DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Into the death of

Jessica in November 2015

Report Author

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The Castle Point & Rochford Community Safety Partnership and the Review Panel members would like to express their sincere condolences to Jessica's family. We are very aware of how much she is missed and the enormous gap her loss has left in their lives.

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1 The Review Process:

1.1 This summary outlines the process undertaken by the Castle Point & Rochford Community Safety Partnership Domestic Homicide Review Panel in reviewing the murder of a resident in the Castle Point Borough Council area.

1.2 Following a Police investigation and criminal trial the perpetrator was found guilty of murder. He was sentenced to a whole life tariff of imprisonment.

1.3 The Review process began with a meeting called by the Chair of the Community Safety Partnership on 2 December 2015 where the decision was taken that the circumstances of the case met the requirements to undertake a Domestic Homicide Review. The Home Office was notified of this decision on the day the decision was taken. This process complied with the timescales required by statute. The Review was concluded on 9 November 2016. This is over the statutory guidance timescale to complete a Review in 6 months due to the criminal proceedings. The Home Office was informed of this delay on 4 April 2016. The Review was able to be completed within 6 months after the trial. The Review remained confidential until the Community Safety Partnership received approval for publication by the Home Office Quality Assurance Panel.

Agencies Participating in the Review

1.4 A total of 20 agencies were contacted and 8 responded has having had involvement with the individuals involved in this Review; 12 had no contact. Agencies participating in this Review and the nature of their contribution as follows:

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

The victim's family have also contributed to this Review.

1.5 To protect their identity and maintain the confidentiality of the victim, perpetrator, and their family members pseudonyms have been used throughout the Review. They are:

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

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

1.6 Purpose and Terms of Reference for the Review:

The purpose of the Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- To seek to establish whether the events leading to the homicide could have been predicted or prevented.
- This Domestic Homicide Review is not an inquiry into how the victim died or who is culpable. That is a matter for the coroner and the criminal court.

Specific Terms of Reference for the Review:

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

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

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

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

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

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

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

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

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

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

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

1.7 Agencies were asked to give a chronological account of their contact with the victim and perpetrator prior to her death. Where there was no involvement or insignificant involvement, agencies advised accordingly.

Summary of Agencies Contact:

1.8 The perpetrator William Smith has a long history of violence, especially towards women, which brought him into contact with criminal justice agencies. It is known that he witnessed significant domestic abuse as a young child. His first violent offence was age 17 years when he slashed another youth across the face with a Stanley knife. Aged 21 years he was arrested for rape. He had invited the victim back to his flat and approached her for sex, and when she refused William Smith assaulted her by grabbing her around the throat and punching her in the face; he then raped her. He was convicted at the Central Criminal Court for a reduced offence of Actual Bodily Harm and sentenced to 2 years imprisonment. He was released from prison on 24 April 1989 on licence, but just over 3 months later following a very short relationship he attempted to murder a 17 year old female. He became very jealous and when the victim refused to have sex with him and he attempted to strangled her, cut her many times with a carving knife and stamped on her throat. He fled to Ireland after this offence with the assistance of his father. His licence was recalled on 29 August 1989, but he was not apprehended for this offence until he was arrested for strangling another partner in 1993 after she told him their relationship was over and he had to leave. At his trial for the murder and the previous attempted murder the judge commented that he had "an inability to tolerate rejection by women". His offence history is as follows:

5 Offences against the person including:

- Wounding with intent to cause grievous bodily harm - May 1984: Community Service Order 150 weeks
- Assault occasioning bodily harm - October 1988: 2 years imprisonment (offence downgraded from rape charge)
- Murder and wounding - June 1994: Life imprisonment minimum tariff 16 years & 5 years (concurrent)
- Theft and kindred offences
- Offences relating to Police/Courts and Prisons

1.9 Whilst in prison William Smith attended a number of courses to address his offending behaviour, including the Healthy Relationships programme, and the Integrated Domestic Abuse Programme (IDAP). He was also subject to a Domestic Abuse Risk and Needs Analysis carried out by a prison psychologist to assess the ongoing risk he might

pose to future partners. His release from prison was delayed to enable him to complete courses judged necessary, as a result he served 2 years over his sentence tariff. Behaviour raising concern from his previous offence identified in the Domestic Abuse Risk & Needs Analysis included:

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

Protective factors were:

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

Warning signs might include:

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

1.10 Prior to William Smith's release from prison an initial MAPPA[1] meeting took place on 15 February 2012 where the decision to manage him at Level 1 was ratified. However, after reviewing his offending history the Essex Police MAPPA coordinator raised concerns as the officer observed that William Smith had not been in the community for any length of time without committing violent attacks on women and considered him to be a serious risk. In March 2012 the MAPPA level was raised to level 2. However, there is no record of other agencies attending MAPPA meetings other than the responsible authorities of Probation, Police and Prison. In line with MAPPA guidance a ViSOR[2] nominal record was raised by Essex Probation.

1.11 William Smith was released to Probation Approved Premises on 30 March 2012. His licence contained conditions for him to reside at Approved Premises and thereafter as directed by his supervising officer; to disclose emerging intimate relationships with women, not to contact directly or indirectly the victim or family [from the previous crimes] and to comply with any requirements specified by his supervising officer to address alcohol misuse, offending behaviour and any medical assessments and treatment (counselling, mental health referrals). He was to be subject to alcohol and drug testing at the Approved Premises (all tests were negative), and the Job Centre had been notified on 30 April 2012 of any restrictions in terms of future employment. Essex Police recommended that the licence should include a requirement to submit to Police monitoring visits, however, the Parole Board considered this inappropriate. Instead a joint visit between the Police and Probation took place to William Smith's Approved Premises accommodation on 11 May 2012.

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

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

1.12 Whilst in Approved Accommodation William Smith contacted Castle Point Borough Council Housing Department on 13 April 2012 requesting housing assistance as he said he had to leave the bail hostel by mid-May. He disclosed his length of time in prison and that he was having weekly contact with the Probation Service. He reported that he had friends and family who could assist with a deposit. He was given general advice regarding rental accommodation and crisis loan.

1.13 A risk assessment was completed by probation officer 1 on 1 May 2012 and the following day, a further MAPPA meeting was held at which it was unanimously agreed to reduce management to MAPPA Level 1; thereafter William Smith was managed by Essex Probation, however the duty of all agencies to share information remained. This was reinforced at the final MAPPA level 1 meeting on 18 July 2012 where it was recorded in the minutes that an action was allocated to all agencies '*To liaise outside of MAPPA, particularly in relation to developing relationships'.* Any agency could refer back for discussion if required.

1.14 William Smith was seen for weekly supervision by Probation in line with life licence guidance until it was judged appropriate to gradually reduce this over time to monthly. At the beginning of June 2012 there was activity by Probation and William Smith to find move on accommodation. The Housing Department was informed by William Smith's his probation officer of his MAPPA status and imminent housing need. On the same day, William Smith made further contact with the Housing Department himself regarding housing; he reported that family were no longer able to assist with a deposit. He claimed to have had no advice or assistance from Probation regarding housing, however the Probation chronology clearly shows he had the support of his probation officer and the Probation housing liaison officer and he was being empowered to be proactive himself to arrange his accommodation. He informed the housing officer that he was a MAPPA offender and gave the name of his probation officer. The Council housing officer contacted the Probation Service and expressed concern regarding the lack of communication and difficulties in resolving housing issues, and about arrangements being made at short notice.

1.15 William Smith submitted a homelessness application on 1 July 2012; Housing case notes recorded that he was MAPPA managed. He was offered temporary accommodation after checks were made with Probation as to whether any restriction regarding children or vulnerable adults needed to be considered when housing him. No such restrictions were noted. There was liaison between his probation officer and a Local Authority housing officer who was advised that William Smith was being managed under MAPPA, and a joint visit with William Smith by the housing officer and his probation officer to his planned move-on independent accommodation took place on 10 July 2012. The joint visit was reported verbally to the Housing Department Individual Management Review report author; it was not recorded on the Housing Department system. On 13 July 2012 a permanent housing application was submitted for William Smith. There was no mention of MAPPA on this application document to this Housing Department which had a separate databases to the Temporary Housing Department at this time, therefore knowledge of his MAPPA status was not known by this department.

1.16 William Smith moved to a flat in the Castle Point area, and on 28 August 2012 Essex Police were informed by Probation of his new address. He was assessed by Probation as adjusting well after release and had the support of his family, although it was noted that he expressed some frustration that he could not find work.

1.17 During late 2012 - early 2013 William Smith was in contact with the Local Authority relating to rent arrears, and in March 2013 Housing Department records show that he

attended the office to report that his Job Seekers Allowance had ceased as he was deemed not to be looking for work.

1.18 In August 2013 William Smith stole a television and food items valued at £160 from a large supermarket. He received a 12 month Conditional Discharge and a £15 fine. He did not immediately disclose this offence to his offender manager, nor were they informed by the Police of the arrest. A Probation senior manager sanctioned the sending of a warning letter to William Smith.[3]

1.19 William Smith was again arrested for theft from a supermarket in September 2013 when he stole groceries valued at £29.37. He was sentenced to one day's detention deemed served after he pleaded guilty. No further action was taken on the breach of the Conditional Discharge which was to continue for the remaining 11 months. The court would have been updated and known about his life licence; the decision to impose a sanction or not for the breach of the Conditional Discharge is at the Court's discretion. William Smith was given a final warning on his licence and as part of this he was instructed to attend the Bridge Project which provided a period of intensive community supervision and intervention.

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

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

1.22 William Smith was allocated to probation officer 3 in May 2014. During this period of his supervision the focus was on employment and financial management. He secured work in November 2014 and informed the Housing Benefit Department; his benefit was reassessed. There followed a period of difficulties in keeping up with his rent and on 12 February 2015 a Notice of Seeking Possession was served for non-payment of rent. However, on 17 February 2015 William Smith contacted the Rents Department to advise them that he was now claiming Job Seekers Allowance and he put in a claim for housing benefit. However, his Probation records show that he did not report to his probation officer that he was made redundant in May 2015 until October 2015. Rent Department records suggest that he was already out of work in February 2015 or being untruthful about being in receipt of Job Seekers Allowance to gain housing benefit.

1.23 Jessica's family suggest that she probably met William Smith when she was staying temporarily in a ground floor flat with a friend after her own property was affected by flood water during floods in July 2014. They believe William Smith was living in the first floor flat above, and suspect that Jessica and her friends would have socialised with

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

him through the network of friends who used drugs and drank alcohol together. However the actual time they met cannot be confirmed.

1.24 Jessica suffered from mental ill-health. She had a diagnosis of Bi-Polar Affective Disorder and Emotionally and Unstable Personality Disorder; she was well known to mental health services. Her health condition and consequent behaviour and lifestyle frequently put her at risk and she was vulnerable. Jessica had been a victim of domestic abuse in previous relationships which had involved the attendance of the Police, and on a few occasions she had also been seen as the aggressor. Her Bi-Polar Disorder meant she could be unpredictable; sometimes low in mood, caring, and accepting of her family's love and support, and sometimes manic, impulsive and volatile. Jessica was capable of insight into her condition on occasions and would seek help. In 2013 she was detained under Section 2 of the Mental Health Act due to a deterioration in her mental health precipitated by non-compliance with her medication, disengagement with services, and poly-substance misuse. There were also times where she disengaged from services and ignored all attempts to contact her. In early 2015 staff made several attempts to re-engage her through contact with her mother, her housing support worker at Family Mosaic, and via letters put through the door at her home and her temporary accommodation, however these were unsuccessful.

1.25 January 2015 appears to have been a time when Jessica realised she needed support with the practical side of her life. She referred herself for support from Family Mosaic[4] for a range of issues including benefits, debts and financial management, property repairs, and her difficulty in managing and keeping various appointments. After a period of assessments Jessica was allocated a support worker and during 2015 she had the consistent support of the same person from the end of May 2015. Her support worker was aware of Jessica's mental ill-health and her brief periods of stability, when she abstained from drugs and alcohol, and when she relapsed. Contact with Jessica or advocacy with agencies on her behalf was very frequent. During this period Jessica was rejecting contact from mental health services.

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

1.27 William Smith was only seen once by a Family Mosaic male support worker on 27 July as he had cancelled a previous appointment due to attending the Jobcentre. He reported that he had settled his electricity debt and power had been reinstated. William Smith advised his support worker that he no longer needed the support as he had been offered a job for 40 hours per week and felt he would be able to address his debts with his increased income.

[4] Family Mosaic is a registered social landlord who provide tenancy support services.

1.28 William Smith contacted Family Mosaic for a second time in August 2015; he stated that he could not afford white goods and he asked if a charity could be approached. An application to a charity was explored, but when the support worker tried to arrange a visit to him via text they received no reply. A voicemail was eventually left by William Smith to say he no longer required support. Anecdotal evidence from Jessica's family from information in the local community suggests William Smith sold his white goods to pay off gambling debts. He was known to frequent local betting shop and was seen t information. However, following his arrest for Jessica's murder William Smith did admit in an interview with his probation officer that he had started gambling at this time.

1.29 Between July and September 2015 Jessica self referred to the Improving Access to Psychological Therapies Service. In line with the service policy Jessica was assessed by telephone. However, although contact with her was established on two occasions, she declined further services. During her last contact on the 24 September she said that she was going to return to the Community Mental Health Team whom she called on 29 September 2015. The call taker described Jessica as being in a very agitated state, and it was difficult to understand her reasons for calling as she was speaking loudly to someone else in the background at the same time. Jessica said that she needed admission as she had thoughts of harming others. Support and advice was attempted on how to re-access services through the South Essex Partnership Trust Rapid Assessment Interface and Discharge Team (Liaison Psychiatry) based at a nearby hospital and the team were informed of Jessica's call as the Duty Worker was unable to ascertain the details.

1.30 September 2015 appears to have been a very unsettled time for Jessica. During a home visit by her Family Mosaic support worker Jessica reported that she had a gun in her house. This was not probed further at the time as her support worker was well attuned to Jessica's moods and did not wish to escalate the situation, instead the matter was referred to the Police. As there was no firm evidence to act on no warrant was issued to search Jessica's home. Family Mosaic informed the Local Authority Housing Department in case officers were to visit Jessica at home. It was not substantiated whether there was a gun in the property or not.

1.31 On 14 October 2015 Jessica reported to the Police that someone had tried to set fire to sand bags and damaged her front door, however Police enquiries implicated Jessica as being responsible. On 15 October Jessica's support worker recorded the incident concerning the scorched property, Jessica had no money having spent it or lent it to friends, and she wanted to admit herself to the Mental Health Unit. Jessica was taken by her mother to the hospital Accident & Emergency Department suffering from suicidal thoughts and voluntarily admitted to a Mental Health Assessment Unit on 17 October 2015. Jessica had stated that she was no longer able to cope with the numerous social issues she faced, in the main the flooding of her home and the recent death of her dog. Following a period of psychiatric assessment Jessica improved and her suicidal thoughts reduced. On 21 October the decision was made that she was fit to be discharged, following which Jessica was arrested for arson by the Police and bailed until 23 November to enable further enquires to be made.

1.32 Jessica was referred from the hospital Mental Health Unit to the Crisis Response and Home Treatment Team with a planned re-referral for on-going support. However, her actions suggest that she was still in a vulnerable and volatile state of mind. The Home Treatment Team was unable to contact Jessica for follow up and she failed to attend an outpatient appointment, nor did her mother know her whereabouts, therefore an incident alert was raised on 30 October 2015 and the Police were contacted. Numerous checks were made at Jessica's home address, but she could not be traced. On 1 November 2015 Jessica arrived briefly at her parent's home. They confirm that

she arrived in a car with a new boyfriend saying that she was going to make a new life in Luton. The new boyfriend was not William Smith. Mental health services contacted their opposite number in Luton in case Jessica should approach services there. However, the next day Jessica phoned her support worker at Family Mosaic confirming she would be attending a local appointment, but she then failed to appear. On the 4 November the cessation of support was discussed with Jessica and she agreed to use the local drop-in facilities.

1.33 On 22 October 2015 William Smith consulted his GP and he appears to have given his offending history which is recorded as: *"He was in prisons all over UK from 1993 to 2013 because he killed a woman, his girl friend, with his hand. He was released into probation which used to be weekly then fortnightly & has been monthly for the past 8 months or so".* He informed the GP that his crime took place in London, that he was released into a hostel in Basildon and then moved to a council flat. William Smith reported to the GP that he was suffering from panic attacks and anxiety and he requested a sick note. He said he had seen a counsellor the previous year, but he did not want to see the counsellor again. He maintained that he was not suicidal. A patient health questionnaire use to assess levels of depression was completed and he was prescribed Citalopram and asked to return for review in one month. He returned on 4 November 2015 requesting sick leave for 3 months for panic attacks and anxiety. Medication was prescribed and a sick note issued. On 11 November he reported that he had lost his sick certificate. A duplicate was issued. His GP had no contact details for his probation officer.

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

1.35 The cause of Jessica's death was determined to be blunt force trauma to the head and multiple stab wounds; she had suffered 40 stab wounds.

1.36 Information revealed during the investigation found that Jessica may have had a brief casual affair with William Smith, but it could probably not constitute the description of a 'relationship'. It is understood that Jessica had at some time gone to the flats where William Smith lived and shouted up to his window that she had a new boyfriend. Although anecdotal evidence to the Review Panel reported that a few friends had warned Jessica about William Smith, their warnings were not born out of any knowledge they had about his previous history, the friends warning appears to have purely instinctive, perhaps augmented by local knowledge of his behaviour in betting shops.

2 Key Issues Arising from the Review:

Management of the Offender

2.1 The lessons and key issues arising from this Review are primarily to be drawn concerning the management of the perpetrator. The victim Jessica, was a vulnerable young woman who had her challenges due to her mental ill-health. She was truly an innocent victim unaware that her sometimes unpredictable actions which most reasonable men would ignore, would be lighting the touch paper of William Smith's intolerance of rejection by women and would unleash such terrible violence by a man

who took no responsibility for his actions. Even at his trial, in the face of irrefutable evidence he pleaded not guilty and tried to blame an innocent neighbour for the crime. His history of escalating violence from a young age, and the lack of early learning and change from his two previous non-fatal but very violent crimes, then continuing until he murdered, not once, but twice, suggests that similar domestic violence offenders need to be managed more carefully and thoroughly.

2.2 The offender's very clear risk assessments after his first murder conviction and whilst in prison, particularly of his risk to women and inability to cope with rejection by them, became lost over time. His management in the community following release on life licence became all about employment and financial management, and important though these subjects are for reintegration into society, his past history and risk to women was subsumed by these issues.

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

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

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

2.6 A review of the management of life licence offenders "considered that ensuring quality of input by offender managers and maintaining this consistency of approach was far more important than ensuring that the same person maintained the supervisory link with the offender",[5] thus quality of management and consistency of message to any offender by an offender manager about what is required of them, what is acceptable, and what is not, is more important. To successfully achieve this it is incumbent on anyone seeing an offender to read records and be clear what is expected of an offender before supervising them. This requires a whole team system approach, and gives the whole team responsibility for the management of life licence offenders.

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

MAPPA

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

Information Sharing

2.8 There is a need for greater information sharing between Probation and other agencies in the community with regard to those on life licence for serious crime. The Review recognises the resource pressures on Probation staff, therefore closer working with those agencies based in the communities where their offenders live is essential. Outside of MAPPA arrangements agencies can share information in prevention of crime under the Crime and Disorder Act 1998. Service providers outside the statutory sector could have formal information sharing and confidentiality agreements. Information on ViSOR[6] also needs to be accessed promptly to ensure that probation officers are notified of an offender's arrest as soon as possible rather than waiting for a court appearance.

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

Housing Location

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

Domestic Abuse and Support Awareness

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

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

domestic abuse, provided they are given the necessary information about resources and agencies to whom they can refer.

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

3 Conclusions:

3. 1 The Police were right in 2012 to raise concerns about the MAPPA level William Smith was to be subject to on his release from prison. In interview for the Police IMR the officer who challenged the decision said she was concerned that William Smith had never been in the community for any length of time without committing violent attacks on women and considered him a serious risk. This was an astute assessment. As one IMR commented, whilst he may have impressed the Parole Board with his behaviour in prison, and he may not have raised concerns whilst in Approved Accommodation on release, there was no real assessment and monitoring of how he would react when he had a relationship with a woman and whether his previous jealousy and violence would return. It is also worth comment that there is a significant difference between assessing the behaviour of an offender like William Smith in the controlled environment of prison and Approved Accommodation which are male environments, and gaining a meaningful assessment of his interactions with women.

3. 2 The Probation supervision lost sight of William Smith's serious past offending history of violence to women, and the nature of that violence. His was a pattern of conduct which escalated over time, triggers for which were clearly identified in the assessment after his sentence for his first murder and by the prison psychologist's assessment. If there has been previous domestic abuse risk rises, as prior domestic abuse is the highest risk behaviour for predicting future homicide[7]. William Smith had already committed a domestic abuse murder thus his risk was undoubtedly higher still; he was also said to be intolerant of rejection by women. Men who are unable to deal with rejection, or who feel powerless without control, have status issues or sociopathic or psychopathic traits, and are more likely to be the most dangerous kind of abusers[8].

3. 3 Perhaps the earlier assessments were not readily visible on William Smith's file, but even if this was the case the nature and the specific victims of his previous crimes, and the fact that he had to report relationships with women, should have heightened awareness of risk and a professional curiosity to investigate further. Instead the focus became matters such as employment and finances. In common with a finding by a Joint Inspection by HMI Probation and HMI Prisons there was an insufficient focus on victims' issues[9]. This does not mean that employment and finances are not important, indeed they can be life stressors which can impact on an offender's ability to integrate

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

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

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

into a regular law abiding life. Financial difficulties can impact on levels of stress and sometimes control of aggression, as well putting accommodation at risk. Nevertheless, there should have been a greater concentration on recognising his triggers and risk to others as well as challenging and checking his progress and information provided by him in supervision.

3. 4 William Smith's history means he should have been more closely supervised and checked up on to corroborate what he was reporting and what he was not. He failed to tell his probation officer about relationships, about his arrests for theft, and that he had been made redundant at the time he lost his job rather than months later. His failure to report the arrests should have been a flag to monitor him more closely. Housing did not appear to have the continuing links with his probation officer following his secure tenancy in order to report his rent arrears and threatened repossession of his flat. This third party information could have been valuable to his probation officer, but it appears that with the end of MAPPA level 2 meaningful inter-agency coordination also ended.

3. 5 The agencies in the community who had contact with William Smith appeared not have full details of the risk he posed to women. This formed a barrier to engendering a sense of professional curiosity about him, the circle of people who lived in the same flats, and those who were known to visit the accommodation. The value of support staff who know the people and the issues in a neighbourhood well is under appreciated and could have been a helpful resource for the Probation service tasked with supervising William Smith.

3. 6 William Smith consistently maintained that he did not feel able to form an intimate relationship because of his life licence. He did not disclose a relationship with anyone, including Jessica. Is it possible that by explicitly including the notification of emerging relationships into his licence that this acted as a perverse incentive to openness and the ability to bring to supervision any relationships or issues with women he may have had? Could this have created an unintentional barrier which increased risk to women?

3. 7 William Smith's previous extremely violent behaviour to women, suggests he not only had an inability to accept when a woman said 'no' or ended the relationship, but that he also wanted to control them. Sadly, Jessica's mental illness and other problems meant that she was very vulnerable, and her Bipolar condition meant that she was sometimes disinhibited and unpredictable; she was not a young woman who could be controlled. The fact that she also appears to have publicly rejected William Smith as his neighbour reported by calling out to him that she had a new boyfriend, unwittingly put her at severely high risk which ultimately proved fatal. Jessica would have been totally unaware of this. Had agencies been aware that Jessica was in his social circle and had a very brief relationship with him, then the risk of serious harm to her may have been predicted.

3. 8 Whilst research reveals that "The vast majority of life sentence prisoners are successfully integrated back into the community, with only 2.2% of those sentenced to a mandatory life sentence and 4.8% of those serving other life sentences reoffending in any way, compared to 46.9% of the overall prison population"[10], this does not minimise

[10] (25 July 2013), Table 19a, 'Adult proven re-offending data, by custodial sentence length, 2000, 2002 to September 2011', Proven re-offending tables- October 2010 to September 2011 , Ministry of Justice, London, https://www.gov.uk/government/publications/proven-re-offending-statistics-october-2010-to September-2011 cited in *A Joint Inspection of Life Sentence Prisoners 2013* page 6 A Joint Inspection by HMI Probation and HMI Prisons
http://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2014/04/Life-sentence-prisoners.pdf (accessed 4/11/16)

the terrible trauma caused to families such as Jessica's when one of this small cohort does commit a further serious crime. Whether William Smith could have been prevented from murdering again is a difficult judgement. We know from research that those experiencing mental ill-health are particularly vulnerable to domestic abuse, with women at higher risk than men.[11] Jessica's mental ill-health put her at such a heightened risk, but she was not the only vulnerable woman in the vicinity. There were women living in the same block of flats who could also have been at risk if William Smith had started a relationship with them, and at very high risk if they had rejected him. Therefore, one could surmise that it would only have been a matter of time before he injured or killed another woman again. Monitoring arrangements of a man with William Smith's history were wholly inadequate; his violent history towards women seems to have been forgotten over time. Greater attention should have been paid to closely monitoring him, probing his relationships, and using local knowledge and intelligence to enhance risk assessments and to seek corroboration of the self-report information he gave during supervision sessions.

4 Recommendations:

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

County Level:

Multi-Agency Public Protection Arrangements (MAPPA)

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

National Probation National Probation Service Essex

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

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

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

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

Recommendation 5:
The Probation Service as a lead agency should ensure that all relevant 'Duty to Cooperate'[12] agencies relevant to the offender's case are invited to MAPPA level 2 and included on the MAPPA referral. This should include relevant agencies from the area to which the offender will move on leaving Approved Accommodation.

Local Level:

Castle Point Borough Council Housing Department IMR

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

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

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

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

County Level

Essex Police

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

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

Clinical Commissioning Groups

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

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

Southend, Essex and Thurrock Domestic Abuse Board

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