Colchester Community Safety Partnership

Executive summary of the Domestic Homicide Review into the death of Laura. September 2013

Initial report and analysis: Dr Jane Monckton Smith
Independent Chair and report writer for submission to the Home Office: Elizabeth Hanlon

May 2018

Executive summary

Section 1: Introduction

1.1 Commissioning of the review

1.2 The overview report and executive summary has been commissioned by the Colchester Community Safety Partnership concerning the death of Laura that occurred in September 2013. The independent chair and report writer for this latest review is Elizabeth Hanlon, who is independent of Colchester Community Safety Partnership and all agencies associated with this overview report. She is a former (retired) senior police detective from Hertfordshire Constabulary, who has several years' experience of partnership working and involvement with several previous domestic homicide reviews, partnership reviews and serious case reviews. She has written several Domestic Homicide Review for Hertfordshire and Essex County Council. She is also the current independent chair for the Hertfordshire Safeguarding Adults Board. Elizabeth Hanlon was commissioned to review the previous report and recommendations presented by independent chair Dr Jane Monckton Smith. This overview report pulls together that review and its analysis and has been adapted for

submission to the Home Office. The review panel would like to extend their thanks to Dr Jane Monckton Smith for all her work in carrying out the previous review process.

1.3 It is important to understand what happened in this case at the time, to examine the professionals' perspective at that time, although it is likely as a consequence that hindsight will be encountered. This will be rationalised by taking key matters forward in order to broaden professionals' awareness both for the future and to ensure that best and current practice is embedded and that any learning is maximised both locally and nationally.

1.4 The death of any person in circumstances such as examined herein is a tragedy. Family members were contacted during this review and a request was made to speak to them regarding the family dynamics. The family of Laura were provided with the Home Office leaflet for families, and were represented by a specialist advocate from AAFDA (Advocacy After Fatal Domestic Abuse).

1. 5 The family have been involved in the review from an early stage. They were visited by the first Chair in April 2014, and were involved in the decision to re-visit the review after the first Overview Report. They did not want to meet with the panel. They have been updated through their AAFDA advocate. The family also met three times with the second Independent Chair. The families AAFDA advocate has since contacted the family and an agreement was made that the amended report will be shared with the family prior to its being sent off to the Home Office.

1.6 Elizabeth Hanlon met with the family together with their advocate and talked through the amended report.

1.7 The panel wish to send their condolences to the family of Laura. They would also like to thank them for their time and patience throughout the review process. Pseudonyms for both the victim and the perpetrator have been used throughout this report to maintain anonymity. The family were spoken to regarding the anonymity of the report and stated that they were happy for the name Laura to be used.

1.8 The Home Office was notified by Colchester Community Safety Partnership (CSP) on the 17th September 2013 of their intention to carry out a Domestic Homicide Review. The Essex Coroner was also notified that a Domestic Homicide Review was taking place. Given the criminal conviction of Paul for Laura's murder, a formal inquest was no longer required.

1.9 The Domestic Homicide Review was started in April 2014 when the first meeting took place.

1.10 Paul was subsequently convicted of the murder of Laura in April 2014 and sentenced to life imprisonment with a tariff of 23 years.

1.11 The findings of each Individual Management Review (IMR) are confidential. At the beginning of the meetings of the review panel, attendees were asked to sign a confidential agreement.

1.12 **The Review Panel in relation to the agreed report and recommendations**

Name	**Position/Organisation**
Elizabeth Hanlon	Independent Chair and Report Writer
Melanie Rundle	Community Safety and Initiatives Manager, Colchester Community Safety management.
Alison Hooper	Detective Inspector, Essex Police
Chris Pearson	Senior Probation Manager, National Probation Service
Andrew Harley	Equality and Safeguarding Co-ordinator, Colchester Borough Council
Helen Hammond	Named Nurse Safeguarding Children, Virgin Healthcare
Paul Secker	Director for Safeguarding Children, Essex County Council
Ruth Cherry-Galal	SaferPlaces
Sandra Garner	Designated Nurse Safeguarding Children, North East Essex Clinical Commissioning Group.
Sonia Carr	Minute taker, Colchester Borough Council

1.13 Reasons for conducting the review

1.14 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of a person in accordance with the provisions of the Domestic Violence, Crime and Victims Act 2004, Section 9(3)(a). Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. The Act states that a DHR should be a review:
Of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by –
A person to whom he/she was related or with whom he/she was or had been in an intimate relationship with, or
A member of the same household as themselves, held with a view to identifying the lessons learnt from the death.

1.15 The purpose of a Domestic Homicide Review (DHR) is to:

a) 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;
b) Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result;
c) Apply these lessons to service responses including changes to policies and procedures as appropriate; and
d) Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

1.16 Terms of Reference

In conducting the Domestic Homicide Review into the death of Laura, the Panel shall have regard: -

- To examine the roles of the organisations involved in the case, the extent to which they had involvement with those agencies, and the appropriateness of single agency and partnership responses to the case.
- To establish whether there are lessons to be learnt from this case about the way in which organisations and partnerships carried out their responsibilities to safeguard the wellbeing of Laura.
- To identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result.
- To identify whether, as a result, there is a need for changes in organisational and/or partnership policy, procedures or practice in Colchester in order to improve their work to better safeguard victims of domestic abuse.
- To produce a chronology of events and actions leading up to, and in relation to the death of Laura from the period from 1st July 2004 until September 2013 seeking information from: Organisations who had contact with the victim, the perpetrator and their families, local community organisations, their family and friends.
- To review current roles, responsibilities, policies and practices in relation to victims of domestic abuse – to build up a picture of what should have happened
- To review this against what actually happened to draw out the strengths and weaknesses
- To review national best practice in respect of protecting adults from domestic abuse
- To draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse

The review will also specifically consider:

- An assessment of whether family and friends were aware of any abusive or concerning behaviour from the perpetrator to the victim (or other persons).
- An assessment of whether family and friends were aware of any abusive or concerning behaviour from the victim to the perpetrator (or other persons).
- A review of any barriers experienced by the family or any other person, in reporting any abuse or concerns, including whether they (or the victim) knew how to report domestic abuse had they wanted to.
- A review of any previous concerning conduct or a history of abusive behaviour from the perpetrator and whether this was known to any agencies.
- An evaluation of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in Colchester**.**
- Whether family and friends want to participate in the review. If so, find out if they were aware of any abusive behaviour by the perpetrator prior to the homicide.
- Communication to the general public and non-specialist services about available specialist services related to domestic abuse or violence.
- Whether the work undertaken by the services in this case was consistent with their own professional standards, compliant with their own protocols, guidelines, policies and procedures.
- To review the previous overview report.
- Any other information that becomes relevant during the conduct of the review.

8. The panel shall also request access to any parallel reviews taking place by individual agencies regarding their involvement with either Laura or Paul.

9. The Panel shall seek Information in respect of the background and any previous convictions of Paul and whether or not they had ever been subject to Multi Agency Public Protection (MAPPA) Arrangements or Domestic Violence Perpetrator Programs (DVPP).

1.17 Subjects of the review

Name (pseudonyms)	**Relationship**	**Ethnic Origin**
Laura	Victim	White British
Paul	Perpetrator	White British
Jill	Former partner of Pauls	White British

1.18 1.21 This review relates to the death of Laura at the hands of Paul, however the panel have also reviewed Paul's previous relationship with Jill, which has a significant impact on the background of the review and agency involvement with Paul and Jill as a couple and subsequently Paul and Laura as a couple.

1.22 Paul and Jill were in a relationship for several years and had a child from that relationship. There is a long history of agency involvement with the couple. Paul and Jill started their relationship at the beginning of 2010. It is then known that Paul started his relationship with Laura upon being released from prison in 2013.

1.23 Throughout his relationship with Jill, Paul had a complex history requiring agency involvement. He had a history of alcohol abuse and had had several mental health issues and incidences of self harm. Paul had a history of violence and other criminal activities and had been in prison on a few occasions. Paul was also on an alcohol management programme. Jill informed agencies that she had not been subjected to domestic abuse from Paul, however there were incidents reported to the police by Jill's family which were domestic in nature.

1.24 At the end date of Paul's last recall to prison he moves in with Laura at her family home.

1.18 Objectives of the review

1.19 The purpose of Domestic Homicide Review (DHR) is to give an accurate as possible account of what originally transpired in an agency's response to Laura, to evaluate it fairly, and if necessary to identify any improvements for future practice.

1.20 Scoping letters were sent out to GP services, School, Children's Community Health Service, Family services, Essex Police, Colchester Borough Homes and the National Probation Service and as a result of the information received, agencies were asked to submit chronologies. Following a meeting the chronologies were discussed and a decision was made that Individual Management Reviews (IMRs) would be requested from Essex Police, Colchester Borough Homes and the National Probation Service. Information was also provided by the GP surgery and the schools attended by Laura's child. The panel also received comprehensive health records. The Police also supplied statements taken during the course of their investigation to the chair of the review panel.

1.21 Police

Since the time of this incident there have been large scale changes into the management of Domestic Abuse within Essex Police.

1.22 Dedicated teams have been set up in each Local Policing Area and deal with all High and Medium Risk Domestic Abuse crime investigations and are overseen by a Detective Inspector and Detective Sergeants supervising a combination of Detective and Police Constables. Standard risk investigations are dealt with by Local Policing Teams.

1.23 Domestic abuse incidents are attended by Local Policing Team officers who will conduct the DASH risk assessment with the victim and assess the risk as High, Medium or Standard. This risk assessment with then be checked and verified by their supervisor.

1.24 High Risk cases are referred into the Central Referral Unit within the Public Protection Command for enhanced safeguarding.

1.25 ATHENA was introduced in April 2015 and replaced the Crime Recording system, Protect, Intelligence and Custody systems, bring them all together in one system so information is more easily accessible.

1.26 National Probation Service

1.27 In June 2014, The Ministry of Justice (MOJ) split 35 probation trusts into a public sector National Probation Service (NPS) and 21 new Community Rehabilitation Companies (CRCs). The NPS now advises courts on sentencing all offenders and manages those offenders presenting a high risk of serious harm. CRCs supervise offenders presenting low and medium risk of serious harm. CRCs were in public ownership until February 2015 when, following an extensive procurement, they transferred to eight, mainly private sector, providers working under contract to the National Offender Management Service.

1.28 Essex CRC provides statutory supervision to adults (over 18 years) subject to Community Orders, Suspended Sentence Orders and those released from prison subject to a period on licence and Post Sentence Supervision Period who reside in Essex including Southend and Thurrock. Essex CRC complete risk assessments and sentence plans for those under statutory supervision.

129 Diversity considerations

1.30 All of the protected characteristics of the 2010 Equality Act were considered by both the IMR authors and the DHR panel.

1.31 Sex: Gender is always relevant in cases of domestic homicide. Women are far more likely to be killed as a result of domestic abuse, and men are far more likely to be offenders.

The majority of victims of domestic homicides recorded between April 2013 and March 2016 were females (70%).[1]

1.32 Paul had a history of mental health issues and had been seen by the Mental Health Services, however he was found not to have a mental health illness that required follow up treatment.

1.32 Laura was a first time mother trying to keep a job and look after a child.

Section 2: The facts

2.1 Case specific background

2.2 Laura lived in a flat on a social housing estate in Colchester. She was the sole tenant, and was recorded as living in the flat with her four-year-old child. Paul lived there with her also, but was not named on the tenancy. He had been in a relationship with Laura for around twelve to eighteen months. Prior to meeting Laura, he was in a relationship with Jill.

2.3 In January 2007 Paul is arrested for a serious assault on a male in a public place. He caused life changing injuries to that person, and was accused of kicking and stamping to the victim's face and head after luring him into an alleyway. This offence was committed jointly with another male. Paul was charged with, and convicted of, a S.18 Grievous Bodily Harm for which he was sentenced to 72 months in prison. At this point Paul was considered to be high risk to the public.

2.4 Upon release from prison, In February 2010 Paul reports to his offender manager that he has started a relationship with Jill. A short time later he makes a request to be able to live with Jill. This very quick beginning to a relationship is a noted risk marker for men who have control and relationship issues. Although not necessarily concerning on its own, when put in the context of violence and abuse it does add to the risk profile. The offender manager refused Paul's request to move in with Jill, which was a good decision. The offender manager also noted concerns with Paul's alcohol use and asked him to complete 'drink diaries'. At this point the safety of Jill could have been a key factor in Paul's management. Violent people are very often violent or controlling in their domestic lives, there is often what is called 'criminal coherence'. This just means that violence is a response to challenges and this will be a feature wherever that challenge occurs. The private nature of personal relationships makes partners particularly vulnerable to violent offenders.

1 Office of National Statistics for Domestic Abuse for England and Wales ending in March 2017

2.5 In April 2010 Paul moves in with Jill following a risk assessment carried out by Probation. Paul's estimated risk to the public is reduced to medium harm, which means 'there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious 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, drug or alcohol misuse'. Any decision to reduce harm from high risk to medium risk requires management oversight. This does not appear to be unreasonable to this case. There Is, however, some debate as to whether at the point of beginning a relationship someone like Paul should be monitored more closely to assess how they deal with the pressures of a relationship before having their risk reduced. This is especially the case when a relationship is moved on very fast, with a proposal of marriage and co-habitation so fast after meeting. This is a known behaviour of those men likely to be coercive and controlling. The start of a relationship is not always a sign of stability; it is a time of potentially increased pressure. The National Probation Service, however, assessed Paul as entering a stable relationship, having a stable home life and employment which indicated a lowering of risk factors to them.

2.6 Paul is recalled to custody as the result of an allegation of two offences of theft, but police take no action over the allegations. Whilst in prison Paul contacts Jill and her mother and threatens to kill himself. Threats of self-harm in a relationship, especially where that threat is made to a partner, is a high risk marker.

2.7 Paul is released from prison on licence but received a second recall to prison in May 2011 for offences of taking a vehicle without the owner's consent, driving without insurance, driving other than in accordance with a licence, and driving with excess alcohol. Paul was sentenced to 8 weeks in prison which he served during his period of recall.

2.8 The circumstances surrounding this recall were domestic in nature. Jill's mother called police and reported a domestic abuse incident between Paul and Jill, and also that he had taken her car. She told police that Jill was pregnant with Paul's child. He had made statements saying he hoped the baby would die, and also that Jill's mother would die. He was drunk.

2.9 In May 2011 Children's Social Care carry out an initial assessment in relation to Jill due to her being pregnant following a referral from Paul's Offender Manager.

2.10 Jill has her baby in October 2011 and Probation make a referral for an assessment to take place surrounding Jill and the new baby, given Paul's history and his plans to return home to where they both reside. During the initial assessment Jill stated that Paul did not pose a risk to the baby as there had been no domestic violence between them. She stated that they had only had two arguments within the three year relationship. A

recommendation was made that a core assessment was required. This is good practice. Jill informed authorities that Paul wasn't going to live with her upon his release from prison.

2.11 Paul had come to live with Laura on being released from prison. He is at his sentence end date and is therefore not on licence. He is said to have left the prison and gone to seek out Laura immediately. They were not known to have had a relationship prior to this, but had met some years previously when Laura was in a relationship with Paul's brother. Paul moved in with Laura very quickly and this may have been a mixture of his own need to be in control of the situation, and is quite common in domestic abuse and coercive control. It is also likely to have been tied to his difficulties in securing accommodation for himself on leaving prison.

2.12 In April 2013 Jill makes a 999 call after receiving threats from Paul that he is going to kill her and her child and mother, and to sexually assault them. He talked of masturbating over their dead bodies. Jill stated that she had received 23 calls in one week. The risk assessment classed Jill as medium risk. This could have been considered high risk if the behaviours reported were given due weight. Threats to kill and stalking are both very high risk behaviours. Paul was arrested, he denied the offences and was bailed. He was living with Laura and her child at the time. Risk should not necessarily be considered as confined to one person in these situations. Laura was at high risk also. This is an opportunity for learning, in that professionals should consider current partners, as well as former partners where there is negative behaviours towards both. Laura could have been risk assessed at this point. Paul's police bail was extended on several occasions and it is noted that he was still on bail at the time of the murder.

2.13 Paul did not contribute financially to the household and did not have regular work. Laura had been working but had to resign from her job as it is believed that Paul became unreliable as a carer for her child when she was at work.

2.14 In September 2013 Laura and Paul were at their home address and Laura's child was present also. They were having a drink with a few friends from the local area. Laura was drinking alcohol, and Paul was drinking alcohol too, Paul appeared to be very drunk. There was also cocaine in his urine the following morning. Paul and Laura were heard arguing loudly in the kitchen, and because of this the friends were asked to leave the house by Laura.

2.15 It is said that the argument stemmed from Paul's jealousy. He had been searching Laura's phone and had found contact with a male friend. The contact was not intimate and Laura was not having a relationship with the man. It appears that Paul had accused Laura of having an affair with another man on several occasions.

2.16 Family also say that Paul had been asking about Laura's contact with an old family friend, and behaving strangely. Paul was showing controlling and jealous behaviour, and his paranoid tendencies were escalating in response to Laura's apologies on that night.

2.17 Laura's child, who was there at the time, told police that Laura was apologising to him. Some thirty minutes later Laura turned up at a friend's house stating that Paul had beaten her and smashed her phone. She stayed for around twenty minutes but then went home. This is estimated to be about 0130. Laura told her friend that she didn't want to leave her child with Paul. Loud arguing was heard by neighbours until around 0300.

2.18 The following morning a female neighbour saw Laura's child in the street outside the house. The child told the neighbour that their mummy was dead. The neighbour went into the house and found Laura on the floor in the lounge. There was a significant amount of blood on Laura and in the house.

2.19 At 0726 Essex Police received a call from the Ambulance Service that they were treating a 23 year old woman (Laura) in cardiac arrest. She died at the scene whilst being treated for multiple stab wounds.

2.20 Laura had six stab wounds to her neck and chest. The child was present and had witnessed the murder. The key suspect was Paul and he was arrested on suspicion of Laura's murder.

2.21 Individual Management Reviews

2.22 The aims of the Individual Management Reviews (IMRs) are to:

- Enable and encourage agencies to look openly and critically at individual and organisational practice and the context within which people were working;
- Identify whether the homicide indicates that changes to practice could and should be made;
- Identify how those changes will be brought about; and
- Identify examples of good practice within agencies.

2.23 IMR authors were informed of the primary objectives of the process, which is to give as accurate as possible an account of what originally transpired in the agency's response to Laura and Paul and to evaluate it fairly, and to identify areas for improvement for future service delivery. IMR authors were encouraged to propose specific solutions which are likely to provide a more effective response to a similar situation in the future. The IMRs have also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of, or experiencing domestic abuse.

2.24 Family involvement

2.25 Laura's family state that when Paul was released from prison and was living with Laura, the two of them initially kept it a secret from friends and family. Paul is believed to have moved in with Laura at the beginning of 2013. Laura's family believe that Laura kept their relationship quiet because of the previous relationship with Paul's brother. It could also have been because Paul had not accepted the end of his relationship with Jill. Family also say they were shocked when they found out about the relationship as Paul was not the type of man that Laura would ordinarily have been attracted to.

2.26 Laura's family state that Paul was not friendly with them and they did not really get to know him. Whenever they visited Laura and her child at home he would always stay out of the room. It was also said that Laura would leave the room to go and sit with Paul in the kitchen, and leave her family with her child, not returning to spend time with them. This was seen as quite concerning, and out of character for Laura. This is a common behaviour of people living with controlling and abusive partners. The controlling person isolates the victim from outside influence, especially friends and family. They often make it a point that the victim must prove their loyalty. Laura may well have felt she was walking on eggshells and been very worried about talking to her mother. There may well have been consequences for Laura in having her mother in the home. The evidence strongly suggests that Laura's behaviour was changing and those changes reflected chronic fear of Paul.

2.27 Chronic Fear is different to immediate fear of violence and can make people behave in ways which others do not necessarily understand. Chronic fear is related to fear of consequences, rather than just violence. It may be that there were consequences for Laura if her mother turned up to visit.

2.28 Laura would turn up regularly at her mum's flat with her child saying she had argued with Paul. She would ask to stay the night. She was always gone before morning, back to her home with Paul, but would leave her child with her mum. This may have been keeping her child away from the danger, or managing Paul's moods; perpetrators often complain about the behaviour of children so mums lock them away, or get them away, to stop things escalating. Reports from her child show that they were often locked in their bedroom. This is common behaviour. Perpetrators will complain about the attention the child is getting, or get angry by normal child behaviours like noise or crying. Laura leaving her child with her mum is a sign that she may have been trying to manage things and manage Paul's moods.

2.29 In the summer of 2013 Laura began to change. Her mother described being aware that Laura and Paul were having a lot of arguments and that on several occasions she would have to leave work early to go and pick Laura up after she had had a row with Paul. Laura's

mother also believed that Laura had ended the relationship with Paul on several occasions. Laura's family stated that Laura stopped looking after her appearance, and stopped tidying her home. Laura's family say that although the home was not dirty, it was untidy and there were often signs of damage and broken things lying around which had not been cleared. This is another classic sign of domestic abuse and coercive control. Laura started to pay less attention to herself and her home. She may have been focusing her attention on Paul. He may have objected to her spending time on herself or the home. Laura was also giving Paul money and was asking to borrow money from family members. She had stopped paying her rent. Her things were seen lying broken around the living areas.

2.30 In August 2013 Laura's child minder let her down and had refused to take her child to nursery. This coincided with Laura changing from working the day shift to the night shift. Paul and Laura's mother started looking after her child but Paul would let her down at the last minute and would always put conditions on him helping out. As a result of this Laura had to leave her job. This is not uncommon in coercive control and domestic abuse situations, where the victim becomes isolated from all help, the perpetrator makes themselves indispensable and then use that to further control the activities of the victim.

2.31 Laura's family state that Laura had fallen out with her friends because of Paul's behaviour and their relationship. Laura took the side of Paul when her friend alleged that he stole her car. Friends of Laura believe that she lost her job as Paul had caused damage to Laura's friends car, this friend also was Laura's boss.

2.32 In the weeks before Laura's murder, Laura's mother says she noticed a change in Laura's child. She says the child had started to show signs of anxiety and was wetting the bed. She said that upon Laura's death she noticed that Laura's child's bed at her home was absolutely soaked with urine. It was also noticed by the family that a stairgate had been put up at the door of Laura's child which was identified as being unusual. This suggests that the child was both anxious and controlled. This is an indication of domestic abuse and coercive control.

2.33 Laura's mum didn't like Paul so was quite surprised when he turned up at her flat one night 'out of the blue'. He was on his own and behaved very strangely and wanted to know where Laura was. He said he had been at a party close by. Laura's mum was suspicious and assumed he was out looking for Laura. She made him leave. This is characteristic of stalking behavior directed at Laura. This behaviour was not known to any agency.

2.34 Friends of Laura stated that both Laura and Paul drank heavily, although Laura would appear to be happy and in control when drunk, Paul would sometimes turn aggressive and become verbally agitated towards them. They stated that they would often

hear Laura and Paul having arguments. One friend described Laura and Paul as having "major rows once a week for the whole street to hear". Friends describe Laura showing them bruising but always saying that Paul had only caused them through play fighting and that he hadn't meant to hurt her. One friend had also seen a mark on her chest which Laura stated she had received from Paul where he had bitten her. This was also described as being in jest.

2.35 Laura's friend described Paul as being a jealous man and always wanting to know where Laura was and who she was out with.

3.0 Analysis

3.1 It is not known exactly when Laura began her relationship with Paul, but it does seem clear that on his release from prison he went straight to her home and seemed to move in within a short space of time. Laura's family state that the relationship wasn't going on whilst Paul was in prison but that he turned up on Laura's door step upon being released.

3.2 There was no Probation scrutiny of Paul's behaviour when he was released at his SED as he had reached the end of his sentence and there was no licence period.

3.3 There is now greater emphasis on returning individuals to the community for a period of management under licence rather than keeping someone in prison to SED. Whilst this is high on the NPS agenda at present, there are still likely to be cases where offenders are recalled and kept in custody until their SED rather than seeking their early release to both manage and address any risks posed by them.

3.4 Where an offender continues to pose at least a medium risk of serious harm at their licence/ order end date, this information must be shared with relevant agencies who are likely to have ongoing contact with the offender.

3.5 Essex Police receive daily emails via the PINS system (Prison Intelligence Notification System) which notifies the Police of certain individuals who are being released from Prison custody. The criteria for a PINS notification is where the offender's prison sentence was 12 months or longer, alternatively, PINS requests can be individually requested and placed against someone's prison record for early notification of their release.

3.6 The daily PINS emails are received by the Essex Police Intelligence Bureau. These are all reviewed, PNC (Police National Computer) is updated and a notification is placed on Athena. In domestic abuse cases the intelligence team notify the Central Referral Unit so that the victim can be contacted and their safeguarding reviewed. PINs relating to domestic abuse cases are regularly reviewed by a safeguarding officer to identify and action any safeguarding.

3.7 Prompt use of MAPPA to drive risk management and sentence planning should be used to ensure that where it is assessed as safe re-release will be pursued prior to SED to facilitate resettlement risk management.

3.8 All relevant agencies working with an offender need to ensure that information continues to be shared outside of the MAPPA arena.

3.9 Since 2016 the National Probation Service within Essex have introduced a new system in relation to offenders being released from prison who were subject to MAPPA. These offenders are now referred to the MAPPA board prior to their release so a multi-agency discussion can take place regarding the risk they pose to themselves and the public. This, however would not have helped in this case as no agencies appeared to know that Paul was moving in with Laura. If the offender is released at his SED then a suitable address for release is not always obtained.

*3.*10 Had there been some scrutiny they may have been able to pick up that Paul had moved in with a woman and young child. This may be an issue to consider at a national level that those offenders who serve their whole sentence have no licence period where they receive support or scrutiny from the probation service. It does seem problematic that those prisoners who behave well enough to have early release are supported, but those whose behaviour is challenging and criminal, and as such have to serve their full sentence, are released with no scrutiny or support. It may be that if there was some scrutiny as a result of the recalls to prison, that Paul may not have moved in with Laura, Laura may have been risk assessed, her child risk assessed, and Paul monitored for escalating problem behaviours. MAPPA could potentially be developed so that police are at least aware that calls relating to high risk offenders are given priority in risk assessment terms.

3.11 Paul entered into the relationship with Laura with known behavioural issues, and having witnessed or experienced violence in the home. Laura appeared to have better relationships with her family at this time, and was a good mother to her child at the point of starting a relationship with Paul. Paul's problem and violent behaviour on the other hand, escalated to a point where he was imprisoned for violence and was considered at least at some period of time, high risk to the public.

3.12 The police took some considerable time to gather evidence for the allegations made by Jill. Processes within the police meant that Paul was repeatedly bailed whilst police sought evidence to prosecute; specifically evidence related to Jill's phone. In April 2017 the Policing and Crime Act 2017 reformed pre-charge bail. It introduced the requirements for pre-charge bail to be authorised for an initial period of up to 28 days by an Inspector, a further period up to 3 months by a Superintendent and any extension beyond that requires authorisation from Magistrates Court.

3.13 When officers attended the incident on the 8th April 2013 between Jill and Paul the risk assessment of Medium was determined by the attending officer based on the information provided by Jill and the answers that she gave to the DASH risk assessment. This was then signed off by their supervisor.

3.14 The DV/1 (Domestic Violence) booklet which included the DASH risk assessment was then forwarded to the Central Referral Unit where a further review of the risk assessment and further conversation with Jill was completed and verified by a Domestic Abuse Safeguarding Officer (DASO) and recorded on the PROTECT system.

3.15 The attending officer noted that Jill was not frightened of Paul, her only concern was that he would try to take their daughter away. The writer of the IMR reviewed the information held on the electronic record of the DV/1 and the PROTECT record and was satisfied that MEDIUM was the correct grading for this incident.

3.16 A DASH risk assessment is completed for every Domestic Abuse incident that Essex Police attend regardless of risk level. Officers complete this DASH regardless of the relationship between the perpetrator and the victim, as long as the relationship fits the DA definition. A DASH should be completed for each victim to obtain their correct risk level and therefore trigger any necessary safeguarding. Immediate concerns for the safety of the victim, children or other vulnerable people must be addressed. A secondary rationale is completed by the necessary supervisor (High/Medium Crime incidents then Op Juno Sergeant, all others would fall to the sergeant).

3.17 The Police would not complete a DASH for anyone not involved in the incident (i.e. a new partner, when an incident involves an offender and ex-partner), however if those details are known of a new partner then consideration should be given to usage of the Domestic Violence Disclosure Scheme DVDS/Clare's Law disclosure which could also lead to safeguarding if felt necessary.

3.18 The Domestic Violence Disclosure Scheme was rolled out nationally in March 2014. It utilises the police's common law powers to disclose information where it is necessary to prevent crime.

3.19 The Scheme was introduced to set out structures and processes that could be used by the police in relation to disclosure of information about previous violent and abusive offending by a potentially violent individual to their partner where this may help protect them from further violent and abusive offending.

Following a review in 2015 the scheme was extended to include disclosure relating to ex partners.

3.20 There are two entry routes into the scheme:

- "Right to know" – triggered by the police making a proactive decision to disclose information to protect a potential victim.
- "Right to ask"- triggered by a member of the public applying to the police for a disclosure.

3.21 Essex Police would not complete a DASH risk assessment for an identified new partner, unless an incident of Domestic Abuse has occurred between them and the perpetrator.

3.22 Laura always denied that Paul was violent to her, but the circumstantial evidence strongly suggests otherwise. People who are controlled will often deny violence or any problems. They do not want to be challenged, and do not want anyone to challenge the perpetrator, as this can escalate things dangerously for them.

3.23 Text messages downloaded from Laura's phone show that she was being accused by Paul of sleeping with one of her mother's friends. She denied this. Analysis of text messages sent to Jill's phone also confirm that Paul had been threatening her. Paul was still on police bail at the time of the murder. The panel and family members were very concerned regarding the length of time that Paul was on bail for the original offence and that his bail kept on being cancelled and then extended. It has been identified that there were issues regarding the downloading of the phone and obtaining the evidence from it to help in a prosecution. The implication of this is that Paul could potentially have been unable to abuse either Jill or Laura at this point had he been successfully prosecuted and maybe sentenced. This is speculation, but the extended bail is clearly a problem which needs addressing and this was in fact addressed by Essex Police in their IMR and this has instigated recommendations which go some way towards ensuring this extended bail would not happen again as procedures are now in place to make sure that evidence can be sought more quickly with clear instructions and guidance for officers.

3.24 The GP saw Laura just before she was killed and she complained of low mood lack of support. Although within North Essex the IRIS[13] project has not been commissioned, the Panel learnt that there was an extensive programme of training in place regarding the recognition of, and support for, adults experiencing domestic abuse and that this training had been provided to a wide range of health professionals including GPs, nurses, social workers, police officers and safeguarding leads in schools. This training involves the full definition of domestic abuse including coercive, controlling and threatening behaviour.

3 "IRIS" – "Identification and Referral to Improve Safety" – a General Practice based domestic violence and abuse training support and referral programme. (Trialed in Hackney & Bristol in the period 2007 to 2010 – ref: irisdomesticviolence.org.uk.

Information regarding domestic abuse is available in locations such as inter alia, Jobcentres, Council Offices, Community centres, GP Surgeries and Children's Centres.

3.25 The J9 Domestic Abuse project has been introduced throughout certain areas of Essex. This Initiative is named in memory of Janine Mundy, who was killed by her estranged husband while he was on Police bail. The initiative was started by her family and the local police in Cambourne, Cornwall, where she lived and aims to raise awareness of domestic abuse and assist victims to seek the help they so desperately need.

3.26 J9 training sessions delivered by Safer Places are intended to raise awareness and increase knowledge and understanding of domestic abuse for staff in public and voluntary sector organisations. In the course of their work, these staff may come into contact with someone they suspect is a victim of domestic abuse, or a client may reveal that they are suffering abuse. The training aims to ensure that staff are equipped to respond appropriately and effectively.

3.27 Whilst the Panel recognises the huge strides made in identifying and making available services to those who are subject to domestic abuse, the Panel believes that health professionals should remain mindful at all times, that symptoms of depression or similar may well be masking an underlying episode or episodes of domestic abuse, whether or not there are accompanying physical signs of such abuse. Therefore, health professionals should ensure that they remain familiar with relevant local services and initiatives designed to support those being subject to potential domestic abuse and make referrals accordingly.

4.0 Conclusion

4.1 This is a very sad case, and when all the information is pulled together an escalating and dangerous situation can be seen. Not all the information presented in this report was known by any one agency at the time, and some information was not known by anyone.

4.2 Paul's behaviour was violent from an early age, but he was not always considered as having a high level potential for violence, especially in a domestic context. There were times when he was considered high risk, but this was reduced without full consideration of the things happening at the time. This is not necessarily just about what should have happened, and whether the risk reduction should have been checked, but is also about professional knowledge. Without the knowledge of how domestic abuse is linked to all violence, and without knowing that new relationships can reveal risky behaviours, the risk assessment may not have been questioned at any level. This may be about systems strengthening, and education around domestic abuse and coercive control.

4.3 The end of the relationship with Jill seemed to be a key event, and Paul did not accept the end of that relationship. He continued to pay unwanted attention to Jill.

4.4 When Laura met him, he was already a man who was violent as a child, violent in and out of prison, and showing disturbing and controlling behaviours to a partner.

4.5 Although in domestic abuse there is a clear focus for control and violence, it is often the case that others can become a target. This is especially the case with children, and other partners. Children get killed in high risk domestic abuse. Laura's child was present when she was murdered.

4.6 There were a number of the commonly agreed high risk markers present, which could have alerted police and probation to the risk he posed to partners and former partners he was stalking. There seemed to be an assumption that his violence was only against other males. Paul's violence, as is nearly always the case, was not contained and focused, he was generally violent and this should be considered in any risk assessment.

4.7 The high risk markers present were identified as:

Threats to kill: These were reported by Jill as against her, her child, and her mother, and police responded to this allegation. Paul was bailed but there was a very slow response to investigating the evidence. There was also evidence of breaching the bail conditions which could have been acted on with more speed.

Threats to suicide: this is as dangerous as threats to kill in standard risk identification checklists. Paul was threatening self harm from the beginning of his relationship with Jill and when he was threatened with separation from her. This is known to be a high risk behavior, and threats to suicide should be considered as threats to kill.

Alcohol and substance misuse: This is known to exacerbate problems that perpetrators have in their relationships. They are not a cause of coercive control and abuse, but should be considered as escalating any risks.

Extreme violence: Paul had been convicted of extreme violence. He had a clear propensity for violence. It should never be assumed his violence would be confined to confrontations with other men.

Violence against Laura: Any use of violence is a risk marker.

Control: There was strong evidence that Paul was controlling of Laura, and attempted to control Jill. Threats to suicide are a method of control, as is speeding up the journey of a relationship, and stalking.

Stalking: There is evidence from witnesses and police to show that Paul was stalking Jill, and family members talk about stalking behaviours with Laura. Stalking is highly correlated with coercive control, and with homicide.

Excessive Jealousy: Paul was shown by witnesses to be very jealous and possessive.

Escalation: Paul's concerning behaviours were escalating in the weeks before Laura's murder. He was violent with Laura, threatening violence to Jill and pursuing forced contact and stalking.

Breach of restraining orders/bail: Those people who breach court orders or bail present higher risk than those who do not.

4.8 As has been noted no one agency had the full picture of all these risk factors.

4.9 The conclusions of the panel are that there were missed opportunities to safeguard Laura, and missed opportunities to properly risk assess Paul.

5.0 Recommendations

Recommendation 1: **National Probation Service**
All individuals released at Sentence End Date (SED) who have been subject to the MAPPA process are to be referred back to MAPPA prior to release date so a multi agency risk assessment and risk management plan can be completed.

Recommendation 2: **Colchester Borough Council**
The J9 project is to be rolled out through North Essex.

Recommendation 3: **Essex Domestic Abuse Strategic Board**
Essex Domestic Abuse Board to consider a campaign specifically targeted towards raising awareness within communities and clear guidance on how to report domestic violence.

Recommendation 4: Essex Police
Essex Police are to review their phone data analysis procedures to make sure that they are clear and well known and that this process is to be publicised internally via the Essex Police intranet to all staff likely to find themselves making applications.

Recommendation 5: Essex Police
Each Local Policing Area provides a person responsible for providing advice to officers completing communications data requests. This will provide consistency in advice and ensure that each application is of the required standard from the outset.

Recommendation 6: National Probation Service
The National Probation service to review their processes in relation to the de-escalation of risk of harm from high. Discussions need to take place with managers and decisions are to be clearly recorded.

Appendix A: Glossary

AAFDA - Advocacy After Fatal Domestic Abuse
A&E- Accident and Emergency
ATHENA – Police crime recording system
CRC- Community Rehabilitation Companies
CPS - Crown Prosecution Service
CSP - Community Safety Partnership
DASH - Domestic Abuse, Stalking and 'Honour'-Based Violence Risk Identification Checklist
DASO- Domestic Abuse Safeguarding Officer
DV/1- Domestic Violence booklet
DVDS- Domestic Violence Disclosure Scheme
DHR - Domestic Homicide Review
DVPP – Domestic Violence Perpetrator Programme
FLO - Family Liaison Officer
GBH- Grievous Bodily Harm
GMPS - Government Protective Marking Scheme
IMR - Individual Management Reviews
MARAC - Multi-Agency Risk Assessment Conference
MAPPA - Multi-Agency Public Protection Arrangements
MOJ – Ministry of Justice
NPS- National Probation Service
OM- Offender Manager
OASys- Risk assessment used by the National Probation Service
PINS- Prison Intelligence Notification System
PNC- Police National Computer
PROTECT system- System used by Essex Police to record incidents of domestic abuse
RE- Routine Enquiry
RTK- Right To Know procedures
SED- Sentence End Date
SIO - Senior Investigating Officer
SMART - Specific, Measurable, Achievable, Realistic and Timely
TOR - Terms of Reference
TWOC- Taken Without Consent
VCS - Voluntary and Community Sector