

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

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

**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**

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**Domestic Violence Homicide Review and Serious Case Review
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FOREWORD

“The welfare of the people is supreme”

Inscription above Court 3¹, Grand Hall of the Central Criminal Court

In the field of domestic violence and abuse, particularly when children are involved, it has always been the case that professionals should not only deal competently with the challenges they encounter within their own field of expertise; they should also strive to work together with other agencies and specialist advisers to keep people safe from harm.

Unfortunately for Ms AB and her daughter, Child D, as will be understood from reading this overview report, the Metropolitan Police did not demonstrate either competence in their duty to investigate the report of a threat to life from Mr YZ or a proper understanding of the importance of working collaboratively with partner agencies that could have opened up a second line of defence with children’s social care and other specialists.

It is plain that there was a very difficult operating context prevailing at the time for both the MPS and the individuals involved with this case, including significant organisational change and reduced resources in the Community Safety Unit combined with increased workloads. Accepting that humans under pressure are more fallible, it is hoped that the systems learning from this double tragedy will be embraced and changes implemented with vigour.

This independently chaired review into the circumstances leading to the deaths of Ms AB and her daughter Child D has been well supported by the Hackney Safer, Cleaner Partnership, the City & Hackney Safeguarding Children Board (CHSCB) and the agencies and specialist advisers involved. I am very grateful to the members of the Panel for their hard work to support this dual-purpose review and also for their wise and expert counsel during discussions. My understanding of the issues and appreciation for the work they do in the field of domestic abuse and child protection has been greatly enhanced.

I should also place on record my grateful thanks to Tony Hester and Sancus for the invaluable management support to this combined review.

W Griffiths CBE BEM QPM
Independent Chairman
25 January 2016

¹ Where trial held of Mr YZ in December 2014

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INTRODUCTION

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. 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. The Metropolitan Police Service (MPS) referred the circumstances to the Independent Police Complaints Commission (IPCC).
2. Other children of Ms AB are A, aged 27 by another partner and living with the maternal grandmother and, by Mr YZ and living with Ms AB, B aged 15 years and C aged 14 years. Mr YZ has two other children with Ms EF (age unknown): aged 23 and 16 years respectively.
3. Under s9 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. Tony Hester has supported him throughout in the role of Secretary to the Panel and manager of the process. Their respective background and 'independence statements' are attached at appendix 1.
4. Following agreement by the National Panel of Experts to combine this review and the Serious Case Review (SCR) process initiated by the City and Hackney Safeguarding Children Board (CHSCB), paragraph 8 of the Terms of Reference (ToR) was drafted. Subsequently, a meeting with the daughter/sister of the deceased and their Solicitors led to the addition of paragraphs 10 and 11. The Chair issued revised Terms of Reference on 12 September 2014 (appendix 2).
5. The first Panel meeting was held on 1 May 2014 and agencies were represented as shown in the table at appendix 3. Chronology reports were prepared by relevant agencies and an integrated chronology assembled, reviewed and discussed. It was decided that the only requirement for an Independent Management Review (IMR) was from the Metropolitan Police Service (MPS) and that was provided and discussed in detail on 13 October 2014.
6. While apportioning blame is not the purpose of a review under this legislation, opening a window on the system and conducting analysis of what has happened, should provide learning for the safeguarding agencies and any recommendations from the Panel should identify opportunities to make improvement to systems. Forensic and non-judgmental consideration that identifies why services may have been less effective than intended can and should inform how to more proactively reduce harm to those at risk and what change is needed to improve vital safeguarding services. In particular, one of the operating principles for the review has been to be guided by humanity, compassion and empathy with Ms AB's and Child D's voices at the heart of the process.

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Management of the review

7. For ease of reference, all terms suitable for acronym will appear once in full and there is also a glossary at the end of the report. Ms AB will be referred to herein as Ms AB and her deceased daughter as Child D as appropriate to the narrative. Mr YZ may also be referred to as YZ or the perpetrator. Ms AB's eldest daughter 'A' was a significant witness at the trial and her account features strongly in the report. Initials will be used to refer to all other parties and all are listed in the Glossary.
8. This review report is an anthology of information and facts from the organisations represented on the Panel, most of which were potential support agencies for both Ms AB and Mr YZ and their children B, C and D. From the table below it may be noted that six agencies have records of relevant contact for the period agreed by the Panel, 1 January 2009 to 31 March 2014, with either deceased, Mr YZ and children B, C and D and provided chronology reports that also included matters of relevance prior to that time period.

Table 1 – Agencies and records of relevant contact in the order that it occurred

| No | Agency | Summary |
|-----------|---|---|
| 1 | Metropolitan Police Service (MPS) | <p>Convictions for YZ from 09/96 to 07/08 for drugs and driving offences some with short periods of imprisonment imposed, the last being 4 months for driving whilst disqualified and no insurance</p> <p>Between 05/11 and 01/14, five instances of 'child coming to notice' involving Child B and Child C</p> <p>On 12/02/14, allegation of threat to kill by YZ burning down the house with AB and children inside</p> <p>On 31/03/14, police called to double homicide of AB and Child D and YZ charged with both</p> |
| 2 | National Probation Service (NPS), formerly London Probation Trust | <p>Between 07/99 and 04/07 YZ was known and supervised by NPS with respect to imprisonment and probation for Class A drug possession and possession with intent to supply drugs. Pre-sentence report written in 2007 for disqualified driving and excess alcohol offences</p> |

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| | | |
|---|---|---|
| 3 | Hackney Drugs and Alcohol Team (DAAT) Service | Between 02/02 and 06/02 DAAT had brief correspondence and telephone contact with YZ regarding history of drug abuse whereby he had experienced hallucinations when taking crack/cocaine. Not followed up due to prison sentence (5 years imposed 12/07/02) |
| 4 | A General Practice within NHS City and Hackney Clinical Commissioning Group (CCG) | Routine GP records for YZ from 09/06 to 03/14 Nothing exceptional noted Last seen for blood results in 12/13 |
| 5 | A different GP Practice within NHS City and Hackney CCG | GP records for AB. No disclosures about domestic violence in Primary Care notes 2009-2014 No A&E attendances or GP visits with unexplained injuries GP records for Child D from registration on 25/09/12 Although this was late at 5 months, there is not a robust mechanism for ensuring registration of babies with a GP. There were no safeguarding concerns identified |
| 6 | Homerton University Hospital NHS Foundation Trust | Routine school health record for Child B until 18/11/13 when a school leaver. Nothing exceptional noted Health Visitor records for Child D from 09/05/12 Nothing exceptional noted regarding Domestic Abuse (DA) or the child |

9. For the reader's reference, appendix 4 provides a timeline with summary analysis. A comprehensive action plan to embrace all the findings and recommendations from IMRs, the IPCC lead investigator and the Panel has been developed as part of this review process and is set out in appendix 5. At appendix 6 is a letter dated 27 May 2016 from the Home Office DHR Quality Assurance Panel approving publication of this overview report with minor amendments.

Policy Research

10. This review was commissioned under Home Office Guidance issued in August 2013 and statutory guidance for Serious Case Reviews set out in Working Together to Safeguard Children 2013. In particular, the agreed cross-government definition of domestic violence and abuse has assisted the learning from this review and is set out here in full:
11. *“Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:*

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psychological

physical

sexual

financial

emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”

12. The following policies and initiatives have also been supplied and scrutinised:

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews published by the Home Office August 2013

Domestic Homicide Reviews: Common Themes Identified as Lessons to be Learned published by Home Office November 2013

MPS Domestic Violence Investigation and Supervisors Toolkit issued in July 2013

MPS Threats to Life Standard Operating Procedure issued in May 2010

Association of Chief Police Officers (ACPO) “Safe Lives – DASH” risk assessment model from 2010)

London MASH (Multi Agency Safeguarding Hub) Project

Protecting Adults at risk: London multi-agency policy and procedures to safeguard adults from abuse (Social Care Institute for Excellence (SCIE) Report 39)

CPS Policy for prosecuting cases of domestic violence 2009

ACPO Crime Business Area - Joint CPS and police evidence check list published 22 November 2012

CAADA MPS Minimum Standards for Domestic Violence MARACs draft issued in October 2013

NSPCC report ‘Domestic abuse: learning from case reviews’ November 2013

London Safeguarding Children Board, Child Protection Procedures 5th Edition 2015

HMIC (Her Majesty’s Inspectorate of Constabulary) Reports: ‘Everyone’s business: Improving the police response to domestic abuse’ 2014 and ‘The Metropolitan Police Service’s approach to tackling domestic abuse’ 2014

Domestic Abuse: learning from case reviews, NSPCC November 2013

London Child Protection Procedures, chapter 27, London Children Safeguarding Board 4th Edition 2014

Hackney Council Scrutiny Commission – a review of domestic violence services in the Borough in 2010

Hackney Community Safety Partnership domestic violence and gender strategy 2011-2013

Comparative case analysis

13. There have been three prior domestic homicide reviews in Hackney and 49 recommendations made and the Panel has studied these. Given in this case the lack of prior contact with agencies, save for the police in February 2014, it has been concluded that there are no local recommendations from prior reports in Hackney that should be compared or re-examined for effectiveness.

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Family and friends

14. The Chair met with Daughter A on 9 September 2014 at the offices of Bhatt Murphy Solicitors (BMS), Hoxton. The position regarding her status as a witness in the case was clarified and her evidence was not discussed. Ms AB's siblings and children B and C are also represented by BMS who undertook to relay key points from the meeting. As a result of the meeting and a written submission from BMS, the Chair issued revised ToR (paras 10-11).
15. Family, neighbours and work colleagues gave evidence at the trial. Apart from a threat by YZ that, rather than leave the house as requested, he would burn down the house with Ms AB, himself and the children inside, there is no evidence that anyone knew of domestic abuse that should have been brought to the attention of the authorities.
16. The family kindly provided a copy of the combined family and community impact statement that was read out before sentencing. In July 2015, the family and their Solicitors were afforded supervised access to the fourth draft of this overview report and they provided a written submission on 4 August that was debated by the Panel on 12 August and views incorporated in subsequent versions.

The Perpetrator

17. The National Probation Service assessed Mr YZ within three months of sentence. In interview he persisted with his claim of innocence and the defence that was presented on his behalf at the trial (see paragraph 123). It follows that he did not express remorse and that he would not contribute to the learning from this review.

Police investigation, conduct investigation and Coroner

18. The Chair set up liaison with the Senior Investigating Officer (SIO) and the IPCC lead investigator to ensure the judicial process was effectively managed, including the disclosure of material in the course of the review. He attended some aspects of the trial, including evidence from family and friends and the summing up. The Coroner opened and adjourned an Inquest into the death of the deceased on 28 May 2014.

Equality Act 2010

19. Consideration has been given to the nine protected characteristics under the Act in evaluating the various services provided. All parties are Black British. Both victims are female.

Confidentiality

20. The Government Protective Marking Scheme (GPMS) was adopted throughout with a rating of 'Official-Sensitive' for shared material. Either secure networks were in place (gsi, pnn) and adopted (cjsm) or papers shared with electronic password protection.

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THE FACTS

Background – Ms AB

21. Ms AB is from African Caribbean heritage and has three sisters and one brother. Her mother is still alive and lives with MS AB's eldest daughter, A aged 27, whom Ms AB had with a former partner. Since 2006, Ms AB had worked as an office manager locally for a community development charity. She also made and sold greetings cards and jewellery both as a hobby and for a small amount of income. She had a talent for poem writing and she enjoyed cooking. She was a confident and popular woman and any domestic issues remained behind closed doors².
22. Prior to her report of serious domestic abuse to the police in Hackney in February 2015 (set out in detail below), there are no records of contact with agencies other than through general health matters and most recently through the birth of Child D in May 2012. Mr YZ chose to suggest at his trial that Ms AB suffered from acute post-natal depression as the result of this birth, such that she became mentally disturbed and murdered her before attacking him. There is not a shred of medical or other evidence that this was the case.

Background – Child D

23. Her mother described Child D, born when Ms AB was aged 45 years, as her 'miracle baby'. Most of the family knew her by one part of her name, whereas; her father would use another. She was also called 'an old soul' who brought renewed life and joy to the family. She is described as a clever and advanced little girl who had a healthy appetite and loved singing and dancing. Above all, she will be remembered for her smile³.

Background – Mr YZ

24. Mr YZ is also from African Caribbean heritage but nothing is known about his parents or siblings, if any. He has a former partner, Ms EF, with whom he had two children, respectively aged 23 and 16 years. At the time he formed the relationship with Ms AB, he ran his own businesses in property management and a taxi company and seemed to have ready access to money⁴.
25. Enquiries by the police with Immigration Enforcement reveal that he had first entered the UK from Jamaica in November 1989 and left after six months. He re-entered illegally in 1990 and was subject to numerous deportation processes and appeal hearings. The last of these was on 1 July 2009 when he was granted 'Discretionary Leave' (DL) to remain until July 2012. While Ms AB was the lead applicant for this leave, the DL was in fact granted on the basis that separating him from his previous partner EF and their children would breach Article 8 of the Human Rights Act. Although the DL order had expired, the Article 8 decision meant there was no active interest from Immigration Enforcement and their case was dormant.

² Source: Interview with Daughter A on 09/09/14

³ Source: Family 'impact statement' prior to sentencing

⁴ Source: Daughter A

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26. Mr YZ is known within police records from 1996 for possession of, and possession with intent to supply, Class A drugs for which he sentenced to five years imprisonment in July 2002 (through which he is also known to Hackney Drugs and Alcohol Action Team – DAAT and the National Probation Service) and driving offences, including with excess alcohol and driving when disqualified for which he has received community sentences and short terms of imprisonment, the latest in July 2008 which was his last contact with police.
27. There is one prior domestic abuse incident recorded in November 2000 when EF alleged he had repeatedly punched her shoulder whilst lying in bed. She had left to stay with her father and the report was taken there, including photographs of the bruising. However, she declined to substantiate the allegation and provided a withdrawal statement. Accordingly, the investigation was closed. She also disclosed that he had conducted an affair (with Ms AB) and fathered two children and that she was seeking a divorce. Mr YZ was not arrested in connection with the investigation and it is not known whether he was aware of the report.
28. In 2005, National Probation Service records show that Mr YZ had responded positively to probation supervision following his conviction for drug offences and had tested drug free. It was also noted that he was running a painting and decorating sub-contracting business.
29. Mr YZ had been regularly seen by his GP for checks on his known conditions of Type 2 Diabetes and Hypertension. There was no history of mental health problems but he had been assessed on two occasions for depression in 2012 and 2013 and no depression diagnosed.

Their relationship together and contact with the safeguarding services

30. Their relationship commenced some time in 1996 and they began living together in 2000. At some point before 2009, they moved to housing trust accommodation in Hackney, where they lived with their children B and C.
31. In November 2011, when pregnant with Child D and seen at Homerton University Hospital, Ms AB reported that she was living with her partner who is supportive and there was no domestic violence reported upon routine enquiry. It was further noted that there had been no social work involvement and no alcohol, substance misuse or mental health concerns.
32. Following the birth of Child D in May 2012, both mother and child were anaemic but recovered and were discharged within three days. At a new birth visit by the Health Visitor later in May, Ms AB reported that her husband and children are all very supportive of her and the baby. There were no underlying health conditions and no low mood or history of depression reported. Information on Post Natal Depression was given and the home environment was noted as clean and safe.
33. Daughter A provides a different perspective. She is clear that Mr YZ was not at all supportive of her mother. In fact, while she knows of no examples of physical violence, there was a sustained amount of emotional, financial and controlling type domestic abuse that worsened after the birth of Child D. In her opinion, this was the reason that Ms AB wished to bring an end to the relationship.

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34. Some of the examples provided by Daughter A are:

Financially, Ms AB carried Mr YZ and paid all the household bills

He thought of himself as an entrepreneur and always had a new business project under development such as catering, DIY or gardening (A believes he was working on the garden next door on the day before the murder) that required funding to initiate – Ms AB or her mother were usually the source for this but nothing ever progressed as he said it would and the ‘loan’ was never repaid

He had use of her car and if he incurred a traffic or parking fine she would be expected to pay

The only time he paid anything toward the upkeep of Child D was £10 when he purchased some nappies

He controlled the way Ms AB dressed for social occasions – if in his opinion she looked too attractive preparing for a night out he would tell her to change clothes for something less glamorous; he could not bear for her to be the centre of attention; it was all about him

35. Daughter A has added that, generally, Mr YZ was indifferent to Child D and providing minimal support. However, she knows of one occasion of apparent neglect in February 2014 that provoked an argument between him and Ms AB. He had taken D to nursery care and it had rained heavily on the way. He did nothing to protect her from the rain and by the time he arrived her clothing was soaked through. The registered child minder, who was also a friend to Ms AB, has confirmed this story and described a complete absence of concern by YZ for the welfare of his daughter and his responsibility in that respect. However, she has also confirmed that this was an isolated example of neglect and she harboured no other reasons to fear for D’s safety.

36. By October 2013, Ms AB wanted to end the relationship. Initially, she set him a ‘deadline’ to find somewhere else to live and leave the house by January 2014. However, there was a misunderstanding about this date and on 3 January she set a new date for his departure in April, later refined to a date in March 2014. In the interim, she required him to pay £150 a month toward his keep and, if not for his keep, then £50 a month for each of their three children’s keep. The sleeping arrangements were that Ms AB and Child D shared a room with child C. Mr YZ and child B had their own rooms.

37. After the deadline was given, YZ’s behaviour changed. He became jealous and difficult. Witnesses report that he would accuse Ms AB of having affairs, sneak around the house and listen in to her telephone conversations.⁵

Relevant text messages from Ms AB

38. Retrieved in the course of the murder investigation and produced in evidence to the Jury, a series of text messages are helpful to understanding the sequence of events prior to the murders of Ms AB and Child D and to ‘hear’ Ms AB’s developing concerns for her and her children’s safety. Obviously, these were private between family and friends at the time and not

⁵ Source: Prosecuting Counsel opening speech

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known to anyone in authority. This text message⁶ was sent to her inner group of six family and friends in early January:

I've done it.

I told him I want to speak with him before the children wake up.

I said last yr I told you I wanted a break, u said no and that u weren't moving out, well this year [date in early] Jan this relationship is over and I don't want you living here. I want £150 each month for your keep, but if not for ur keep then £50 a month for each of ur children. I will not be carrying you free of charge from this day onwards. He said I have nowhere to go and need to make some money to maintain where I'll be living.

You have until the [date in early] April to find urself a place and get out from here, please know that I am serious about this. You have to go and find a job bcos I'll be bugged if I'm getting up every morning five days a week and u ain't doing shit. You've continuously sung the same song for too many yrs that it's worn out and no longer tolerated. I can't stand u just like u can't stand me, so now u know what I want and I will get what I want please start making ur preparations.

There's alot more said but this is the main drift of things.

39. To one of her sisters [sister G], she added this rider to the message:

Believe me I know it ain't gonna be easy for the next few months, just looking at his face and body language tells me I have to be very very careful and pray for my safety each day and night. But the main thing is that he knows it is over full stop and that he has to leave this house.

40. And to a friend, she added this:

Not gonna lie [Name], feeling abit scared of him but if I continue to be guided by my angels I'm gonna come through good.

41. On Monday 13 January, to her older sister H she wrote:

As I'm sitting here, I realize that this is a very very sad period in my life.

The man who I gave myself to and loved like I've never love anyone before, never really existed.

Before the veil was removed from my eyes, all his faults, bad ways and laziness, I always made excuses for. His business ventures that I always found the money to finance always fell by the way side, but still I continued to believe in him, thinking he must surely make this one work, wasted money down the drain.

When he ran up debts he knew that I would cover, because he knew I would always be his financial crutch.

When the bad men came calling with guns in their pockets and showed me what they had, threatening to kill me and mine, I paid the debt, to keep him safe simply because I loved him.

⁶ All text messages noted are in the original language as logged on AB's mobile telephone

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42. Within a few minutes, she had written to sister G in similar vein:

When he denied my [Child B] 3 times in order for him to maintain his stay, I should have walked away but I didn't, simply becoss I loved him.

When he wanted to see my new born daughters fingers and toes so he could tell if she was his, I should have told him, get lost, but I didn't, simply bcos I loved him. I should have walked away when he told me I won't divorce my wife yet, bcos I need her to get my stay, but how could this be when it was I who got him his stay. I should have walked away along time ago but I didn't, simply bcos my love for him was more than what I had for myself.

But now the time is right for me to walk away, bcos now the veil has been removed I'm shown that the man who I thought loved me never really loved me at all an this is what has really broken my heart.

Will I ever love again, only the Almighty will tell.

43. [Note: From these messages it can be inferred that YZ had been in trouble with organised crime and that he could be illegally in the UK. There is a possible connection to his conviction in 2002 for drug possession with intent to supply. It has been established that the Immigration Enforcement case file has been dormant since July 2012].

44. On a day near the end of January, Ms AB updated Daughter A, her two sisters and two friends on progress with this message:

Lol just spent the last 20mins speaking with this man. He thinks we need to go counselling and the counsellors are mummy and [sister H] and two members of his family. Not happening [first name of YZ] it is over. I'm confused I don't understand what is happening here. What is happening here is that you have taken no notice of what I've been telling for the last few yrs, your a grown man who doesn't know what it's like to pay rent, gas, electric, put food on the table and help keep ur home bcos it's always been done for you. You are to complacent and expect everyone to keep on giving to you. Now it's time for u to step up, grow up and fend for yourself. It is over between us and it's entirely up to u if u want to maintain a relationship with your children. Lot more said but I got to get ready for work.

45. In mid February at 1929, the eve of her report to the police (below), she sent this message to her mother:

Mum I was told this evening that he went to see a solicitor to find out what his rights are to staying in the house and was obviously told he has no rights except to see the children but only with my permission and my conditions. He has said that if he has to move out on the [date in March] he will set fire to the house, killing the children if he has too, along with myself and then go back in and kill himself also.

I'm going to go to the police tomorrow to report what I've been told so that they have it on report.

If you and pastor haven't finished prayers yet, pls include me and mine.

Love you

V

46. At 2127, she sent a follow-up message:

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Mum I need to think long and hard about what I'm going to do in terms of either going to the police or calling immigration, either way I feel like I'm fucked whichever one I choose. The police won't do nothing until he physically assaults or kills me and wit immigration he'll know it's me, cos they know were he lives and they ain't come looking for him even though his time is up. Right now I feel messed up in my head and my strength is draining away from me. I will pray for protection but most of all for guidance. I promise you one thing, I will not lose my belief or my faith.

47. From evidence provided by Daughter A at the trial, it is known that she was influential in this decision to inform police of the threat, saying that she: “Had to coax mum to go and log this with the police”.

48. The next morning at 0700, Ms AB sent this message to Daughter A and a friend:

I was told to much information last night to let this man continue to stay in this house. He has to go and he has to go now. What he is planning sickens me to the pit of my stomach.

Other relevant information from the murder investigation

49. The Major Investigation Team (MIT), has in the course of their enquiries established that, four years beforehand, Ms AB reported to her close friend that Mr YZ had threatened to burn the house down with her and her children in it and that he would slit the throats of the two children she had at the time if she tried to leave him. In similar vein, about a year before these events, Ms AB disclosed to Daughter A that she was scared and did not know what he was capable of. Furthermore, the friend reported that Ms AB would cry and shake and say, “This guy is going to kill me and my kids; if I stay, he won’t hurt my kids”.

50. The same neighbour that informed Ms AB of the threat that she then reported to police in February had, in December 2013, been told by Mr YZ that he would: “Get a shotgun, kill everyone in the house and then kill himself, rather than go to prison”. It is not known if Ms AB had been told this, but it was not reported to police at the time, nor mentioned by her when reporting the threats to the police below.

51. From evidence provided by Ms AB’s brother at the trial, it is known that he contacted Mr YZ by telephone and challenged him about this latest threat to burn down the house with Ms AB and the children inside. His response was that he had said nothing like that and had no intention to do anything like that. He also said that he knew he had to leave the house, and would leave, by the date set in March. The brother was not happy with the response but felt he had at least let YZ know that he knew of the threat and had given a warning. When he called his sister to update her, she was already on her way to Stoke Newington police station to report the matter.

Threats reported to police in mid February 2014

52. Since July 2013 the MPS has replaced its SOP (Standard Operating Procedure) approach with operational ‘toolkits’ as a checklist containing mandatory and discretionary options for which, in relation to domestic abuse, there are four sections: primary investigation, primary supervision, secondary investigation and secondary supervision.

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53. It is felt that this single report to the police of domestic abuse is so important to understanding what happened and what should have happened, it is appropriate to set out their actions in fine detail under these headings⁷. This will be followed by an explanation assembled from officer accounts of the prevailing operating context.

Primary investigation

54. On a weekday in mid February 2014 at about 1030, Ms AB attended Stoke Newington Police Station with a friend (JK). He played the role of supporter throughout and said little, other than to occasionally reassure her that she was doing the right thing. She informed the station officer that she wished to speak about a domestic matter and they were shown to a side room. Ms AB appeared to the officer to be nervous, hesitant and softly spoken, at times was tearful, and apologised for wasting police time. The officer ('PC1') reassured her and she composed herself.

55. She wanted to know if she made an allegation about a male would the police arrest him, and made it clear that she did not want him arrested; she just wanted the police to know about what had happened. She was informed that the matter would be investigated and that he may be arrested.

56. Ms AB then disclosed to the officer that she had separated from Mr YZ in October 2013 after 13 years together⁸ but that he had difficulty in accepting that the relationship was over and still believes they are together even though she had told him numerous times that the relationship is over.

57. She had visited her friend and near neighbour (LM) at about at 1700 the day before and been informed that Mr YZ had told the neighbour earlier that day that, due to the separation, he intended to burn down the house with Ms AB and their three children in it and kill himself. When she asked LM why he had said this, she reported his response as: "If he can't have me, no one can". LM had added that YZ had told her of a conversation with a solicitor about the separation in which he had been advised that he would have no rights to see his children⁹.

58. Ms AB provided the reporting officer with details of Mr YZ, including a description and his mobile telephone number, but stated she did not know his address. Although not recorded, the officer has recalled that she told him she believed Mr YZ was 'sofa surfing' with friends without knowing the details. He did visit the address to see their children. She provided contact details for the witness LM. As far as can be ascertained, Ms AB did not share the fact that she had set the date in March for Mr YZ to leave the home permanently and there is nothing recorded to that effect.

59. The officer that took the report completed a Book 124D, a notebook specifically designed for instances of DA. It was recorded therein that Ms AB was offered a referral to a DA support agency but declined and signed a declaration to that effect. She also declined the offer of a referral to Victim Support but accepted a 'victim care card' that contained contact details for the reporting officer and his line manager. With respect to a question about emotional disposition,

⁷ A timeline and summary analysis is available at appendix 4

⁸ 13 years is consistent with the DA incident and separation between YZ and EF in Nov 2000

⁹ Enquiries were made by the MIT and the only Solicitor traced through YZ's diary was an immigration specialist who had not given YZ advice on family matters

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PC1 recalls that he asked Ms AB how she was feeling at this point and her response is recorded as: “drained”.

60. In addition, the officer completed an electronic crime report on the CRIS (Crime Report Information System) and typed a witness statement on form MG11 that Ms AB signed. All entries to the CRIS are automatically timed. Within the CRIS record it is noted that Ms AB felt this was bizarre behaviour from Mr YZ, while also commenting that he drinks a lot but does not have a drink problem, and that she was scared about what Mr YZ may do and also what: “repercussions reporting the matter to police could inflict”. She had not yet informed her children about the situation.

61. The list of 20 questions printed in report book 124D is shown. Ms AB is recorded as responding to the first two questions as follows:

Victim's perception of risk

Are you afraid of what they might do to you or anyone else?

“Yes right now I am”

Separation (child contact)

Have you separated/tried to separate from them?

“We are separated”

62. She provided a simple “YES” response (without any elaboration recorded) to the following four questions:

Controlling and/or jealous behaviour

Do they try to control everything you do or are they excessively jealous?

Do they hurt or threaten to harm/kill the children?

Use of / access to weapons or credible threats to kill

Have they made threats to kill you or your family?

Suicide - homicide

Have they ever threatened or attempted suicide? [Note: The original “No” response is deleted and “Yes” substituted]

63. The remaining questions below are marked with a “NO” response:

Separation (child contact)

Is there conflict over child contact?

Pregnancy / New Birth

Are you pregnant or recently had a baby?

Escalation

Is the abuse happening more often and is the abuse getting worse?

Community Awareness and isolation

Are there any personal or cultural issues which make it harder for you to seek help?

Is there any other person that has threatened you or that you are afraid of?

Do they isolate you from support or help/family or friends?

(Consider HBV cases e.g. forced marriage, house arrest, being 'policed' by relatives.

Consider disability, LGBT people, older persons, traveller communities, etc)

Stalking and harassment

Do they constantly text, call, contact, follow, stalk or harass you?

Sexual assault

Do they say or do things of a sexual nature that make you feel bad or that physically hurt you or someone else?

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Strangulation (Any attempt to block airway)

Have they ever attempted to strangle/choke/suffocate/drown you?

Abuse of alcohol/ drugs / mental health

Have they had problems with drug (prescription or other), alcohol or mental health problems that influence their ability to live a normal life?

Abuse of Pets / Animal

Have they ever mistreated an animal or the family pet?

Suicide - homicide

Other relevant information which may alter risk levels e.g. vulnerability of victim (disability, suicidal, mental health problems, age, substance misuse), occupation/interest giving access to firearms (ex-military, police, pest control) breach of bail conditions/injunctions?
Is there anything else you would like to add?

64. The risk assessment should be recorded within the CRIS report. It is understood that the practice is for officers to have a pre-prepared word document that can be 'cut and paste' into the CRIS record in order to save time. This would appear to account for the slightly different wording to the Book 124D. The officer has recorded that there was no history of domestic violence [*sic*¹⁰] but that there were other factors which indicate CSU contact is required / desirable. He recorded that children were present at the home address but not present at the time of the incident. In response to the question about why the suspect had not been arrested at the scene, the officer recorded:

"VICTIM has come into Police station to inform Police about threats of criminal damage to endanger life. Suspect will be circulated"

65. He has recorded "YES" without elaboration against the following DASH questions in the CRIS report:

Victim perception of risk?

Any other threats?

Controlling and / or jealous behaviour?

Child abuse:

Suicide / Homicide:

66. For the question, 'Use of / access to weapons or credible threats to kill:' the officer has recorded "NO". This is at odds with the "YES" recorded on the Book 124D and also fact that he was dealing with a threat to commit criminal damage that could endanger life; however, it is consistent with the incorrect classification later recorded on CRIS (see below).

67. Using the DASH risk assessment process, the officer recorded a judgement of 'high' in the Book 124D and 'medium' within the CRIS report. In the witness statement he has provided to the IPCC investigation, the officer writes that, at some point, he left Ms AB and JK to seek advice from a colleague (whose identity he cannot now recall) who suggested that the risk might be medium rather than high. The reason for approaching the colleague for advice was because, as an inexperienced neighbourhood-policing officer, this was the first time that he had been deployed on station officer duties and also the first time he had reported a domestic abuse matter. He did not feel he had been directed to downgrade the risk assessment; rather, he 'took the advice'.

¹⁰ The MPS adopted the definition for 'Domestic Abuse' in 2013

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68. The DASH risk assessment model was adopted by the MPS in August 2010 and it was incrementally implemented during 2011. On the basis of responses to the Book 124D questionnaire, officers use professional judgment to evaluate, and supervisors to confirm or adjust, the risk level as standard, medium or high, against this definition set out in the book:
- Standard* – Current evidence does not indicate risk of causing serious harm
Medium – There are identifiable indicators of 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 and drug or alcohol abuse
High – There are identifiable indicators of serious harm. The potential event could happen at any time and the impact would be serious
69. The positive responses to the questionnaire were not elaborated upon within the CRIS report or the witness statement. The IMR author has pointed out that the level of risk attributed to an incident does not affect the level or outcome of the investigation; rather, it is intended as a catalyst to trigger other processes.
70. In cases assessed as medium or high risk, there is a requirement within the procedure to complete a secondary risk assessment and the appointed investigating officer from the Community Safety Unit (CSU) normally undertakes this. Obviously, elaboration on positive responses to the indicators of risk or subsequent exploration sheds more light on the subject and deepens the quality of professional judgement. High-risk cases should be considered for referral to the Borough MARAC (Multi Agency Risk Assessment Conference) that meets three-weekly in Hackney¹¹.
71. Full details of Children B, C and D were recorded as potential victims of the threat along with Ms AB in both the 124D and the CRIS reports. For this reason and also the fact that 'Child Abuse' had been identified as a specific risk factor in the CRIS report, there followed the requirement to complete a MERLIN (Missing Persons and Related Linked Indices) PAC (Pre Assessment Checklist) report that would be shared with relevant agencies, specifically, children's social care in Hackney.
72. This requirement is shown clearly as a prompt on the front cover of Book 124D. The reporting officer did not complete a MERLIN/PAC report because he mistakenly believed it was required only if he had seen the children; furthermore, this omission was not identified and corrected in either the primary supervision phase or the secondary investigation and secondary supervision phases within the CSU.
73. The CRIS record shows the allegation as one of threats to commit criminal damage with the 'method' recorded as: "burn down VIW (Victim, Informant or Witness) 1 (ie Ms AB's) house with her and the children in it", a clear report from Ms AB that the threat was to kill her and the children. Moreover, within the details of investigation, the officer has recorded that Ms AB was scared about what Mr YZ might do to her and the children and therefore had reported this to the police as a matter of urgency.

¹¹ This was changed to weekly meetings in May 2014

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74. There are hundreds of possible crime classifications within the Home Office counting system for recorded crime and, within the CRIS, officers are presented with a drop down menu of possible crime classifications from which to choose. PC1 cannot recall how this inappropriate classification was chosen and, again, this fundamental error was not recognised and rectified on any of the following phases.
75. Had the allegation been recorded as a 'threat to kill' (TTK), then that would have invoked another process known as the 'threat to life' (TTL) procedure. This would have required the duty inspector to conduct a further assessment. Subject to that judgement, there would be a safety plan developed and considered with respect to Ms AB and the children. If followed, this process would also have reinforced the need to ensure the proper MERLIN/PAC notification to other agencies such as children's social care with respect to the children at risk.
76. It is known from the reporting officer that, while Ms AB and her colleague were at the police station, he sought advice from a Detective Sergeant (DS) in the CSU and the duty inspector prior to recording the allegation within the CRIS report. From the time shown for the officer to conclude his part of the CRIS record, it is likely that Ms AB left Stoke Newington police station at about 1440, some four hours after she attended with her friend and the CRIS report was first opened at 1050.

Primary supervision

77. Supervision of the work of a constable would normally fall to the 'section sergeant' who is the first line supervisor responsible for the products and processes generated on his or her shift and there may be several available for this task. Within the 'Grip and Pace' arrangements for command and control, one sergeant is nominated to the HOT (Harm, Opportunity and Threat) assessment role and takes a seat in the control room situated on the ground floor near to the front office to receive reports and provide advice.
78. The Book 124D along with Ms AB's witness statement was received and logged in the CSU the next day. It has been examined on behalf of the Panel and a supervisory signature of a sergeant ('PS1') discovered. This officer was not interviewed in the course of the IPCC investigation. PS1 has confirmed to the Chair that it is his signature as supervisor for the Book 124D completed by PC1 and that he was working the early shift the day the report was made, possibly in the HOT role. He has also discussed the Book 124D and the CRIS report with the duty inspector (INSP1) to see if memories can be refreshed as neither officer became aware of the significance of these reports until some 15 months after the event.
79. Unfortunately, while able to describe what he would have done on examination of such a report, PS1 has no recollection of it or anything that he did do as a result. Moreover, his name does not appear on any other available record such as the CRIS report. He cannot rule out that he was approached with the report by PC1 and nor that he could have provided the advice to attend the CSU.
80. The account given by PC1 is that he did at some stage approach a sergeant for the Book 124D to be supervised and believes it was then that he was directed to attend the CSU for advice. He had never been to that unit before (which is located on the fifth floor of a separate building) and it was happenstance that it was DS1 that he approached for the advice. He feels on reflection that, had he not been directed to bring the report to the attention of the CSU by a

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supervisor, his lack of experience at that time means that he would not have done so on his own initiative.

81. The CSU DS ('DS1') who was approached for advice accepted the CRIS report direct without other supervisors reviewing it; furthermore, he has recorded the crime assigned to himself for investigation at 1446, within eight minutes of the reporting officer concluding his work on CRIS.
82. In his account to the IPCC, DS1 says that he assumed that 'uniform' supervision had been conducted prior to his being approached for advice. He assigned the investigation to himself in order to be able to place the details of Mr YZ on the Police National Computer (PNC) as 'wanted' in connection with the report. Under the 'details of investigation section, he has recorded at 1445 under a typed heading of 'Supervision':
- The reporting officer has made myself and GD1¹² aware of this incident
I have reviewed and there is no address for suspect so no arrest enquiry has been generated
I have circulated suspect on PNC and when doing this an address of [Ms AB's home address] is stated*
83. Elsewhere under 'details of investigation' he recorded, also at 1445:
- I have called victim but there is no answer and there is [sic]¹³ facility to leave a message at present*
84. There will be one inspector, or 'duty officer' available on each shift for oversight, the granting of certain authorities and providing advice for the work generated in any given shift. The early shift Duty Officer for the day of the report was not interviewed in the course of the IPCC inquiry; however, 'INSP1' has since provided an account to the Chair by written statement and telephone interview. His unequivocal position is that the reporting officer, PC1, was not on his team, is not known to him and did not bring the crime report to his attention that day. Had he done so and based on the content of the CRIS record, INSP1 states he would have followed the MPS policy for managing threats to life and personally taken command of the next steps. The archived duty officer's 'handover log' for the early shift that day (completed at 1430) has been recovered and there are no significant events noted therein.
85. On the other hand, PC1 has also met with the Chair and remains confident that he did inform INSP1, whom he recognised from prior service in the Borough when a PCSO (Police Community Support Officer), and INSP1 signified approval of his actions although he cannot be precise about what information he relayed to him. Moreover, his memory was prompted within one day of the murders when he was asked to provide a witness statement regarding his interaction with Ms AB in February 2014; whereas, both PS1 and INSP1 were not approached until June 2015 some 15 months afterwards. The dichotomy between the accounts of PC1, PS1 and INSP1 remain un-reconciled; however, the contemporaneous records on CRIS tend to support the account by PC1.
86. The Crime Report Information Bureau (CRIB) is a team of staff that remotely manages the processes within the CRIS, primarily to ensure that each allegation of crime is consistent with

¹² Radio call sign for Hackney Borough duty inspector

¹³ In his IPCC interview, the officer recalled that there was not a facility to leave a message

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the Crime Counting Rules laid down by the Home Office. At 1434 on the 'General Information' page for the crime, a police staff member ('CIV1') of the CRIB 'screened in' the report for investigation.

87. At 1435 CIV1 also completed actions that had not been carried out by PC1, for example, by ticking the 'Domestic Incident' button. This action prompted consideration of the three choices for initial risk assessment between standard, medium and high. CIV1 opted for 'standard' so clearly had not read PC1's assessment of 'medium' recorded in the free-text investigation pages. At 1443, CIV1 went on to confirm the initial classification¹⁴ (recorded on the system by PC1 at 1241) as: 'Threat to Commit Criminal Damage'.

Secondary investigation

88. DS1 contacted the bureau for the PNC and gained the necessary authority to place Mr YZ on the PNC as 'wanted' for the offence of 'threat to commit criminal damage'. To achieve this by telephone, he was required to provide an inspector's name for the authority and he provided that of his line manager 'DI1'. In fact, he did not specifically seek that authority; it was the local practice that this was assumed without further reference.
89. A separate database known as the EWMS (Wanted Offenders Management and Enforcement) is utilised to record the actions taken to locate and detain the suspected offender as soon as practicable, together with the supervisory conduct and this should be fully populated within 24 hours of an urgent PNC request. A separate unit within the Borough police maintains oversight of this database and monitors progress on EWMS enquiries.
90. The point of 'circulation' as it is known, is for any patrolling officer who may then have contact with Mr AB to be empowered to detain him for interview in connection with the allegation at Stoke Newington Police Station. When interviewed, DS1 gave this positive action as the reason for recording himself on CRIS as the investigating officer. In fact, his intention was to allocate the investigation to one of his team once he had completed the PNC procedure.
91. Following the PNC entry, it is apparent that the laid down procedure to then record on the EWMS an action plan to secure the arrest of Mr YZ, together with an investigation strategy on CRIS, was not noted as it should have been: as soon as practicable and within 24 hours. To add to these omissions, the requirement within the procedure to complete a secondary risk assessment process was not followed. [Note: The EWMS function has since been centralised and it is no longer possible for a PNC 'wanted' record to be generated locally without a supervised action plan recorded on the EWMS system]
92. A secondary risk assessment should be completed in all cases that are assessed medium or high. The DASH Part 2 (DASH2) has 24 questions, including the original 20 from Part 1, and is designed to secure clarification and additional detailed information from survivors of domestic abuse to aid the risk assessment process and strategy development. Due to the sensitive nature of some of the additional questions, trained CSU officers undertake this process. The responses can be highly sensitive so this data should be recorded on the 'review pages' of CRIS that cannot routinely be printed for, say, disclosure in a CPS prosecution file by other

¹⁴ Description of the allegation in line with a potential criminal charge within the law

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than officers authorised to read such information. It is also possible to restrict access to the CRIS report in sensitive cases.

93. Apart from the actions recorded under the primary supervision section above, DS1 did not undertake any investigation and did not assign the investigation to anyone on his team of investigators as was his intention. Within five days, this officer had reported sick with work related stress (see operating context below for circumstances) and, eight days later, a Detective Constable from his team was appointed Acting DS ('ADS1') to supervise the work of the team.
94. In undertaking this role, ADS1 had to maintain his own workload as well as supervise new incoming work and did not have any contact with this investigation. Instead, the decision was taken on the same day to require another CSU DS (DS2) to supervise the work of two teams in the absence of DS1.
95. Technical analysis shows that DS2 accessed this CRIS report for a matter of seconds on that day, then in mid March (27 days after the original report) for about 45 minutes when also accessing a further nine reports contained in the work file of DS1. When interviewed, this officer reported no recollection of either access but accepts that it must have occurred for the time and period shown.
96. About a week later, the Detective Inspector (DI) ('DI1') responsible for the work of the CSU paid a welfare visit to DS1 and, the next day, DS2 further accessed the work file and, as a result, a Temporary Detective Constable¹⁵ ('TDC1') was assigned this matter to investigate. This officer acknowledged responsibility for the investigation by 'noting' the CRIS report three days later at 17.09 but there are no further details of action or investigation undertaken recorded on the CRIS report.
97. However, technical analysis shows that he also accessed the PNC record for YZ that afternoon and at 18.13 rang Ms AB and left a message asking that she contact him regarding her visit to the police station in February. He briefly accessed (presumably to view) the CRIS record again near the end of March about four days before the homicides.

Secondary supervision

98. The structure of the CRIS ensures that any officer logging on to the system will be presented with their 'work file' that lists all investigations for which they are responsible. Any supervisor logging on will be presented with a work file that lists all the investigations for those under their command. It is understood that very little information is displayed about content; it is more a numerical count of work to be completed.
99. When expected updates are falling behind then the CRIB or a supervisor at any level will generate a 'memo' on the system that will also appear in the respective officer and supervisor work files each time they sign on to CRIS. The CRIB oversees this process and generate periodic reminders. In this investigation, the CRIS records that the CRIB sent two memos to DS1 (who was on sick leave at the time) asking for a '10 day update' at 12 and 22 days after the original report.

¹⁵ Police Constable under training to be appointed a detective constable

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100. When DS2 twice accessed the CRIS report in March, the opportunity was presented to undertake a DASH2 risk assessment and other critical aspects such as the MERLIN/PAC that had not been done. And, when assigning the investigation to TDC1, DS2 should have recorded an investigation plan.
101. No other action was taken with respect to this investigation until the terrible events near the end of March.

Ms AB's further text messages and family awareness

102. Bearing mind that the content of text messages and any action by the family was not known to the police at the time, nonetheless, it is helpful to discover where possible what happened over the seven weeks between the report to police and the homicides so far as Ms AB and her family are concerned.
103. After the February threats and because of YZ's behaviour, Ms AB began recording her conversations with him. When she could not do so, she would ring Daughter A or a sister on an 'open line' so that they could overhear the conversation between the couple.
104. On a Sunday early in March at 1038, she sent the following message to her elder daughter and two sisters:
*The lord is my guide and my protector, whosoever tries to inflict wickedness or evilness upon me shall stumble and fall into their own pit of hell for this is not my portion.
As I type this [YZ first name] has gone into the bathroom to have a spiritual bath and only the good lord knows what he has planned or is planning for me.
My angels are surrounding me.*
105. At 1047, she followed up with this comment:
It's amazing how people reveal their true intentions when you remain calm and in control of situations.
106. One week prior to the March deadline, YZ asked Ms AB if he could stay for a further two weeks as, although he had a deposit for a flat, he claimed it was not yet ready. Ms YZ refused.
107. Just before the homicides, many of the family and some close friends celebrated Mother's Day with Ms AB and a happy occasion was spent in the absence of YZ. She was said to be in good spirits. However, on her return home at 2116, Ms AB sent this message to Daughter A:
I've just been given the most dirtiest of looks from Mr [YZ] lol, I do believe he saw the roll of black bags¹⁶ on the bed
108. A response to the same message from sister H at 2132 reads:
*dont matter. his time soon end at the house he's been living for how long for free.
dont let that look scare you. be strong. listen to the message i sent you.*

¹⁶ It is known from Daughter A that AB had placed a roll of black plastic bags on the bed that was being used by YZ because he had complained he did not have anything in which to pack his belongings

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109. On Monday 31 March at 0602 this message was sent to Ms AB by Daughter A:
TODAY IS THE DAY!!! I FEEL LIKE BREAKING OUT IN A DANCE. LET'S HOPE IT GOES SMOOTHLY AY.

Double homicide on 31 March 2014

110. On the day that had been set in late March 2014 at about 08.30, a workman from Hackney Homes called at the house to inspect the kitchen ceiling where there had been a leak. He was there for 10-15 minutes and noticed nothing amiss. Ms AB had also spoken by telephone to her close friend, NP, and they chatted for 10 minutes. Ms AB told her friend about the black bags on the bed and said everything would be OK.
111. At 08.56, Ms AB called Daughter A on an 'open line'. Daughter A was at work at a nearby hospital but realised what was happening and listened in. She heard the couple arguing about YZ leaving the house. Ms AB was heard to say: "I gave you three months" and, "You are to be out of the house today" to which YZ would hark back to their 18 years together, that he had nowhere to go and that they should stay together as a family. Ms AB made it quite clear that she and he were "done" and they were no longer a family.
112. Ms AB was also concerned, and expressed it quietly to Daughter A because she did not know why he kept moving away from where they each were, walking off and going down to the ground floor kitchen. Daughter A gathered that her mother was on the middle floor at this time and she was able to tell that Child D was with her. The call cut off after just over nine minutes.
113. At 09.06, a neighbour who had arranged to plant some bulbs in the garden telephoned to check if it was a good time to come over. Ms AB answered the call, stated she could not talk, and hung up. Also at 09.06, Ms AB again called Daughter A and asked her, "Did you hear all of that?" and a moment later said, "He's coming back, he's coming back". After further argument, Ms AB was heard to say, "[Child D], go to your Dad" and then YZ said he had to use the bathroom¹⁷ to which Ms AB asked if she could use it first as she needed to work.
114. Daughter A then heard her mother screaming and she was obviously under attack, followed by similar from Child D to which her father was heard to say, "[His name for Child D], keep quiet". She then heard him say, "This is the destruction you have brought onto the family".
115. At 09.11, Daughter A called the emergency number for police to attend her mother's home. Through her understandable distress and worst fears at what was happening, she was rapidly able to provide the address and details of the attack together with names and descriptions. She also managed to convey that Mr YZ had threatened to: "Burn down the house with her [AB] and the children in it" some weeks before and her belief that there was a warrant out for his arrest.
116. Examination of the call transcript and the CAD (Computer Aided Despatch) record show that two police officers ('PC2' and 'PC3') had been dispatched by 09.13 and arrived at 09.17.

¹⁷ Located on the third floor of the house

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During this period, they were able to view everything that had been typed onto the CAD on the Mobile Data Terminal (MDT) in the car. As they reached the scene, the operator ('CIV2') informed them by radio that Mr YZ was shown as 'wanted' for the offence reported in February and that the address they were attending was also his last known address.

117. On arrival, the officers quickly established that front and rear doors were securely locked and there was no response to loud knocking and shouts of "Police" through the letterbox. From their limited view of the ground floor they could see no signs of disturbance. They caused further enquiries to be made with Daughter A via another CAD operator. As a result, an 'enforcer'¹⁸ was sent for and at the same time a neighbour approached them and explained that Ms AB could be at work. Two other officers accompanied this witness to the [Local Charity] Partnership to make enquiries. Then Ms AB's mother arrived at the scene by taxi. She indicated that Ms AB may have taken Child D to a private nursery on way to work but she could not help with the location. Daughter A was also reported to be on her way to the scene with the keys to the house.
118. At 09.58, it was reported that Ms AB had not arrived at work and, as the equipment was by then available, the officers forced a panel in the rear door and gained entry at about 10.00. On the top floor, Mr YZ was found lying in the foetal position by the bathroom door with a hammer, a machete and a screwdriver next to him. He was unclothed from the waist up and had three self inflicted minor stab wounds to his abdomen, superficial cuts on his left wrist, left neck and left ear to the chest. He had swallowed bleach.
119. Child A was nearest to the bathroom door, dressed in a baby-grow, apparently lifeless and suffering from a deep laceration across her neck that had been achieved progressively with severe force and had caused her death
120. Ms AB was dressed in pyjamas, lying on her back further into the bathroom and apparently lifeless. She had a large cut to the side of her face and puncture wounds to her abdomen and chest, together with defence wounds to her hands. She had died from multiple injuries, including at least 17 hammer blows to her head, 15 lacerations to her head, face and hands caused by the machete and 8 penetrative wounds to her body from the screwdriver
121. A blood-stained note was covering her face that read as follows:
"[Ms AB name in full] you never stop playing dirty tricks for many years on all people places and things you target. Now the world must see the destruction you create in our family home and on yourself. Our fame in history sign: [first name of YZ]"
122. Attempts at resuscitation by PCs 1 and 2 and paramedics were unsuccessful for Ms AB and her daughter. When aroused by paramedics, Mr YZ vomited the ingested bleach, was taken to hospital and recovered from his injuries within a few days. When questioned on his release, he provided 'no comment' responses throughout his police interviews.
123. A trial at the Central Criminal Court was concluded in December 2014. Mr YZ advanced the defence that Ms AB was in a very depressed state after the birth of Child D and had been following the dark side of spiritualism. He alleged that she first attacked and killed Child D and

¹⁸ Equipment designed to break through locked doors

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then attacked him and he was forced to defend himself in the course of which Ms AB became fatally injured. When confronted with the compelling forensic evidence that Child D was the second to die, he shifted his defence to one of 'loss of control' following the breakdown of the relationship.

124. The Jury unanimously convicted YZ on both counts of murder and he was sentenced to Life Imprisonment with a minimum of 35 years to be served.

MPS operating context – the investigation

125. The purpose of this section is not in any way to seek to defend what the police did or did not do correctly in their handling of the report of crime by Ms AB in February 2014; rather, it is to widen the window on the system operating in Hackney Borough Police at the time. There are multiple clear breaches of MPS policy and procedures apparent in the course of the 47 days between the report of threats by Ms AB in mid February and the carrying out of threats, albeit with a different method, by Mr YZ in late March and it is vital to understand why this happened.
126. While it has not been possible to speak directly to the officers under misconduct investigation, access to their accounts given to the IPCC lead investigator together with enquiries and interviews with other officers by the Chair have shed some light on contextual factors that are relevant to understanding why the system checks and balances did not alert supervisors to the problem.
127. In June 2013, the MPS implemented the 'Local Policing Model' (LPM), a framework to standardise the resource allocation at the Borough level that resulted in a large redeployment of staff. For the CSU at Hackney, this included a change in shift pattern from five to three teams each led by a DS, thus significantly reducing the number of 'spare days', when not dealing with fresh daily demands, in order to keep on top of on-going investigations. Commensurate with budget limitations, the overall number of staff was less but the fewer teams were greater in number and it was argued that this would be more resilient as a result, each team set up as one DS and seven DC/TDC/PC. However, the impact of the change on the CSU at Hackney was contemporaneous with an increase in reports of domestic abuse and the workload had increased by some 30%.
128. By the early months of 2014, the CSU at Hackney also carried a number of vacancies, for example, for a budgeted establishment of 10 constables to support investigations across the three teams, they had one assigned, meaning they were about 30% down on overall strength before other abstractions such as training, sickness and leave are taken into account. A number of officers spoken to have noted, wryly, that six additional officers were assigned to the CSU shortly after the end of March.
129. In fact, this was a planned increase in strength arising from a senior management decision in December 2013 due to the performance in the CSU being at "crisis point". In January 2014 the MPS East Area Delivery Unit highlighted performance concerns, in particular, that victims were not being contacted and suspects were being circulated on PNC but not on the Wanted Management System. As a result the Area Commander twice visited the Borough in February and met with senior leadership team members. He was content that their action plan, including the planned staff increase for April 2014, had satisfied the concerns in the performance report.

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130. The CSU line manager was a Detective Inspector (DI1) who had numerous other responsibilities within his portfolio. He has estimated that, since implementation of the LPM, the three teams were operating with one DS and 4-5 investigators most of the time. He reports to one of the Detective Chief Inspectors (DCI) on the Senior Leadership Team (SLT) for the Borough. In turn, this team was under strain as the Borough Commander was on a course between January and March and his colleague who had stepped up in his place was also required to cover the neighbouring Borough of Newham for much of that time.
131. The various officers involved with the investigation also had individual contextual challenges to manage and these are summarised in the table below.

Table 2 – Officer, role, circumstances and account given

| Officer | Role | Circumstances of involvement | Account given to IPCC/Panel Chair |
|-----------------|---|--|---|
| SUPT1 and SUPT2 | Members of the senior leadership team and responsible for the conduct of policing in the Borough of Hackney | Oversaw implementation of the LPM in June 2013 that resulted in fewer staff in the CSU at the same time as an increase in workload | Accepted that there was an increase in domestic abuse reporting but challenged the view that this had a major impact on how the CSU performed By December 2013 actively discussed the need for staff increases to improve performance (described by SUPT2 in an email as at “crisis point”) and, following the critical performance review in January, a plan was agreed by February for implementation in April The change to the LPM also presented staffing challenges in other units within the Borough and the ‘Grip and Pace’ meetings were utilised to balance competing demands day to day <i>[Note: The IPCC investigation has concluded that neither SUPT1 or 2 has a case to answer for gross misconduct]</i> |
| PC1 | Reporting officer and primary investigation | On duty as station officer on 12/02/14 and took first report from AB. | As an inexperienced neighbourhood officer (two weeks after initial training at Hendon), this |

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| | | <p>Completed a 124D report, typed a witness statement and generated a CRIS report of: 'Threats to Commit Criminal Damage'</p> | <p>was his first time on station officer duties and this was only the first or second time he had taken a statement. It was the first time he had reported a domestic incident. He followed his training and also took advice from a colleague regarding the DASH risk assessment that accounts for the difference between his judgement of 'High' in the 124D and 'Medium' in the CRIS report</p> <p>He visited the 'Grip and Pace' Control Room where he believes he informed the HOT sergeant (likely PS1 as he signed as supervisor of the Book 124D) who directed him to the CSU where he took advice from DS1. He returned to the control room and informed the duty inspector (INSP1) whom he knows from his prior service as a PCSO in the Borough and who signified approval for his actions. This is consistent with entries on the CRIS report</p> <p>His inexperience resulted in the following errors/omissions: Did not record his rationale for the change in risk assessment from High to Medium within the CRIS record and had that signed off by a supervisor Did not complete a MERLIN/PAC with regard to the three children at risk¹⁹ A clear allegation of threats to kill was wrongly recorded as threats to commit criminal damage</p> <p><i>[Note: PC1 was treated as a witness throughout the IPCC investigation and was also interviewed by the Chair]</i></p> |
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¹⁹ In speaking to the Chair, PC1 disclosed that his prior PCSO experience had led him to believe, wrongly, that the MERLIN/PAC process only applied at the primary investigation stage if the child or children had been seen by police

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| PS1 | Supervising sergeant | Can be seen to have signed the Book 124D completed by PC1 and therefore has assumed responsibility for supervision of the content | <p>PS1 has confirmed to the Chair that it is his signature as supervisor for the Book 124D completed by PC1. Subsequently, he has also discussed the report with INSP1 in an attempt to refresh his memory. He has no recollection the report or any action he took as a result. He did not view the CRIS report.</p> <p><i>[Note: PS1 was not interviewed by the IPCC on the basis that DS1 had accepted responsibility for the primary supervision and has then recorded that position on the CRIS report. He was interviewed by the Chair]</i></p> |
| INSP1 | Duty officer, call sign GD1, at the time of the initial report | According to PC1, was consulted for advice | <p>INSP1 has made it clear to the Chair that the reporting PC was not on his team and believes he has never met or spoken to him. Although he knows DS1 fairly well, he has no recollection of speaking to him about the report either. He has examined the CRIS record and does not recall that either officer informed him of it. He is also emphatic that, had he been informed, he would have taken strong action, including the correct classification of TTK and implementation of the TTL policy [Note: It is likely that this would have also led to the creation of a MERLIN report with respect to the three children]. He has recovered and provided his typewritten handover record saved at 1430 on the actual day of the report by AB and, other than a non-suspicious death, he has logged nothing else of note for Hackney Borough on that morning</p> |

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| | | | <i>[Note: INSP1 was not interviewed by the IPCC on the basis that DS1 had accepted responsibility for the primary supervision and has then recorded that position on the CRIS report. He was interviewed by the Chair]</i> |
| INSP2 | Duty officer for the late shift who took over from INSP1 at 1430 | It was likely that INSP2 would have been present in the control room from about 1330 being briefed by INSP1 for a handover in order to brief the late shift team at about 1400. This is around the time that PC1 was travelling back and forth to the CSU and it is possible that he mistook INSP2 for INSP1 | INSP2 knows PC1 as he is now a member of his team. INSP2 has no recollection of being informed of this CRIS report and is not named therein. He has recovered and provided his typewritten handover record for the late shift. Unsurprisingly, this shift was far busier than the early shift from which he can recall being heavily involved in a high risk missing child for most of his duty <i>[Note: INSP2 was not interviewed by the IPCC but was seen by the Chair in order to evaluate the possibility of mistaken identity by PC1 for INSP1 – ruled out]</i> |
| CIV1 | Police staff working in the CRIB | Confirmed CRIS report classification of 'Threat to commit criminal damage' as compliant with Home Office 'Counting Rules' Selected Domestic Violence 'Flag' on the report Opted for 'standard' risk assessment | This member of police staff has not been spoken to but is understood to have followed procedures within the Bureau <i>[No issues were raised by the IPCC lead investigator but, on receipt of his report the MPS Department for Professional Standards (DPS) recommended that: "this matter is brought to the attention of the Classification Unit and referred to as departmental learning in relation to the classification of incidents"]</i> |
| DS1 | CSU team supervisor and | On duty when approached by PC1 and gave advice | Trained in major investigation but not specifically CSU and some DV awareness training in 2004 |

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| | <p>secondary investigation</p> | <p>Appointed himself investigating officer for the purpose of ensuring urgent PNC entry for YZ with intention of assigning investigation to one of his team Reviewed CRIS entry and decided that there was no address for the suspect other than the address for AB so no arrest enquiry generated Called the number for AB but not able to leave a message</p> | <p>He cannot recall this case and depended on the CRIS report for any actions that he undertook He accepts that basics were not done but he expected first line supervisors to pick up on those things He agrees that the classification should have been 'Threats to kill' but he assumes that the fact that it has been seen by an inspector meant the one shown was approved His reasoning for showing himself as investigator was the urgency of the PNC entry for YZ and he knew EWMS would have to be completed within 24 hours He had intended to assign the investigation to one of his team the next day and he would have set out a strategy for the investigation and action plan that would have included the EWMS enquiry to trace and arrest YZ. However, he had to deal with an urgent welfare matter with one of his team members that took up the whole of this day (day after) Because of this problem, he did not attend the daily management meeting (DMM) where this report would have been listed. He guesses that the criminal damage classification would not have attracted much attention and the suspect circulation on PNC would have provided reassurance to the meeting that enquiries were in hand. Both the IPCC and the IMR author have made enquiries to recover any electronic records for the DMM of that day without success. Even as an experienced officer, DS1 had been experiencing workload stress in the CSU and had applied for a transfer to</p> |
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| | | | <p>uniform sergeant duties which had been declined because of skill shortages</p> <p>In the week prior to the week of AB's report he had been sick with the flu and was still feeling run down through that week</p> <p>He was scheduled rest day on the weekend and then reported sick on the Monday with work related stress. He returned to work in uniform duties in May</p> <p><i>[Note: The IPCC investigation has concluded that DS1 should be subject of a Misconduct Meeting and this concluded in October 2015 with the sanction that the officer will be given a written warning]</i></p> |
| <p>ADS1</p> | <p>CSU team supervisor appointed 'acting' in absence of DS1</p> | <p>On return from leave 12 days after the initial CRIS report, appointed to manage the work of team 1 and held that position until April</p> | <p>Most experienced DC on the team, although not qualified or trained for the role, had acted as DS before</p> <p>On this occasion, he pointed out his other commitments and high case load and his understanding was that he would supervise new investigations for team 1 and that DS2 would look after retrospective work, indeed, he received memos (not connected with this case) from DS2 in this regard</p> <p>He did not examine DS1's work file</p> <p>He has no knowledge of the CRIS completed by PC1, including that it had been allocated to TDC1 by DS2 in mid March (he was on leave that day)</p> <p>However, was aware that TDC1 had accumulated a high case load and gave him two 'free days' (last week in March) from new work so as to reduce the load</p> <p><i>[Note: The IPCC investigation has concluded that ADS1 does not have a case to answer for misconduct]</i></p> |

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| <p>DS2</p> | <p>Fellow CSU team supervisor asked to resolve outstanding work of DS1 8 days after he reported sick</p> | <p>In mid March, viewed the work file for DS1 containing 10 investigations for 45 minutes The next week, at request of DI1, conducted a review of DS1's work file and allocated this investigation to TDC1 to progress at 15.51 that day</p> | <p>DS2 understanding was that the support to team 1 was to supervise the incomplete crime reports as, being the leader of team 2 and on different shifts, the ADS would have to supervise the day to day work of team 1 As DS1 had been absent for some time, there was a massive backlog of supervision Although had looked at the list of supervision for DS1 (which would only appear in the summary as a number), did not look at his personal work file and was not aware of this CRIS report until one of two days in mid March when discovered that there were ten reports and saw that this particular one was five weeks old Did not review classification, just read it, and took no other action than allocate for investigation and does not recall considering the DASH2, MERLIN/PAC or EWMS requirements As DS2 considered TDC1 to be an experienced and competent officer, did not think it necessary to set an investigative strategy when assigning this to him and did not do so Was aware that TDC1 was on night duty at the time Did not inform ADS of the allocation to TDC1 and was rest day the next day</p> <p><i>[Note: The IPCC lead investigator recommended in his report that DS2 had a case to answer for gross misconduct. This was submitted to the MPS, which made representations that a misconduct meeting was suitable in the circumstances. The IPCC</i></p> |
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| | | | <i>Commissioner responsible for the investigation accepted the representations made and chose not to direct that a misconduct hearing take place. DS2 was subject of a misconduct meeting and this concluded in October 2015 with the sanction that the officer will be given a written warning]</i> |
| TDC1 | CSU team 1 member and allocated secondary investigation | As member of team 1, allocated CRIS report to investigate by DS2 in mid March 'Noted' the CRIS report at 17.03 and checked the PNC at 17.09 three days later | <p>On the day of allocation, was in the middle of a week of night duty CID and had also been required at Magistrates Court all the next day and so had briefly slept at the police station</p> <p>Night duty ended at 07.00 on two days after that but the new shift pattern meant he had to start an early shift immediately. However, was sent home at 10.00 to return for duty at 14.00</p> <p>Recalls that he noted the CRIS record that afternoon and accepts that there are no other actions recorded on CRIS</p> <p>However, PNC shows that he accessed the record for YZ at 17.09</p> <p>Telephone records show that, at 18.13, he called the contact number for AB and left a message for her to contact him regarding her visit to Stoke Newington in February</p> <p>His recollection is that, in the process of conducting the research, he was interrupted and asked to assist with a serious domestic assault investigation that resulted in a charge and the person detained for Court. This resulted in his finishing duty at 05.30 so he again slept at the police station in order to start again at 07.00 the next day</p> |

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| | | | <p>On that day, he was again required to deal with persons detained, this time for a witness intimidation matter</p> <p>He was then on two days leave and when he returned [5 days prior to the homicides] he was tasked by ADS1 to “Sort your crimes out” for the next two days, there being too many outstanding</p> <p>This he did and reduced his case load from 20 active investigations to 12</p> <p>He recalls that he started at the top with the oldest matters and cannot say where the AB case was in that list, nor whether he instigated any further actions</p> <p>He was then on rest days for 3 days returning to work on the day of the homicides</p> <p><i>[Note: The IPCC investigation has concluded that TDC1 does not have a case to answer for gross misconduct but should be subject of a Misconduct Meeting. This concluded with an appeal in January 2016 with a final sanction that TDC1 will receive management advice]</i></p> |
| D11 | Line manager for the three teams in the CSU as well as an extensive portfolio of public protection duties | Had responsibility for the work of the CSU officers that dealt with this CRIS report | <p>Very experienced officer, particularly in CSU work and the associated portfolio of public protection</p> <p>Provided a comprehensive analysis of his portfolio commitments and the specific commitments during this period and the email messages he had generated for the SLT that deal with the pressing issue of staffing levels and his concerns about excessive workloads</p> <p>Was aware of the work related stress reported by DS1 but was</p> |

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| | | | <p>unable to release him for his transfer request Appointed ADS for team 1 8 days after DS1 reported sick (13 days after the report by AB) Asked DS2 to supervise the investigations already in progress for team 1 within the period of absence for DS1 Paid welfare visit to DS1 the day before asking DS2 to look at his work file and re-allocate within team 1 Had no direct knowledge of this CRIS report and, due to a meeting elsewhere, was not present at the DMM the day after when it was listed</p> <p><i>[Note: The IPCC investigation has concluded that DI1 does not have a case to answer for gross misconduct]</i></p> |
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MPS operating context – the emergency response to the emergency call from Daughter A

132. Having advised her mother on the decision to report the threats to life in mid February and then being heavily involved in the build up to the March ‘deadline’, it must have been acutely frustrating as well as distressing for Daughter A when attempting to convey the urgency of the situation on that fateful morning. Moreover, she was privy to a live feed of information from inside the house and it is to her credit that she overcame the initial difficulty and delay of connecting to the emergency service and was then, commendably in the circumstances, conveying lucid and vital information.
133. Balancing the need for an immediate response with the need for best information to brief the responders is a key challenge for all blue-light service call handlers. Within one minute, CIV2 had mobilised an immediate response and the officers had arrived outside the house within a further five minutes. There was then a delay of 40 minutes (46 minutes after the original call) before PCs 2 and 3 forced entry at the rear door.
134. Examination of the transcript of Daughter A’s call compared with the information that was recorded by CIV2 on the CAD system show the following omissions:
 That Ms AB was being attacked in her home (the venue they had been called to)
 That a child was present in the house
 That Daughter A could hear her sister screaming in the background
 That Daughter A believed YZ ended the live telephone link

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135. CIV2's account to the IPCC is that he believed he had provided sufficient salient information in the time available. The IPCC view is that the omissions from the CAD information combined with an absence of probing for more and better particulars, or even to listen in to the third party call had an adverse effect on the decisions and actions by the officers at the scene.
136. On their arrival, PCs 2 and 3 noted the house was silent and there was nothing suspicious that could be seen through the letterbox and windows (victims were on the third floor) and there was no response to repeated knocking. Within 7 minutes they had requested that the informant (Daughter A) be called back and, as a result, they called for an 'enforcer' to gain entry. When this arrived, a young neighbour suggested that Ms AB would be at work and, shortly after that, her mother who had arrived at the scene, indicated that Ms AB could be taking Child D to nursery. Other officers were dispatched to follow these lines of enquiry.
137. The officers' account to the IPCC is that, based on the information available via CAD, they did not believe they had sufficient grounds to force entry. They caused further enquiries to be made of Daughter A that prompted a request for the enforcer and they also had to consider other options with the conflicting information they were given about Ms AB's possible whereabouts.
138. The IPCC investigation has concluded that CIV2 has a case to answer to face disciplinary proceedings that were concluded in October 2015. CIV2 was given a three-month action plan by Professional Standards during which his performance with regard to his tasks and duties will be monitored. Any failure to improve would result in further formal action and possible dismissal. The IPCC investigation has further concluded that PCs 2 and 3 do not have a case to answer for misconduct.

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ANALYSIS

Performance pressures in the Community Safety Unit at Hackney Borough

139. There is ample evidence that the unintended consequence of the strategic shift by the MPS to the Local Policing Model in Summer 2013 combined with an increase in the reported rate of domestic abuse meant that a discernable and sustained increase in workload was felt by individual officers assigned to work in the CSU at Stoke Newington. The senior leadership team acknowledged this problem in December, CSU performance had been specifically reviewed at the Area level in January and an action plan developed in February for implementation in April 2014.
140. The Panel have noted that two lessons for this particular investigation were also highlighted in the performance review in January 2014:
- Failure to contact victims
 - Suspects circulated on the PNC but not on the EWMS

The investigation of threats to kill reported in mid February 2014

141. It is now known that the only safeguarding agency in a position to interfere with the murderous intent developed by Mr YZ against Ms AB and their daughter was the Metropolitan Police in Hackney Borough who, consequently, were also the only possible channel of communication to others such as children's social care. Ms AB's family members and neighbours who were aware of the threat could have approached the council or the domestic violence team directly but that did not happen either.
142. Through her report of crime in February 2014, Ms AB presented the police with the opportunity to disrupt Mr YZ and take action to help keep her and her children safe. In the event, the only positive action by police was to have Mr YZ recorded on the PNC as wanted for an offence of threats to commit criminal damage. As before, a more detailed analysis follows the stages set out in the MPS toolkit for domestic abuse.

Primary investigation

143. Although new in service and inexperienced in domestic abuse investigation and statement taking, PC1 applied himself diligently to complete Book 124D, a CRIS report and a witness statement from Ms AB, indeed, he spent more than four hours with her and her supporter. He offered access to services such as the local domestic abuse project and victim support and provided follow-up contact information in line with the toolkit checklist. He correctly listed the three children as victims as well as their mother. He conducted a DASH risk assessment and sought advice from an experienced officer regarding the correct level of assessment. He informed an inspector and CSU DS of his actions and a sergeant supervised his report book.
144. His relative inexperience may account for an incorrect recording of the allegation as a threat to cause criminal damage when it was manifestly a threat to kill as well. Also, the failure to appreciate that any threat involving children required completion of a pre assessment checklist

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prior to sharing a MERLIN report with other safeguarding agencies was a critical gap in his professional knowledge.

145. He completed the DASH risk assessment in Book 124D and used his judgement to assess the risk as 'high'. He then consulted an unidentified, but more experienced, officer and followed the advice given that this was a 'medium' risk for the DASH assessment he later recorded on CRIS. This adjustment would not have adversely affected the next steps because either high or medium assessment should generate a secondary assessment within the CSU. However, he could and should have recorded his rationale for the change within the CRIS report and brought this to the attention of a supervisor.
146. The Panel has identified that, while the construct of the DASH assessment questionnaire is consistent with national guidance, it is unfit for what was intended because there is no requirement of, nor guidance to, the writer (other than: "Please comment") to expand upon positive responses elicited from the victim, for example in this case, to the question of child abuse.

Primary supervision

147. The IPCC view is that once PC1 approached DS1 in the CSU for advice, the latter became the primary supervisor within this framework. This opinion is supported by the fact that DS1 holds supervisory rank and completed the relevant CRIS entry as the supervisor in order to generate the additional work regarding PNC (see secondary investigation below). His account is that this was expedient and he, as the customary supervisor for secondary investigation, assumed that unformed supervisors had undertaken the checklist within the toolkit for primary supervision.
148. Enquiries by the Panel have established that INSP1 claims not to have been briefed and then approved primary actions as reported by PC1, citing the fact that his log for that morning's shift as duty officer for the Borough records nothing of note as it would have done had he been so informed. PS1 has accepted that he has signed as first line supervisor in the report book but has no recollection of it and there is no evidence that he undertook any primary supervision other than to direct PC1 to attend the CSU for advice. PC1 believes that a sergeant (he cannot recall if it was PS1) did advise him to visit the CSU and, due to inexperience, he would not have done this on his own initiative.
149. The CRIB is a centrally based team that remotely manages the processes within CRIS. One of the functions carried out is to confirm the initial classification ('Threat to commit criminal damage') recorded by the reporting officer as compliant with crime counting rules and this was done by CIV1 within 9 minutes of scrutiny. It would have been obvious on reading a method that states that the named suspect (YZ) had told a witness (LM) that: "He was going to burn down the victim's (Ms AB's) house with her and the children in it" contained a threat to kill. Therefore, it seems likely that CIV1 did no more than complete missing information on the general information page that had been missed by PC1, such as the domestic violence flag and the initial risk assessment.

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Secondary investigation

150. While Ms AB was still at the police station, PC1 visited the CSU and informed DS1 of the report. DS1 asked if an arrest enquiry had been generated in respect of Mr YZ and PC1 disclosed that, due to inexperience, he had not realised this was required. DS1 then took responsibility to place a record on the PNC that he noted included the family address as the one on file for YZ and, in order to complete this task, he self-assigned the secondary investigation with the intention of allocating it to one of his team in due course. He then called the mobile telephone number for Ms AB without response.
151. DS1 did not follow through with his intention, and the next day he became distracted with other duties and two scheduled rest days followed. He then reported sick with work related stress and took no further part in this investigation.
152. During his period of responsibility for secondary investigation he has not complied with the domestic abuse toolkit in that he had omitted to:
- Change the classification to threats to kill and invoke the threats to life policy which would have elevated the matter to inspector level to direct next steps
 - Conduct a secondary DASH2 risk assessment
 - Ensure a MERLIN/PAC was completed and reported to child social care
 - Ensure the EWMS contained an arrest strategy
 - Record an investigation strategy
 - Alert his line manager or a fellow supervisor that these matters urgently should be re-assigned in his absence
153. DS2 re-assigned this investigation to TDC1 some five weeks later, in mid March. TDC1 was on night duty at the time and was also distracted by contemporaneous work demands. His only actions were to access the PNC record for YZ and to leave a voice message on AB's telephone inviting a return contact. He did not address any of the omissions above but, as the junior officer, should have been given direction from his supervisor, at the very least in the form of an investigation strategy.

Secondary supervision

154. ADS1 was appointed by DI1 to supervise the work of the team in the absence of DS1 but this was not retrospective so did not embrace this report. However, within general concern for the high workload of TDC1, he sanctioned two 'free' days in late March in order for him to focus on reducing the amount. This did not result in any progress with respect to this investigation.
155. DS2 was asked to look at the work in hand for DS1 and the 10 CRIS reports in his work file were examined twice in March when this investigation was assigned to TDC1. DS2 also retained responsibility for the supervision of her own team throughout this period. DS2 did not identify the omissions by DS1 listed above and did not record an investigation strategy within CRIS for TDC1 to follow as she felt he was sufficiently experienced and competent to develop his own strategy.
156. Meanwhile, the CRIB had issued two standard 10-day progress memos to DS1 who was on long-term sickness absence. The Panel has commented that such routine processes should

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have intrinsic warning alerts for the chain of command when an officer is not available to respond such as when on extended sick leave.

157. The workload for DI1 was such that it was unreasonable to expect him to personally review the CRIS reports that, for his three teams, could be counted in the hundreds and it is clear that he did not view this one, although he did assign DS2 to pick up the work of DS1 within 12 days. Nonetheless, the fact that DS1 had reported work related stress as the reason for his absence should have heightened concern about his work file and, notwithstanding the appointment of DS2 to take responsibility, it took five weeks and a welfare visit to DS1 for DI1 to prompt further action by requiring DS2 to look again at the work file for DS1.

The emergency response to the homicides

158. As is clear from the Terms of Reference for this review, the family are understandably concerned that the opportunity to enter the murder scene as speedily as possible in order to save life was not seized by the officers who responded. This has been examined in some depth by the IPCC investigation that has found that the call handler (CIV2) dealing with Daughter A's emergency call, failed to ask key questions of her and to record on the CAD all that he had been told by her for the information of the response officers.
159. Had he done so, the two response officers may have made the decision to force entry to the property at a far earlier point than actually happened and the Panel concur with this analysis and conclusion by the IPCC lead investigator. Sadly, and given that Child D's screams heard by Daughter A over the open telephone channel only minutes earlier were not audible to the officers on arrival, it is also apparent that both victims were beyond saving by the time police had arrived at the scene.

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CONCLUSIONS AND LESSONS LEARNED

160. The Panel have viewed the full impact statement provided by family and friends to the Court and it runs to six highly charged pages. With the utmost respect to the memory of Ms AB and Child D, this extract has been chosen as a prelude to our conclusions:
- “Whoever came up with the saying ‘time is a healer’ either lied or has never been through real trials. Time will never heal the hurt, the loss, the pain, the betrayal, the yearning to hear their voices, their touch, their cheeky smiles, their beautiful spirit, our mother’s pranks, our sister’s antics, the laughter that we can barely show, let alone share with them. Time has just and will continue to force us to move on and get on with our lives without them, when all we wish for it to do is pause to before they were barbarically taken.”
161. The IPCC investigation has concluded that the Metropolitan Police Service failed Ms AB and Child D and their family at large. The performance of Hackney Borough CSU was poor in that little if any positive action was taken to arrest Mr YZ or protect the lives of Ms AB and Child D. The vast majority of the mandatory actions associated with a crime report, such as Ms AB’s, were never completed. The type of crime it was recorded as was also wrong. Due to poor communication and carelessness, the crime report sat within the work file of a CSU officer signed off with stress for more than a month before being assigned to another officer. In turn, this officer did very little to further the investigation and was hampered by a high caseload at the time.
162. Whilst the performance of the CSU was very poor, this was exacerbated by the fact that there were not enough officers assigned to the unit to effectively deal with its workload. This was recognised by management but too late to prevent the failures in this case. It is of concern that the implementation of the Local Policing Model appears to have had a significant detrimental impact on the CSU and it took nine months to rectify the fact that too few officers were assigned to the unit. The report by East Area Delivery Unit and answers given by officers during misconduct interviews suggest that poor practices were far from isolated to this one case within the CSU.
163. In the response to the murder scene, further poor communication meant critical details from the call of Daughter A were not passed onto officers who attended the scene within six minutes, which meant there was a further delay of 40 minutes in forcing entry to the property.
164. As a result of the IPCC investigation, three police officers have been subject to a misconduct meeting, with the outcome that two received a written warning and one management advice. One member of police staff has faced misconduct proceedings and placed on a three-month action plan.
165. Finally, the IPCC conclude that we will never know whether a more robust police response to Ms AB’s visit to Stoke Newington Police Station would have prevented the murder of both her and her daughter, but the Metropolitan Police Services’ inaction meant Ms AB was left to deal with YZ on her own when the tragic events at the end of March 2014 unfolded.

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166. From the family's perspective this opinion may not be very satisfactory and a widening of perspective available from the systems analysis within this overview may shed additional light. In contemplating such profound issues, it is important to avoid hindsight and outcome biases and, when pondering the "What if?" questions, to also reflect all perspectives in the answers, not least, the operating context of significant organisational change (the LPM), reduced resources in the CSU and increased workloads.
167. It seems clear that the established police procedure for managing reports of domestic abuse was set up to succeed, but a combination of basic errors and omissions reinforced by an almost complete absence of proper supervision of the investigation meant that it did not produce the intended outcome. We need to understand why.
168. The approach we have adopted is to identify the missed opportunities for safeguarding through the available evidence that:
- A MERLIN/PAC was not generated, as it manifestly should have been, to share with children's social care who 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 MERLIN 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 MARAC
 - The EWMS procedure to have an arrest plan for 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 witness LM, without whose evidence there would not be a case to put to YZ should he be arrested by other officers for the PNC report
 - The DASH2 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 have led to a referral to the local MARAC for a multi-agency response
169. Although the secondary investigator supported the reporting officer by undertaking the work to ensure Mr YZ was recorded as wanted for the offence, he did not take the action to confirm the wanted management system was activated. Thereafter, there is no evidence of any robust action taken by the police to investigate further. Secondary supervision was eventually assigned but did not happen. The electronic crime system generated two reminders for progress updates but these were sent to the original investigating officer who was on sick leave and could not receive or act upon them.
170. 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

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paucity of proper checks and alerts in the system failed the individual officers and staff as well as Ms AB and Child D.

171. Overall, it is felt that the IPCC conclusion may be fairly put but the number of missed opportunities by the Metropolitan Police to make a difference, uncorrected through each of the four phases by investigators and supervisors alike, reflects a clear collective failure by the police to do everything within their power to keep Ms AB and her children safe from harm.

172. The Panel conclusions with respect to the specific Terms of Reference for the Serious Case Review aspect and for the issues raised by the family are respectively set out in Tables 3 and 4 below.

Table 3 – Panel conclusions regarding specific Serious Case Review Issues

| Para | Term of Reference | Conclusions of review |
|------|--|---|
| 8.1 | Whether the presentation to professionals by any family member could/should have triggered further professional curiosity and/or action as a result to protect Child D | The disclosure to police by AB of a clear threat to burn down the house with her and her three children, including Child D inside should have generated substantial professional curiosity and action to protect them. Apart from the recording of YZ on the PNC as 'wanted', and two attempts by investigators to contact AB by telephone that did not connect directly with her, no other action was taken |
| 8.2 | Whether agencies, together, or individually, missed opportunities to act on or share information that was known (or knowable at the time) to protect Child D | The opportunity was missed to follow up AB's disclosure with a professional criminal investigation within clearly laid down policy, procedures and expectations. The opportunity was further missed to identify this omission through proper supervisory checks and attention to the alert systems available through CRIS. The absence of a secondary risk assessment conducted by a more experienced and better trained officer was also a missed opportunity. Consequently, the opportunity was missed for a 'second line of defence', such as through children's social care, to become mobilised as it should and would have been had the correct MERLIN/PAC procedure been followed. |
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| 8.3 | Whether the specific risk of harm to Child D or other children was given consideration and/or assessed at the point of AB's presentation to the Police | Albeit two risk assessments were recorded by the reporting officer they were not followed up by supervisors or investigators or a DASH2 assessment undertaken, as it should have been within the secondary investigation |
| 8.4 | Whether the details concerning Mr YZ's history and concerning background was fully known to any agency involved with Child D and/or children of YZ living with AB | Prior to the report of crime by AB, there was no reason for any agency involved with YZ, AB, Child D and their other two children to develop concerns for their safety and wellbeing |

Table 4 – Panel conclusions regarding specific issues raised on behalf of Ms AB's family

| Para | Term of Reference | Conclusions of review |
|-------------|---|---|
| 10.1 | Whether the police made any attempt to apprehend or speak to YZ, including if there was a warning marker placed against his name on police databases and the nature of that marker and what likely action would have followed | <p>Urgent action was taken to record YZ on the PNC as 'wanted' for the offence of 'threats to commit criminal damage'. Had he subsequently had contact with police and a search conducted on his name he would have been detained for questioning. In this event, the absence of any follow-up investigation, particularly to interview witness LM, would have presented the investigators with a further problem because the only evidence that would have been available on arrest was the witness statement of AB which contains only 'hearsay' evidence with respect to the threat allegation</p> <p>Although YZ's last known address was the family home, this fact was not linked to the address for the threats due to the mistaken belief that he had separated from AB and was of no fixed address. The correct EWMS procedure was not followed so an action plan for his arrest was not formulated or implemented</p> |
| 10.2 | Whether the police made any attempt to contact AB for further information or to check on her | Two separate investigators made a call to the mobile telephone number provided by AB without |

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| | welfare or that of the children, or made any visits to the house, and the nature of any warning marker placed against the address on police or agency databases as being a potential location for domestic abuse incidents | success and it is not known if she received those messages There were no visits made to speak to Ms AB or the significant witness LM who informed her of the threats Consideration was not given to a 'Special Scheme' arrangement whereby the address would have been 'flagged' on the police CAD database for the information of emergency responders |
| 10.3 | Whether any referrals were made to other agencies and, if not, what referrals should have been made and what likely action would have followed | No referrals were generated to other agencies In the light of the risk assessment (whether medium or high), a MERLIN report should have been generated in respect of all three children and shared with Children's Services who would then have been alerted and made their own assessment of threat, risk and harm. This would then have triggered police actions to act in partnership |
| 10.4 | Whether any Merlin report was made in respect of the three children and, if not, what reports should have been made and what likely action would have followed | See 10.3 above |
| 10.5 | Whether any referral was made to the nia Project for consideration of an Independent Domestic Abuse Advocate service for AB and, if not, what referrals should have been made and what likely action would have followed | No referral was made by police Ms AB was offered and declined a referral |
| 10.6 | Whether any referral was made to Victim Support and, if not, what referrals should have been made and what likely action would have followed | No referral was made by police Ms AB was offered and declined a referral |

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| 10.7 | Whether any referral was made to Hackney Homes and, if not, what referrals should have been made and what likely action would have followed | No referral was made by police Ms AB did not make any request for Hackney Homes assistance |
| 11.1 | Whether the police call handler treated the call seriously and responded appropriately to the nature of the attack | The IPCC investigation has concluded that more information could have been asked of Daughter A and more done by CIV2 to appraise the scene attendees of the urgency of the situation |
| 11.2 | If there was no warning marker on police databases against the address and/or YZ's name, whether the call would have been treated differently and the response been different as a result had the warning marker(s) been in place | There was no warning marker placed on databases other than could be gleaned from the PNC record for YZ Daughter A had relayed key aspects of risk in the emergency call but not all of it was passed on by CIV2 to PCs 2 and 3 |
| 11.3 | Whether research and analysis of the sequence and timings of calls from the police call handling centre to the ambulance service and the times of the arrival of the three ambulances and the air ambulance that attended reveal reasons for the length of time each took to arrive at the address | Options and choices for the response officers were driven by the information that was relayed to them by the call handler and then made more complex by the well-intentioned but conflicting information regarding Ms AB's possible whereabouts that emerged from the neighbour and Ms AB's mother who arrived at the scene PCs 2 and 3 did seek further information from Daughter A via the control room and this prompted them to send for the forced entry equipment that they used on its arrival. Paramedics were mobilised immediately they had discovered the scene The IPCC investigation has concluded that the information conveyed by the call handler omitted key aspects that could have injected greater certainty and, thereby, an earlier forced entry to the house |
| 11.4 | Whether research and analysis of the timings of the police response to the emergency call reveal whether appropriate | It is felt that appropriate urgency and seriousness was provided by the police response, however, further and better particulars could and should have been sought by the call handler and critical |

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| | urgency and seriousness was attached to the response | information provided by Daughter A relayed to the officers on the ground in order to speed up the forced entry |
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173. It is well known that humans are prone to error, particularly when under operational pressure and with increased workloads; therefore, systems are designed and implemented to provide checks and balances that identify errors and bring them to notice for remedial action. Notwithstanding the clear individual failures identified through the IPCC investigation, it is apparent that the system that was set up to support officers and staff when under operating pressures and constraints manifestly failed to do so.
174. Remedial action is required to ensure that, in all domestic abuse cases, the electronic support and alert systems available through the CRIS can identify:
- That a crime report recording a threat to life has not been elevated to inspector level for consideration and direction in line with the extant threat to life policy
 - That primary supervision has been undertaken by the first line managers and not adopted by the CSU who should retain responsibility for secondary investigation/supervision only
 - That, when children are named as potential victims, a MERLIN/PAC has been generated and shared with Children’s Services
 - That the CRIB will not confirm the classification unless and until the above has been completed
 - That a record placed on PNC must have a contemporaneous arrest strategy recorded on the Wanted Offenders Management and Enforcement System [Note: This has already been rectified by the MPS and the function has been automated under central supervision]
 - That a report of staff absence through work-related stress should prompt an immediate review of the officer’s work file and clear accountability transferred and monitored by the next level of supervision until return to duty
 - That system generated reminders for such an officer will be diverted (and not just copied) to the line manager for attention
175. It is well known that children, young people and adults are better protected from harm through coordinated action by a range of agencies. The errors and omissions in this case that failed to engage other agencies beyond the MPS must be addressed. The MPS needs to provide assurance to partners in the London Borough of Hackney that it has learned and rectified the system errors and there is multi-agency confidence that the police response to reports of domestic violence and abuse is safe and robust.
176. The significant date or ‘deadline’ in late March 2014 featured strongly as a catalyst or ‘tipping point’ in this incident. While there is no evidence that the police or any other agency knew of this date, the Panel is aware of other domestic abuse homicides where significant dates have featured; moreover, it is well researched that 70% of domestic homicides occur at the point of separation in the relationship.
177. It is felt that 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).

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RECOMMENDATIONS

Recommendations identified within Independent Management Reviews

178. The only IMR that was relevant to this review was from the MPS. The IMR author made the following recommendations:

It is *recommended* that officers are reminded of the necessity to explore, clarify and record information when victims provide positive responses during the DASH risk assessment process

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

It is *recommended* that the current MPS toolkits include guidance to officers in responding and investigating allegations of threats to kill

179. The Panel support these recommendations and would add that there should be a *robust training plan* to ensure that they are embedded in Hackney and also across the Service. It is also recommended that the Hackney Borough Police ensure their *front-line staff have access to and attend multi-agency training* delivered by the City and Hackney Safeguarding Children Board to further promote their understanding of partnership working and the role of other agencies in protecting children and young people from harm (see recommendation 4).

180. The MPS has 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. Within the next 12 to 18 months, the rollout of mobile data terminals will also provide the opportunity to require responses to the risk assessment section to be populated with more detail from the victim and ensure that the primary supervisor's actions are recorded.

Independent Police Complaints Commission Recommendations

181. Under Paragraph 28A of Schedule 3 to the Police Reform Act 2002 and in addition to misconduct recommendations with respect to individual officers and staff, the IPCC lead investigator has made four system recommendations for consideration by the MPS. The recommendations, which are supported by the Panel, are set out together with the MPS response in the table below.

Table 5 – IPCC system recommendations and the MPS response

| Recommendation | MPS Response |
|--|--|
| <p><u>1 Victim Codes of Practice</u> One tool used by the MPS to track the progress of open crimes is the Victim Codes of Practice (VCoP). The VCoP is essentially a record of when the victim of any reported crime was last contacted by an officer. At present, a successful contact includes a</p> | <p>The MPS instructs officers as to their responsibilities through MPS policy statements and toolkits. Toolkits contain checklist guidance for frontline officers and their supervisors; they also contain other practical guidance in the form of question and answer documents, a useful</p> |

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| <p>voicemail being left on a victim's given phone number. However, there is no way of the police knowing whether or not the victim has heard a voicemail, or whether the alleged aggressor has accessed the voicemail. The IPCC recommends that a successful contact should, at the minimum, be recorded where an officer has managed to talk to the victim and verify their identity and welfare</p> | <p>resources section and further links to more information. The instructions in these toolkits have actions for officers to take, some of them are mandatory and some are for officer consideration should the situation demand it; these actions and their status are clearly set out within the checklist sections of the toolkit and where instruction sit within another part of toolkit, it clearly states when action must be taken by officers, again, making the action mandatory.</p> <p>The Victim and Witness Care Toolkit is currently being developed to provide mandatory actions and as such, a minimum standard when dealing with victims and witnesses of crime.</p> <p>In the meantime TP Crime Policy will ensure that any current reference or action within any of its policy/toolkits with regard to VCOP is highlighted with the below text:</p> <p>'Officers must ensure that, when contacting victims of crime, it is done via the preferred method (chosen by the victim). If that chosen method is via a telephone system, officers must ensure that they speak to the victim and not any other person (unless they are acting as a previously agreed representative). They must also ensure that the victim is able to speak freely without any risk of alerting a potential suspect (this is particularly relevant in domestic abuse cases). Officers must not leave a voicemail message or use an alternative method of communication (i.e. sending a text message to the preferred number). If it is not possible to speak with the victim on a particular occasion, then record your attempt showing the date and time on the CRIS DETS pages</p> |
| <p><u>2 Details needed by police when attending incidents</u> During subject interviews it became obvious to the IPCC that there was a discrepancy</p> | <p>This recommendation is rejected – there is clear evidence in the report that had the national call</p> |

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| <p>between the level of detail police require when responding to an incident and the level of detail the control room feel necessary to include in the remarks of the CAD. It is the view of the IPCC that had more detail from the call of Daughter A been recorded, the attending officers would have had a better understanding of the situation than they did on that late March morning in 2014. The IPCC recommends that part of the training regarding relaying details to police officers attending incidents focuses the quality of this information, particularly where the information has come from a third party – for example stating explicitly how the incident location has ascertained in the remarks section of the CAD and gaining more detail from the informant about critical information if possible</p> | <p>handling protocol been applied fully and had the operator used more diligent questioning of the third party, more information could have been recorded on the CAD. It is also recognised however that the first Police unit arrived on scene prior to the call completing. It is therefore difficult to establish if further information on CAD would have assisted officers at the scene (albeit the fact that they asked for additional information would indicate that it could have)</p> <p>The recommendation itself does not indicate how success will be measured and is therefore difficult to apply. However it is recognised that this is an opportunity for Met CC to review its process and share lessons learnt from this incident both within training and by communication with staff. This will be taken forward immediately by the Professional Standards Unit at Met CC</p> |
| <p><u>3 Minutes from Daily Intelligence Meetings</u> During its investigation, the IPCC was unable to verify whether or not CRIS 4603***/14 was discussed during any of the Daily Intelligence Meetings Hackney Borough held. The IPCC recommends that at the bare minimum a list of the cases discussed during these meetings is recorded – ideally with actions and who they are assigned to</p> | <p>The primary tool for Senior Management Team oversight of ongoing matters at local Borough level across the whole of the MPS area are the three times a day ‘Pacesetter’ meetings. These in turn are prepared for by the local subject area leads on each Borough holding their own pre-meets. The Local Intelligence Team will have a ‘THOR’ (‘Threat, Harm, Opportunity, Risk’) Daily Intelligence Meeting internally to decide what to take to the Pacesetters, and this will be documented on the ‘THOR’ document that the LIT will take to Pacesetters. This will include intelligence from the ‘CRIMINT’ (Criminal Intelligence) database, but will not ordinarily include risk from CRIS (the crime recording database), which should be brought to the Pacesetters by the relevant unit representative. I understand that it is specifically the intelligence aspect that this recommendation addresses, and in relation to this I have directed:</p> <p>LIT supervisors to record in the Supervision page of the CRIMINT entry for the THOR document who chaired the meeting, who now</p> |

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| | <p>owns the risk, and any further actions required of the LIT eg to develop the intelligence.</p> <p>All intelligence taken to Pacesetters to be flagged up as such with the status on CRIMINT.</p> <p>I believe these measures together address the auditability and accountability concerns raised in this recommendation. If any actions come out of the subsequent Pacesetter meeting regarding any particular <i>crimes</i>, however, best practice dictates these should be recorded on the relevant CRIS so that they are auditable.</p> <p>In summary, this is a positive recommendation regarding transparency in intelligence matters which we have immediately adopted. We leave issues relating to crimes, offender management, over night prisoners etc to be captured separately if need be in a Pacesetters document, managed by the Borough</p> |
| <p><u>4 Staffing within Community Safety Units</u> During its investigation the IPCC came to the conclusion that MPS Hackney borough CSU was left understaffed following the implementation of the LPM. It is recommended that the MPS ensures that it has processes in place to consider resourcing of domestic violence units is adequate in light of demand levels and its responsibilities under the Public Sector Equality Duty</p> | <p>The MPS monitor staffing levels in all units across the organisation and demand is also monitored, this applies to CSUs. Recently the MPS uplifted numbers of officers in CSU's following a force wide review; this will be established as a regular process through the Domestic Abuse Diamond Group.</p> <p>The Domestic Abuse training group is currently undertaking a scoping exercise of CSU's across London to identify any training gaps</p> |

182. With respect to recommendation 3 above, the Panel feel that the point may have been missed. There is nothing wrong with the extensive MPS response regarding intelligence management as it answers the question framed by the IPCC. However, this was a report of crime, not intelligence, so the answer does not really address what happened here. *A retrievable record is required regarding decisions and actions taken with respect to individual crime reports.* It is suggested that the MPS reconsider this aspect within the overall plan for improvement that must follow the IPCC investigation and this review.

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Panel recommendations for single and multi agency implementation

183. The Panel have identified through both the DHR and SCR components of this overview that more wide-ranging changes are required to demonstrate that the MPS has learned the lessons from this enormous tragedy and can provide evidence of its commitment to embed them in a system that ensures so far as possible that inevitable human fallibility cannot in itself increase threat, risk and harm.

Recommendation 1

184. 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

Recommendation 2

185. The MPS should review its electronic Crime Report Information System (CRIS) to make 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

Recommendation 3

186. 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

Recommendation 4

187. 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

Recommendation 5

188. 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

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and Crisis Unit, which have expertise in 'deadline' management. Such research may improve the assessment of risk within the National Decision Model (NDM).

189. The Metropolitan Police have advanced the view that Recommendations 2 and 3 should be widened so that threats to life and work-related stress are treated as matters for concern and follow-up action in all aspects of police work and not just in the domestic abuse context. This is a reasonable and obvious point and there would be no objection to the police being proactive in widening the scope of change as part of their response to this report.
190. However, our objection to widening the recommendations from the Panel responsible for this particular domestic homicide and serious case review, is the shared concern that these policies were extant at the time, yet were insufficiently robust to be implemented and supervised so that proper safeguarding action followed. Therefore, from the family, community and safeguarding partner perspectives, it is a question of what priority is now given to rectifying the system errors revealed in this review and there is an expectation that particular focus and energy will be demonstrably applied to domestic abuse processes, hence Recommendation 4.
191. A comprehensive action plan to embrace the above findings and recommendations has been developed by the CSP and is set out in appendix 5.

Author

Bill Griffiths CBE BEM QPM

25 January 2016

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Ms AB and Child D killed in Hackney, March 2014**

Glossary and list of code letters used

| | |
|---------|---|
| 124D | MPS domestic abuse report book |
| ADS | Acting Detective Sergeant |
| BMS | Bhatt Murphy Solicitors |
| CAADA | Safe Lives - Coordinated Action Against Domestic Abuse |
| CAD | Computer Aided Dispatch |
| CCG | Clinical commissioning Group |
| CRIMINT | CRIMInal INTelligence system |
| CRIB | Crime Report Information Bureau |
| CRIS | Crime Report Information System |
| CSC | Children's social care |
| CSU | Community Safety Unit |
| DAAT | Drugs and Alcohol Team |
| DA | Domestic Abuse |
| DASH | Domestic Abuse, Stalking and 'Honour'-based violence |
| DI | Detective Inspector |
| DS | Detective Sergeant |
| DV | Domestic Violence |
| DVHR | Domestic Violence Homicide Review |
| EWMS | Wanted Offenders Management and Enforcement |
| HOT | Harm Opportunity and Threat |
| IDVA | Independent Domestic Violence Advocate |
| IMR | Independent Management Review |
| INSP | Inspector |
| IPCC | Independent Police Complaints Commission |
| LB | London Borough |
| MAPPA | Multi Agency Public Protection Arrangements |
| MARAC | Multi Agency Risk Assessment Conference |
| MERLIN | Missing Persons and Related Linked Indices |
| MPS | Metropolitan Police Service |
| NPS | National Probation Service, formerly London Probation Trust |
| PAC | Pre Assessment Checklist |
| PC | Police Constable |
| PCSO | Police Community Support Officer |
| PNC | Police National Computer |
| RWG | Recommendations Working Group |
| SCR | Serious Case Review |
| SIO | Senior Investigating Officer |
| SOP | Standard Operating Procedure |
| TDC | Temporary Detective Constable |
| ToR | Terms of Reference |
| TTL | Threat to Life |
| TTK | Threat to Kill |
| VIW | Victim, Informant or Witness |

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Code Letters used (in order of appearance)

Family and friends

| | |
|------------|--|
| Ms AB | Domestic homicide victim, mother of Child D and former partner of Mr YZ |
| Child D | Domestic homicide victim, daughter and third child of Ms AB and Mr YZ |
| Mr YZ | Double homicide perpetrator, former partner of Ms AB and father of Child D |
| Daughter A | Daughter of Ms AB by another partner and living with maternal grandmother |
| Child B | Teenage first child of Ms AB with Mr YZ and living with her |
| Child C | Teenage second child of Ms AB with Mr YZ and living with her |
| EF | Earlier partner of Mr YZ whereby they had two children together (not involved) |
| Sister G | Sister of Ms AB |
| Sister H | Older sister of Ms AB |
| JK | Friend and work colleague of Ms AB who accompanied her to report threat |
| LM | Neighbour of Ms AB who told her of threat to kill by Mr Mr YZ |
| NP | Close friend of Ms AB who called her on morning of homicides |

Police officers and staff

| | |
|-----------|---|
| SUPTS 1&2 | Oversight of implementation of Local Policing Model and staff shortage in CSU |
| PC 1 | Took initial report from Ms AB when she attended with JK |
| PS 1 | Signed as supervisor of report book 124D completed by PC 1 |
| INSP 1 | Duty inspector at time of report |
| INSP 2 | Duty inspector for late shift to whom INSP 1 handed over responsibility |
| CIV 1 | Police staff member in Crime Report Information Bureau at time of report |
| DS 1 | DS in CSU that received report from PC 1 and accepted it for investigation |
| ADS 1 | Appointed supervisor of team in prolonged absence of DS 1 |
| DS 2 | CSU supervisor of another team given responsibility for work file of DS 1 |
| TDC 1 | Assigned CRIS report by DS 2 for investigation |
| DI 1 | Line manager for CSU |
| CIV 2 | Police emergency call handler for call from Daughter A |
| PCs 2&3 | Attended scene of double homicide as result of call from Daughter A |

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Distribution list

| Name | Agency | Position/ Title |
|-------------------------------------|---|--|
| Tim Shields | Hackney Council | Chief Executive |
| Sophie Linden | Hackney Council | Councillor, Deputy Mayor and lead on domestic abuse |
| Steve Bending | Hackney Council | Head of Safer Communities |
| Cathal Ryan | Hackney Council | Interim Domestic Violence Transformation Manager |
| Sarah Chapman | Hackney Homes | Head of Neighbourhoods |
| Steve Liddicott | Hackney Council | Interim Assistant Director CYPS |
| Sarah Wright | Hackney Council | Head of Safeguarding and Learning CYPS |
| Adrienne Stathakis | Hackney Council | Interim Assistant Director Adult Social Care |
| Penny Bevan | Hackney Council | Director of Public Health LB Hackney |
| Jim Gamble | City and Hackney Safeguarding Children Board | Independent Chair |
| Rory McCallum | City and Hackney Safeguarding Children Board | Senior Professional Advisor |
| Dr Robert Dolan | East London NHS Foundation Trust | Chief Executive |
| Simon Laurence | Metropolitan Police | Borough Commander |
| Chris Brown | Metropolitan Police | Detective Sergeant Specialist Crime Review Group |
| Mark Rochester | Metropolitan Police | Detective Superintendent |
| Sir Bernard Hogan-Howe | Metropolitan Police | Commissioner |
| Stuart Webber | National Probation Service | Assistant Chief Officer |
| Douglas Charlton | London Community Rehabilitation Company | Head of Stakeholder and Partnerships (North East London) |
| <i>Post is vacant</i> | NHS England | Named GP for Safeguarding Children |
| Mary Lee | City and Hackney Clinical Commissioning Group | Designated Nurse City and Hackney CCG |
| Shiela Adam | Homerton University Hospital Trust | Chief Nurse |
| Karen Sobey Hudson | NHS England | Patient Safety Projects Manager (London Region) |
| Rahni Binjie | nia project | Head of Operations, IDVA Service |
| Caroline Birkett | Victim Support | North & West Area Manager |
| Bill Griffiths | Independent Chair | Independent Chair of the Domestic Homicide Review |
| Quality Assurance Panel | Home Office | - |
| Baljit Ubhey | Crown Prosecution Service | London Chief Crown Prosecutor |
| Deputy Mayor for Policing and Crime | Mayor's Office for Policing and Crime | - |

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Appendix 1

Independence statements

Chair of Panel

Bill Griffiths CBE BEM QPM was appointed by Hackney Safer, Cleaner Partnership as Independent Chair of the DVHR Panel and is the author of the report. He is a former Metropolitan police officer with 38 years operational service and an additional five years as police staff in the role of Director of Leadership Development, retiring in March 2010. He served mainly as a detective in both specialist and generalist investigation roles at New Scotland Yard and in the Boroughs of Westminster, Greenwich, Southwark, Lambeth and Newham.

As a Deputy Assistant Commissioner he implemented the Crime and Disorder Act for the MPS, leading to the Borough based policing model, and developed the critical incident response and homicide investigation changes arising from the Stephen Lawrence Inquiry. For the last five years of police service, as Director of Serious Crime Operations, he was responsible for the work of some 3000 operational detectives on all serious and specialist crime investigations and operations in London (except for terrorism) including homicide, armed robbery, kidnap, fraud and child abuse.

Bill has since set up his own company to provide consultancy, coaching and speaking services specialising in critical incident management, leadership development and strategic advice/review within the public sector.

During and since his MPS service he has had no personal or operational involvement within the Borough of Hackney, or direct management of any MPS employee. He knows DCI Barry Loader as a Panel Member on another Domestic Homicide Review in Hackney Borough. This fact was shared with the family and their Solicitors and no objections arose.

Secretary to Panel

Tony Hester has over 30 year's Metropolitan police experience in both Uniform and CID roles that involved Borough policing and Specialist Crime investigation in addition to major crime and critical incidents as a Senior Investigating Officer (SIO). This period included the management of murder and serious crime investigation.

Upon retirement in 2007, Tony entered the commercial sector as Director of Training for a large recruitment company. He now owns and manages an Investigations and Training Company.

His involvement in this DVHR has been one of administration and support to the Independent Chair, his remit being to record the minutes of meetings and circulate documents securely as well as to act as the review liaison point for the Chair.

Other than through this review, Tony has no personal or business relationship or direct management of anyone else involved. He knows DCI Barry Loader as a Panel Member on another Domestic Homicide Review in Hackney Borough.

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Appendix 2

Terms of Reference for Review

1. To identify the best method for obtaining and analysing relevant information, and over what period of time, in order to understand the most important issues to address in this review and ensure the learning from this specific homicide is understood and systemic changes implemented
2. To identify the agencies and professionals that should constitute this Panel and those that should submit Individual Management Reviews (IMR) and agree a timescale for completion
3. To understand and comply with the requirements of the criminal investigation, any misconduct investigation and the Inquest processes and identify any disclosure issues and how they shall be addressed, including arising from the publication of a report from this Panel
4. To identify any relevant equality and diversity considerations arising from this case and whether either the adult victim or alleged perpetrator was a 'vulnerable adult' and, if so, what specialist advice or assistance may be required
5. To identify whether the adult was subject to a Multi-Agency Risk Assessment Conference (MARAC) or the alleged perpetrator subject to Multi-Agency Public Protection Arrangements (MAPPA) or Domestic Violence Perpetrator Programme (DVPP) and, if so, identify the terms of a Memorandum of Understanding with respect to disclosure of the minutes of relevant meetings
6. Following agreement by the National Panel of Experts to combine the DVHR and Serious Case Review processes, the review will consider any associated learning that will improve safeguarding practice in relation children. The review process will adhere to the following principles set out in Working Together to Safeguard Children 2013 (4:10):
 - Recognise the complex circumstances in which professionals work together to safeguard children
 - Seek to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did:
 - Seek to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight
 - Be transparent about the way data is collected and analysed; and
 - Make use of relevant research and case evidence to inform the findings.
7. Children's Services staff and the CHSCB will be represented on the DVHR Panel to ensure that all questions that would have been asked as part of a separate SCR are addressed. The CHSCB SCR Sub Committee will quality assure the final draft report which will require formal sign off by the Independent Chair of the CHSCB on behalf of the full Board.
8. Specific questions to be addressed by the review in respect of child safeguarding will include:
 - Whether the presentation to professionals by any family member could/should have triggered further professional curiosity and/or action as a result to protect Child D
 - Whether agencies, together, or individually, missed opportunities to act on or share information that was known (or knowable at the time) to protect Child D

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- Whether the specific risk of harm to Child D or other children was given consideration and/or assessed at the point of MS AB's presentation to the Police
 - Whether the details concerning Mr YZ's history and concerning background was fully known to any agency involved with Child D and/or children of YZ living with Ms AB.
9. To identify how should family, friends and colleagues of the victim and other support networks (and where appropriate, the perpetrator) contribute to the review and how matters concerning them in the media are managed during and after the review.
10. Following a family meeting on 9 September and a written submission dated 11 September 2014, specific questions to be addressed by the review in respect of the police handling of a report in mid February 2014 of threats by YZ to kill Ms AB and Children B, C and D by setting fire to their house with them inside are:
- Whether the police made any attempt to apprehend or speak to YZ, including if there was a warning marker placed against his name on police databases and the nature of that marker and what likely action would have followed
 - Whether the police made any attempt to contact Ms AB for further information or to check on her welfare or that of the children, or made any visits to the house, and the nature of any warning marker placed against the address on police or agency databases as being a potential location for domestic abuse incidents
 - Whether any referrals were made to other agencies and, if not, what referrals should have been made and what likely action would have followed
 - Whether any Merlin report was made in respect of the three children and, if not, what reports should have been made and what likely action would have followed
 - Whether any referral was made to the nia Project for consideration of an Independent Domestic Abuse Advocate service for Ms AB and, if not, what referrals should have been made and what likely action would have followed
 - Whether any referral was made to Victim Support and, if not, what referrals should have been made and what likely action would have followed
 - Whether any referral was made to Hackney Homes and, if not, what referrals should have been made and what likely action would have followed
11. In addition, the family have identified specific questions to be addressed in respect of the police handling of an emergency call by Daughter A in respect of the fatal attack on Ms AB and Child D when in progress at the end of March 2014 are:
- Whether the police call handler treated the call seriously and responded appropriately to the nature of the attack
 - If there was no warning marker on police databases against the address and/or YZ's name, whether the call would have been treated differently and the response been different as a result had the warning marker(s) been in place
 - Whether research and analysis of the sequence and timings of calls from the police call handling centre to the ambulance service and the times of the arrival of the three ambulances and the air ambulance that attended reveal reasons for the length of time each took to arrive at the address
 - Whether research and analysis of the timings of the police response to the emergency call reveal whether appropriate urgency and seriousness was attached to the response

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12. To identify how the review should take account of previous lessons learned in Hackney and also from relevant agencies and professionals working in other Local Authority areas
13. To keep these terms of reference under review and subject of reconsideration in the light of any new information emerging

Operating Principles

- a. The aim of this review is to identify and learn lessons so that future safeguarding services improve their systems and practice for increased safety of potential and actual victims of domestic violence (as defined by the Home Office – see below)
- b. The aim is not to apportion blame to individuals or organisations, rather, it is to use the study of this case to provide a window on the system
- c. A forensic and non-judgmental appraisal of the system will aid understanding of what happened, the context and contributory factors and what lessons may be learned
- d. The review findings will be independent, objective, insightful and based on evidence while avoiding 'hindsight bias' and 'outcome bias' as influences
- e. The review will be guided by humanity, compassion and empathy with the victim's voice at the heart of the process
- f. It will take account of the protected characteristics listed in the Equality Act 2010
- g. All material will be handled within Government Security Classifications at 'Official - Sensitive' level

Definition of Domestic Abuse

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

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Appendix 3

| Panel member | Role |
|---|---|
| Bill Griffiths CBE BEM QPM | Independent Chair |
| Tony Hester | Management support to Chair |
| Liz Hughes | Head of Safer Communities LB Hackney (to 11/14) |
| Steve Bending | Head of Safer Communities LB Hackney (from 11/14) |
| Rory McCallum | Senior Professional Advisor to the City & Hackney Safeguarding Children Board |
| Sarah Wright | Children and Young Persons Services (Head of Safeguarding and Learning) |
| Dr Ruth Hallgarton | City & Hackney CCG (Named GP Safeguarding Children) |
| Mary Lee | City and Hackney CCG (Designated Nurse for Safeguarding Children) |
| Sarah Chapman | Hackney Homes (Head of Neighbourhoods) |
| DCI Barry Loader | Metropolitan Police Hackney (Crime Manager) |
| DS Jack Spratt | Metropolitan Police Specialist Crime Review Group (to 03/15) |
| DS Chris Brown | Metropolitan Police Specialist Crime Review Group (from 03/15) |
| Rahni Binjie | nia Project, Head of Operations, Independent Domestic Abuse Advocate Service |
| Provided briefing to Panel and/or chronology information provided by letter | |
| DS Nick Whittle | Metropolitan Police Serious Crime and Operations 1 (Case Officer) |
| Assistant Chief Officer Linda Neimantas | National Probation Service, formerly London Probation Trust |
| Laurence Wrenne | Hackney Drugs and Alcohol Team (DAAT) Service |

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|--------------|---|
| GP for Mr YZ | GP Practice within NHS City and Hackney CCG |
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Appendix 4

Timeline of events with summary analysis²⁰

| Date & Time | Phase and who involved | Actions |
|------------------------|--|---|
| Oct 2013 | Prior to report by Ms AB to police in Hackney Borough of domestic abuse threat from YZ | Breakdown of relationship between AB and YZ |
| Early Jan 2014 | As above | Ms AB informed YZ that their relationship is finally over; he should find somewhere to live and leave her house by the end of March 2014 |
| Mid Feb 1700 | As above | Near neighbour (LM) informed AB that YZ had told her he would burn down the house with AB and their three children in it rather than accept the breakup of their relationship |

²⁰ For acronyms see glossary

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|--|---|---|--|--|
| Day AB reported to police 1000 | As above | Brother of AB contacted YZ by telephone and confronted him with the neighbour's allegation which YZ denied saying that LM was mistaken. AB informed of this by telephone when on her way to Stoke Newington Police Station to report the allegation | | |
| Police Actions following report: | Correct | Incorrect | Missed Opportunities | |
| Primary Investigation phase | | | | |
| Day in mid Feb AB reported to police 1030 to 1440 | AB attended with her friend (JK) and reported allegation to PC1 who was on station officer duty | <p>Showed AB to private room and supportive about her reporting</p> <p>Completed Book 124D including details of AB's three children as victims and recorded the DASH risk assessment as 'High'</p> <p>Typed witness statement (MG11) signed by AB</p> <p>Completed CRIS report in which risk assessment changed to 'Medium' after advice from colleague</p> <p>Informed supervisor and attended CSU where informed DS1 who then generated a 'wanted' record for YZ on the PNC</p> | <p>Selected classification from drop-down menu of: 'Threat to commit criminal damage' when there was clear evidence of a 'threat to kill'</p> <p>Having changed risk assessment should have recorded rationale and been signed off by supervisor</p> <p><i>[Note: This should not have had an adverse effect because either high or medium should have led to a secondary DASH2 assessment within the CSU]</i></p> | PC1 did not generate the MERLIN/PAC that would then have been shared with children's social care who would have become involved in safeguarding activity, including their own expert assessments and possibly case conferences with the police |

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| | | Offered VS and IDVA support which AB declined Provided victim contact card | | |
| Primary Supervision phase | | | | |
| Same day 1330 - 1443 | <p>PC1 approached PS1 who signed the Book 124D as supervisor and (in all probability) directed PC1 to attend the CSU for advice which was provided by DS1 who was on duty there</p> <p>The CRIS report shows that PC1 also informed the Duty Officer (believed to be INSP1)</p> <p><i>[Note: Neither PS1 or INSP1 can recall being informed of this matter and insist they would have taken the correct action if properly briefed]</i></p> | <p>DS1 supported PC1 by taking responsibility for generating a PNC 'wanted' record for YZ</p> <p>CIV1 working in the CRIB placed a DV flag on the CRIS report</p> | <p>DS1 assumed that 'uniform supervision' had been undertaken and was sufficiently reassured to note in the CRIS record that INSP1 had been informed</p> <p>CIV1 'confirmed' the classification as 'threat to commit criminal damage' which may have been expedient so far as HO crime counting rules are concerned but was clearly not appropriate to the method described (threat to kill AB and three children)</p> <p>CIV1 opted for a standard risk assessment apparently without reading the details of investigation</p> | <p>DS1 did not correct (as he had the authority to do) the crime classification to one of 'Threat to kill'</p> <p>Did not notice and rectify that the MERLIN/PAC had not been generated and shared with agencies</p> <p>Did not ensure that, following the PNC record, the EWMS recorded an action plan for the speedy arrest of YZ</p> |
| Secondary Investigation phase | | | | |

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|-----------------|--|---|--|---|
| <p>Same day</p> | <p>DS1 assigned the investigation to himself in order to be able to generate the PNC record for YZ, with the intention of assigning the investigation to one of his team. This was not done, as he was distracted with other duties on the next day. He was then on two rest days. He then reported sick with work related stress and did not return until May</p> | <p>DS1 noted the CRIS report that he contacted the mobile telephone for AB but there was no answer and no facility to leave a message</p> | <p>DS1 wrongly assumed that INSP1 had 'approved' the crime classification of 'threat to commit criminal damage' and did not challenge that it was also a clear 'threat to kill'</p> <p>At 12 and 22 days later, the CRIB generated reminder 'memos' to update progress on this investigation. These were automatically sent to DS1 who remained on sick leave, there being no capability to bring to the attention of a supervisor</p> | <p>DS1 did not allocate the investigation to a member of his team which would have also required him to set an investigation strategy</p> <p>Did not populate the EWMS within 24 hours (as required by the policy) that would have ensured that a separate team responsible for the pursuit of offenders would have drafted and implemented an arrest strategy for the detention of YZ</p> <p>Did not consider the use of YZ's mobile as a means of tracking him or contacting him</p> <p>Did not undertake a DASH2 risk assessment as trained and required to do when presented with a high <u>or</u> medium primary assessment</p> <p>Did not make any attempt to contact the witness LM, without whose evidence there would not be a case to put to YZ if he was arrested for the PNC report</p> |
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| <p>13 days later</p> | <p>DS2 was appointed to take responsibility for the retrospective work of DS1 (ADS1 was appointed on the same day to be responsible for supervision of new work on DS1's team)</p> <p>14 days after that, DS2 looked at the 10 investigations in the work file for DS1 but took no action</p> <p>8 days later (27 after original report by AB) DS2 allocated this investigation to TDC1 who was on night duty</p> | <p>Four days after allocation by DS2, TDC1 'noted' the report, conducted a PNC check on YZ and called the mobile telephone for AB. He was able to leave a message for her to contact him regarding her original visit to Stoke Newington Police Station (38 days earlier)</p> <p>Four days after that, TDC1 was given time by ADS1 to reduce his workload of about 20 investigations and he briefly examined this report but took no action</p> | | <p>TDC1 did not challenge the incorrect crime classification</p> <p>Did not pick up that the EWMS was not in place or the tactical potential from YZ's mobile telephone</p> <p>Did not conduct a DASH2 risk assessment</p> <p>Did not rectify the prior omission to share a MERLIN/PAC with children's social care</p> <p>Did not attempt to contact the witness LM</p> |
| Secondary Supervision | | | | |
| <p>13 days after original report</p> | <p>DS2 was given responsibility for the retrospective work file of DS1 prior to him reporting sick 8 days earlier in</p> | <p>14 days after being given the task, DS2 accessed the CRIS work file of DS1 for 45 minutes and noticed there were nine crime reports requiring attention</p> | | <p>DS2 did not set an investigation strategy for TDC1 on the basis that he was experienced and competent</p> <p>Did not challenge the incorrect crime classification</p> |

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| | addition to supervising the work of her own team | Accessed this crime report again 8 days later and assigned it to TDC1 for investigation | | <p>Did not pick up that the EWMS was not in place</p> <p>Did not conduct a DASH2 risk assessment</p> <p>Did not rectify the prior omission to share a MERLIN/PAC with children's social care</p> <p>Did not inform ADS1 that this investigation had been allocated to TDC1</p> |
| Day of emer call 0900 (47 days after original report of crime) | Double homicide of AB and Child D committed by YZ | Daughter A contacted the emergency system and police arrived within 6 minutes. Due to inadequate questioning of her and relaying of information of what was known by CIV2, there was a further 40 minute delay before access to the house was gained by PC's 2 & 3 where they discovered the murder scene on the third floor and detained YZ | | |

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Appendix 5

ACTION PLAN

| Recommendation | Scope of recommendation | Action to take | Lead Agency | Key Milestones Achieved in enacting recommendations | Target Date | Date of completion and outcome |
|--|--------------------------------|---|--------------------|---|---|--|
| <p>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</p> | <p>MPS service level</p> | <p>Design electronic version of officer notebook 124D for handheld devices with any affirmative response from the victim within the DASH risk assessment requiring a further field to be completed with more detail</p> <p>Train front line officers and first line supervisors on a Borough in the use of the electronic 124D</p> <p>Evaluate effectiveness and identify roll-out programme for all Boroughs [Note: This study has been conducted. The benefits observed, amongst others, were the inability on the part</p> | <p>MPS</p> | <p>Electronic version of 124D</p> <p>Pilot and evaluate use on a Borough</p> <p>Include new design in roll-out programme for handheld electronic devices</p> <p>Complete MPS rollout programme for handheld devices</p> | <p>November 2015</p> <p>November 2015</p> <p>November 2015</p> <p>June 2017</p> | <p>June 2017</p> <p>Ongoing</p> |

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| | | of the reporting officer to navigate past the DASH questions without populating the response field <u>and</u> 100% compliance with the initial supervision of the DASH risk assessment] | | | | |
| <p>2 The MPS should review its electronic Crime Report Information System (CRIS) to make sure that:</p> <p>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</p> <p>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</p> | MPS Service level | <p>a. The MPS has accepted that action is required in respect of items a – d and have adopted the National Guidance on Threats to Life (TTL), a standardised approach to TTL investigations to ensure that TTLs are properly risk assessed, objectively investigated & effectively gripped, reviewed & monitored, regardless of crime type. This requires supervisory assessment and action by an officer of Inspector rank in all cases. When there is a MEDIUM or HIGH risk is identified, an officer of Superintendent rank</p> | MPS | <p>Design appropriate guidance and learning from this DVHR</p> <p>Using the ‘case study’ approach provide specific training to all MPS Inspectors, CMU/CRIB supervisors and CSU DI’s</p> <p>Evaluate effectiveness of training through the Area Performance Inspection process delivered to Inspectors, CMU/CRIB supervisors and CSU DI’s</p> | <p>December 2015</p> <p>June 2016</p> <p>September 2016</p> | <p>March 2017</p> <p>Ongoing</p> |

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| <p>cause delay to the investigation</p> <p>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</p> <p>d. The Crime Report Information Bureau will not confirm the classification unless and until the above has been completed</p> <p>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</p> | | <p>must also review the circumstances and will ensure an Investigating Officer of Inspector rank is appointed to lead the police response.</p> <p>b. When a crime has been reported the assessment conclusion will be recorded on the updated crime report and the usual processes of recording and investigating such incidents should also continue. Therefore even in LOW risk cases the National Guidance makes clear the assessment conclusion (second line manager) MUST be updated within the report before the usual processes of recording and investigating such incidents continue. This will precede any secondary allocation process.</p> | | | | |
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| | | <p>c. The extant DA Policy checklist for initial investigating officers requires that they take appropriate action, where not already done, where a child is involved/present and any of the Every Child Matters Key Outcomes are not being achieved. Notify social services immediately if a child is subject to a Child Protection Plan or the child is accommodated formally away from their parents e.g. foster care. The MERLIN will be referred into the Multi Agency Safeguarding Hub for further dissemination to Children’s Service. A MERLIN report will be generated in all cases where children are included in the relationship, whether present or not and including unborn</p> | | | | |
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Ms AB and Child D killed in Hackney, March 2014**

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| | | <p>children and cross-referenced on CRIS.</p> <p>d. All of the above will precede any confirmation of classification on CRIS.</p> <p>e. The MPS fully accepts the intention behind this limb of the Panel recommendation, however, this would not take into account an officer who has ignored memos or supervisory responsibility within that timeframe and system generated reminders may be diverted even when the officer is actually at work. This could lead to supervisors needlessly having to acknowledge reminders generated due to this approach. It is possible to view the CRIS work file of any officer using their warrant number. Second and Third Line managers should be</p> | | | | |
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| | | <p>fully aware of their professional responsibilities when such circumstances arise and this is not an uncommon occurrence, not just with absences concerning sickness, but leave entitlements, course attendances etc. It is the responsibility of the unit head (DI) to re-allocate supervisory responsibility and they will be aware of when their staff member (DS) is likely to be away from duty for any extended period. It is their responsibility to review their work file (using their warrant number) and reallocate investigations and ensure memos are answered. Upon re-allocation of the supervisor on CRIS, the new supervisor will receive the reminders.</p> | | | | |
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| <p>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</p> | <p>MPS Service level</p> | <p>For the same reasons as recommendation 2e above the MPS fully accepts the intention behind this recommendation, but this is clearly a responsibility of the CSU head (a Detective Inspector)</p> <p>If any member of staff becomes absent due to unforeseen circumstances for any period of time this should prompt an immediate review of their work file to assess if there are high risk safety concerns, time sensitive enquiries etc. that need to be re-allocated to other members of staff</p> | <p>MPS</p> | <p>This aspect of lessons learned will become a strong point of emphasis within the actions for rec 2 above</p> | <p>As rec 2 above</p> | <p>As rec 2 above</p> |
| <p>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</p> | <p>MPS in Hackney Borough</p> | <p>There are service policies in place for the investigation of all 'Hate Crime', in particular a tool kit for the investigation of Domestic Abuse. In addition to mandatory training,</p> | <p>MPS in Hackney Borough</p> | <p>In partnership with the CHSCB, devise an approach to future performance data with respect to Hackney CSU that reflects the lessons learned from</p> | <p>December 2015</p> | <p>January 2017 Ongoing</p> |

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| <p>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</p> | | <p>comprehensive checklists and other sources of guidance are available on the MPS intranet Policy Pages site for primary investigation, primary supervision, secondary investigation and secondary supervision.</p> <p>There are no automated notifications on the Crime Report Information System (CRIS) to notify a supervisor, or line manager that a domestic abuse incident has been reported. Line managers are required to conduct a manual search of CRIS to identify any reports that require supervision.</p> | | <p>this DVHR, for example, through:</p> <ul style="list-style-type: none"> • Dip sample of 124D reports to assess quality of completion and timely supervision. • CRIS supervision data for primary and secondary investigations • Percentage of MERLIN records completed for DA allegations where children are present • Percentage of MARAC referrals made by police • Staffing levels in the CSU • Percentage of CSU officers who have completed the CSU course • The number of investigations held by each officer in the CSU | | |
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| | | | | <ul style="list-style-type: none"> • Percentage of first and second line supervisors that have attended multi-agency training places offered by the CHSCB • Presentation detailing reassurance processes and compliance systems for DA investigations including MERLIN compliance, third party MARAC referrals and primary supervision <p>London East Delivery Unit to conduct independent quarterly performance assessments of primary and secondary investigation and supervision, partnership, offender</p> | <p>January 2016 for 12 months</p> | |
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Ms AB and Child D killed in Hackney, March 2014**

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| | | | | <p>management and leadership and provide reports for consideration by the CHSCB</p> <p>The CHSCB to record its confidence that the MPS in Hackney Borough have satisfactorily implemented the learning from this review</p> | January 2017 | |
| <p>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</p> | <p>MPS service level and then national level for England and Wales</p> | <p>This recommendation will be researched and developed by the Recommendations Working Group (RWG) chaired by D/Supt Dr Jacqueline Sebire</p> | <p>MPS followed by College of Policing if justified by the research</p> | <p>RWG to research and analyse the evidence from this review together with other DVHR overview reports which feature a 'deadline' or other significant date (anniversary/birthday) at which point prior threats or actual violence is carried out by the perpetrator</p> | <p>January 2016</p> <p>April 2016</p> | <p>September 2016</p> <p>Ongoing</p> |

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| <p>the National Decision Model (NDM)</p> | | | | <p>Identify common features that would be helpful to the understanding of potential victims of domestic abuse that are considering fleeing the relationship so that strategies can be developed for safe exit planning</p> <p>Formulate advice and training for IDVAs and other support agencies and networks that are in a position to assist those fleeing abusive relationships</p> <p>If appropriate, develop and issue practice guidance to inform the police National Decision Model</p> | <p>June 2016</p> <p>September 2016</p> | |
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Appendix 6



Home Office

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848
www.gov.uk/homeoffice

Steve Bending
Head of Safer Communities
Chief Executive's Directorate
London Borough of Hackney
2nd floor, Morris Bishop House Reading Lane
London E8 1FB

27 May 2016

Dear Mr Bending,

Thank you for submitting a combined Domestic Homicide Review and Serious Case Review report on behalf of the London Borough of Hackney for consideration by the Home Office DHR Quality Assurance (QA) Panel.

The QA Panel would like to thank you for conducting this joint review and for providing them with the final report. The Panel found this to be a well-written, thorough and probing report that displays compassion and empathy for the victims. The Panel would like to commend the chair for using a variety of sources to inform the review, including interviewing officers himself. The Panel were particularly struck by the contribution of family members which has given the adult victim a voice in the review.

There were some aspects of the report which the Panel felt could be revised which you will wish to consider before you publish the final report:

- The Panel felt that a separate executive summary that can be read in isolation may be helpful;
- The Panel suggested that anonymity could be enhanced with the removal of the gender of the children in the family. In addition, removing the name of the GP practice may avoid identifying the area where the family lived;
- Bullet points in paragraph 168 on page 48 would help distinguish the sentences;
- There is a typing error in the first line of paragraph 122 on page 30;



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- The Panel recommended that the Metropolitan Police Commissioner and the Mayor's Office for Policing and Crime should also be added to the distribution list on page 62 of the report.

The Panel does not need to see another version of the report, but I would be grateful if you could include this letter as an appendix to the report when it is published.

I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel