LONDON BOROUGH OF HARROW
SAFER HARROW PARTNERSHIP

DOMESTIC HOMICIDE REVIEW
MS AB AGED 34 YEARS
KILLED IN JANUARY 2015

REVIEW PANEL CHAIR AND AUTHOR
BILL GRIFFITHS CBE BEM QPM

Safer Harrow Partnership
DVHR Panel for Ms AB killed in January 2015 in Edgware, Harrow

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FOREWORD

"The welfare of the people is supreme"

Inscription above Court 3, Grand Hall of the Central Criminal Court

In the field of domestic violence and abuse, it has always been the case that professionals should not only deal competently with the problems they encounter within their own field of expertise; they should also strive to see the bigger picture and work together for the right result.

The trial Judge in this case has accepted that this particularly violent homicide occurred in the circumstance of Alcohol Dependence Syndrome (ADS), a relatively new defence to the charge of murder, whereby the perpetrator is assessed by clinical experts as having diminished responsibility due to extreme intoxication. These professional assessments are conducted with the benefit of forensic analysis of blood alcohol concentration and retrospective interviews with the perpetrator in slow time.

Hearing the evidence in the trial must have been particularly shocking and distressing for the family of Ms AB and the Panel offers their heartfelt condolences.

A condition of Alcohol Dependence Syndrome may well present a greater threat of risk and harm to a to a partner, but it cannot be a reason or an excuse for domestic abuse. There could be an underlying pattern and escalation of violence, control and coercion with a heightened risk at the point of separation, as there was in this case. One positive from this tragedy will be the opportunity to learn more about the consequences of ADS, to develop shared understanding of the condition and its potential for harm within the safeguarding system. This exceptional case also has the potential for learning nationally.

This independently chaired review into the circumstances leading to the death of Ms AB has been well supported by the Safer Harrow Partnership and the agencies involved and I am very grateful to the members of the Panel for their hard work to support the review and for their wise and expert counsel during discussions. My understanding of the issues and appreciation for the work they do in the fields of domestic abuse, primary health care and mental health care 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 review.

W Griffiths CBE BEM QPM
Independent Chairman
28 May 2017

Safer Harrow Partnership
DVHR Panel for Ms AB killed in January 2015 in Edgware, Harrow

EXECUTIVE SUMMARY

This summary outlines the process taken by the Safer Harrow Partnership Domestic Violence Homicide Review Panel established on 16 July 2015 under s9 Domestic Violence, Crime and Victims Act 2004, independently chaired by Bill Griffiths CBE BEM QPM, to review the death of Ms AB aged 34 caused by multiple stab wounds in early January 2015. Her partner, Mr YZ aged 34, appeared at the Central Criminal Court and a plea to manslaughter with diminished responsibility was accepted. Expert clinicians had diagnosed that he was suffering from Alcohol Dependence Syndrome (ADS) at the time of the homicide. In January 2016, Mr YZ was sentenced to 12 years' imprisonment with five years supervision on release.

The process began with a meeting on 25 August 2015 of all agencies that potentially had contact with the family prior to the death of Ms AB. Agencies participating in the review are:

- Metropolitan Police Service
- NHS England
- Harrow Clinical Commissioning Group
- Local Medical Centre for Ms AB, Harrow
- Local GP Surgery for Mr YZ, Harrow
- London North West Healthcare NHS Trust
- Central and North West London NHS Foundation Trust
- Victim Support
- Safer Communities, London Borough of Harrow

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

> *A chronology of interaction with the victim and the perpetrator; what was done or agreed; and whether internal procedures were followed.*

The accounts of involvement with this victim cover different periods of time prior to their death. Some of the accounts have more significance than others. The extent to which the key areas have been covered and the format in which they have been presented varies between agencies. Apart from Safer Communities who had no contact with either party, each of the above agencies provided a full Independent Management Review that included conclusions and recommendations from the agency's point of view.

<u>Key issues arising from the review</u>
Ms AB arrived in the UK from Poland in 2001 when aged 21 and pursued a career in the pub and restaurant industry. Her manager described her as a consummate professional, highly regarded by colleagues and customers alike. She met Mr YZ in 2011 and, by May 2014, she was living with him at his semi-detached suburban home in Edgware, Borough of Harrow. Mr YZ was not in employment due to his alcoholism and lived by benefits and support from his parents.

Alcohol was a factor in each of the incidents reported to police. In the diagnosis of ADS, Mr YZ disclosed that he was a daily drinker who, over time, required ever increasing amounts of alcohol to function to the point where, on the day he killed Ms AB, he was so intoxicated that he is unable to recall anything about the sudden and savage multiple knife attack he inflicted upon her. Ms AB's alcohol consumption was far less and more under her control in that she did not drink at all when she worked or was in the presence of family but, on the evening of her death, she too had been drinking

for most of the day and was quite intoxicated. However, the extent to which her alcohol consumption was an avoidance device or coping mechanism for a burgeoning pattern of abuse is unknown.

The first incident of domestic abuse known to anyone in authority occurred in September 2014 when, having locked herself in the house for personal safety, Ms AB called police to report that Mr YZ had attacked her car with a metal pole causing considerable damage. He was detained and the weapon retrieved. Ms AB left him at that point and stayed for a few weeks at the pub where she worked. She provided information about the incident to police but did not wish to support a prosecution. When interviewed, Mr YZ professed not to remember what happened but was contrite and wished to make amends. He accepted a caution for causing criminal damage.

Social media records show that Ms AB had thrown away his source of alcohol to try and limit his drinking that day and this had infuriated him. From the same source she also intimated to a friend that she loved him and was very fond of the cats they shared. While staying at the pub, she disclosed to her manager what he had suspected for some time: that she had been the subject of assaults and jealous / controlling behavior by Mr YZ for many months, resulting in a few occasions when she left him to stay a for a while at the pub. She opined that the attack on the car was “meant for me”. Nonetheless, she returned to live with him after a few weeks.

A few days after this incident, Mr YZ did seek help for his alcoholism from his GP, falsely claiming that the argument and car incident had caused him to break from a lengthy sober period [his parents had previously supported him with private clinic treatment]. The local drugs and alcohol referral centre that had also seen some success with his treatment in recent years, was a short distance away but in a different Borough so he was then referred to the locally funded service some five miles distant. At this, he seems to have lost motivation because he never attended there.

In mid-October 2014, Mr YZ called police to the home to allege that Ms AB was about to drive whilst drunk. This was not in fact the case and the incident can be now seen as an attempt to prevent her from leaving him alone. Not long after that, Ms AB lost her job at the pub because she failed to appear on the day that the manager was due to go on holiday and she was supposed to take charge. She quickly found similar employment and, again, became highly regarded as an employee.

From around this time, Ms AB’s mother, who heard from her daughter by telephone every day, noticed that she sounded sad, although she made no complaint about her relationship with Mr YZ.

Social media records in late November show that Ms AB was considering leaving Mr YZ and this provoked a threat from him to cause a “black eye and a smashed rib”. In late December, a friend who had visited asked by text how Ms AB was feeling and she responded that Mr YZ had shown jealous / controlling behaviour by calling her friends in ‘contacts’ to check on the nature of the relationship.

Access to social media records for the day of the homicide in January 2015 also reveals a darkening mood between the couple as they spent Ms AB’s day off from work paying bills and shopping for food whilst also drinking steadily in pubs and with friends and, at one point, becoming separated from each other. They had argued over whether to have a take-away meal and whether to take a taxi home. The taxi driver who took them home at the end of the evening noticed nothing of concern as they chatted in the back. They purchased some alcohol from an off-licence on the way.

The terrible fatal attack happened within about an hour of their return home. Ms AB was wearing her outside coat as if about to leave.

Conclusions and recommendations from the review

Mr YZ's diminished responsibility defence due to Alcohol Dependence Syndrome does not fully account for the sudden and savage slaying of Ms AB. Whilst it is accepted by expert clinicians, lawyers and the Court that Mr YZ has no recall of the fatal attack, it is also appropriate to take account of everything else that is known about the prelude to it to understand why it happened.

It is likely that Ms AB was preparing to leave, possibly due to arguments earlier in the evening, as indicated by some judgmental texting by Mr YZ. A few days earlier he had exercised control of her private life by questioning people on her calls list. The false drink-drive claim to police in October 2014 was because she had announced she was leaving him. In November, her text message that she would rent somewhere to live was responded to with a threat to assault her. The abuser's fear of breakup is a well-documented and significant risk factor for the person fleeing a relationship.

The window on their lives subsequently provided by work colleagues reveals that Ms AB disclosed to them an escalating pattern of controlling abuse, that included unexplained injuries, damaged spectacles and replacement telephones, and culminated in the frenzied attack on her car through frustration that Mr YZ could not get at her to punish the disposal of his alcohol supply. While Ms AB intimated to colleagues and friends that it was love for Mr YZ that motivated her return to live with him after that terrifying attack on a car with a weapon that she believed was meant for her, the relationship they were in could not be described as a loving one.

At this ominous incident, the police officers who attended and heard Mr YZ's account that he was so intoxicated he could not remember what had happened, were not qualified to assess this as ADS. Thus, they could not have foreseen the danger and acted reasonably in the circumstances known at the time. Similarly, what clinicians knew of this incident was limited to the account Mr YZ provided to his GP and would not feasibly have made the connection with ADS as a possible diagnosis, even if such expertise was available, as his alcoholism was reportedly under control.

In summary, Ms AB was in an abusive relationship where the escalating violence, the increasing control and the evident fear from Mr YZ that she intended to flee, made her position highly vulnerable to harm. Extreme intoxication on his part clearly was a factor in his apparent loss of control but does not alone explain or justify this fatal attack. Nor does intoxication on her part, which may well have been part of her survival technique, contribute in any way to the cause of her death.

However, there was nothing known to anyone in authority during this period that could have anticipated such a dramatic turn of events. While there are lessons to be learned, there is no identifiable 'root cause', no omission or dereliction of duty by any individual or single safeguarding agency that failed to limit the opportunity for Mr YZ to inflict the fatal injuries on Ms AB. There is no evidence of a collective failure in this case.

Lessons learned and six recommendations were identified by agencies within the course of their IMRs. The Panel has identified and an additional two recommendations and drafted an action plan for all eight recommendations to be implemented:

1. Harrow Borough Operational Command Unit Senior Leadership Team (SLT) debrief officers involved to disseminate the lessons learnt regarding:
    - The completion of CRIMINT reports
    - DASH
    - Coercive Control
    - Conditional Cautions

2. Harrow CCG to ensure better communication of cross boundary mental health provision and individual funding request
3. Harrow Public Health to agree clear guidance in relation to patient choice access issues for the cross boundary provision of local drug and alcohol services
4. NHS England to ensure clinical staff in GP practices have training in domestic abuse as specified within 2014 NICE guidance hhtps://www.nice.org.uk/guidance/ph50
5. London North West Healthcare NHS Trust to improve increased capability for community alcohol teams to deliver rapid assessment and treatment for difficult to reach patients who attend hospital in a crisis
6. London North West Healthcare NHS Trust to lead a review of the pathway between mental health and alcohol presentations in the acute setting and implement improvements
7. Harrow Safer Communities to review the Harrow Council website and to provide clear pathways to advice on domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague, including in languages relevant to the local community
8. Harrow Local Adult Safeguarding Board to develop a joint practice guidance for Alcohol Dependence Syndrome in domestic abuse cases that ensures consistency of:
   - Risk assessment;
   - Information sharing; and
   - Professional curiosity

   With further consideration for learning nationally

Safer Harrow Partnership
DVHR Panel for Ms AB killed in January 2015 in Edgware, Harrow

OVERVIEW REPORT

INTRODUCTION

1. In the early hours of a morning in early January 2015, police were called to a semi-detached house in Edgware in the London Borough of Harrow, where Ms AB aged 34 years (born in Poland) was found with fatal stab wounds. One of three murder weapons was found lying on her body. Also present was her partner Mr YZ aged 34 years (born in London). He had called police to the scene and volunteered that he was responsible for her injuries. There is a history of domestic abuse between them.

2. Mr YZ was charged with the murder of Ms AB and stood trial at the Central Criminal Court in October 2015 when a plea to manslaughter with diminished responsibility because he was diagnosed with Alcohol Dependence Syndrome (ADS) at the time of the offence was accepted. The sentence handed down was reviewed by the Crown Prosecution Service and referred to the Attorney General for an appeal against undue leniency. In January 2016, the sentence was increased to 12 years imprisonment with five years supervision on release.

3. Under s9 Domestic Violence, Crime and Victims Act 2004, a Domestic Violence Homicide Review (DVHR) was commissioned by the Safer Harrow Partnership and, on 16 July 2015, Bill Griffiths CBE BEM QPM was appointed Independent Chair of the DVHR Panel. Tony Hester supported him throughout in the role of Secretary to the Panel. Their respective background and 'independence statements' are attached at appendix 1.

4. The first Panel meeting was held on 25 August 2015 with the membership and agencies represented as shown in the table at appendix 2. Following discussion, the Chair issued a second version of Terms of Reference for the review on 26 August (appendix 3).

5. 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 <u>why</u> services may have been less effective than intended can and should inform <u>how</u> to more proactively reduce harm to those at risk and <u>what</u> change is needed to improve vital safeguarding services.

6. In particular, one of the operating principles for the review has been to be guided by humanity, compassion and empathy with Ms AB's voice at the heart of the process.

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. The deceased will be referred to herein as Ms AB, AB or A as appropriate to the narrative. Similarly, the perpetrator will be referred to as Mr YZ, YZ or Y. Initials or numbers will be used to refer to all other parties.

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. From the table below it may be noted that seven agencies have records of relevant contact with the deceased during the period of their relationship, from around January 2011 to her death in January 2015.

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

Contact period	Agency	Summary of contact
06/00 to 01/15	Metropolitan Police Service (MPS)	Prior to the relationship with AB that commenced in 2011, YZ had two criminal convictions for drink driving and been issued with three fixed penalty notices for drunkenness (2000-2006) Within the relationship: 11/12 – AB reported theft of her moped 11/12 – YZ's mother reported burglary at his house 12/12 – AB reported theft of wallet at work (a public house) 12/12 – YZ called police to someone attempting to break in. He was intoxicated and no evidence of intrusion or attempt 05/14 – police called to fare dispute between AB and taxi driver. Arrested for assaulting police officer. Dealt with by fixed penalty notice for disorder and also taken to hospital for head injury 09/14 – police called to domestic incident in which YZ had damaged AB's car by use of a metal pole. YZ accepted caution 10/14 – YZ called police because he believed AB about to drive while drunk. Not the case, but logged as domestic incident 12/14 – YZ called police to intoxicated passenger at Harrow station

		01/15 – YZ called police to homicide of AB
05/11 to 05/14	Local Medical Centre for AB, Edgware	GP records for AB 2011-2015 05/11 –Treated for headaches and dizziness after fall from bicycle 01/12 – Attended with YZ for anxiety symptoms. Admitted to 70 units per week (later retracted as actually 7) and invited to self-refer to Barnet Drug and Alcohol Service (BDAS) 05/14 – attended Barnet Hospital A&E with 1cm laceration to the back of her head following a fall (see police incident on same date above)
05/12 to 09/14	Local GP Surgery for YZ, Edgware	GP records for YZ 2012-2014 Extensive notes of treatment and referral for alcohol dependence. No risk of violence identified apart from disclosure of police incident in 09/14 above
05/12 to 01/15	London North West Healthcare NHS Trust (LNWH)	One admission emergency department for AB in 05/14 above Records of 26 attendances by YZ at emergency departments within the Trust, variously for symptoms associated with alcohol misuse or alcohol withdrawal No risk of violence identified
01/13 to 05/13	Central and North West London NHS Trust (CNWL)	Two admission episodes at Northwick Park Hospital for YZ for alcohol withdrawal symptoms. Seen by Psychiatric Liaison Team alcohol specialists as well as consultant psychiatrist. No risk of violence identified Discharged to Barnet Drug and Alcohol Services
04/13 to 04/13	COMPASS	Received YZ referral from CNWL but informed that BDAS dealing
09/14	Victim Support	Received police report of criminal damage to AB's car by YZ in 09/14. Although flagged by police as domestic abuse, report 'unsupported' and screened out so no follow up contact with AB

10. In addition, a request was made for information made to Barnet Drugs and Alcohol Service who treated Mr YZ for alcohol dependency but the records could not be found.

11. Records held by a private clinic that treated him in the context of two rehabilitation residencies during 2012 were obtained by the police investigation into the homicide of Ms AB. The author of the Individual Management Review has examined the records and there is no information therein regarding violent or homicidal ideation.

Policy Research

12. This review was commissioned under Home Office Guidance issued in August 2013. In particular, the agreed cross-government definition of domestic violence and abuse should aid the learning from this review and is set out here in full:
"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."

13. 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
    - Association of Chief Police Officers (ACPO) CAADA DASH risk assessment model
    - Protecting Adults at risk: London multi-agency policy and procedures to safeguard adults from abuse (Social Care Institute for Excellence (SCIE) Report 39)
    - MOPAC (Mayor's Office for Policing and Crime) consultation on tackling violence against women and girls August 2013
    - CPS Policy for prosecuting cases of domestic violence 2009
    - CAADA MPS Minimum Standards for Domestic Violence MARACs draft issued in October 2013

- HMIC (Her Majesty's Inspectorate of Constabulary) Reports: 'Everyone's business: Improving the police response to domestic abuse' 2014 and 2015 and 'The Metropolitan Police Service's approach to tackling domestic abuse' 2014 and 2015
- Undated report (*circa* 2013) 'Families experiencing domestic violence, parental substance misuse and parental mental health needs (known as the Toxic Trio) in Harrow'
- LB Harrow Domestic and Sexual Violence Strategy for Action 2014 – 2017
- LB Harrow Action Plan 2014 – 2017 on Prevention, Provision, Partnership, Perpetrators

Comparative case analysis

14. There have been no DVHR cases reported in the London Borough of Harrow since the legislation and prior to this case. There was a DVHR in 2011 that is currently with the Harrow Safer Partnership for consideration. There are no parallels to be drawn from the conclusions and lessons learned.

Family and friends

15. With the assistance of the police family liaison officer and the support of a translator, a lengthy telephone call with the cousin of Ms AB on behalf of her family in Poland established that there were no additions to the second draft of the Terms of Reference for the Review. He provided some useful insights to the nature of her relationship with Mr YZ. In April 2016, with the assistance of the police and Language Line, the Chair updated and briefed the cousin of Ms AB on the content of the second draft of this overview report, in particular the analysis, conclusions and lessons learned. He expressed admiration for the DVHR process in this country and his satisfaction on behalf of the family that all issues had been thoroughly explored.

16. When Ms AB was killed, such was the regard in which she was held at her former place of employment (a public house and restaurant) that a large sum of money was raised to pay for the repatriation and burial of her body in Poland. The Chair interviewed three of her former colleagues who knew her well, one of who is also Polish. He was also given access to other relevant witness statements gathered in the course of the police investigation.

Perpetrator

17. The Chair contacted the Governor for the establishment of Her Majesty's Prison Service where Mr YZ is serving sentence with the request for a visit and interview to provide his perspective on learning for safeguarding agencies. In December 2015, Mr YZ declined this opportunity to contribute to the review.

18. Given the close involvement and support by his parents in attempts to treat Mr YZ's alcohol dependency, the Chair wrote to them in January 2016 offering to meet and hear their views on agency engagement with their son and there was no response received.

Police investigation and Coroner

19. The Chair set up liaison with the Investigating Officer (IO) to ensure the judicial process was effectively managed, including the disclosure of material in the course of the review. The Coroner has determined that the trial outcome is sufficient to negate the requirement for an Inquest hearing.

Equality Act 2010

20. Consideration has been given to the nine protected characteristics under the Act in evaluating the various services provided. Both victim and perpetrator are of White European heritage. Given that domestic abuse is committed predominately by men against women, gender was a relevant characteristic with respect to Ms AB. It was agreed by the Panel that, given his mental health history, consideration could have been given to agencies treating Mr YZ as an 'adult at risk'[1].

Confidentiality

21. 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 password protection. A copy of chronologies and IMRs was provided to all Panel members for comprehensive review and discussion.

[1] Formerly known as a 'Vulnerable Adult'

THE FACTS

Ms AB

22. Information about Ms AB prior to her death has been gathered from the following sources:
    Her mother
    Her male cousin who is the police point of contact for the family in Poland
    Her manager and colleagues from work
    Her General Practice medical records
    Metropolitan Police records
    Victim Support records
    The police investigation into her homicide, including prior social messaging.

23. Ms AB was born in 1980 and lived in Opole, Poland with her parents and an older brother. When she was aged two, Ms AB's father was tragically killed in a road traffic accident leaving her mother to raise both children alone. Ms AB was bright and industrious at school with an aptitude in sciences and learned to read, write and speak English to a good standard. She was also sporty and represented her school at judo and was a competent horsewoman. After school, she took a 3-year polytechnic course in rehabilitation of offenders.

24. Her mother further describes her as honest and sincere; someone who liked to help others and she wore her heart on her sleeve. She was popular, lively and funny. She loved animals. She drank beer occasionally but never at home and never in front of her mother.

25. In 2001 when aged 21, Ms AB travelled to London for a sabbatical and found work in restaurant management. She would telephone her mother every day and visit Poland 4 to 5 times a year. Her seven-year relationship with a school friend broke down due to the separation.

26. In 2011, Ms AB informed her mother that she had met Mr YZ. She also disclosed that he had some problems and that she wanted to help him. When her brother stayed with the couple for a holiday, he reported back to their mother his opinion that she would not like him but did not give a reason.

27. In 2013, Ms AB's mother visited London for a week and met Mr YZ for the first time. He made an effort to engage her in conversations, even though he did not speak Polish and she had limited English. She did not see him consume alcohol in that week but she noticed his hands were shaking to the extent that he had trouble holding a knife and fork and she noticed he sometimes did not eat when others were having a meal. She formed the impression that he was strange and inconsistent, either deep in thought and distant, or overbearingly talkative.

28. In September 2014, Ms AB returned to Poland to attend her maternal grandmother's funeral and that was followed by a short holiday in October. This was the last time that A's mother saw her and things seemed normal although there was little talk of Y. The daily contact continued on her return to the UK but her mother noticed that she sounded sad. When asked what was wrong, A insisted there was nothing. Then, at Christmas time, A disclosed that she was thinking of leaving Y, which pleased her mother because it had become clear that the relationship was not working.

29. They last spoke by telephone on the morning of the day before her death in January 2015 when, again, A's mother had the impression of great sadness in her daughter's mood.

30. A's cousin had always enjoyed a close and positive relationship with her. He knew about the relationship with Mr YZ and his recollection is that they had met at some kind of self-help group, possibly Alcoholics Anonymous. He had suspected that she had a problem with drinking because of family history but they never discussed the matter.

31. The only concern he acquired about her relationship with Mr YZ arose from a visit he made to the UK for a holiday in about 2012 when he had hoped to visit A, but Y declined because she had been involved in an accident. Her cousin suspected that this had been used as an excuse because, when he texted her telephone for contact information about the hospital, she did not respond.

32. In April 2014, he holidayed briefly with A in Paris. She did not drink anything and she told him she was trying not to drink. She seemed happy in the relationship with Y and bought small gifts such as fridge magnets for her return. At no time did she disclose anything untoward in the relationship and the details that emerged through the trial were a complete revelation to him and A's mother.

33. From about the time that Ms AB had formed a relationship with Mr YZ, she had worked at a public house and restaurant in West Hampstead, mainly working on evening shifts and at weekends responsible for the dining side of service. She was very highly regarded by her manager, work colleagues and customers alike.

34. Mr EF her manager says that she was a consummate professional who was an excellent team member with colleagues and very popular with customers so much so that, even though she ceased working there in late October 2014, in excess of £12,000 was raised for the repatriation and burial of her body in Poland after she was killed.

35. Colleagues were aware that there were problems in the relationship with Mr YZ. There had been three or four instances where A had appeared with a bruise over the eye and had to buy new spectacles. She would cover the bruise with heavy makeup. She also had to replace her

mobile telephone on at least four occasions because it became damaged. Ms AB would always provide reasons for the injuries and damage that were barely plausible.

36. She was given refuge at the Pub on between four and five times when she left Y due to arguments, then stayed for four to six weeks until moving back to live with him and the cats they shared and she adored. The last occasion followed the damage to her car in early September 2015 (see DAI 1 below).

37. Mr EF was aware that, sometimes, she joined Y in binge drinking sessions that occasionally made her late for work but he never observed her to take a drink whilst at work. Nonetheless, such was his confidence in her professional abilities, he placed her on the licence for the Pub so that she could and would act as licencee in his absence for holidays.

38. This came to an end in October 2014 when Mr EF lost confidence in A and terminated her employment. The circumstances are that he had arranged to visit his mother in Ireland and, when at the airport, established that A had yet to arrive at the Pub to take over as licencee. Mr EF could not raise contact with any of her telephone numbers and concluded that he would have to cancel his flight and holiday. Ms AB did not turn up for a week. As a result, he dismissed her from his employ; however, he harboured the hope that she would learn from this necessary sanction and would eventually return to work for him.

39. Mr EF received some missed calls from A's Polish telephone number over Christmas and on New Years Eve. He assumed she was on holiday there and regrets not returning those calls as he may have talked her into returning to work for him.

40. By November 2014, A had found employment at another public house and restaurant in Bushey, Hertfordshire. Her manager described her as a model employee who was universally popular with colleagues. She never took a day off work and her last shift was on the evening of the day before her homicide in January 2015.

41. A female work colleague, Friend 4, said that A kept her relationship with Y mostly private but did disclose that Y did not work due to alcoholism but she loved him all the same and wanted to help him recover. Friend 4 visited A at home on one occasion between Christmas and New Year and found that Y seemed a 'nice person'. He was drinking cider. Friend 4 did not detect any problem in the relationship at that point in time.

42. Having moved in with Mr YZ, Ms AB registered with a local GP and the first visit was in May 2011, some two weeks after the fall from her bicycle and a head injury as she was experiencing headaches and dizziness. No fracture was revealed.

43. In January 2012, she reported anxiety symptoms and, in the course of the consultation, admitted to alcohol consumption of 70 units per week. She was advised to self-refer to Barnet

Drugs and Alcohol Service (BDAS). It was noted that her 'boyfriend' [presumably Mr YZ] was also present for the consultation and that he "talked non-stop".

44. When Ms AB returned four weeks later for blood tests, she claimed that the weekly alcohol consumption she reported was actually 7 units. The IMR author has commented that the GP is unlikely to have referred Ms AB to BDAS for such a low consumption.

45. A's medical records have been thoroughly examined and there are no safeguarding concerns noted therein but there is no record of 'Routine Enquiry' being made by clinicians with respect to domestic abuse.

Mr YZ

46. Information about Mr YZ in the years prior to the homicide has been gathered from the following sources additional to the above sources for Ms AB:

    His General Practice records

    The Psychiatric Assessment on behalf of the Prosecution for the condition known as 'Alcohol Dependence Syndrome (ADS)

47. Mr YZ was raised locally in Harrow by parents of Irish heritage. His father was a gas engineer who then owned his own company and his mother was a nurse. He has two younger brothers with whom he has a good relationship. He left school at 16 to obtain an NVQ in electrical installation, then became an apprentice electrician and began working for his father. He subsequently became a gas fitter in his father's company but stopped work some years ago due to his increasing alcohol dependence.

48. Between 2000 and 2006, Mr YZ had two convictions for drink driving and been issued with two fixed penalty notices for disorder that were drink related.

49. He resided at a semi-detached house in a quiet suburban cul-de-sac in Edgware owned by his parents; the home that he shared latterly with Ms AB that became the scene of her homicide.

50. As his alcohol dependence became established, there were numerous occasions when he suffered alcohol-induced epileptic fits and memory blackouts when intoxicated. With the financial support of his parents, he underwent detoxification from alcohol in rehabilitation units for two periods in 2012 at a private clinic in Bedfordshire. He attended Alcoholic Anonymous meetings and this is understood by Ms AB's cousin to be where he met her. The GP records also note that he was abstemious for long periods but this appears to be contradicted by one of the specific instances recorded by the police in September 2014.

51. The Liaison Psychiatry Team at Northwick Park Hospital treated Mr YZ on a number of occasions following his admission to the medical inpatients wards with alcohol related conditions. In January 2013, the team consultant on the Acute Assessment Unit admitted him due to having alcohol related seizures that had been witnessed by his mother. Following review by the Liaison Psychiatry team on a number of occasions, he was discharged from hospital 12 days later after his detox regime had been completed. His follow up in community was arranged with Alcoholics Anonymous as well as Barnet DAS.

52. He was seen again by the Liaison Psychiatry Team in April 2013 when he was experiencing severe alcohol withdrawals. The Liaison Psychiatry consultant conducted a review and risk assessment. He identified that Mr YZ's health was at risk through complications of substance misuse. However this was mitigated as he was receiving treatment for substance misuse in hospital. There were no other risk factors identified. He was discharged from the Hospital in May 2013 and not seen again until after the homicide.

53. In the context of his psychiatric assessment prior to trial, he described being an occasional user of drugs such as cannabis and cocaine but was not dependent. So far as alcohol is concerned, he realised by his mid 20's that he had to have a drink to function, otherwise he would experience shakes, sweats and nausea. Over the next 10 years, as alcohol dependence became established there have been numerous occasions when he has suffered alcohol-induced epileptic fits, memory blackouts when intoxicated and delirium tremens (DTs), an acute confusional state due to alcohol withdrawal.

54. He assessed himself as a "happy drunk" and denied that he was violent with partners and that he does not get jealous. He went on to say: "When I am drunk, I am drunk and I can't really remember what I do".

55. He described Ms AB as "lovely" but that she also had a drink problem and she could be argumentative when drunk. Most of the time they got on well. She worked in a bar and, it was only on her days off that she would drink and she then binged on alcohol, which was her pattern of drinking. In contrast, Mr YZ described himself as "an everyday drinker", but had realised that his tolerance for alcohol was increasing and therefore he was drinking more to get the same effect.

Events relevant to their relationship together

56. It is understood they entered into a relationship in May 2011 and, at some point in 2013, Ms AB moved in with Mr YZ. This is based on the fact that, in November 2012, when Ms AB reported the theft of her moped, she provided a different home address, about 1.5 miles from that address.

57. Also in November 2012, Mr YZ's mother reported a burglary she had discovered at the house when he was in hospital. A witness statement was obtained but an appointment for a forensic examination was cancelled as the family was unable to attend and the investigation was closed.

58. This is possibly linked to the subsequent emergency call to police made by Mr YZ in December 2012 to a believed intruder at his door trying to break in. He is recorded as saying to the police call operator that he was going to "stab him but he was a little kid". When police arrived he tried to wave them away and when he finally opened the door would not allow them access. No evidence was found of an intruder or any physical signs of attempted entry and Mr YZ was reported to be intoxicated.

59. The IMR author has commented that there was a missed opportunity to point out to Mr YZ that any force used to protect him or his property should be reasonable in the circumstances and only if necessary. His reaction indicated a potential for violence that was noteworthy and should have been recorded on an intelligence report for evaluation, risk assessment and future reference.

60. Confirmation that A had moved in with Y is found in May 2014 when police were called to the house where A was involved in a fare dispute with a cab driver. In the course of this, she violently pushed one of the officers and was arrested for assault on police. On arrival at the custody suite, a risk assessment identified that she had been drinking heavily and had a wound to her scalp. She declined the opportunity to speak to a female member of staff or a specialist drugs/alcohol worker

61. Ms AB was taken to Northwick Park Hospital emergency department and treated for a 1cm laceration that she reported on examination as caused in a fall backwards. It was noted that she smelt of alcohol. It is not apparent whether there was any assessment for either safeguarding or alcohol and drug misuse by medical staff. This was a missed opportunity to screen for domestic violence and conduct other welfare checks. Since November 2015, learning from other reviews has led to the appointment of a Trust-wide domestic abuse lead with two Independent Domestic Abuse Advocates (IDVA) available to patients.

62. On return to custody, Ms AB was further risk-assessed and was noticeably more coherent. She was provided with a support agency referral leaflet (Form 61) that set out self-referral contact numbers in relation to addictions, relationships and mental health. The matter was concluded when she accepted a fixed penalty notice for disorder.

Domestic Abuse Incident (DAI) 1 – involving MPS for LB Harrow and Victim Support

63. Late on an afternoon in early September 2014, Ms AB called police to the house, reporting that Mr YZ was smashing up her car with a metal pole (later recovered by police) and that she had locked him out of the house. It appears that Y had been drinking all day and became angry upon discovering that his cider was all gone.

64. Police arrived within six minutes and discovered Y trying to get back into the house. A's car had a smashed front windscreen and damaged roof and front bumper. He was intoxicated and, at 18.05 was detained and taken to Harrow Police Station where a risk assessment was completed. When asked about self-harm, he indicated that he had cut himself in the past but declined any details. He acknowledged that he was depressed and was alcohol dependent. However, he lacked memory of events, including what alcohol and/or drugs he had consumed that day. Due to cuts on his hand and head and a swollen ankle, a doctor examined him.

65. A domestic abuse report (Book 124D)[2] was completed and a witness statement taken from Ms AB. She explained that she had been in a relationship with Mr YZ for three years but was only staying overnight as she resided elsewhere and provided the postal address of the pub where she worked. Two risk assessments (DASH and HOT below) were completed and each graded as 'standard'. Nothing was identified in the HOT assessment and Ms AB responded in the negative to all questions in DASH questionnaire, apart from:

    Are you afraid of what they might do to you and/or anyone else?
    "When he is drinking"
    Have you separated or tried to separate from him within the past year?
    "I will"
    Have they had problems with drugs (prescription or other), alcohol, or mental health problems that influence their ability to live a normal life?
    "Alcohol"

66. It was suggested that Ms AB should arrange for her vehicle to be fixed and to return home to the address she had provided. It is noted that she was given crime prevention advice, but not what that comprised.

67. The IMR author has commented that, although Mr YZ's actions were directed towards property, this was a significant eruption of violence and with a large weapon. Furthermore, in

[2] See paragraph 86 for notes on all MPS forms and processes referred to under DAI 1

her response to the DASH risk assessment, A clearly stated that she was afraid of Y when he was drinking. Taken with the example of alcohol related aggression in the course of the intruder call in December 2012, this signaled an escalation, especially if Y did not seek further help.

68. A more appropriate attribution of risk would have been 'medium' which would have required a more detailed secondary risk assessment (DASH 2) by a trained specialist investigator. This misjudgment was not fully compliant with the Domestic Abuse 'Toolkit' guidance and resulted in a missed opportunity to assess and review the risk by supervisors and secondary investigators. Whilst a higher grading of 'medium' was more appropriate, it is the opinion of the IMR author (who has significant CSU experience) that it is unlikely that a secondary assessment would have resulted in a MARAC referral

69. Ms AB was handed the tear off slip from the 124D with contact details for support agencies and gave consent to be referred to Victim Support. Subsequently, the CRIS report was dispatched the next day and transferred onto the VS Case Management System the day after that. Although the report was 'flagged' by the police as a domestic abuse incident, the Home Office crime classification was one of 'Criminal Damage to a Vehicle' which, within extant Victim Support policy at the time, was an 'unsupported' crime category so there was no file created or follow up contact with the victim attempted.

70. This was due to an automated screening process: 'ADT – Referral Not Supported' that did not 'see' the domestic abuse flag from the police and there was no human involvement in this aspect of the system. The unfortunate consequence of an automated process was that the opportunity to open up a potential 'second line of defence' by the intervention of a Victim Support caseworker was missed. Contact may then have been managed with Ms AB and a further risk assessment from a perspective independent of the police may have followed.

71. The VS IMR author has noted the missed opportunity and lesson learned, however, shortly after this incident, the procedure changed. From October 2014, VS funding was provided direct by MOPAC (Mayors Office for Policing and Crime), and the requirement was for all police referrals to be screened for action. Two new categories were introduced of 'Standard Referral' and 'Enhanced Priority Referral'. Any police referral with a DA flag would attract the latter service and so that perceived fault in the automated system has been corrected.

72. Meanwhile, the incident was referred to the Community Safety Unit (CSU) for secondary investigation. Research over a period of five years was conducted which revealed Ms AB's failure to provide a specimen of breath in the drink-driving case in 2006 and confirmed there were no prior police records of domestic abuse. The investigating officer contacted Ms AB prior to interviewing Mr YZ. She explained she had not yet had the damage repaired, was not seeking to pursue the matter through the courts and would sort out the repairs directly with Y. The police report shows the damage estimated as £580 to repair. There was the opportunity

at this stage to undertake a DASH2 risk assessment by the specialist CSU investigator but this was not progressed as it might have been.

73. The following day, after Mr YZ had sobered up, he was interviewed. He admitted being drunk and having caused the damage. He claimed that he did not know why he had done it other than they had had an argument and he wanted to get back at her. He described himself as an alcoholic who had twice been to rehab. Y was remorseful, indicating he wanted an opportunity to put it right.

74. It was confirmed that there were no children within the relationship and the case was referred to an Evidential Review Officer (ERO) who assessed the case using the 'gravity factors matrix'. A simple caution was authorised and the rationale recorded as:
    - Suspect arrested and admits offence
    - Victim has provided an MG11 [witness statement], would not support a prosecution and happy for the damage to be dealt with by civil redress
    - No apparent history of domestic abuse
    - Suspect has a drink drive related conviction but nothing more
    - Suitable for caution and suspect prepared to accept disposal

    [Note: Had an intelligence report about his threat when intoxicated to stab an intruder been available, this would also have been a consideration].

75. A 'simple caution' was administered at 15:53. Mr YZ declined referral to support agencies and it was noted that he was already receiving treatment for his alcohol dependency. Had he consented, he could have been referred directly to a drugs / alcohol worker. As part of his Pre Release Risk Assessment (PRRA) he was issued with the support agency referral leaflet (Form 61) but the opportunity to review and update the original DASH risk assessment was not taken.

76. The IMR author has provided the opinion that the secondary investigation of this incident was thorough and generally followed the Domestic Abuse Toolkit. However an opportunity was missed in relation to the type of caution administered. A more suitable option was to issue a 'conditional caution' with a condition that Mr YZ recompenses Ms AB for the damage to her vehicle. Had he failed to do so, he could then have been prosecuted for the original offence. This option should have been discussed with A to ascertain her views. It is apparent that this was not done as the officer has recorded:

    > "The victim has been spoken to and is happy with this disposal [a caution]. She is aware that it will be for her and YZ to arrange for the repair of the vehicle and who ultimately pays for it"

77. Good practice has also been identified, in that the incident was captured on Body Worn Video (BWV) for the purpose of supporting case building and assisting with decision making[3]. The investigating officer did note within the CRIS record that there was a BWV available but it cannot be ascertained if it was viewed. The incident occurred in the early phase of a pilot study and a search has been made to recover the video of this incident without success. The necessity to record any examination of BWV and a summary content within the CRIS record had already been identified as a lesson learned from the pilot study and explicit policy guidance is now in place.

78. Unknown to the officers, but later discovered from forensic examination of her telephone in the investigation into her death, are a number of relevant SMS messages between Ms AB, Mr YZ and two of her friends that open a window on what was happening around this time from A's perspective. Obviously, these were private between her and friends at the time and not known to anyone in authority. They are reported below as they are written in the telephone data analysis.

79. <u>On the day of the incident</u> at 15.10 [about 90 minutes beforehand] A to (male) Friend 1:

He is useless. Looking for small studio flat for me n cats. He is looser. Cider is the most important thing

At 16.18 to (mutual and male) Friend 2:

Sorry for everything. I put cider in the sink. He is gone. See people outside. Talking about IRA

At 16.57 to Friend 2:

He just destroyed my car

At 16.57 to Friend 2:

I called police [Note: the call to police is timed at 16.45]

At 19.35 to Friend 1:

I had domestic at home. Have to fixed my front windscreen. The shoyld come 2morrow morning n fixed

At 1945 to Friend 1:

Stressful evening. Need cup of tea n have to start pack my stuff

At 20.09 to Friend 2:

I have to pack everything which belongs to me. Plus 2 cats n bike, books n more junke

At 20.10 to Friend 2:

Next time he can kill me

At 20.23 to Friend 2:

He was completely pissed. I have to wait until 2morrow for my windscreen

At 20.27 to Friend 2:

He broke ariel, wipe screen n ….

<u>The next day</u> at 16.12 A to Friend 2:

[3] BWV will be available to all MPS front line officers by the end of 2016

He call me but I didn't answer. Spoke to Police Officer twice. I didn't press charges

Two days later at 10.36 to Friend 1:

Keeping myself busy. But it is not easy. Still love Y. We been together for a few years. Maybe I bitch but still got feelings

Two days after that at 10.12 to Friend 2:

I fine. Slept well. Spoke to Y yesterday what made me cry. Anyway I feel better today. Got day off 2morrow. Probably will see you. Really want to see my cats 2morrow. Have to pick up few things. Bike seems like a good idea. Can cycling all around

The next day at 19.43 A to Y:

I know that when you are not drunk you care about me

80. Also unknown to anyone outside her immediate circle of friends and colleagues was what Ms AB finally disclosed to Mr EF about what had been happening in the relationship when she stayed for the last time at Mr EF's Pub after this incident. She said she had endured a long series of arguments and fights because she loved Y. She graphically and somewhat presciently described the attack on the car as: "Meant for me". The resulting damage was so severe that she did not have it repaired; instead she sold the car for £400.

81. Having last seen Mr YZ in November 2013 when he reported being abstemious for the previous four months, his GP records an attendance on seven days after the incident and his report of a relapse into alcoholism. He told his GP he had damaged his girlfriend's car following the breakup of their relationship for which he was arrested and that this event caused him to start drinking again. He admitted to some "DSH [Deliberate Self Harm] ideation but no settled intent". He was intoxicated during the consultation.

82. The GP record notes that: "He did not want to return to DAS [Drugs and Alcohol Services] as feels that they will not be able to help him and he cannot afford the fares to travel there". This note must allude to the Harrow service because Barnet DAS is only about five minutes walk from his home which is situated close to the Borough boundary between Harrow and Barnet. Furthermore, he was provided with a referral letter for the Barnet service and he did attend the Barnet Referral Centre for an assessment.

83. By mid September, he had been seen twice at BDAS and assessed but it was reported to the GP that, as a Harrow resident, he would have to attend Compass Integrated Drug and Alcohol Service in Harrow. This is some five miles distance from his home and would require a 50-minute bus journey. In all probability, this was his issue regarding travel noted earlier by the GP. Mr YZ was known to Compass, having briefly attended for treatment in mid 2013, but when it was established he was being treated by Barnet DAS at that time he reverted to that centre. Compass has no record of him attending in September 2014.

84. The IMR author has commented that this could be regarded as a missed opportunity caused by the change to commissioning services because Mr YZ had expressed a desire to engage with detoxification services. The combination of his alcohol dependence, mental illness, low income and reduced motivation is likely to have influenced his choice not to travel to Harrow town centre for treatment. The GP had a positive relationship with Mr YZ; however, there was no follow up to the declined treatment from BDAS to further encourage detoxification treatment with Compass.

85. *Notes on MPS forms and processes*:

The 124D (Domestic Abuse Booklet) will be completed at all incidents falling within the definition of domestic abuse, whether identified as a crime or non- crime incident. The investigation booklet has been designed to assist response officers in the initial investigation of domestic incidents / abuse as it is imperative that corroborative evidence is gathered during the early stages. The booklet provides details of questions to be asked to identify risk and to enable officers to intervene effectively and contains a tear-off slip to be handed to victims; giving them contact numbers for support agencies and information on how police will continue with the investigation.

Professional Investigation Project (PIP)

Since 2013, patrolling officers are assessed at PIP level 1 to be competent in 1) conduct of primary investigation, 2) victim and witness management (including interviewing, preparing and completing a witness statement MG11) and 3) interviewing a suspect.

The DASH ((Domestic Abuse, Stalking and Honour Based Violence) risk assessment model was adopted by the MPS in August 2010 and it was rolled out during 2011. On the basis of responses to the questionnaire, officers use professional judgment to evaluate and supervisors to confirm or adjust the risk level as standard, medium or high, as follows:

Standard – the 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

The HOT (Harm, opportunity and threat) risk assessment is a mandatory victim based risk assessment with a series of questions under headings: Victim, Offence and Offender.

Domestic Abuse Toolkit

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 phases: primary investigation, primary supervision, secondary investigation and secondary supervision. The purpose is to continually seek to identify, assess, reduce, mitigate and manage risk and for a specialist investigator to conduct a

DASH 2 (supplementary) risk assessment on the MPS CRIS (Crime Report Information System) in all medium and high risk cases, if not already completed

MARAC (Multi Agency Risk Assessment Conference) is a Borough based multi agency victim focused meeting where information is shared on the highest risk cases of domestic abuse between different statutory and voluntary sector agencies.

The Gravity Factor Matrix was developed by the Association of Chief Police Officers (ACPO) to assist in making cautioning / charging decisions for adults. The key factors which will be relevant in deciding whether to charge, caution or conditionally caution an offender for an offence are:

a) Do they admit the offence?
b) The seriousness of the offence
c) The previous offending history of the offender and
d) Does the disposal adequately address, support and reduce the risk of reoffending?
e) Where the Full Code Test is met, would the public interest be properly served by issuing a simple or Conditional Caution
f) Views of the victim

Conditional Cautions are an alternative case disposal option to a charge, they are intended to be a swift and effective means of dealing with straightforward cases where the offender is willing to and has admitted the offence AND agrees to comply with specified conditions. These include provision of reparation to the victim or community; being effective in modifying offending behaviour; facilitating removal from the jurisdiction and ensure non-return or provision of an appropriate penalty. The offender should not be charged unless it is determined that the case is too serious for a conditional caution to be appropriate.

DA Incident 2 – MPS Harrow

86. On a Friday evening in mid October 2014, police received an emergency call from Mr YZ stating he wanted to report a drunk driver. A disturbance and argument were heard in the background, followed by the line being cleared. Officers arrived at 20:36 hours. Y and A were separated and spoken to independently.

87. It was established that, following an argument, Y had feared A was going to drive off under the influence of alcohol. A confirmed that this was not the case. No other allegations were made. There were no signs of a disturbance and no evidence of injury or damage.

88. A decided to leave the address to visit friends at which point Y became upset. He then refused to answer any further questions required for the completion of the domestic abuse report (Book 124D). HOT and DASH risk assessments were completed, A answered “No” to all questions and the risk was assessed as ‘standard’. No heightened risk factors were identified. Research was conducted at the scene which disclosed Y’s caution for criminal damage on in September 2014 (DAI 1) and A’s FPN for disorder in May 2014.

89. The incident was referred to the CSU Domestic Abuse Desk who conducted more detailed research and attempted to contact both A and Y independently without success. Individual letters were then sent out providing a crime reference number, CSU contact numbers and

    National Centre for Domestic Violence (NCDV) details. It was established that neither Y nor A had provided consent for agency referral, such as to Victim Support. Compliance with policy was verified and an evidential / risk review conducted. It was concluded that neither the research conducted nor the HOT / DASH risk assessments had indicated any significant risk factors that would modify the original 'standard' risk assessments.

90. The IMR author has observed that it is not clear from the CRIS report whether or not A was under the influence of alcohol when officers arrived. This is relevant when considering Y's motivation and should have been explored and documented fully at the time so that it would be a consideration for the CSU staff that have specialist training in DASH 2 risk assessments and would likely have made a greater effort to conduct a follow-up interview with A.

91. Officer witness statements secured after A's death note their joint opinion she had not in fact been drinking and she had no intention of driving. With that revelation, Y's behaviour in this incident can, with fresh hindsight, be viewed as an example of coercive control motivated by his intention to prevent her from leaving him alone that evening. Taken together with Y's serious eruption of violence with a weapon, albeit directed at a proxy target, approximately one month before, consideration could and should have been given to raising the assessment to 'medium'. That said, it is the opinion of the IMR author that the 'high' risk assessment threshold for a MARAC referral had still not been met.

92. Within two weeks of this incident, Ms AB lost her job at The Alliance Pub in the circumstances set out in the interview with her manager Mr EF in paragraph 39 above. She soon found employment of a similar nature at another Pub and Restaurant in Bushey and there befriended Friend 4.

<u>Build up to the homicide</u>

93. At the end of November 2014, telephone data analysis shows that Ms AB was in text contact with (male) Friend 3 about finding alternative accommodation and she also included Friend 2. This resulted in an exchange with Mr YZ in late November indicative of the perilous state of their relationship:

    At 21.11 A to Y:

    I will spend all my wage but rent new place. I don't care if I won't have a penny. I sac

    At 21.14 Y to A:

    Plus a black eye and a smash rib

    At 21.15 A to Y:

    You planning to beat me?

    That night at 00.15 Y to A:

You forgot about drink at work and then a bottle o

At 00.19 Y to A:

Short memory

At 00.22 A to Y:

On the phone to your mum in the morning call mum o

At 00.25 from Y to A:

They will not give a shit then try [name] or [name]

94. After Friend 4 visited Ms AB and also met Mr YZ in the period between Christmas and New Year, the following exchange shows that Y had developed the habit of calling contact numbers on A's telephone and accusing them of being somehow involved with her:

At 01.29 from A to Friend 4:

In bed sweet dreams ,, x Y is an arsehole but massive remember ---

At 12.43 Friend 4 to A:

R u ok ?

At 14.12 A to Friend 4:

I pissed off with him

At 15.43 A to Friend 4

We didn't do anything wrong. Had a few bottles that's all. I am just upset with Y calling people from my self phone. I not talking to him. Me n Ziggy [one of A's cats] occupied bed ;-);-)

95. During the day preceding the homicide in early January 2015 Mr YZ and Ms AB were drinking in a local public house and then visited the house of Friend 2 where they carried on drinking before returning to the pub. Following an argument about taking a minicab home or walking, a cab arrived at 2245. They stopped at a supermarket where Ms AB purchased some alcohol. The driver recalls that they were acting normally and chatting together in the rear of the car without sign of disagreement.

96. Mr YZ did not provide an account to the police but was able to describe to the psychiatrist a day where they had been drinking heavily together because his money had come through and they had household bills to pay and purchase shopping. He recalls an argument over a take-away meal whereby he wanted one and she pointed out that they had shopped for food. They did argue about the minicab, as he wanted to walk because it was only five minutes. He also believes they were in a pub and they became separated when he returned from the toilet and she was not there and he started to look for her. He has no recollection of leaving the pub and the next thing he remembers is being at the police station.

97. Analysis of Ms AB's text messaging that evening provides some insight to the developing mood between them that day:

At 17.24 A to Y:

This place is empty

At 18.49 Y to A:

Drink that and you will be an even more mental moody person than you are now!! Don't be a bitch please I love you

At 19.38 Y to A:

As predicted

At 19.39 Y to A:

Loves me loves me Not

At 19.40 A to Y:

I always love

At 19.43 Y to A:

Cats out side but you just think about is number 1

At 19.45 A to Y:

I wanted go home

DA Incident 3 – MPS Harrow and Major Investigation Team

98. At 00.18 that night, Mr YZ called the police emergency operator, provided his name and said that he had killed his girlfriend. He then broke down, sobbing and would or could not provide any further information, including the address. The call was traced and officers arrived at 00.28.

99. The officers could see Mr YZ at the front window looking out and, on closer scrutiny, observed the apparently lifeless body of Ms AB on the sofa with a kitchen knife on top of her body. The police control room called him back and, through the continuing sobs, he disclosed that his girlfriend was dead and his hands were covered in blood.

100. The officers persuaded him to leave the house and he was detained on suspicion of murder. He responded: "Murder? Is she dead?" and then said, "I've killed her". On his way to, and at, the police station he repeated the disclosure that he had killed her yet also asked if she was OK.

101. Ms AB's lifeless body was found lying across the sofa in the living room with severe and visible knife wounds. It was obvious she was beyond saving. Ms AB was fully clothed, wearing an outdoor coat and footwear and had an unlit rolled cigarette in her hand as if about to leave. There was a large serrated bread knife laying across her body and two other kitchen knives next to the sofa.

102. A post mortem examination pointed to a frenzied attack and identified the cause of death as knife injuries:

One to the upper back that could have been fatal (from the body position, probably the first inflicted)

One to the upper chest that could have been fatal
Five to the neck, one of which could have been fatal
One to the outer upper arm, which has exited the inner arm and identified as a classic defence injury

103. Subsequent toxicological examination revealed a blood alcohol concentration (BAC) of 253 milligrams per 100 millilitres (mg%) and, that being more than three times over the legal limit for driving (80 mg%), significant intoxication could be expected.

104. Following similar examination of the blood provided by Mr YZ, conclusions are more complex because the sample was not taken until almost 17 hours after arrest. The scientist has calculated that Mr YZ's BAC at 00.18 could have been as low as 214 mg% or as high as 466 mg% depending on how much alcohol had been consumed in the previous hour that was still in the stomach. Taking a mid-point on 348 MG% (more than four times the driving limit), the average social drinker would be showing signs of a very extreme degree of intoxication with many symptoms, including the possibility of stupor, unconsciousness or coma.

105. In interview over the next two days, Mr YZ confirmed his relationship with Ms AB and claimed that they loved each other. He admitted he had been drinking throughout the day before the homicide and then made no further comment about the attack on Ms AB later that evening. He was charged with her murder.

106. In October 2015 at the Central Criminal Court, and in the light of evidence from two Forensic Consultant Psychiatrists, the Prosecution accepted a plea of guilty to manslaughter with diminished responsibility due to Alcohol Dependence Syndrome. The sentence handed down was reviewed by the Crown Prosecution Service and referred to the Attorney General for an appeal against undue leniency. In January 2016, the Court of Appeal increased the sentence to 12 years' imprisonment with five years supervision on release.

ANALYSIS

Context

107. There is no doubt that alcohol consumption was a significant factor in the terrible and tragic homicide of Ms AB, indeed, 'Alcohol Dependence Syndrome' was Mr YZ's defence to the murder charge, the expert clinical evidence for which was reviewed and accepted by the Crown and the trial Judge. Forensic evidence from the time of her death showed that Ms AB was herself intoxicated to a level beyond normal social drinking.

108. There is ample evidence that Mr YZ had been alcohol dependent for most of his adulthood and, consequently, he led a sedentary life, dependent on his parents for accommodation and the State for income in the form of benefits.

109. In his interviews with the Consultant Forensic Psychiatrist, Mr YZ described Ms AB as a binge drinker, a choice confined to days when she was not at her job in the restaurant industry. A few recorded examples that Ms AB sometimes consumed alcohol to excess have been revealed: the GP consultation when she disclosed consumption of 72 units of alcohol a week, the confrontation with police following a fall when intoxicated, the occasional lateness for work, then failing to turn up to take over management responsibility, which lost her the job.

110. On the other hand, she was never seen to consume alcohol at work, was highly respected as a conscientious employee and colleague and very popular with customers at both places of employment. What is unknown is the extent to which Ms AB's alcohol consumption when off duty and with Mr AB was as an avoidance device or coping mechanism for the burgeoning violent, controlling and coercive abuse she suffered at the hands of Mr AB.

111. They had met in 2011 and lived together at his home in Edgware, Harrow from early 2014. Prior to the first incident reported to the police in September 2014, their relationship was reported by each of them to be a loving one and they had two cats that Ms AB adored. Relatives from her native Poland thought Mr YZ strange and had observed bi-polar type behaviour but had not developed any concerns about domestic abuse. Her mother did notice a reduction in her daughter's mood from around the time of the first reported incident.

112. Ms AB's work colleagues had not warmed to Mr YZ and, due to instances where she had to replace her spectacles and disguise bruising, harboured the suspicion that he was abusing her. When they argued, A would stay at the Pub where she worked for two to three weeks and then return to him. It was noted that she changed her telephone a few times, which may also have been connected to controlling abuse.

What was known to safeguarding services

113. In December 2012, the incident where Mr YZ called police to an intruder was, on the balance of probability, a false alarm; however, there was a missed opportunity to record for intelligence purposes that he had openly threatened to stab the believed intruder. This would have been relevant and helpful to future risk assessments.

114. In May 2014, when police arrested Ms AB for assaulting the officer who had attended the call to a dispute with a taxi driver that was dealt with by way of a fixed penalty notice for disorder, there was a missed opportunity for health professionals at Northwick Park Hospital to screen for domestic violence and other welfare checks.

115. The domestic abuse incident in September 2014 was far more serious as it involved a violent attack by an extremely intoxicated Y on A's car in her presence. This may well have signaled an ominous 'tipping point' in their relationship. A's mother noticed that she had sounded sad in their daily telephone contact from about this time. When she took refuge at the Pub following the incident, A made the first disclosure to her manager about the recent history of domestic abuse and the fact that the attack on the car was "meant for me" as she looked on from the relative safety of the house. She also texted a friend: "Next time he can kill me". From other text messaging with her friends, it is reasonable to construe that Y's uncontrollable rage at her was down to the fact that she had poured his supply of cider down the sink to try and limit his drinking that day.

116. The police who attended did not gain this understanding of the context and full seriousness because A provided limited disclosure and Y had only an intoxicant's very limited recollection of what happened. It is not known why A did not disclose that she was living with Y (as is clear from her text messaging), instead saying she had only stayed overnight and providing police with the home address of the Pub where she worked. A did make it clear that she was afraid of Y when he was drinking and that he had a problem with alcohol but may have reassured the officers by stating her intention to leave him. She did not disclose to police through the DASH questionnaire the history of domestic abuse that she subsequently shared with her manager, Mr EF.

117. The officers dealt with the reporting of the incident correctly in line with the Domestic Abuse Toolkit and it was referred to the specialist CSU for investigation. There is a question, however, about their professional judgment in assessing the DASH risk as standard because the ferocity of the attack on Ms AB's car with a weapon was a clear portent of potential harm to her person. Furthermore, the CSU investigator with the benefit of specialist training and experience could and should have reviewed the primary assessment using DASH 2 and reached the same conclusion as the IMR author that the risk to Ms AB was at least medium. Whilst this would not have materially altered the management of the risk, for example, by

referral of the case the local MARAC, it is a missed opportunity to undertake further engagement with her during the secondary investigation phase.

118. Extant policy and automation of the police referral system within Victim Support meant that the CRIS report was screened out as an 'unsupported' case, despite there being a domestic abuse flag attached. This was a missed opportunity to open a 'second line of defence' by a VS caseworker initiating contact with Ms AB. [Note: The reader is reminded that this would not be the case in current VS policy and procedure]

119. The judicial disposal of a report of crime by way of the simple caution for causing criminal damage to the car that was accepted by Mr YZ may have been expedient at the time and was broadly consistent with the gravity factors matrix applied by the reviewing officer, including that there was no history of domestic abuse apparent. However, the fact that Ms AB would not be willing to support a prosecution was not in fact a limitation on prosecution because the officers had seized the weapon and had evidence of the damage together with A and Y's first accounts at the scene captured on video. With this evidence, a 'victimless' prosecution was certainly feasible but it was not considered. It is, of course, not known if the Crown Prosecution Service would have taken a decision to prosecute or, as is also possible, to recommend disposal by way of conditional caution.

120. The police could and should have considered, and discussed with Ms AB, the option of a conditional caution that would have ensured that Mr YZ followed through on his promise to arrange for the repair to her car. Again, it is not known what her reaction might have been or whether Mr YZ would have agreed to the conditions and what effect this might have had on the relationship going forward.

121. Within 10 days of the incident, Mr YZ visited his GP whom he had not seen since November 2013, at which point in time he had been in remission from alcohol abuse for four months. He claimed that this incident in September 2014 (noted as a "domestic upset") had followed a break up in the relationship that had in turn caused a relapse into drinking. Other evidence confirms that this was rather more than an 'upset' and that neither [underlined] assertion was true, although there was no reason for the doctor to disbelieve his account.

122. Y was intoxicated at the time of the consultation, reported suicidal ideation and railed against attending Compass in Harrow due to travel time and cost. The GP did refer him to the local Barnet service but due to commissioning changes, Y was told by BDAS to seek treatment instead at Compass in Harrow town centre and he chose not to do that.

123. The next incident of domestic abuse in October 2014 did not involve personal violence to A but, from evidence adduced in the homicide investigation, it can now be seen as an example of coercive control. By calling police to prevent the 'crime' of drink-driving, Y was in

fact exercising controlling behavior by seeking police assistance to prevent A leaving him after an argument.

124. The officers followed the guidance in the domestic abuse toolkit, including research that identified both the disorder incident in May and the criminal damage in September that year. The fact that A was not in fact drunk was not recorded on the CRIS report and this omission may have arisen from the fact that the prior disorder incident did involve an intoxicated A. One consequence of this omission is that the CSU investigator that conducted further research and assessment did not know that A was sober, so would be unlikely to develop the concern that this was an example of control and seek to further interview her away from Y's presence in line with guidance.

125. Had anyone taken a step back and compared the two incidents, it would have been discoverable that, within the intervening six weeks, Ms AB had moved in with Mr YZ having earlier said she would leave him, and somehow reduced her reported fears of personal harm and alcohol abuse in September to zero concern in October. This would have increased the DASH2 risk assessment to medium and, again possibly, led to greater proactivity in the follow-up engagement with Ms AB.

126. So far as the fatal incident in January 2015 is concerned there is nothing known to any agency that could have presaged such an extreme act of violence. There is no possibility that the response officers could have done anything to save Ms AB's life. A highly professional homicide investigation ensured that all relevant evidence was available to the Court.

What support was available to Ms AB and Mr YZ

127. A specific Term of Reference for this review is to identify how people in the LB of Harrow gain access to advice on domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague.

128. Harrow is a relatively low crime Borough, including in domestic abuse, and have a strategy for domestic and sexual violence 2014-17 together with a wide-ranging action plan that addresses the strategic aims of prevention, provision, partnership and perpetrator management. Of particular relevance to the circumstances of this review is that the Borough seeks to ensure better prevention through making the public more aware of the services available in Harrow through publicity campaigns and improved provision through ensuring accessibility to victims from diverse communities.

129. At the time of Ms AB's homicide the communications plan had been completed (October 2014) and the re-tendering of services to obtain a lead provider was in preparation for

a new service from April 2015. Therefore, it is unlikely that significant change to the provision of access advice and information, including to the Polish heritage community, was embedded in time to be of assistance in this case. To be fair on this point, it should be born in mind that there is no evidence available to this review that Ms AB had formulated the idea to access advice or was encouraged by others to do so.

130. At the time of writing this overview, Harrow Council's website provides general advice under its page on Domestic and Sexual Violence. Specific referral pathway advice on the next page is dated 2013 and a search on domestic abuse advice for the Polish community does not yield any information. Updating of the website was not integral to the action plan and publicity campaigns so there is scope to cover this perceived gap going forward.

131. In the course of multiple alcohol treatment referrals and emergency department attendances by Mr YZ for his chronic alcohol conditions there are no references to violence or homicide ideation in any of the clinical notes so there was no reason for any clinician to connect his alcoholism with domestic abuse until his disclosure in September 2014 when he was less than frank about the circumstances.

132. Due to the complexity of Mr YZ's health problems it was not suitable or safe for his detoxification to be managed in primary care. Had he been able to engage with the local Barnet drugs and alcohol service, the GP surgery (which is also nearby) could have provided shared care and it could be argued that, together, they had a track record of, albeit limited, success in treating Y who had been abstemious for at least a few months in 2013/14.

133. Therefore, it is unfortunate that commissioning changes precluded the more convenient and proven arrangement across a road (Burnt Oak Broadway) that happens to be a Borough boundary rather than send him five miles to the Harrow provider of drugs and alcohol services.

CONCLUSIONS AND LESSONS LEARNED

134. The fundamental purpose of reviews carried out under this legislation is to establish what lessons are to be learned regarding the way in which local professionals work individually and together to safeguard victims, in this case, Ms AB. Findings from reviews of this nature can work to eradicate a conducive culture for domestic abuse and violence between partners.

135. While sceptics may question the validity of Alcohol Dependence Syndrome as a form of diminished responsibility and a legal defence to the charge of murder, as it was in this case, it also could be argued that Mr YZ's extreme alcoholism condition presented an additional challenge of understanding for clinical safeguarding practice.

136. The inherent risks to be avoided in formulating conclusions and identifying lessons are 'hindsight biases' and 'outcome biases'. The Panel has sought throughout to understand the agency operating contexts in which this tragedy occurred so that the report does not become 'should've-ist' or 'second-guessing' in character. Nonetheless, the review has identified a number of missed opportunities and learning from them that could improve the system for safeguarding in the London Borough of Harrow and elsewhere for the future

<u>Metropolitan Police Service</u>

137. The Metropolitan Police were the only agency to encounter violent behaviour or intent on the part of Mr YZ and, as played out in the first reported abuse incident, this was directed at the inanimate object that was A's car. The officers who attended did not at the time identify that it was probably a proxy act against her person and, therefore, a higher risk than standard. There was also a tenuous connection with his threat to stab an unknown intruder that an intelligence report at the time may have helped with subsequent risk assessment processes.

138. When called to the second incident where Y was attempting to control A's freedom to leave by alleging that she was too drunk to drive, the officers did not fully record their observation that she was not in fact intoxicated and this information would have been helpful to the secondary risk assessment and may have led to greater effort by the investigator to engage with her.

139. In both incidents, the CSU secondary investigators did not review the primary risk assessments and use more specialist knowledge and judgment to raise the risk to medium. Nor did they adopt a holistic perspective to make the connections between events, and thereby seek to engage further with A. This observation should be balanced against the position that Ms AB was not compellable and her response to further engagement is not knowable.

140. The option of a simple caution for the damage to A's car was a missed opportunity to provide a minor deterrent and some element of influence on Y's behaviour through a conditional caution.

Victim Support

141. The single opportunity available to Victim Support to engage with Ms AB was screened out by the automated case management system in place at the time. Had this policy and procedure not been changed in October 2014, there would have been a recommendation from this review to do so.

Mr YZ's GP Surgery and local Drugs and Alcohol Services

142. When, after the first incident with the car damage, Y sought medical help with detoxification, the lack of flexibility within commissioning arrangements to provide support locally rather than five miles distant may have led to loss of motivation on his part. Y having presented while intoxicated and to seek help, there was then a lack of systemic proactivity and effective communication between the GP Surgery, BDAS and Compass to follow up on the rejection by the local referral centre.

Harrow Council

143. It appears the Harrow Council have yet to publish on their website the detail of their agreed communications plan to provide greater awareness of the domestic abuse services available in the Borough, including to diverse communities.

Overall conclusions

144. Mr YZ's diminished responsibility defence due to Alcohol Dependence Syndrome does not fully account for the sudden and savage slaying of Ms AB in January 2015. Whilst it is accepted by expert clinicians, lawyers and the Court that he has no recall of the fatal attack, it is also appropriate to take account of everything else that is known about the prelude to it to understand why it happened.

145. Within an hour of being dropped at home by taxi, Ms AB was attacked while wearing her outer coat and it is likely that she was preparing to leave, possibly due to arguments earlier in the evening, as indicated by the judgmental texting by Mr YZ. Ms AB had also complained to a friend a few days earlier that he had started exercising control of her private life by calling the contacts listed on her telephone to question why they had been speaking to her. The incident in October when he called the police to falsely claim that she was about to drive whilst drunk was because she had announced she was leaving him. Her text message to him in November that she would rent somewhere else to live was met with a threat to give her a black eye and broken rib. The abuser's fear of breakup is a well-documented and significant risk factor for the person fleeing a relationship.

146. The window on their lives subsequently provided by work colleagues reveals that Ms AB disclosed to them a pattern of escalating controlling abuse, that included unexplained injuries, damaged spectacles and replacement telephones, and culminated in the frenzied attack on her car through frustration that YZ could not get at her to punish the disposal of his alcohol supply. While A intimated to colleagues and friends that it was love for Y that motivated her return to live with him after that terrifying attack on her car with a weapon that

she believed was meant for her, the relationship they were in could not be described as a loving one.

147. At this ominous incident, the police officers who heard Mr YZ's account that he was so intoxicated he could not remember what had happened, were not qualified to assess this as ADS. Thus, they could not have foreseen the danger and acted reasonably in the circumstances known at the time. Similarly, what clinicians knew of this incident was limited to the account Mr YZ provided to his GP who would not feasibly have made the connection with ADS as a possible diagnosis, even if such expertise was available, as his alcoholism was reportedly under control.

148. In summary, Ms AB was in an abusive relationship where the escalating violence, the increasing control and the evident fear from Mr YZ that she intended to flee, made her position highly vulnerable to harm. Extreme intoxication on his part clearly was a factor in his apparent loss of control but does not alone explain or justify this fatal attack. Nor does intoxication on her part, which may well have been part of her survival technique, contribute in any way to the cause of her death.

149. However, there was nothing known to anyone in authority during this period that could have anticipated such a dramatic turn of events. While there are lessons to be learned, there is no identifiable 'root cause', no omission or dereliction of duty by any individual or single safeguarding agency that failed to limit the opportunity for Mr YZ to inflict the fatal injuries on Ms AB. There is no evidence of a collective failure in this case.

RECOMMENDATIONS

150. All the IMRs received have been studied for the recommendations made therein as follows.

Metropolitan Police Service

151. It is recommended that Harrow Borough Operational Command Unit Senior Leadership Team (SLT) debrief officers involved to disseminate the lessons learnt regarding:

- The completion of CRIMINT reports
- DASH
- Coercive Control
- Conditional Cautions

Mr YZ's GP Surgery

152. We would recommend that clear guidance be agreed in relation to patient choice access issues for the cross boundary provision of local mental health services and drug and alcohol services. This lends itself to sub-division between Harrow CCG and Public Health:

Harrow CCG

153. Harrow CCG to ensure better communication of cross boundary mental health provision and individual funding request

Harrow Public Health

154. Harrow Public Health to agree clear guidance in relation to patient choice access issues for the cross boundary provision of local drug and alcohol services

NHS England

155. Clinical staff in GP practices should have training in domestic abuse as specified within 2014 NICE guidance hhttps://www.nice.org.uk/guidance/ph50

London North West Healthcare NHS Trust

156. Improve increased capability for community alcohol teams to deliver rapid assessment and treatment for difficult to reach patients who attend hospital in a crisis

157. Review the pathway between mental health and alcohol presentations in the acute setting and implement improvements. This will involve more than LNWHT because it involves other services and commissioners

158. There were no specific recommendations relating to service provision arising from the following reviews:
Ms AB's local Medical Centre

Central and North West London NHS Trust
Victim Support [single issue of concern already corrected – see paragraph 139]
COMPASS

159. In checking that the Terms of Reference for the review have been fully discharged the Panel has linked the finding in paragraph 141 as relevant to item 9 in the ToR. As a result, the Panel has identified the following recommendation for the Local Authority to implement.

Harrow Council

160. Review the Harrow Council website and to provide clear pathways to advice on domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague, including in languages relevant to the local community

161. The Alcohol Dependence Syndrome suffered by Mr YZ that, subsequent to the homicide of Ms AB, was diagnosed by expert clinicians, provided a defence acceptable to the Judiciary for the charge of murder. This judgment is believed to be the first of its kind in England. ADS may be familiar to specialists but the consequent risk of extreme harm that manifest in this case may not be so well known across the safeguarding agencies.

162. This issue goes generally to concerns in the field of domestic abuse about the quality and consistency of risk assessments, the perennial challenge of timely sharing of relevant information and the need for professional curiosity [that Lord Laming described in his report on Victoria Climbie as: “An open mind, a healthy skepticism and an investigative mindset”]. The Panel is aware of initiatives to implement joint practice guidance and feel that is this appropriate for learning locally and also nationally from this case.

Harrow Local Adult Safeguarding Board

163. The Harrow Local Adult Safeguarding Board to develop a joint practice guidance for Alcohol Dependence Syndrome in domestic abuse cases that ensures consistency of:

- Risk assessment;
- Information sharing; and
- Professional curiosity

With further consideration for learning nationally

164. Each of the eight recommendations above has been incorporated into an Action Plan for implementation as the result of this review [appendix 4] and accepted by a meeting of the Safer Harrow Partnership on 29 September 2016.

Author
Bill Griffiths CBE BEM QPM
28 May 2017

Glossary

ACPO	Association of Chief Police Officers
ADS	Alcohol Dependence Syndrome
A&E	Accident and Emergency
BDAS	Barnet Drugs and Alcohol Service
CAADA	Safe Lives - Coordinated Action Against Domestic Abuse
CCG	Clinical Commissioning Group
cjsm	Criminal Justice Secure eMail
CNLW	Central and North West London NHS Trust
CPS	Crown Prosecution Service
CSU	Community Safety Unit
DAAT	Drugs and Alcohol Team
DA	Domestic Abuse
DAI	Domestic Abuse Incident
DASH	Domestic Abuse, Stalking and 'Honour'-based violence
DHR	Domestic Homicide Review
DVHR	Domestic Violence Homicide Review
ERO	Evidential Review Officer
GP	General Medical Practitioner
gsi	Government Secure Internet
HMIC	Her Majesty's Inspector of Constabulary
HOT	Harm, Opportunity and Threat
IDVA	Independent Domestic Violence Advocate
IMR	Individual Management Review
LB	London Borough
LBH	London Borough of Harrow
LNWH	London North West Healthcare NHS Trust
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MOPAC	Mayor's Office for Crime and policing
MPS	Metropolitan Police Service
NHS	National Health Service
PNC	Police National Computer
pnn	Police National Network
SHP	Safer Harrow Partnership
SIO	Senior Investigating Officer
SOP	Standard Operating Procedure
ToR	Terms of Reference
VS	Victim Support

Safer Harrow Partnership
DVHR Panel for Ms AB killed in January 2015 in Edgware, Harrow

Distribution List

Name	Agency	Position/ Title
Michael Lockwood	LB Harrow	Chief Executive
Simon Brown	LB Harrow	Cabinet Member for Adults and Older People
Pamela Fitzpatrick	LB Harrow	Assistant portfolio holder for Adults and Older People
Sachin Shah	LB Harrow	Leader of the Council
Rachel Gapp	LB Harrow	Head of Policy
Alex Dewsnap	LB Harrow	Divisional Director – Strategic Commissioning
Tom Whiting	LB Harrow	Corporate Director for Resources and Commercial
Bernie Flaherty	LB Harrow	Director of Adult Social Services and Chair of Local Safeguarding Adults Board
Charisse Montero	LB Harrow	Head of Troubled Families
Seamus Doherty	LB Harrow	Safeguarding Adults Coordinator
Bridget O'Dwyer	LB Harrow	Public Health Commissioner
Graham Henson	Safer Harrow	Chair
Simon Rose	Metropolitan Police	Deputy Borough Commander
Simon Pickford	Metropolitan Police	Detective Inspector Serious Crime Command
Pam Chisholm	Metropolitan Police	Detective Sergeant Specialist Crime Review Group
Tanya Paxton	Central and North West London NHS Foundation Trust	Director Mental Health Services
Claire Murdoch	Central and North West London NHS Foundation Trust	Chief Executive
Robyn Doran	Central and North West London NHS Foundation Trust	Chief Operating Officer
Sally Kingsland	NHS England	Designated Nurse, Safeguarding Children,

		Harrow CCG
Mrs Ajatha Ratnayake	Mr YZ's GP Surgery, Edgware	Practice Manager
Caroline Peters-O'Dwyer	Mr AB's Medical Centre, Edgware	Practice Manager
Sue Sheldon	Harrow/Brent Clinical Commissioning Group	Designated Nurse Safeguarding Children Line Manager of Safeguarding Adult Nurse
Christine Asare Bosompem	Harrow/Brent Clinical Commissioning Group	Lead Nurse for Safeguarding Adults
Jacqueline Docherty	London North West Healthcare NHS Trust	Chief Executive Officer
Lee Martin	London North West Healthcare NHS Trust	Chief Operating Officer
Lesley Tilson	London North West Healthcare NHS Trust	Associate Director for Safeguarding Children
Delroy Ettienne	Compass	Service Manager
Kenny Tang	Victim Support	Enhanced Service Delivery Manager – Harrow and Brent
Caroline Birkett	Victim Support	Divisional Manager
Bill Griffiths	Independent Chair	Independent Chair of the Domestic Homicide Review
Tony Hester	Director Sancus Solutions Ltd	Independent Administrator and Panel Secretary
Quality Assurance Panel	Home Office	-
Baljit Ubhey	Crown Prosecution Service	London Chief Crown Prosecutor
Sir Bernard Hogan-Howe	Metropolitan Police Service	Commissioner
Sophie Lindon	Mayor's Office for Policing and Crime	Deputy Mayor

Appendix 1

Independence statements

Chair of Panel

Bill Griffiths CBE BEM QPM was appointed by Harrow SCP 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 Harrow, or direct management of any MPS employee.

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.

Appendix 2

Panel Members

Name	**Agency/Role**
Mike Howes	Senior Policy Officer, Strategic Commissioning, LB of Harrow
Rebecka Steven	Policy Officer, Strategic Commissioning, LB Harrow
Richard Metcalfe	Detective Chief Inspector, MPS LB Harrow
Pam Chisholm	Detective Sergeant, MPS Specialist Crime Review Group
Bill Griffiths	Independent Chair
Tony Hester	Independent Administrator and Panel Secretary
Sally Kingsland	NHS England
Sue Sheldon	Designated Nurse Safeguarding Children Harrow Clinical Commissioning Group (CCG) NHS
Tanya Paxton	Director Mental Health Services Central and North West London NHS Foundation Trust
Lesley Tilson	Associate Director for Safeguarding Children, London North West Healthcare NHS Trust
Caroline Birkett	Victim Support

Safer Harrow Partnership
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Appendix 3

Terms of Reference for Review

1. To identify the best method for obtaining and analysing relevant information, and over what period of time [Note: Agreed on 25/08/15 as from 1 January 2011 to date of homicide with any relevant prior information to be summarised] 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 chronologies and Individual Management Reviews (IMR) and agree a timescale for completion [Note: Agreed on 25/08/15 that should include records held within the London Boroughs of Harrow, Barnet, Brent and Camden]

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 victim or alleged perpetrator was a 'vulnerable adult' and, if so, what specialist advice or assistance may be required

5. To identify whether the victim 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 meetings

6. To determine whether this case meets the criteria for a Serious Case Review, as defined in Working Together to Safeguard the Child 2013, if so, how it could be best managed within this review [Note: there are no children known for either victim or defendant]

7. 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.

8. To identify how the review should take account of previous lessons learned in the London Borough of Harrow and also from relevant agencies and professionals working in other Local Authority areas

9. To identify how people in the LB of Harrow gain access to advice on domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague

10. 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

Cross Government 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

Safer Harrow Partnership
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Appendix 4

ACTION PLAN

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key Milestones Achieved in enacting recommendations	Target Date	Date of completion and outcome
1 Harrow Borough Operational Command Unit Senior Leadership Team (SLT) debrief officers involved to disseminate the lessons learnt regarding: •The completion of CRIMINT reports •DASH •Coercive Control •Conditional Cautions	Harrow Borough Police	Conduct a debrief with officers involved in Domestic Abuse Incidents involving AB and YZ for lessons learned Disseminate the lessons learned using the 'case study' approach to response officers and investigators	Harrow Borough SLT	1. Debrief with specific officers 2. Development of a case study narrative 3. Dissemination to response officers and investigators	1. September 2016 2. October 2016 3. November 2016	December 2016 **Ongoing**
2 Harrow CCG to ensure better communication of cross boundary mental health provision and individual funding requests	Harrow CCG CNWL	A small task and finish group with representatives from Harrow CCG and CNWL to lead on drafting a flow chart and pathway that is common to GP practices and mental health services in Harrow	Harrow CCG	1. Form task and finish group 2. Identify flow chart and pathway 3. Disseminate to GP practices and mental health services	1. September 2016 2. October 2016 3. November 2016	December 2016 **Ongoing**

3 Public Health to agree clear guidance in relation to patient choice access issues for the cross boundary provision of local drug and alcohol services	Harrow Public Health/ Drug & Alcohol services in Barnet & Harrow	A small task and finish group with representatives from Harrow Public Health/Drug & Alcohol services in Barnet & Harrow to lead on drafting a flow chart and pathway that is common to GP practices/Drug & Alcohol services in Harrow, including clarity on reciprocal arrangements within West London Alliance	Harrow Public Health	1. Form task and finish group 2. Identify flow chart, pathway and reciprocal arrangements 3. Disseminate to GP practices and drug and alcohol services	1. September 2016 2. October 2016 3. November 2016	December 2016 **Ongoing**
4 Clinical staff in GP practices should have training in domestic abuse as specified within 2014 NICE guidance hhttps://www.nice.org.uk/guidance/ph50	NHS England	Named GP to identify one of the four annual training sessions to share the Safeguarding Adult narrative from this DHR withy particular reference to diagnosing and managing ADS risks	NHS England	1. Develop narrative from this DHR appropriate to Adult Safeguarding 2. Identify training session 3. Deliver training	1. September 2016 2. October 2016 3. December 2016	April 2017 **Ongoing**
5 Improve increased capability for community alcohol teams to deliver rapid assessment and treatment for difficult to reach patients who attend hospital in a crisis	LNWH NHS Trust/CNWL/ Harrow CCG Commissioners COMPASS & WDP Public Health Commissioners	A small task and finish group with representatives from LNWH, Harrow CCG Harrow Public Health, CNWL and COMPASS to review rapid assessment capability of community alcohol	Harrow Public Health	1. Review rapid assessment capability of community alcohol teams 2. Make recommendations to increase capability	1. September 2016 2. November 2016 3. December 2016	December 2016 **Ongoing**

		teams to treat difficult to reach patients who attend hospital in a crisis, with emphasis on ADS risks		3. Implement recommendations		
6 Review the pathway between mental health and alcohol presentations in the acute setting and implement improvements	LNWH NHS Trust/CNWL/ Harrow CCG Commissioners COMPASS & WDP Public Health Commissioners	A small task and finish group with representatives from LNWH, Harrow CCG Harrow Public Health, CNWL/COMPASS/WDP to review the pathway between mental health and alcohol presentations in the acute setting and implement improvements with emphasis on ADS risks	CNWL/LNW HT/Harrow Public Health/ Harrow CCG	1. Review the pathway between mental health in the acute setting to identify improvement 2. Make recommendations to implement improvements 3. Implement improvements	1. September 2016 2. November 2016 3. December 2016	December 2016 **Ongoing**
7 Review the Harrow Council website and to provide clear pathways to advice on domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague, including in languages relevant to the local community	Harrow Council	Harrow DSV website to be updated, ensuring all information provided is accurate and up to date	Harrow Council	1. Ascertain via IT colleagues the possibilities around enabling the webpage to be presented in different languages 2. Provide appropriate members of the Policy Team with	1. September 2016 2. September 2016 3. December 2016	December 2016 **Ongoing**

				training to enable the website to be updated/ maintained 3. Update the website, ensuring all information is accurate and includes up to date referral pathways		
8 The Harrow Local Adult Safeguarding Board to develop a joint practice guidance for Alcohol Dependence Syndrome in domestic abuse cases that ensures consistency of: •Risk assessment; •Information sharing; and •Professional curiosity with consideration for learning nationally	Harrow Adult Safeguarding Agencies	Develop Professional Guidance that covers the following areas: •Purpose •Scope •Key principles and actions •Key components of effective practice •Risk and protective factors •Summary of lessons learned	Harrow Local Adult Safeguarding Board	1. Identify a small task and finish group to lead on drafting the professional guidance 2. A guidance note that is ratified by the appropriate strategic body 3. Dissemination to safeguarding agencies to safeguarding agencies in Harrow 4. Dissemination for consideration at national policy level	1. September 2016 2. October 2016 3. November 2016 4. December 2016	December 2016 **Ongoing**