LONDON BOROUGH OF HACKNEY
SAFER, CLEANER PARTNERSHIP
AND
CITY AND HACKNEY SAFEGUARDING CHILDREN BOARD

EXECUTIVE SUMMARY

COMBINED DOMESTIC HOMICIDE REVIEW AND SERIOUS CASE REVIEW

MS AB AGED 45 YEARS
CHILD D AGED 22 MONTHS

EACH KILLED IN HACKNEY
IN MARCH 2014

REVIEW PANEL CHAIR AND AUTHOR
BILL GRIFFITHS CBE BEM QPM

Domestic Violence Homicide Review and Serious Case Review
Ms AB and Child D killed in Hackney, March 2014

EXECUTIVE SUMMARY

This summary outlines the findings of a review into the deaths of Ms AB aged 45 and her daughter Child D aged 22 months in March 2014. They were each callously and brutally murdered with multiple wounds from three weapons inflicted by Ms AB's partner and father of Child D, Mr YZ aged 53. He was convicted of their murders at the Central Criminal Court in December 2014 and sentenced to 35 years imprisonment.

The review, initiated in April 2014, was undertaken through a joint process that engaged a Domestic Violence Homicide Review Panel established under s9 Domestic Violence, Crime and Victims Act 2004 and a Serious Case Review Panel convened in line with Regulation 5 of the Local Safeguarding Children Board Regulations 2006. Bill Griffiths CBE BEM QPM independently chaired the Panel.

The process began with a meeting on 1 May 2014 of all agencies that potentially had contact with Ms AB and Child D prior to the point of death. Agencies participating in the review included:

- Metropolitan Police Service (MPS)
- National Probation Service, formerly London Probation Trust
- Hackney Drugs and Alcohol Team Service
- Two General Practices within NHS City and Hackney Clinical Commissioning Group (CCG)
- Homerton University Hospital NHS Foundation Trust
- Safer Communities London Borough of Hackney
- The City and Hackney Safeguarding Children Board
- Hackney Homes
- nia Project Independent Domestic Abuse Advocate Service (as specialist advisers)

Agencies were asked to give chronological accounts of their contact with the victims prior to their deaths. Each agency's report covered the following:

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

The only agency that reported any relevant contact with Ms AB and her family was the Metropolitan Police and a full Independent Management Review was provided.

<u>Key issues arising from the review</u>

Ms AB and Mr YZ had been in a relationship for 18 years, had lived together for 14, and produced children, B aged 15, C aged14 years and D aged 22 months. Ms AB had a daughter, 'A' aged 27 with another partner who was living with Ms AB's mother. Mr YZ had been previously married with two children aged 23 and 16. While friends, work colleagues and neighbours were aware that Mr YZ was very controlling and financially exploitative in their relationship, there was no known physical violence and domestic matters were kept behind closed doors. Their relationship broke down in October 2013 and, by January 2014, Ms AB had given an ultimatum that Mr YZ should have found somewhere else to live by a date in March 2014, the day of the homicides.

From the summer of 2013, the MPS had implemented a structural change to Borough policing, the 'Local Policing Model', that had a significant impact on the work of the Community Safety Unit (CSU) in that a revised team structure and shift pattern occurred at the same time as staff

shortages and an increased workload. In December 2013, a senior officer described the situation as "at crisis point". In January 2014, a performance inspection raised concerns that victims were not being contacted and 'wanted' suspects were not being placed on the wanted management system. A plan was agreed in February 2014 to increase the staff by six officers from April 2014.

On a day in February 2014, Ms AB attended Stoke Newington Police Station with a friend to report that a neighbour had informed her that Mr YZ had threatened to burn down the house with her and their three children in it rather than accept the break up in their relationship. She provided details of YZ, including his mobile telephone number, and suggested that he was no longer living with her and was 'sofa surfing' with friends. She did not disclose the 'deadline' date in March 2014.

PC1 who received her report was inexperienced and, although attentive and empathetic, correctly completing most of the required reports and assessments, lacked the knowledge to accurately record the report as an offence of: 'threat to kill'. Instead, referring to a drop-down menu, PC1 inappropriately selected and recorded the report as: 'threat to commit criminal damage'. The more appropriate classification would have prompted attention and responsibility for action at inspector level. PC1 also omitted to complete the pre-assessment checklist for a report to be shared with Hackney children's social care, as should have been done because the threat also involved the three children living at the house. This error and critical omission were not identified and rectified as they could and should have been in the following phases of supervision and investigation by the police.

There were then missed opportunities and confusion as to who was responsible for what in the primary supervision of the report that, in this case, overlapped with the secondary investigation phase. DS1 in the Community Safety Unit that gave advice to PC1, also assisted by recording Mr YZ as 'wanted' on the Police National Computer and, in order to carry out this task on the electronic crime reporting system, adopted responsibility for primary supervision. DS1 had wrongly assumed that uniformed colleagues had already conducted primary supervision. The back up system for wanted offenders that required a strategy and actions set out to ensure YZ's arrest for the offence was not activated, however, so nothing was in fact done to track him down.

This officer then became distracted with other pressing matters and did not assign the investigation to one of the team as intended and was then on rest days before reporting sick with work-related stress. Twelve days later, DS2 was appointed to look at the work of the colleague on sick leave but did not assign the investigation to TDC1 for a further 23 days. TDC1 made some cursory checks and left a message on Ms AB's voicemail requesting her to make contact. This officer also became involved in other matters and had leave commitments. As a result, the police did no more until called to the terrible events of the day in March 2014, 47 days after Ms AB had brought the threat to notice.

The reality was that YZ had stayed at the family home for most of this period and one of the coping strategies Ms AB had adopted was to telephone her relatives and friends when he verbally abused her so that they could listen in and bear witness if required. She also sent text message with updates on progress, including detail of their arguments, as the deadline approached.

On the morning she had set for his departure, Ms AB phoned her eldest daughter A who was at work and she was able to overhear her mother in an argument with YZ that was cut off after nine minutes. Ms AB made it clear they were "done" and he had to leave. Within two minutes Ms AB called her daughter back and there was a whispered conversation between them. Child D could

be heard in the background. From A's knowledge of the house, she could tell that all three moved to the third floor bathroom.

A was then the auditory witness to a horrific violent assault upon her mother and sister that ended with YZ's words: "This is the destruction you have brought onto the family". With considerable presence of mind and overcoming some local difficulty with dialling out from her workplace, she contacted the police emergency call centre within a few minutes and relayed the information that resulted in the attendance of PCs 2 and 3 within six minutes of her call.

They were unable to raise an answer from the house and could see no signs of a disturbance through their limited view of the ground floor. They did seek further information and sent for equipment to aid a forced entry but they were not provided some of the key information that A had shared with the call handler; also a neighbour and Ms AB's mother who had arrived at the scene provided alternative explanations as to Ms AB's whereabouts that prompted further investigation.

This combined confusion and uncertainty resulted in an additional delay of 40 minutes before entry was forced. Ms AB and Child D were found lifeless in the bathroom with multiple cut, stab and compression wounds inflicted by means of the machete, screwdriver and hammer recovered at the scene. Mr YZ was found with self-inflicted cut and stab wounds and had ingested bleach. A note expanding on the overheard words was left on Ms AB's face. Mr YZ recovered after a short hospital stay. Distressing, as it must be for Ms AB's family, to learn of a 40-minute delay in gaining entry to the house, there is no doubt that, due to the severity of wounds inflicted, the victims were beyond saving at the time the officers arrived at the scene.

The MPS referred the circumstances to the Independent Police Complaints Commission (IPCC). It was determined that the three detectives involved in the secondary investigation should be subject of a misconduct meeting, with the outcome that two received written warnings and one management advice. The call handler for the emergency call on the morning of the murders has faced misconduct proceedings and placed on a three-month action plan to improve performance of tasks and duties.

<u>Conclusions and recommendations from the review</u>
The MPS had introduced the 'Local Policing Model' within Boroughs to improve efficiency and effectiveness. An unintended consequence was its impact on the work of the CSU at Hackney Borough at a time of staff and skills shortages, increased workload and significant gaps in performance – the lack of contact with the victim and the lack of action to secure an arrest - that subsequently resonated strongly in this case. Decisions and plans to deal with what had been identified as a crisis through more resources were not timely enough to prevent the system breaking down with respect to this investigation.

The requirements of the MPS 'toolkit' for reports of domestic abuse provide clear guidance on mandatory and discretionary actions in four phases: primary investigation, primary supervision, secondary investigation and secondary supervision. This is a robust system, but only effective when it is properly followed.

Given the inexperience of PC1, including being unaware of the toolkit guidance availability, a reasonable and reassuring service was provided to Ms AB at the police station. The error in choosing the wrong classification from a menu was down to lack of knowledge and the omission to

conduct the pre-assessment checklist that would generate a report to Hackney children's social care was based on a misunderstanding of when the procedure applied.

These key requirements should have been identified and rectified by primary supervision but, due to a combination of communication failures between the reporting officer and the first and second line supervisors on duty at the time and a false assumption on the part of the secondary investigator that this phase had been properly completed, they were not put right.

Although DS1 supported PC1 by undertaking the work to ensure Mr YZ was recorded as wanted for the offence, follow up on the wanted management system to generate proactive steps to secure his arrest was not activated. Thereafter, no meaningful investigation was undertaken. Secondary supervision was assigned twelve days later but did not function, as it should have done. The electronic crime system generated two reminders for progress updates but these were sent to DS1 who was on sick leave so was not in a position to respond.

As a result, there were many missed opportunities for safeguarding arising from both individual and systemic mistakes and omissions, then repeated or missed at each of the four phases in the MPS toolkit:

- The pre-assessment checklist was not generated, as it manifestly should have been, to share with children's social care that would then have become involved in safeguarding actions, including their own expert risk assessments.
- The incorrect classification went unchallenged throughout and, had it been corrected to 'threats to kill', the threat to life policy would have been invoked and promptly elevated the responsibility for robust action to inspector level which, in turn, would have brought the omission of the pre-assessment checklist to attention and, if the consequent risk assessment was graded 'high', would have led to a referral of the case to the local Multi Agency Risk Assessment Conference (MARAC).
- The wanted management procedure to have an arrest plan for Mr YZ was not implemented and referred for action as required by the policy.
- Consideration was not given to the tactical use of YZ's mobile telephone number as a means to track him down or even to invite him to surrender to custody for interview.
- There was no attempt to contact the neighbour, without whose evidence there would not be a case to put to Mr YZ should he be arrested by other officers for the wanted report
- A secondary and more sophisticated risk assessment was not undertaken (as it should have been in the secondary phase) that would have required further contact with Ms AB and may also have led to a referral to the local MARAC.

Action on any one of these missed opportunities by investigators or any attempt at meaningful supervision could have provided a different outcome. Moreover, the system that was in place to guide these actions lacked the mechanism to bring errors and omissions to the attention of second line supervisors or was so unreliable as to allow them to remain unchallenged or unobserved by the first line. Thus, to some extent it could be argued that the paucity of automated checks and alerts in the system failed the individual officers and staff as well as Ms AB and Child D.

The number of missed opportunities by the Metropolitan Police to make a difference, unchallenged and uncorrected through each of the four phases by investigators and supervisors alike, reflects a clear collective failure by the Metropolitan Police to do everything within their power to keep Ms AB and her children safe from harm

The MPS review identified the need to remind officers of correct procedures in line with the toolkit for domestic abuse through a local training plan. This must also include access and attendance by front-line staff to the training delivered by the City and Hackney Safeguarding Children Board.

The IPCC investigation identified four system recommendations regarding:

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

This Panel has identified and proposed an action plan for an additional five recommendations to be implemented:

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:
    a. 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
    b. 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
    c. 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
    d. The Crime Report Information Bureau will not confirm the classification unless and until the above has been completed
    e. 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).

W Griffiths CBE BEM QPM
Independent Chairman
25 January 2016