



Joint Serious Case Review & Domestic Violence Homicide Review – Child D



city & hackney
safeguarding
children board

Background

- Child D aged 22 months and Ms AB (aged 45) died in March 2014.
- They were murdered by Ms AB's partner and father of Child D, Mr YZ (aged 53).
- In December 2014, Mr YZ was convicted of murder and sentenced to 35 years imprisonment.

Scope and Focus

- Review undertaken by:
 - Domestic Violence Homicide Review Panel (established under s9 Domestic Violence, Crime and Victims Act 2004), and
 - Serious Case Review Panel (in line with Regulation 5, LSCB Regulations 2006).
- Joint review agreed by National Panel of Experts.
- Undertaken alongside IPCC investigation.

Methodology

- Independent Reviewer & Review Team.
- Multi-Agency Chronology.
- Individual Management Report (MPS).
- Interview with eldest daughter of Ms AB.
- Liaison with the MPS Senior Investigating Officer and the IPCC lead investigator.
- Final report produced.
- **Feedback to family.**

Involved Agencies

Six agencies had records of relevant contact during the period for review (January 2009 to March 2014):

- Metropolitan Police Service
- National Probation Service
- Hackney Drugs and Alcohol Team (DAAT)
- GP Practice x 2 (Mr YZ and Ms AB/Child D)
- Homerton University NHS Foundation Trust

Prior to February 2014 no records of contact with agencies other than general health matters and birth of Child D.

Background and key issues

- Ms AB and Mr YZ were in a relationship for 18 years and had three children together.
- They had lived together for 14 years.
- Ms AB and Mr YZ also had children from previous partners.
- Friends, colleagues and neighbours knew Mr YZ to be controlling and financially exploitative but no known physical violence.

Background and key issues

- In October 2013, the relationship broke down.
- By January 2014, Ms AB gave ultimatum that Mr YZ should move out by March 2014.
- In the same period, a Local Policing Model was introduced to improve efficiency.
- This impacted on the Community Safety Unit at a time of staff and skill shortages, increased workload and gaps in performance.

Background and key issues

- In February 2014, Ms AB reported to Police that a neighbor informed her of a threat from Mr YZ. He allegedly said he'd burn down the house with her and children in it rather than accept the break-up.
- This was inaccurately recorded as 'threat to commit criminal damage' rather than 'threat to kill' (inexperience).
- There was a failure to complete a pre-assessment checklist to share with Hackney CSC as threat involved children.

Background and key issues

- These errors should have been rectified in primary supervision. However communication failure led to:
 - Incorrect assumption by secondary investigators that uniformed colleagues had undertaken primary supervision and rectified actions.
 - Strategy and actions to ensure Mr YZs arrest not activated.

Background and key issues

- Due to sick leave, the case was not progressed for 12 days.
- It took another 23 days for it be assigned for investigation.
- cursory checks then undertaken and a voicemail left with Ms AB to make contact.
- Due to other commitments / leave, no further action undertaken by police until events in March 2014.
- This was 47 days after Ms AB brought threat to notice.

Background and key issues

- As a coping strategy, Ms AB telephoned relatives/friends when Mr YZ verbally abused her.
- Ms AB also sent text messages to update on progress and detail arguments as the deadline date approached.

Background and key issues

- On the morning of Mr YZs departure, Ms AB phoned her adult daughter (A) who overheard an argument for nine minutes before phone cut off.
- Two minutes later, Ms AB called back and had a whispered conversation. Child D could be heard in the background.
- (A) then was an auditory witness to the violent assault.
- (A) called the police and two PCs attended within six minutes of the call.

Background and key issues

- There was no response at the house and no signs of disturbance from their limited view on the ground floor.
- PCs requested equipment for forced entry but were not provided with key information that (A) had shared with the call handler.
- Neighbour and Ms ABs mother also provided alternate explanations as to her whereabouts.
- Uncertainty and confusion resulted in 40 minutes of delay.

Background and key issues

- Ms AB and Child D were found lifeless in the bathroom with multiple cut, stab and compression wounds inflicted by means of a machete, screwdriver and hammer recovered at the scene.
- Mr YZ was found with self-inflicted cut and stab wounds and had ingested bleach.
- A note was left on Ms AB's face.
- Mr YZ recovered after a short hospital stay.

Background and key issues

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

Missed Opportunities

- Pre-assessment check list not completed (referral to CSC).
- Incorrect classification meant not escalated to inspector level:
 - Would have flagged omission of pre-assessment check list
 - Referral to Multi Agency Risk Assessment Conference (MARAC)
- Arrest plan for Mr YZ not implemented.
- No consideration of use of Mr YZ's mobile to track or invite to surrender to custody for interview.
- No attempt to contact neighbour to provide evidence of threat.
- Secondary and more sophisticated risk assessment not undertaken.
- MPS system lacked mechanism to highlight errors or omissions and allowed them to remain unchallenged/unobserved.

Recommendations

- MPS Review:
 - Remind officers of correct procedures through local training plan. To include attendance at CHSCB training.
- IPCC investigation:
 - Victims Codes of Practice
 - Details needed by police when attending incidents
 - Minutes from Daily Intelligence Meetings
 - Staffing within Community Safety Units

Recommendations

- DVHR/Serious Case Review:
 - Risk assessment for planned mobile system to include clear guidance and requires full explanation of context and supervision actions to be recorded
 - MPS to review Crime Report Information System (CRIS)
 - MPS to review HR support system to ensure staff absence for work-related stress prompts review of officer's work file
 - MPS to provide reassurance that all failed processes rectified
 - Research to be commissioned into safe 'exit planning'. Specialist advice sought regarding 'deadline management'.

Current activity in the City

- Two year action plan coming to an end:
 - Linking independent and statutory victim services
 - Engagement: residents and workers
 - Re-commissioning Vulnerable Victim Advocate
 - Training staff, most recently on FGM/FM/HBV and the law
- Being clear on referring pathways (linking in Threshold of Need) for support
- MARAC review and enhancing our service protocol

Current activity in the City

- 16 Days of Action
 - Raising awareness among residents, agencies and City workers about what domestic abuse is
 - Promoting our specialist services in the City
 - Making sure people have access to information and what happens when reporting
 - Looking at how people can support a friend/colleague
 - Working with Lloyds Bank to pilot some training
- Finalising the VAWG strategy and writing the next two-year strategic plan
 - Focus on information sharing so we can help all communities
 - Work in schools with children and young people around healthy relationship
 - Bringing in recommendations from a variety of sources including tragic ones like this.

Current activity in the City

- For more information, contact Robin Newman:

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CHSCB website: www.chscb.org.uk



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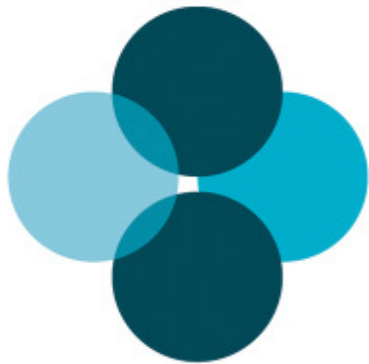
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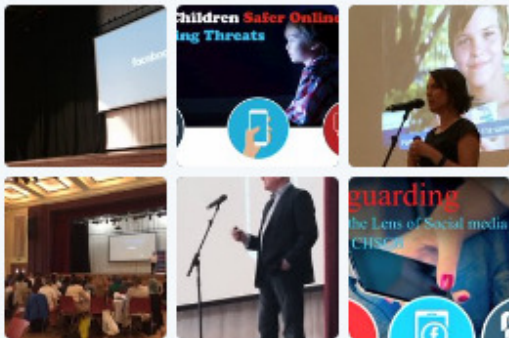
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Jim Gamble @JimGamble_INEQE · Sep 4

#SEXTING Interesting article.
IMO the law is wrong & the advice provided by many so called experts

Questions and Comments



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