Executive Summary
Domestic Homicide Review

1. The Review Process

This summary outlines the process undertaken by Southend Domestic Homicide Review Panel in reviewing the murder of AB.

YZ was convicted of AB''s murder on 14th August 2012 and sentenced to life imprisonment with a minimum term of 27 years.

The Review process was commissioned on 25th August 2011 by the Chairperson of the Southend Community Safety Partnership. It began with an initial meeting on 9th September 2011 of all agencies that potentially had contact with AB prior up to the point of death. The key purpose of the review is to learn lessons about how agencies can work together more effectively in tackling domestic abuse.

Agencies participating in this case review are:

- Southend Borough Council Children and Learning Department
- Southend Borough Council Adult and Community Services
- Southend University Hospital NHS Foundation Trust
- Southend Borough Council Housing Services
- Essex Police
- Essex Probation
- Victim Support
- South Essex Partnership University NHS Foundation Trust
- NHS South East Essex Primary Care Trust
- Her Majesty's Courts and Tribunal Service
- Crown Prosecution Service
- South Essex Homes
- Southend Drug and Alcohol Action Team
- Southend Domestic abuse Partnership Manager
- Family

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

Each agency's report covered the following:

- *A chronology of interaction with the victim and/or their family;*
- *what was done or agreed;*
- *whether internal procedures were followed*
- *conclusions and recommendations from the agency's point of view.*

The accounts of involvement with this victim cover different periods of time prior to their death. Some of the accounts have more significance than others. The extent to which the key areas have been covered and the format in which

they have been presented varies between agencies. All of the Individual Management Reviews were assessed as adequate by the overview report writer. Where it was felt that the IMR recommendations were not adequate, further recommendations to address this have been added to the Overview Report. It is intended that both the IMR and the Overview Report recommendations are to be tracked and monitored by the Community Safety Partnership.

17 of the 17 agencies responded. In total, 3 agencies responded as having had no contact with either the victim or the suspect or with any children involved: South Essex Homes, SOS Domestic Abuse Projects, Safer Places.

The remaining 14 responded with information indicating some level of involvement with the victim, these were:

- Essex Police
- Essex Probation
- Southend Borough Council Children and Learning Department
- Southend Borough Council Adult and Community Services
- Southend Borough Council Housing Service
- Victim Support
- Southend University Hospital NHS Foundation Trust
- South Essex Partnership University NHS Foundation Trust (SEPT)
- NHS South East Essex Primary Care Trust
- Multi Agency Risk Assessment Conference (undertaken by the Southend Domestic Abuse Partnership Manager)
- South East Essex Community Health Care (now delivered by SEPT, previously delivered by NHS South East Essex Primary Care Trust delivery arm)
- SERCO
- Crown Prosecution Service (CPS)(after the trial)

The IPCC report and the SEPT Serous Incident report were also reviewed. Her Majesty's Courts and Tribunal Service (HMCTS) did not provide an IMR but provided input and comment at appropriate stages and a representative attended the Review meetings. In addition a meeting was held with the family of AB, and they continued to be involved and to have the opportunity to review the overview report in order to provide feedback from the family's perspective.

An interim Overview Report was presented to the Southend Community Safety Partnership on ( ).At this time legal proceedings, in the form of the trial of YZ for murder, were still ongoing, so the review could not be fully completed. Nevertheless the interim review contained a number of recommendations arising from lessons learned, which were put forward and agreed for immediate action, in order to strengthen local partnership working.

On 14th August 2012, YZ was found guilty of the murder of AB and although he subsequently appealed, at this point further information was shared with the review team by the CPS, and the overview report was completed and shared with the family of AB.

2. Key issues arising from the review

It is believed that AB and YZ began an intimate relationship in about 2010, although they had known each other for longer than this. AB had three children but they did not like YZ and they either had left home, or, as in the case of the youngest child, they stayed at their fathers house when YZ visited. AB was part of large and supportive extended family but sadly they were not aware of the extent to which YZ threatened the well being of AB. Whilst the reasons for this cannot be known, it is thought that AB may have been trying to protect her family by this means. There is absolutely no doubt that had they known the extent of YZ's behaviour, they would have been overwhelmingly supportive. AB reported at one point that she had no previous experience of domestic abuse and did not know how to deal with it. AB and YZ never lived together and it is not clear, at times, where YZ was living.

From January onwards AB began to report concerns about YZ to Essex Police. It was noted by police officers that AB had two black eyes, although she did not make an immediate report about these. AB reported that YZ had threatened her and that she had ended the relationship. Following these reports AB was correctly assessed by the police, using the DV1 form, as being at High Risk of domestic abuse and her case was in consequence referred to the Multi Agency Risk Assessment Conference (MARAC), and AB was supported by both a Domestic Abuse Liaison Officer (DALO) and an Independent Domestic Violence Advocate (IDVA). In total the case involving AB was heard at the MARAC on three occasions. On one occasion the initial DV1 was wrongly assessed by the police as Medium Risk. It should have automatically been upgraded to High Risk in the light of the previous assessment, but due to backlog which had grown up at this time, the assessments were not always entered onto the system in a timely way. Whilst the assessment was subsequently correctly upgraded, the backlog is of concern as it meant that real time information was not available, which could put a victim at greater risk. The MARAC looked at steps it could take to encourage AB to protect herself, and some support for her youngest son.

It was found by the review that the MARAC had a high volume of cases, that it did not always follow up that actions agreed in the minutes had been taken, and that it was not always clear whether AB knew her case was being discussed at the MARAC, which made it difficult to represent her voice there. Equally importantly, although the MARAC focussed on protecting the victim, it was found that it was not connected to the legal process, and other issues associated with the perpetrator. It was also found that not all the relevant local agencies were represented on the MARAC, most noticeably some of the community health services.This was significant in this case because AB was in receipt of counselling and YZ was in receipt of both general practice and specialist mental health services at times, and information known to those services about YZ's level of drinking in particular, would have been a significant factor in assessing the risk he posed. The MARAC is the means by which partners know that they have permission to share information under the

relevant legal frameworks. If this had happened, a fuller picture of the risks posed by YZ might have emerged, in particular in relation to his alcohol abuse.

Nevertheless, the MARAC was effective in co-ordinating protective measures for AB, including the fitting of security measures at her home, and in co-ordinating efforts to support AB in making a statement about YZ. Some consideration was also given to the needs of AB's youngest child, and how he could be supported.

The IDVA was particularly persistent in trying to engage with AB and to encourage her to take up the offer of enhanced security and a police alarm at her home, which AB eventually did. AB was encouraged to report her concerns and to be prepared to make a statement in court in order that YZ could be convicted, which she was reluctant to do, the main apparent reason being the fear of AB, which sadly and with hindsight can be seen to be totally justified, namely that YZ would pose an even greater threat to her if she did this. AB did eventually provide a witness statement in respect of YZ, but when the first hearing for this offence came up, on 23rd March 2011, AB's father had recently died and this, combined with her general level of fearfulness, meant that she did not feel strong enough to present the statement in court.

During the early months of 2011 offences committed by YZ escalated in intensity and were perpetrated against both AB, and others. These resulted in a number of court appearances by YZ at Southend Magistrates Court, and some sentences being passed. YZ was given some Community Service with Unpaid Work Orders and did not carry these out. He was given some fines and costs and did not pay these. On one occasion a sentence was incorrectly logged on the Probation Service system as a Conditional Discharge and therefore YZ was never instructed to work this order.

In addition, it was found that at times there were differing expectations and understandings about the court process, between the police, probation, Crown Prosecution Service (CPS) and Her Majesty's Courts and Tribunal Service(HMCTS), so that it was not always clear whether pre -sentence reports could or should have been called for, whether hearings of cases involving YZ or should or could have been deferred for further reports, and the police information as supplied to the court was not always up to date. In particular the probation service did not always have access to information held by the CPS, although it is reported that these issues have been rectified now.

In respect of the offences carried out YZ, on one occasion two offences committed at the same time against AB became separated through the court process, resulting in the domestic abuse context of a criminal damage charge being lost, and making the offence appear more trivial than it was. With the frequency of YZ's offending it is not clear that the court always knew about further recent new offences when they were hearing an earlier case. The referral of AB's case, involving YZ, to the MARAC, did eventually highlight to

the Probation service that YZ was a High Risk offender, but at this point YZ had been remanded in custody through the refusal of bail, and it was decided to delay his probation risk assessment until he was back in the community, this never taking place as events subsequently unfolded. One consequence of the Probation Service being less involved than they should have been was that, had Probation been more involved, and earlier, YZ could potentially have accessed a perpetrator programme, and AB a victim support programme.

By May 2011 the police became aware of the high level of stalking and harassment that YZ was undertaking in relation to AB. YZ committed two further offences of breach of bail and assault. For a period YZ was remanded in custody, the CPS having successfully opposed bail by proving breaches of bail had occurred. AB reported being extremely fearful of YZ's reaction to her, in respect of his being refused bail.

In June 2011 the CPS files were reviewed and it was recorded by the CPS that they were highly unlikely to gain convictions in two charges relating to AB, unless AB gave evidence or a hearsay application was gained. The CPS listed the hearsay application at the Southend Magistrates Court but were advised it was likely to be unsuccessful due to insufficient evidence being available to support it. The “victims volatility” was cited by the Bench as a reason why a restraining order was unlikely to succeed. Pleas of “Not Guilty” to one charge, and “Guilty”, but on a reckless basis, (a lesser plea), were made by YZ's defence team. AB provided medical evidence outlining her unfitness to give evidence in person as she was not feeling strong enough to attend. It was at this point that YZ was released from his previous unpaid work orders, sentenced to a conditional discharge and released on the basis that the time spent in remand was as long as any suitable custodial sentence would have been.

Once released from custody YZ was bailed with curfew condition and an electronic tag, awaiting the hearing of the further more serious charges. He proceeded to be absent from the bail address, was reported to be making threats to kill AB, was out of contact and his whereabouts unknown for several days before turning himself in to the police station, assaulted the SERCO operative who came to fit the tag, was drunk at bail addresses, and was put before the court in respect of the bail breach. This was not heard as YZ was drunk in custody, the police not seemingly aware that his case could have been brought before the bench in his absence, or with use of a representative, the result of this was that YZ was released again by the police, as the 24 hour window for bringing him to court had thereby elapsed.

The CPS were not informed about YZ's breaches of bail by the police, meaning they could not use these to challenge ongoing bail. There was poor coordination between these two services on this matter. In addition, there would appear to have been some degree of confusion and misunderstanding amongst those involved, including the police, of the differences between breaches of bail and breaches of bail conditions. In addition, the matter of YZ making threats to kill in respect of AB, was put down for further investigation, and not acted upon immediately by the police. Nor was the whereabouts of

AB ascertained and her safety immediately checked, although the police did set up patrols in her street at one point, in order to see if YZ was breaching bail by being in the neighbourhood. In addition, unsuitable bail addresses were used by YZ's defence, including a sheltered housing scheme and the address of one of his former domestic abuse victims.

On 24th July 2011 police received a non emergency call from AB to the effect that YZ was in her neighbourhood and was harassing her. AB reported this as a breach of his bail conditions. AB said she was going into town and would be back at 4.30pm. The police response was deferred until 4. 30 pm but was not then reactivated. At 7.30 pm that same day the alarm at AB's home was activated and AB was murdered by YZ. He had broken through her fence and attacked her in the garden.

The IPCC have reviewed the handling of events on this day and outlined a number of flaws in the police response which led to the failure of the police to respond appropriately.

3. Conclusions and recommendations from the review

The most significant, and also complex, area of this review is the interaction between the agencies involved in the criminal justice system with YZ. From the time that AB first reported an assault by YZ, and was assessed as a High Risk domestic abuse victim, a lot of emphasis was laid upon supporting AB to make a statement and to give evidence in court. As the offending behaviour of YZ escalated throughout 2011, he accumulated a number of potential and actual charges, and was making frequent appearances in court. Looking at the sentences passed it is clear that YZ never in fact served these sentences- he did not complete unpaid work orders, he did not pay fines, and his community orders were later revoked in favour of an 18 month Conditional Discharge, which meant that he was released from these requirements. The argument used in favour of this approach was that YZ had already spent time on remand, equivalent to a custodial sentence. From the perspective of YZ however, there was a theme in that he was never being required to suffer any actual consequences of his actions. It is also not clear that the Bench, at the time of making further sentences, always had this information about the outcomes from previous sentencing of YZ.

As the offending by YZ escalated, and included breaches of bail and bail conditions, there was poor communication about these matters between the police and CPS, and YZ was re bailed with varying conditions and to different addresses, when in fact he had breached previous conditions. He had also been drunk at one address, which was apparently not a breach. Again from the perspective of YZ, he was never paying any consequences for these actions. Looked at from the perspective of AB the situation must have been very alarming, she had made a statement against YZ, and was very fearful of the consequences of having reported him, he appeared to be breaching legal conditions designed to protect her, but there appeared to be no consequences.

The review uncovered errors and missed opportunities in the interaction between Police, Probation, CPS and the Court. These included the following: sentences incorrectly logged onto probation records, the failure of probation to have access to information which the CPS held, the police DV1 notifications were not always entered onto the police system in good time as a backlog had grown up, the Police National Computer was not always up to date so not all the relevant information was provided to the Court, police Custody Officers made a mistake about a bail hearing, thereby losing the opportunity to potentially deny bail, there was an expectation about so called “Narey Courts” on the part of Probation, that cases should be heard and completed on the day, and there was the issue of the splitting of charges arising from a single incident, so that the domestic abuse content was lost. The overall thrust of these issues is the importance of all those making decisions, including the Bench, in having all of the accurate, up to date, real time information relevant to the case or situation they are dealing with. Recommendations are therefore made in respect of these matters.

Balanced against this there was some good practice in evidence, where individuals and agencies within the legal process attempted to support AB in gaining a good outcome. These included efforts made by the CPS to use hearsay evidence to protect AB, to gain a bad character application in respect of YZ, and the general level of support which was given to AB by both the CPS, who considered her position in terms of giving evidence, and the IDVA in terms of gaining her trust and confidence, and persuading her to take security measures. On occasion the police were proactive, for example in using patrols to try and catch YZ breaching his bail conditions by entering AB's street. On other occasions however, the police response was less good, for example in respect of ascertaining the whereabouts of AB when YZ was making threats to kill, and in not fully seeming to understand the opportunities available to them to challenge YZ's position in respect of bail.

In terms of the support services provided, the review uncovered issues with the MARAC which are addressed in the recommendations, most significantly that the Essex MARAC is very busy with a high caseload. All cases at the MARAC are High Risk, at the time of these events the Essex Police DV1 process did not include the ACPO recommended additional module which deals with perpetrator behaviours in respect of stalking and harassment. These behaviours have been shown in some research to be more strongly associated with men who kill. They are therefore to some extent, predictive behaviours. As YZ's offending and other anti social behaviour escalated throughout 2011, and the extent of his stalking and harassment became known to the police and others, this should have acted as a warning signal which would have identified the more extreme nature of the risk he posed. This DV1 module is now used by Essex Police, but nevertheless it is not just the assessment but the actions which flow from it which will make a difference. The MARAC needs to be more effective in co-ordinating the support and protection for the victim along with the management of casework relating to the offender, something it does not currently do.

Recommendations are made in respect of this area too, therefore, including the need for all local health services to be connected to the MARAC.

In terms of services and support to the victim and her family, the MARAC did look at these areas and AB was persuaded to have security measures at her home, which sadly proved to be inadequate. The DV1 referrals were appropriately transferred to Children's Social Care Services and the follow up from this service was deemed to be adequate, although a recommendation about increased management oversight was made, to occur when domestic abuse referrals involving children reach a certain level.

In respect of support for AB from other services, it emerged that AB was a very private person and did not want her family to know much of what was happening. However, the family feel that if AB had truly known how much risk she was in and had been able to disclose more information to them, the outcome might have been different. Like many families of domestic abuse victims they feel that AB had lost perspective due to the longer term impact of YZ's behaviour on her. The family believe that a DVD or other easily accessible material which could powerfully covey to a potential victim the danger that they are in, and the abnormality of the situation, this would encourage victims to open up to their family, a friend or a trusted professional. This is therefore included as a recommendation.

In conclusion, whilst the majority of the concerns in this case arise from the interaction of the four key agencies involved in the criminal justice system (Probation, Police CPS and HMCTS) there was no one catastrophic error, apart from the delay in the police response on the day of AB's death, which would account for the failings leading to the death of AB. Rather there were a number of weaknesses in the management of charges and convictions relating to YZ which allowed him to apparently evade, at least in the short term, the consequences of his actions. These were combined with some weaknesses in protecting AB and in managing bail in respect of YZ. These seem to stem primarily from the development of local misunderstandings about the operation of the court system, knowledge about bail on the part of the police in particular, and the failure to have, and to provide, up to date information at all times. In addition there were some mistakes in recording information. Even if none of these had occurred it is difficult to determine that these sad events could or would have been prevented.

Nevertheless, the primary finding of this review can be summarised as the need for the agencies key to the criminal justice process in domestic abuse, especially Essex Police, the Crown Prosecution Service, Her Majesty's Courts and Tribunal Service(including Southend Magistrates Court) , and Essex Probation Service, to address themselves towards developing a tighter, technically better informed and better co- ordinated process in terms of how they respond to domestic abuse. This progress needs to be closely scrutinised by the Community Safety Partnership (CSP), not least because, in the context of current organisational change and budget reduction currently underway, it is absolutely essential that the actions and recommendations arising from both Individual Management Reviews, and the Overview Report

in this case, are tracked,managed and reviewed by the CSP to ensure they are delivering improved outcomes and safer systems.

Finally I would like to thank all those who worked so hard on this review for their time and considered input. Most importantly I would like to thank the family of AB for contributing their valuable perspective at such a difficult time, and to express my most sincere condolences to them. Whilst clearly nothing can ever begin to compensate for the loss of beloved family member, I do hope that can be some reassurance that acceptance of the report, and its recommendations, will prevent such a tragic sequence of events recurring.

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Independent Overview Report Writer
May 2013

Appendixes:

Recommendations (Appendix A)
Full terms of Reference

APPENDIX A – Recommendations

Recommendations made in the Interim Overview Report

- That following the completion of the criminal case in respect of MB, the CPS and HMCTS be requested to complete a full IMR, using the terms of reference of this Review, and that the findings within these should be integrated within the Overview Report, along with the outcome of the criminal case and any other findings, such as the Coroner's Inquest.

The recommendations of the Overview Report should then be reviewed with a particular emphasis on any learning which derives from a better understanding of the interaction of key agencies within the Criminal Justice process.

- A recommendation will be made to the Home Office to the effect that the CPS and HMCTS should be made statutory partners to a DHR, by amending the Home Office Guidance.

- It is recommended that the Community Safety Partnership undertakes a review of the leadership and governance arrangements for domestic abuse within the local system. This should include consideration of how HMCTS and CPS could become part of the Community Safety Partnership in order to develop a better understanding of working effectively within the "whole system" in addressing domestic abuse.

- There should be clear links made between the Community Safety Partnership and Domestic abuse Strategy Group, the Health and Wellbeing Board, and the range of partners who link to it, to ensure that all these partners have governance systems, and policies and procedures, in respect of domestic abuse.

These policies and procedures should include a clear and comprehensive section on information sharing. This should include sections on data protection, permissive opportunities and should promote consent to share information as one of the clear strands of good practice.

The work undertaken in the "Deep Dive" should be reviewed, and lessons learned from this should be incorporated as appropriate into the local service strategy for domestic abuse.

- The local MARAC should be reviewed. Matters to be considered by this review should include the following areas:
  - The membership should be sufficiently comprehensive to allow for effective engagement with all partners, particularly those within the health system. Every

partner within the local system should understand who their link is to the MARAC, how they can access this link, and what sort of matters they should report to their link person for the purpose of sharing information. The health service requirement to input into the MARAC is covered by their general duty co-operate on safeguarding matters. Consideration needs to be given to ensuring that Clinical Care Commissioning Groups are aware of the need for GPs to be linked to the MARAC, and that the Drug and Alcohol Services provided via the DAAT should continue to have input commissioned via the Southend Borough Council public health function under the new arrangements now coming into force.

- There should be greater focus on the perpetrator as well as the victim in assessing risk, in particular whether there could be greater focus on assessing and addressing the issue of levels of dangerousness of the perpetrator and how these can be dealt with.
- Actions arising from the MARAC need to be carefully minuted and followed up in all cases.
- In the absence of IDVA representation at the MARAC, this matter should be reviewed and robust arrangements for locating case responsibility should be identified. Local IDVA capacity should be reviewed. If IDVA capacity remains insufficient to allow this role to be undertaken by the IDVA, then it could be formally assigned within a lead professional role arrangement, within the partnership, in respect of each case.
- The victim should wherever possible be aware of the MARAC discussion and process and should be supported in gaining a full understanding of it, and have their views clearly represented and recorded at the MARAC. Where it is not deemed to be appropriate that they are informed (for their own protection) this should be a clearly documented decision with supporting grounds.
- Consideration should be given, within the MARAC process, to the opportunities to use information shared within the MARAC to better support the court process, in the victim's interests. In doing this MARAC should consider both the risks and potential benefits, and wherever possible act on the victims wishes in this matter.

- Local services to support victims should be strengthened in the following ways.
  - The production and delivery of a DVD based, or downloadable, informative suite of materials for victims which powerfully exposes the way that perpetrators manipulate victims, and which outlines the danger which they pose to victims and their families. The involvement of victims in the production and editing of this material would be highly effective.

Grants or charitable funds for to cover the cost of this could be explored.

- More detailed information should be given out at local level about the separate elements of the Sanctuary Scheme, and what realistic degree of protection they offer.
- In the very small number of cases where the assessed level of dangerousness indicates the need, there is consideration given to advising victims, through the MARAC process, that the Sanctuary Scheme is unlikely to be sufficiently protective, and an offer of suitable alternative housing should be strongly recommended to them.

- That immediate action should be taken to clarify the interface between the Police reporting of DV1 notifications to Southend Borough Council, to ensure that the referral clearly identifies any vulnerable adult or children's safeguarding needs, and that the notification reaches the correct service within Southend Borough Council in a timely manner. In addition, a Southend Borough Council practice should be adopted so that after three notifications a firm decision as to whether or not to allocate the case for an assessment is made, with appropriate supervisory input, and is clearly recorded with reasons given.

- That these recommendations are agreed by the CSP and are then converted into a clear action plan with appropriate timescales. In addition the action plans of the IMRs, which are attached as Appendix 3, are also aggregated and given timescales, both of these sets of actions to be monitored for progress by the CSP. In respect of the Probation IMR, where the action plan was felt by the Overview Report Writer to be comprehensive in its coverage, but insufficiently clear as to how the intended outcomes would be achieved, it is recommended that the CSP agrees to receive a full update at an appropriate time of an evaluation by that service of its means of assessing that the intended outcomes have been achieved.

Further recommendations added to the final Overview Report

- The Police DV1 module to contain the extra section on stalking and harassment that ACPO recommend – this should be introduced and then audited to ensure exactness of completion.

- A random sample audit of Essex Police responses to domestic incidents in Southend to be undertaken and reported to CSP, to include responses (including comprehensiveness of evidence gathering), timeliness, deferrals and other significant issues.

- An audit of Police DV1 completion and entering on system1 in respect of cases in Southend to be undertaken and

reported to CSP, re reported and audited until 100% reached on at least 2 successive audits.

- Training for Police Custody Sergeants on Bail: to cover all matters of bail including the issues raised in the review of understandings about technical bail, what constitutes breach of bail conditions, what types of bail should be opposed, and the opportunities offered to deal with the 24 hour rule when a defendant is not fit to plead themselves.

- There should be a review between the key legal services – the CPS, Courts, Police and Probation. They should look at the learning from this review in terms of the misunderstandings about the use of “Narey” Courts, the missed opportunities to gather all relevant information into a submission by CPS, and the use and opportunities for Pre Sentencing Reports. The task group should report back to the CSP on a suitable action plan to improve these matters. This should include how Magistrates will be briefed on this case and the learning from it in terms of use of suitable bail addresses, understanding of the behaviours of high risk perpetrators and their impact on victims as witnesses.

- The CPS and HMCTS should have a formal link to CSP, targets should be set on securing improved rates of convictions in domestic abuse cases, and these should be monitored by the CPS.

- This case shows the reliance of relevant information being available in real time. The Police should be monitored in terms of entries to the PNC being in line with Bichard recommendations at 24 hours for input. The CPS will have access to this information in order to inform prosecution strategies.

- The use of bail addresses which are unsuitable will be addressed within the Court process by means of CPS checking with Police records and other information as appropriate to ensure that unsuitable addresses (sheltered housing, addresses with children or vulnerable adults, or those where former victims of domestic abuse are resident.

- The SERCO contract should be revised making it a requirement that assaults on SERCO staff by defendants are both reported to the Police and prosecuted.

- Improvements should be made to the systems for entering sentences on the records of agencies in the criminal justice system. There should be a follow up audit to ensure these improvements have occurred, reported to the CSP.