

HACKNEY CLEANER, SAFER PARTNERSHIP

DOMESTIC VIOLENCE HOMICIDE REVIEW

'MARIE' AGED 34

MURDERED IN NOVEMBER 2012

REVIEW PANEL CHAIR AND REPORT AUTHOR

BILL GRIFFITHS CBE BEM QPM

EXECUTIVE SUMMARY

This summary outlines the process taken by a Hackney Domestic Violence Homicide Review Panel established under s9 Domestic Violence, Crime and Victims Act 2004 in January 2013, independently chaired by Bill Griffiths CBE BEM QPM, to review the murder of Marie aged 34, killed by blunt trauma injuries to the body in November 2012. The perpetrator was convicted of her murder in November 2013 and sentenced to 20 years imprisonment (varied on appeal to 18 years).

The process began with a meeting on 29 January 2013 of all agencies that potentially had contact with Marie prior to the point of death. Agencies participating in the review are:

- Metropolitan Police
- London Probation Trust
- Homerton University Hospital NHS Foundation Trust
- Kingsmead Medical Centre
- Victim Support London
- Hackney and Haringey nia Project Independent Domestic Violence Advocate Service
- Hackney Domestic Violence Team
- Hackney Substance Misuse Team
- Hackney Benefits and Housing Needs Service (including Hackney Homes)

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; whether internal procedures were followed; and conclusions and recommendations from the agency's point of view

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. All of the above agencies provided Independent Management Reviews (that included a chronology). Two other agencies (Hackney Adult Services and City and Hackney MIND) confirmed that there had been no contact with the victim. The Crown Prosecution Service was involved in a number of prosecutions of the perpetrator, however, are not required under the legislation to provide a report. Nonetheless, the Chair conducted liaison and discussions regarding lessons learned and recommendations.

Key issues arising from the review

The relationship between Marie and the perpetrator commenced in January 2008 although they maintained separate living arrangements throughout. Incidents of domestic violence notified to the authorities began with an eye injury and hospital visit in January 2010 and there are 15 confirmed domestic violence incidents recorded in all, five known via health services and ten through the police, including the incident that resulted in her murder almost three years later. However, the experience of colleagues, family and friends was that visible injuries to face and ribs were much more frequently observed and in May 2011 Marie informed a specialist victim support caseworker of 20 prior assaults inflicted. A DASH (Domestic Abuse, Stalking and Honour based violence) risk

assessment conducted in that interview scored 'very high' and Marie's case was taken to the following MARAC (Multi Agency Risk Assessment Conference) for the Borough.

Marie made many valiant attempts throughout the relationship to avoid continuing violence, including by taking out a Non Molestation Order in November 2010 that was then breached by the perpetrator on five occasions, sometimes with her apparent cooperation. The perpetrator was sent a warning letter at the first breach and prosecuted on the last three occasions resulting in concurrent sentences of imprisonment for assaulting her and a Suspended Sentence Order that was current at the time she was killed.

Also in force then was a full Restraining Order granted to Marie in August 2011, some 15 months earlier, and there are no recorded instances of domestic violence or abuse in that period. Nonetheless, evidence at the trial showed that, three days before the murder, she had warned the perpetrator in a text message about being assaulted again. However, within 48 hours another message indicated she had an apparent change of mind which led to them spending the next 24 hours together drinking alcohol and having some form of contact with cocaine in the hours before the murder.

The main opportunities for safeguarding agencies in contact with Marie occurred in a 10-week period in mid 2011 and involved three incidents when the perpetrator was detained by police and one where Marie disclosed an assault to her GP:

- Early April – intervention by an off-duty police officer when Marie was being assaulted in the street
- Two weeks later – police called by a member of the public who had witnessed another assault in the street, the incident that led to Marie speaking to the specialist DV case-worker
- Mid May – the day she was assaulted following the perpetrator's release on bail and visited her GP for treatment to an eye injury
- Mid June – police called by a friend who had escaped from Marie's birthday party that the perpetrator had gate-crashed and threatened all present with a knife if Marie would not see him

Local Victim Support referred the DASH assessment of Marie to the local IDVA service early in May and presented her case to the assembled MARAC two weeks later. Difficulty was experienced in contacting Marie by telephone and the case was subsequently closed once it was established with her that she was aware of the granting of the Restraining Order she had applied for. Marie's case was not recorded for follow up review of actions in the minutes of the next MARAC in June, although the Victim Support representative has notes of a discussion that took place.

Critical review of this period of opportunity does expose some omissions in linking between events and agencies and the general inefficiency and inadequacy of the MARAC as it was operating in the Borough at that time. This review has already served a purpose in that remedial action is in progress to improve the efficacy of the MARAC process locally.

Following a 4-month sentence of imprisonment for the early April offence, imposed in August 2011 at around the same time as the Restraining Order was put into force, there was then a 15-month period of relative calm so far as the authorities were concerned as there were no reported instances of domestic violence until the murder was discovered. It seems that, despite the Order, there had been contact between Marie and the perpetrator on and off and certainly in the days leading up to the killing.

Conclusions and recommendations from the review

Due to the passage of time between the last recorded incident in June 2011 and the murder in November 2012, the Panel have concluded that there is no identifiable 'root cause', no omission or dereliction of duty by any individual or single agency that failed to limit the opportunity for the perpetrator to inflict the fatal injuries on Marie. Nor can it be concluded, even on the balance of probabilities, that there has been a collective failure in this case.

However, taking account of the lessons identified in the review, together with the good practice and positive actions revealed through the IMRs, analysis shows there is scope for systemic improvement in the thematic areas of:

- Holistic research, analysis and positive action/good practice
- The operation of the MARAC and offender management
- The criminal justice system.

Thirteen recommendations were identified and implemented by agencies within the course of their IMRs and a fourteenth identified and implemented by the MPS and CPS.

An action plan has been proposed for an additional five recommendations to be implemented and a sixth identified by the Home Office Quality Assurance Panel for local implementation:

1. This review to be utilised in the medical practice revalidation process
2. An information sharing and 'flagging' protocol for the local MARAC
3. Greater attention and focus on the offender management aspect of the MARAC (Op Dauntless)
4. Pilot the use of the police MERLIN database for triage of adult victims that do not meet the current 'vulnerable' threshold
5. Consider legal underpinning and accountability for MARAC that is parallel to the MAPPA
6. Explore ways that local employers may support employees who may be victims of domestic abuse