's appearance - 2014**

13.29 Also in June 2014 Y contacted the Police to check when he was required to renew his sex offender registration and was informed that it had been the day before.

13.30 During this phone call Y specifically enquired if anything would happen to him when he went to the police station. The Review Panel speculated that this call may have, at least partially, been to probe whether the Police had any knowledge of his undisclosed relationship with X.

13.31 Y arranged to visit the Police Station that day. When he did so Y was photographed to update his ViSOR record and for that he insisted on keeping his hat on. The Review Panel concluded that this was likely to have been because he had already changed his overall appearance (see below) and wished to disguise this. The Police made an appropriate recommendation on adopting best practice regarding removal of headgear for the taking of identification photographs.

13.32 During July and August 2014 both Y's Offender Manager and his Risk Assessor noted that he had lost weight, let his hair grow longer and changed his overall appearance; discarding a cloth cap which had formerly been regular attire and wearing jeans and a leather jacket. This appropriately led the Risk Assessor to take a further photograph to update Y's ViSOR record.

13.33 Y was questioned about this change of appearance but denied that there was anything behind it and maintained that he was not in a relationship when explicitly asked about this.

13.34 In August 2014 Y was also asked by his Risk Assessor about a London Underground ticket that was seen at his flat. His explanation that he had gone to London for the day to buy clothes was not however explored further.

13.35 The conditions of Y's licence did not require him to hand over mobile phones, but the Risk Assessor did check the contents of the phone which Y produced and no evidence of a relationship was found. It was however recognised by the Risk Assessor at the time that this may not have been the only phone used by Y.

13.36 The Offender Manager discussed Y's change in appearance with the Police Risk Assessor and although concluding that there was no evidence that Y was in a relationship both agreed to monitor this.

13.37 **Professional Curiosity**

13.38 Whilst, as noted above, the management of Y was in most respects robust and compliant with the relevant local and national guidance the Review Panel considered that the professionals supervising Y could have beneficially exercised greater curiosity when faced with developments in Y's routine and presentation.

13.39 The Police report highlights that the introduction from April 2015 of the Active Risk Management System (ARMS) which is described at Appendix C is intended to promote a more intrusive investigative focus to the management of sex offenders. The Police report made appropriate recommendations regarding the use of that model and on addressing the consequential impact on resource capacity.

13.40 These considerations apply equally to Probation Service staff supervising such offenders. It is therefore positive that training of all relevant Probation Service staff in the use of ARMS was completed in December 2015 and the system will be fully implemented for sex offender cases by June 2016.

14 Murder of X

14.1 On an evening in November 2014 Y visited the address which X shared with other students, entered her bedroom and stabbed her numerous times with a knife that he had brought with him. X escaped from her bedroom but collapsed on the pavement outside her home address. The Police and Ambulance Service were summoned by one of X's housemates and attempts were made to resuscitate X without success.

14.2 Y was arrested nearby and subsequently charged with murder of X.

14.3 In 2015 Y pleaded guilty to the murder of X. He was subsequently sentenced to life imprisonment.

14.4 There is no indication that the ethnicity of X was in any way a factor in her relationship with Y or her murder.

CONCLUSION

15.1 Y's relationship with X was not known to any professional prior to her murder and it is clear that Y had no intention of disclosing the existence of it.

15.2 There were opportunities for the professionals supervising Y to exercise greater curiosity regarding developments in his routine and presentation. This may have improved the understanding of the risk that he posed but within the supervision framework appropriate to Y's risk level it is highly unlikely that the relationship would have been discovered.

15.3 Even if it had been known, X was an adult and there was nothing in her situation which would have provided a basis for professional intervention in the relationship. Furthermore there was nothing in the risk profile of Y, or in the hindsight view available to this Review, that would have suggested that Y posed a risk of physical violence towards X or any other individual.

15.4 The Review therefore concluded that the murder of X was not predictable or preventable.

RECOMMENDATIONS

16.1 The Review Panel made one recommendation from this Review:

That Staffordshire Police and the National Probation Service consider how the professional curiosity of staff supervising offenders might be enhanced, including in conjunction with the use of the Active Risk Management System (ARMS).

16.2 Recommendations for action to improve their services were also made by the agencies which contributed to this Review. These recommendations are provided at Appendix D.

16.3 Implementation of action plans arising from recommendation of the Review Panel and the contributing agencies will be monitored under arrangements agreed by the Stoke-on-Trent Responsible Authorities Group.

Appendix A

DOMESTIC HOMICIDE REVIEW TERMS OF REFERENCE

1 Introduction

1.1 The Terms of Reference for this Domestic Homicide Review (DHR) have been drafted in accordance with the Staffordshire and Stoke Multi-agency Guidance for the Conduct of Domestic Homicide Reviews, hereafter referred to as "the Guidance".

1.2 The relevant Community Safety Partnership (CSP) must conduct a DHR when a death meets the following criterion under the Domestic Violence, Crime and Victims Act (2004) section 9, which states that a domestic homicide review is:
A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

1.3 An 'intimate personal relationship' includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

1.4 A member of the same household is defined in section 5(4) of the Domestic Violence, Crime and Victims Act [2004] as:

- a person is to be regarded as a "member" of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;
- where a victim (V) lived in different households at different times, "the same household as V" refers to the household in which V was living at the time of the act that caused V's death.

1.5 The purpose of undertaking a DHR is to:

- **Establish** what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- **Identify** clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- **Apply** these lessons to service responses including changes to policies and procedures as appropriate; and
- **Prevent** domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

2 Background:

2.1 In about April / May 2014 the victim and perpetrator began a relationship. The perpetrator visited the victim's address which she shared with other students in November 2014, entered the victim's bedroom and stabbed her numerous times with a knife that he had brought with him. The victim escaped from her bedroom but due to the severity of her injuries collapsed and died soon afterwards on the pavement outside her home address. The perpetrator was arrested by Police a short distance from the address and is charged with the murder of the victim.

3 Grounds for Commissioning a DHR:

3.1 A DHR Scoping Panel met on 1 December 2014 to consider the circumstances. The Panel agreed that the following criteria for commissioning a Domestic Homicide Review had been met:

CRITERIA:	
There is a death of a person aged 16 or over which has, or appears to have, resulted from violence, abuse or neglect.	**X**
The alleged perpetrator was related to the victim or was, or had been, in an intimate personal relationship with the victim.	**X**
The alleged perpetrator is a member of the same household as the victim	

3.2 The recommendation to commission this Review was endorsed by the Chair of the Stoke-on-Trent Responsible Authorities Group.

4 Scope of the DHR

4.1 The Review should consider the period that commences from 1 September 2013 (when she started university in Stoke-on-Trent) in respect of the victim and from 1 October 2010 (when he was released from prison at the end of a sentence for indecent assault on a child) in respect of the perpetrator; up to the date of the victims death in November 2014. The focus of the DHR should be maintained on the following subjects:

Name	X	Y
Relationship	Victim	Perpetrator
Age	20	68
Date of Death	November 2014	N/A
Ethnicity	Asian	White British

4.2 A review of agency files should be completed (both paper and electronic records); and a detailed chronology of events that fall within the scope of the Domestic Homicide Review should be produced.

4.3 An Overview Report will be prepared in accordance with the Guidance.

5 Individual Management Reviews (IMR)

5.1 Key issues to be addressed within this Domestic Homicide Review are outlined below as agreed by the Scoping Panel. <u>These issues should be considered in the context of the general areas for consideration listed at Appendix 10 of the Guidance.</u>

- Management of the perpetrator as a registered sex offender released from prison on licence

5.2 Individual Management Reviews are required from the following agencies:

- Heantun Housing
- National Probation Service
- Staffordshire Police

5.3 IMR Authors should have no line management responsibility for either the service or the staff who had immediate contact with either the subjects of the DHR or their family members. IMRs should confirm the independence of the author, along with their experience and qualifications.

5.4 Where an agency has had involvement with the victim and perpetrator and/or other subject of this Review, a single Individual Management Report should be produced.

5.5 Background information and a summary of any significant and relevant events outside of the period considered by the review should be included in the IMR.

5.6 In the event an agency identifies another organisation that had involvement with either the victim or perpetrator, during the scope of the Review; this should be notified immediately to Graeme Drayton, Stoke-on-Trent City Council, to facilitate the prompt commissioning of an IMR / Summary Report.

5.7 Third Party information: Information held in relation to members of the victim's immediate family, should be disclosed where this is in the public interest, and record keepers should ensure that any information disclosed is both necessary and proportionate. All disclosures of information about third parties need to be considered on a case by case basis, and the reasoning for either disclosure or non-disclosure should be fully documented. This applies to all records of NHS-commissioned care, whether provided under the NHS or in the independent or voluntary sector.

5.8 Staff Interviews: All staff who have had direct involvement with the subjects within the scope of this Review, should be interviewed for the purposes of the DHR. Interviews should not take place until the agency Commissioning Manager has received written consent from the Police Senior Investigating Officer. This is to prevent compromise of evidence for any criminal proceedings. Participating agencies are asked to provide the names of staff who should be interviewed to Graeme Drayton, Stoke-on-Trent City Council, who will facilitate this process. Interviews with staff should be conducted in accordance with the Guidance.

5.9 Where staff are the subject of other parallel investigations (including disciplinary enquiries) consideration should be given as to how interviews with staff should be managed. This will be agreed on a case by case basis with the Independent Review Panel Chair, supported by Graeme Drayton, Stoke-on-Trent City Council.

5.10 Individual Management Review reports should be quality assured and authorised by the agency commissioning manager.

6 Summary Reports

6.1 Summary Reports are required from the following agencies:

- NHS England in respect of primary care services

- Staffordshire University
- University Hospitals of North Midlands NHS Trust
- West Midlands Ambulance Service

6.2 The purpose of the Summary Report is to provide the Overview Report Author with relevant information which places each subject and the events leading to this review into context.

6.3 Summary Reports should be quality assured and authorised by the agency commissioning manager.

6.4 In the event an agency identifies another organisation that had involvement with either the victim or perpetrator, during the scope of the Review; this should be notified immediately to Graeme Drayton, Stoke-on-Trent City Council, to facilitate the prompt commissioning of an IMR / Summary Report.

7 Parallel Investigations:

7.1 Where it is identified during the course of the Review that policies and procedures have not been complied with agencies should consider whether they should initiate an internal disciplinary processes. Should they do so this should be included in the agency's Individual Management Review.

7.2 The IMR report need only identify that consideration has been given to disciplinary issues and if identified have been acted upon accordingly. IMR reports should not include details which would breach the confidentiality of staff.

7.3 The Police Senior Investigating Officer (SIO) should attend all Review Panel meetings during the course of the Review.

7.4 The SIO will act in the capacity of a professional advisor to the Panel, and ensure effective liaison is maintained with both the Coroner and Crown Prosecution Service.

8 Independent Chair and Overview Report Author

8.1 The Review Panel will be chaired and the Overview Report prepared by Chris Few, an Independent Consultant. Mr Few has chaired review panels and written overview reports on behalf of numerous Community Safety Partnerships, Local Safeguarding Children Boards and Local Authorities in connection with Domestic Homicide Reviews and Serious Case Reviews. He has no personal or professional connection with any of the agencies and professionals involved in the events considered by this Review.

9 Domestic Homicide Review Panel

9.1 The Review Panel will comprise senior representatives of the following organisations:

- Arch
- Heantun Housing
- National Probation Service
- NHS England
- Staffordshire Police
- Staffordshire University

- Stoke-on-Trent City Council

10 Communication

10.1 All communication between meetings will be in confirmed in writing and copied to Graeme Drayton, Stoke-on-Trent City Council, to maintain a clear audit trail and accuracy of information shared. Email communication will utilise the secure portal established by Stoke-on-Trent City Council for that purpose.

11 Legal and/or Expert Advice

11.1 Graeme Drayton, Stoke-on-Trent City Council, in consultation with the Independent Review Panel Chair, will identify suitable experts who would be able to assist the Panel in regard to any issues that may arise.

11.2 However, the Individual Management Review Authors should ensure appropriate research relevant to their agency and the circumstances of the case is included within their report.

11.3 The Overview Report will include relevant lessons learnt from research, including making reference to any relevant learning from any previous DHRs and Learning Reviews conducted locally and nationally.

12 Family Engagement

12.1 The Review Panel will keep under consideration arrangements for involving family and social network members in the review process in accordance with the Guidance. Any such engagement will be arranged in consultation with the Police Senior Investigating Officer and, where relevant, Family Liaison Officer.

12.2 The Independent Review Panel Chair will ensure that at the conclusion of the review the victim's family will be informed of the findings of the review. The Responsible Authorities Group will give consideration to the support needs of family members in connection with publication of the Overview Report.

13 Media Issues

13.1 Whilst the Review is ongoing the Staffordshire Police Media Department will coordinate all requests for information/comment from the media in respect to this case. Press enquiries to partner agencies should be referred to the Police Media Department.

14 Timescales

14.1 The review should be completed and submitted to the Chair of the Responsible Authorities Group by 1 June 2015.

Appendix B

Multi–Agency Public Protection Arrangements (MAPPA)[9]

1.1 Multi-Agency Public Protection Arrangements (MAPPA) were introduced by the Criminal Justice and Courts Services Act 2000 and strengthened under the Criminal Justice Act 2003.

1.2 They are the arrangements in England and Wales for ensuring that all MAPPA offenders are identified and notified to the Public Protection Unit (PPU) within the National Offender Management Service (NOMS) and for coordinating the work of the Responsible Authorities in the management of such offenders.

1.3 The Responsible Authorities for MAPPA include the National Probation Service, HM Prison Service and the Police Forces of England and Wales.

1.4 All of these agencies use the ViSOR national IT system for the management of people who pose a serious risk of harm to the public.

1.5 MAPPA offenders are categorised as:

- **Category 1:** Registered Sex Offenders.

- **Category 2:** Violent Offenders and Other Sexual Offenders. These are all offenders who have received a custodial sentence of 12 months or more in prison for a sexual or violent offence and whilst they remain under Probation supervision.

- **Category 3:** Other Dangerous Offenders: A person, who has been cautioned, reprimanded, warned or convicted of an offence which indicates that he or she is capable of causing serious harm and requires multi-agency management at level 2 or 3.

1.6 Offenders can only be identified in one of the three Categories at a time. Where two categories may be applicable the lower numbered one takes precedence.

1.7 Legislation requires that the agencies conduct a formal risk assessment of each offender and allocate them to a tier of multi-agency management; known as level one, two or three. An offender should be managed at the lowest appropriate level determined by defensible decision making.

- **Level One:** represents the normal inter-agency management of the offender in the community by one agency, with some liaison.

- **Level Two:** means that Multi Agency Public Protection (MAPP) meetings will be held where the offender's management will be discussed between agencies involved in their case.

- **Level Three:** is essentially the same as Level Two, except that senior management representatives will be in attendance and greater resources are expected to be used in the management of the offender.

[9] The description of MAPPA in this section reflects the arrangements in Stoke-on-Trent and Staffordshire. While working within the same legislative and guidance framework the staffing and coordination arrangements may differ in other areas of England and Wales.

1.8 To inform this and the management of the offender they are assessed[10] to determine the degree to which they pose a risk of serious harm to the public. The following definitions are used:

- **Low** – Current evidence does not indicate a likelihood of causing serious harm.

- **Medium** – There are identifiable indicators of serious harm. The offender has the potential to cause such harm, but is unlikely to do so unless there is a change in circumstances, for example failure to take medication, loss of accommodation, relationship breakdown, and drug or alcohol misuse.

- **High** – There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

- **Very High** – There is an imminent risk of serious harm. The potential event is more likely than not to happen immediately and the impact would be serious.

1.9

1.10 The National Probation Service[11] is responsible for and takes the lead in management MAPPA offenders released in licence from Prison. Where a Registered Sex Offender is involved the allocated Offender Manager works in parallel with the Police. Within this arrangement it is essential that the two agencies establish good levels of communication where each is aware of the other's activities in managing the offender. This activity must be recorded on all case management systems, including ViSOR.

1.11 The Police are responsible for managing MAPPA Category 1 offenders (Registered Sex Offenders) in the community. They ensure that offenders:

- Register as required by legislation.

- Are assessed by suitably trained staff

- Are visited at their registered address. Home visit schedules are assessed, planned, managed and reviewed on a case by case basis. Suggested good practice for medium risk offenders is to visit every six month.

- Are regularly reviewed.

- Have their ViSOR records maintained in accordance with national standards.

1.12 The Association of Chief Police Officers (ACPO) 2010 Guidance on Protecting the Public: Managing Sexual and Violent Offenders provides guidance on planning and conducting home visits. The document states that the purposes of home visits are to;

- Check compliance with legislation and court orders e.g. to ensure notification requirements, bail or licence conditions are being complied with.

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[10] The static risk assessment tool used by Staffordshire Police is Risk Matrix 2000 (RM2000). This is used specifically for males aged at least eighteen years old who have been convicted of a sexual offence with at least one of these sexual offences committed after the age of sixteen.

RM2000 is supplemented by and used in conjunction with dynamic risk assessment which takes into account risk factors such as mental health, drugs and alcohol use, stable employment and suitable accommodation.

The National Probation Service also uses RM2000 to inform their OASys tool, used for undertaking and recording all formal risk assessments and sentence plans.

[11] And formerly in Stoke-on-Trent its predecessor organisation, the Staffordshire and West Midlands Probation Trust.

- Confirm that the offender resides or frequents the address or place notified.
- Fulfil the duty of care to the public to manage the risk posed by the offender.
- Monitor the risk of the particular offender, identify changes in risk factors and ensure appropriate action is taken to manage and, where necessary, review the risk.
- Gather information for risk identification or review, assessment and management of the particular offender and other linked offenders and for intelligence management processes.
- Detect offences.
- Fulfil the duty of care to the offender including referral to other agencies for the provision of welfare, mentoring and support.

1.13 Staffordshire Police has established a Violent and Sex Offender Management (VSOM) team within the Public Protection Department to undertake this role. The Police Officers managing MAPPA offenders are known as Risk Assessors. Each offender is allocated a specific Risk Assessor to provide continuity for the offender and for the risk management of the offender.

Appendix C

Active Risk Management System

1.1 The Active Risk Management System (ARMS) is a new risk management tool for sexual offenders which was mandated for use by all of the Police Forces in England and Wales from April 2015. It provides a national research based standard for the risk assessment of sexual offenders and risk management planning. Of particular note it is designed to support an investigative approach to risk management and the use of an investigative mind-set.

1.2 The focus of ARMS is on the risk and protective factors that are an integral part of a robust risk management plan.

1.3 Risk factors are identified as:

- Opportunity.
- Sexual pre-occupation.
- Offence related sexual interests.
- Emotional congruence with children.
- Poor self –management.
- Hostile orientation.
- Anti-social influences.

1.4 The protective factors are identified as:

- Pro-social networks.
- A commitment to desist.
- Intimate relationship.
- Positive routine including employment.
- Social investment.

Appendix D

Management Review Recommendations

1 National Probation Service

1.1 Review the Offender Manager's caseload to ensure that his OASys are up to date for all of offenders he is offender managing.

1.2 Review back-up systems for tracking OASys completions within the Offender Manager's office. This system is designed to provide a back-up to Offender Managers to ensure that all risk assessments are up to date.

1.3 Work to address alcohol use should be undertaken with all offenders where it is identified as linked to risk, even if there is no evidence of current use. This should help relapse prevention in the future.

2 Staffordshire Police

2.1 For Staffordshire Police to review the structure and the staffing of the Violent and Sex Offender Management (VSOM) team.

2.2 For Staffordshire Police to review the introduction and effectiveness of the ARMS risk management tool.

2.3 For Staffordshire Police to review and ensure that all risk management plans for Registered Sex Offenders are SMART.

2.4 For Staffordshire Police to adopt best practice concerning the removal of headgear when taking identification photographs of ViSOR subjects.

2.5 For Staffordshire Police to ensure that all the relevant staff within the VSOM team are trained in ARMS.

2.6 For Risk Assessors to ensure that all the relevant fields within each ViSOR record are fully complete.

2.7 For the Senior Management Team within Public Protection to consider ways to raise the profile of the VSOM team and develop better organisational understanding of the work that they do.

2.8 For Staffordshire Police to implement any recommendations that are made following the completion of the research commissioned by DCC Skeer.