city & hackney safeguarding children board

CHSCB Response

Domestic Violence Homicide Review
Serious Case Review

MS AB (AGED 45 YEARS) / CHILD D (AGED 22 MONTHS)

June 2016

1. Introduction

1.1 On a Monday in March 2014 at 0911, police were called to a three-story townhouse in Hackney where Ms AB, aged 45 and her daughter Child D aged 22 months were found deceased. Also present was Mr YZ aged 53, a former partner of Ms AB and father of Child D, with non life threatening injuries.

1.2 Mr YZ was charged with the murder of both deceased and was convicted on both counts at the Central Criminal Court in December 2014 and sentenced to life imprisonment with a minimum 35 years to be served.

1.3 Under Section 9 Domestic Violence, Crime and Victims Act 2004, a Domestic Violence Homicide Review (DVHR) was commissioned by Hackney Safer, Cleaner Partnership and, on 2 April 2014, Bill Griffiths CBE BEM QPM was appointed Independent Chair of the DVHR Panel.

1.4 The Independent Chair of the City and Hackney Safeguarding Children Board (CHSCB), Jim Gamble QPM, also decided that the death of Child D met the criteria for a Serious Case Review (SCR). This decision was made in line with Regulation 5 of the Local Safeguarding Children Board Regulations 2006 and consistent with the statutory guidance set out in Working Together to Safeguard Children (2013) (since revised in 2015).

1.5 To avoid the need for two parallel reviews and following agreement by the national panel of independent experts[1] on serious case reviews, the DVHR and SCR processes were subsequently combined.

1.6 The Metropolitan Police Service (MPS) also referred the circumstances to the Independent Police Complaints Commission (IPCC) for a separate investigation into the response by the MPS.

1.7 A comprehensive action plan embracing the findings and recommendations from this review, the Individual Management Reviews (IMR) and the IPCC lead investigator are set out in the Overview report.

[1] https://www.gov.uk/government/groups/serious-case-review-panel

2.0 DVHR / SCR Recommendations

2.1 The Panel coordinating this review identified five recommendations for the MPS. These are set out below and will be monitored by the CHSCB in line with recommendation 4. The wider partnership of the CHSCB, including the MPS, continue to maintain a focus on Domestic Violence and Abuse through its inclusion in the CHSCB Business Plan for 2015-17 and regular interface with the Community Safety Partnership.

1. **The MPS should ensure that the risk assessment section of the planned mobile data replacement for Report Book 124D includes clear guidance and prompts to officers that any response by a domestic abuse survivor in the affirmative must also contain a full explanation of context and meaning as well as a requirement for primary supervision actions to be recorded.**

2. **The MPS should review its electronic Crime Report Information System (CRIS) to be sure that:**
   - **Any threat to life in a domestic abuse context must be reviewed by an inspector who will be responsible for implementing and directing actions in line with the threat to life policy**
   - **First and second line managers have demonstrably undertaken their primary supervision duties before the report can be allocated for secondary investigation by the CSU while ensuring that this not cause delay to the investigation.**
   - **When children are named as potential victims, witnesses or are living in the household, a pre-assessment checklist has been generated and shared with Children's Services**
   - **The Crime Report Information Bureau will not confirm the classification unless and until the above has been completed**
   - **System generated reminders for CSU investigations should be diverted for remedial action (and not just copied) to the next line manager when an officer is absent for any period longer than seven days**

3. **The MPS should review its Human Resources support system to ensure that a report of staff absence in a CSU through work-related stress will prompt an immediate review of**

the officer's work file on CRIS and clear accountability transferred and monitored by the next level of supervision until return to duty

4. **To provide reassurance and improve confidence in the system for safeguarding children and young people, the MPS in Hackney should report to the City and Hackney Safeguarding Children Board that all failed processes have been rectified and appropriate checks and balances are in place in line with the actions arising from this review.**

5. **Research should be commissioned by the College of Policing in consultation with specialists such as Violence Against Women and Girls (VAWG) organisations to identify a model for safe exit planning. Specialist advice would also be sought from the MPS Hostage and Crisis Unit, which have expertise in 'deadline' management. Such research may improve the assessment of risk within the National Decision Model (NDM).**

3.0 MPS Recommendations

3.1 The review identifies that the only IMR that was relevant to this case was from the MPS. The IMR author made the following three recommendations:

1. **It is recommended that officers are reminded of the necessity to explore, clarify and record information when victims provide positive responses during the DASH[2] risk assessment process.**
2. **It is recommended that officers are reminded of the necessity to complete MERLIN/PAC reports in relation to all cases of Domestic Abuse where there are children within the family.**
3. **It is recommended that the current MPS toolkits include guidance to officers in responding and investigating allegations of threats to kill.**

3.2 The CHSCB supports all these recommendations and also supports the Panel's position that there should be a robust MPS training plan as well as staff having access to and attending multi-agency training delivered by the CHSCB. The latter having a focus on further promoting

[2] Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model

an understanding of partnership working and the role of other agencies in protecting children and young people from harm.

3.3 The review identifies that the MPS has in place an ambitious plan to provide refresher training on domestic abuse to all 18,000 front line staff working in Boroughs and this will have a particular emphasis on risk assessment. The CHSCB continues to deliver relevant multi-agency training on domestic violence and abuse (DVA).

3.4 Progress made by the MPS in terms of its response to its IMR recommendations will be subject to ongoing monitoring by the CHSCB.

4.0 Independent Police Complaints Commission Recommendations

4.1 The IPCC made four recommendations for the MPS to consider in relation to the following:

1. **Victims Codes of Practice**
2. **Details needed by police when attending incidents**
3. **Minutes from Daily Intelligence Meetings**
4. **Staffing within Community Safety Units**

4.2 The MPS has agreed with all the recommendations and the IPCC has reported the MPS has put changes in place to adopt them.

4.3 With regards to recommendation 4, the CHSCB continues to monitor risks that might impact on the ability of an organisation to effectively safeguarding and children and young people, including any issues relating to staffing and resources.

4.4 Progress made by the MPS in terms of its response to the IPCC recommendations will be subject to ongoing monitoring by the CHSCB.