Hertfordshire Coroner's Office
The Old Courthouse, St Albans Road East, Hatfield, AL10 0ES

Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

The National Probation Service
Hertfordshire Partnership University NHS Foundation Trust
Hertfordshire Constabulary

2 CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

3 INVESTIGATION and INQUEST

On 28th December 2015 an investigation was commenced into the death of Katie Louisa Locke, who was unlawfully killed on 24th December 2015. An Inquest into Ms Locke's death was opened and adjourned on 16th February 2016. The investigation was suspended on 1st March 2016, pending the outcome of criminal homicide proceedings. In June 2016 Ms Locke's murderer pleaded guilty to and was convicted of her murder. Following the conviction the Senior Coroner for Hertfordshire certified that the Inquest would not be resumed. In October 2018 Ms Locke's family applied to the Senior Coroner for Hertfordshire to resume the investigation into her death and hold an Inquest which would examine the role of a number of public bodies who had contact with Ms Locke's murderer in the months before her death. On 9th May 2019 the Inquest was resumed. The Inquest was heard between 8th and 22nd June 2021. A narrative conclusion was returned and a copy of the Findings of Fact, Determination and Conclusion is attached.

4 CIRCUMSTANCES OF THE DEATH

On 23rd December 2015 Katie Locke went on a date with her murderer, having met each other through an internet dating site around two weeks earlier. Following meeting at a bar in London they returned to Hertfordshire by taxi and booked into the Theobalds Park Hotel in Cheshunt, arriving there in the early hours of 24 December 2015. At some point that morning the murderer killed Ms Locke by means of forceful and prolonged compression of her neck. That fatal assault was accompanied by serious sexual violence. He wrapped her body in bedclothes and left it within the hotel grounds.

Ms Locke's father reported her missing when she failed to return home, and the murderer was traced from information provided to the police by a friend of Ms Locke. The murderer told the Hertfordshire police where he had left Ms Locke's body and he was arrested and charged with her murder.

The murderer, who had been diagnosed with emotionally unstable personality disorder with narcissistic and antisocial traits, was known to two police forces, two NHS Mental Health Trusts and the Probation Service, each of whom had information relevant to his risks to women. There were, however, significant gaps in the information available to each public body, and there was insufficient sharing of the available information between agencies to enable a fully informed assessment of his risks. Three weeks before the killing, the murderer had been given a suspended sentence with a Mental Health Treatment Requirement (MHTR), having been convicted of making threats to kill two other women. Whilst it is not possible to say what sentence the judge would otherwise have given, a fully informed picture had not been placed before the Crown Court. There were a number of lost opportunities for sharing information between the public bodies regarding the murderer and also lost opportunities for further or additional measures to be taken within the criminal justice system.

5 CORONER'S CONCERNS

During the course of the inquest the evidence revealed a matter giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

MAPPA (or multiagency public protection arrangements) is a partnership process established under the Criminal Justice Act 2003 whose aim is to protect the public by assessing and managing the risks of serious harm by sexual and violent offenders. MAPPA requires the local criminal justice agencies and other bodies dealing with offenders to work together in partnership. MAPPA is not a statutory body in itself, but is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a co-ordinated manner

Sitting alongside MAPPA is a non-statutory process known as the PDP (or potentially dangerous persons) procedure. The PDP process is outlined in guidance from the College of Policing[1] and relates to those who are not currently managed under one of the three MAPPA categories, but where reasonable grounds exist for believing that there is a present likelihood of the person committing an offence or offences that will cause serious harm. Although there is no statutory multi-agency framework to govern PDPs, a multi-agency approach is considered good practice. The PDP process will include developing risk management strategies between the relevant police force and partner agencies, who work closely to share information regarding the PDP.

Evidence in the Inquest revealed that, whilst the two police forces who dealt with the murderer both had a PDP process in place, however, the existence of the process and its operation was not known and understood by everyone working at all levels in the police. Furthermore, whilst all other relevant public agencies should have had an awareness of the PDP process and how to make contact via the Police, it seems that knowledge of the PDP process amongst those staff of the

[1] https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/managing-sexual-offenders-and-violent-offenders/potentially-dangerous-persons/

Hertfordshire Partnership NHS Foundation Trust and Hertfordshire Probation Service who gave evidence at the inquest was sporadic.

It is not possible for me to know whether this is a fair reflection of the broader understanding and engagement in the PDP process by the respective organisations. Nevertheless, it gives rise to the concern that information about the PDP process is not sufficiently well disseminated throughout all of the agencies who need to work together within the PDP process to make it work and that further training and/or exchange of information may be helpful.

I consider that unless some action is taken there is a continuing risk that the PDP process will not be properly used to achieve its purpose and provide protection to the public from potentially dangerous people.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 24th August 2021. I, the Coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:
The family of Katie Locke
Avon and Somerset Constabulary
Avon and Wiltshire Mental Health Partnership NHS Trust
Dr. [redacted]

I have also copied this report to the College of Policing for their information.

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the Coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.

29th June 2021
Alison McCormick
Assistant Coroner for Hertfordshire