Part I

- Executive Summary-

1. The Review Process

1.1 This summary outlines the process undertaken by the Tower Hamlets Domestic Homicide Review Panel in reviewing the homicide of LP in April 2011and subsequent suicide of PW.

1.2 The body of the suspect for the homicide, PW, was found hanging from a tree branch in Weaver's Field, London E2 on Sunday 24th April 2011. The body of LP was found in her flat on 26th April by police as a result of enquiries made after the discovery of PW's body.

1.3 The deaths occurred only a matter of days after the implementation of the legislation requiring the conduct of formal Domestic Homicide Reviews (DHR). As a result the necessary supporting arrangements for a DHR were not yet in place in the borough. A pragmatic approach was adopted whereby an Independent Chair for the review (and the author of this report) was quickly appointed by the Community Safety Partnership Board to ensure rapid progress. Invitations to participate in the review as well as immediate requests for information were then sent to the following agencies:

- The Metropolitan Police Service (MPS)
- The Crown Prosecution Service (CPS)
- HM Courts & Tribunals Service (HMC&TS)
- London Borough of Tower Hamlets (LBTH) Adult Services
- LBTH Adult Safeguarding (MARAC)
- LBTH Child Protection
- LBTH Housing Department
- NHS East London Foundation Trust (NHSELFT)
- Victim Support (provider of Specialist Domestic Violence Advocacy services)
- East London Probation Trust(ELPT)
- Primary Care Trust
- The Independent Police Complaints Commission (IPCC)

1.4 Agencies were asked to provide a chronological account of contact with the victim and/or suspect. Where there was no involvement or insignificant involvement, agencies advised accordingly. Each contributing agency's report covers the following:

- A chronology of interactions with the victim and/or suspect
- What was done or agreed
- Whether internal procedures were followed
- Conclusions and recommendations from the agency's perspective

1.5 The accounts of involvement with the victim and/or suspect cover different periods. Some of the accounts have more significance than others. The extent to which key areas are covered and the format in which they have been presented varies between the agencies. Where the accounts from agencies failed to address key issues or raised unresolved issues, further requests for clarification and/or specific items of additional information were made.

1.6 As a result of these requests, the following agreed to act as members of the Review Panel:

- Commander Stephen Watson – Metropolitan Police (Territorial Commander for East London)
- Ms. Katherine Marks – LBTH (Acting Director Adult Services)
- Mr. Alan Tyrer – LBTH (Adult Safeguarding)
- Mr. Stephen McAllister - HMC&TS (Deputy Justices' Clerk)
- Mr. Lionel Idan – CPS (Senior District Crown Prosecutor, Snaresbrook District)
- Ms Emily Fieran-Reed – LBTH (Domestic Violence Forum)
- Mr. John Biggs MLA (Metropolitan Police Authority link member for Tower Hamlets and member of the London Assembly)
- Mr. Gary Atherton – ELPT (Assistant Chief Officer, Tower Hamlets)
- Mr. Jonathan Warren – NHSELFT (Director of Nursing)
- Ms Geraldine O'Donnell – Primary Care Trust
- Ms Ameena Begum – Victim Support (providing IDVA services)

1.7 A total of 12 agencies responded:

- The Metropolitan Police
- The Crown Prosecution Service
- HM Courts & Tribunals Service
- LBTH Adult Services
- LBTH Housing Department
- LBTH Adult Safeguarding (MARAC)
- LBTH Children's Services
- NHS East London Foundation Trust
- Victim Support
- East London Probation Trust
- Primary Care Trust

Two agencies (the Primary Care Trust and LBTH Children's Services) responded as having no contact with either of the two deceased or with any children of the deceased.

Ten agencies responded with information indicating some level of involvement with one or both of the deceased (i.e. the above list, other than the Primary Care Trust and LBTH Children's Services)

1.8 In addition to the initial requests the following additional information was obtained to contribute to the review:

- A report from the MPS Homicide Investigation Command to HM Coroner
- Statements made by various witness to the MPS homicide investigation team
- A letter from LP's GP to HM Coroner
- A letter from PW's GP to HM Coroner
- A report of the findings of the post mortem examination of LP
- A report of the findings of the post mortem examination of PW
- The report of the investigation by the Independent Police Complaints Commission (IPCC) into the conduct of various police officers
- A note of discussions with LBTH Housing Department

- Statistical information provided by the Tower Hamlets Community Safety Partnership concerning the workloads of relevant agencies involved with domestic violence
- Operating protocols for the Tower Hamlets Multi Agency Domestic Violence Safety Planning Panel (the local name for the MARAC)
- CPS Policy for Prosecuting Cases of Domestic Violence
- MPS Standard Operating Procedure relating to cases of domestic violence
- A face to face discussion with LP's closest female friend and neighbour describing LP and PW's relationship
- Information gleaned from a statement to the MPS from a male friend and neighbour of LP who provided her with financial support and occasionally a place of safety

1.9 The police report shows that on eight occasions between March 2010 and April 2011 police had contact with LP in relation to her allegations that she had been assaulted by PW (two occasions), that she wanted him removed from her home or that he was in her flat in breach of bail conditions imposed by Thames Magistrates' Court. Although the LP initially indicated she would support the prosecution of PW, she subsequently withdrew support. LP also declined support from Victim Support, the agency providing IDVA services in Tower Hamlets. Notwithstanding LP's withdrawal of support, the police and CPS continued with the prosecution of PW for the allegation of assault.

1.10 In an effort to ensure the safety of LP and secure PW's attendance at court, police initially withheld bail from PW after charging him with assault. He was, however granted conditional bail by the magistrates' court. PW was subsequently arrested for breach of these bail conditions on two separate occasions when police were called to her home by LP. On both occasions the court released PW on substantially the same conditions as before.

1.11 Unknown to the police and other agencies, despite court imposed bail conditions prohibiting PW from contact with LP, it is clear that the couple were in frequent contact. It is likely that PW was at least intermittently living with LP. Immediately prior to her death, witnesses indicate that she and PW spent the day shopping and sunbathing together and later shared a barbeque.

1.12 Between September 2010 and his death, PW was under treatment, initially by his GP, then at the Tower Hamlets Substance Abuse Unit (THSAU) for substance abuse and mental health problems. He was a regular user of heroin, cocaine and other

substances. He was prescribed methadone as part of his treatment plan. Until February 2011, PW was also a client of the East London Probation Trust as a result of being sentenced to a Community Order with a Drug Rehabilitation requirement arising from his breach of a previous order with which he had failed to comply.

1.13 PW's lifeless body was discovered on 23rd April 2011 hanging from a tree in a park in Bethnal Green. Post mortem examination determined the cause of death as suspension and that at the time of death PW had traces of heroin and/or morphine, cocaine, methadone cannabis and diazepam in his body. The pathologist concluded that it is possible that PW was under the influence of one or more of these substances at the time of his death.

1.14 LP's lifeless body was discovered by police on 26th April as a result of police enquiries into the death of PW. Post mortem examination indicated that the cause of her death was a stab wound to the chest. Toxicological analysis indicated she had taken cannabis before she died.

1.15 On 24th September 2012 the inquest into the death of PW concluded that he took his own life while suffering from a depressive illness. The cause of death was determined as "suspension".

1.16 The inquest into the death of LP was opened and adjourned on 3rd May 2011 and has yet to be concluded (projected date in Spring 2013).

2. Key Issues Arising from the Review

2.1 The history of this case reveals several examples of poor and/or non-compliance with established policies and procedures by officers/staff in Tower Hamlets Police, Probation Service, the Specialist Addiction Unit and HM Courts &Tribunals Service. It is a matter for each agency to deal with these individuals according to its own procedures.

2.2 Analysis of the case history reveals problems in three specific areas: **information management, case management (including practice issues), and bail management.** In each of these areas, compliance with existing policies and procedures was inadequate. The conclusion of this review, however, is that in relation to the two deaths, the identified failings of individuals should be regarded as incidental rather than causal. The essential weakness of the overall response to the case resulted from the fact that within each agency, individuals could only base their actions and

decisions on the incomplete picture that was available to them. *With the benefit of hindsight*, some of those decisions were questionable and some actions are the subject of management and/or disciplinary action. At the time, however, the case was simply one of a large number within a heavy overall caseload. None of the agencies and certainly no individual within any single agency knew that, despite the bail conditions imposed by the courts, LP and PW were in frequent contact right up to the time of LP's death.

2.3 The central feature which emerges from the analysis is the absence of a risk assessment which was as complete and all-encompassing as possible. Inadequate assessment of the vulnerability of LP and the risks posed to her by PW left all agencies in a poor position to prioritise her protection or the prosecution of PW. The Specialist Domestic Violence Court protocol sets out high and commendable standards for the ways in which DV cases should be managed and prosecuted but its provisions are highly resource intensive. Underpinning the Protocol, the CPS Policy for Prosecuting DV Cases and the MPS Domestic Violence Standard Operating Procedures provide detailed instructions for officers and staff engaged in DV cases but these too envisage the availability of considerable resources for DV work. In the current financial climate careful prioritisation is essential.

2.4 It is evident that poor risk assessment left the prosecution of PW and protection of LP as a low priority for all agencies. The prosecution was poorly pursued and the court processes poorly informed. Despite repeated referrals from the police Community Support Unit, the IDVA was unable to engage LP. Enhanced processes have since been introduced by the IDVA service with the intention of improving the levels of client engagement. It must be acknowledged, however, that adults have the right to make their own free choices, even if individual professionals or agencies do not believe their choices to be in their own best interests. Client consent cannot be overridden and nor can clients be forced to engage. The ineffective efforts of the Witness Care Unit and the inability of the courts to provide capacity within the enhanced facilities of the Specialist Domestic Violence Court meant that there were even fewer opportunities for support services to renew their efforts to assist her.

2.5 Had PW been remanded in custody pending his trial at Crown Court he would obviously have been incapable of killing LP and himself. This could have been achieved if an all-encompassing risk assessment had been possible, leading to the prosecution being more thoroughly and robustly presented to the courts. However, systems and practices enabling more complete information being better presented to courts would almost inevitably result in the more widespread withholding of bail and

thus greater restrictions on the freedom of individuals. In any particular case that ends in tragedy, it is easy with the benefit of hindsight to say that a remand in custody would have been the correct and obvious course. General application of such a precautionary approach, however, would change the balance between security and liberty. The maintenance of this fundamental balance must be left to the independent judiciary. It is for other elements of the criminal justice system and Community Safety Partnership to ensure judges are in the best position to make these difficult decisions.

3. Conclusions & Recommendations

3.1 As a result of the review process, constituent agencies and organisations identified several immediate opportunities for the improvement of performance against domestic violence (DV) and have already implemented new measures to ensure greater compliance with the existing policies, processes and procedures. The most significant progress in this context is the joint DV improvement plan to reduce attrition rates developed by East London district of CPS jointly with police and courts. The plan has now been adopted for pan-London implementation.

3.2 ***The principal recommendation of this review is aimed at maximising information sharing between the agencies by establishing a DV-focussed Multi Agency Safeguarding Hub (MASH) in Tower Hamlets***. MASH bring together, in one secure room, statutory and non-statutory safeguarding professionals to share and collate information with a view to identifying where vulnerable people may be at risk. MASH can thus deliver an information product on an individual or family based on the entire safeguarding partnership's collective knowledge. Thus risks may be identified earlier even where no single agency has enough information to reach its own threshold for referral into MARAC. The single most important (but resource intensive) process required is that when any agency becomes aware of even a moderate level of risk to others as a result of its contact with a person, research is conducted within the secure environment of the MASH to determine what information other agencies may have relating to that person or to others with whom s/he has contact. A key feature of the MASH is that whilst all information on a vulnerable person may be shared and assessed within the room, nothing is passed outside the room without the consent of the agency "owning" the information. This gives all partners more confidence to share even the most sensitive material. Even where the agency supplying sensitive information is unable to allow its release outside the secure environment, the fact that the existence of the information has been "signposted" can enable others to gather it through normal

routes, safe in the knowledge that an effective risk assessment has already been completed.

3.3 The IDVA service will carry out a post-implementation review of it's enhanced client engagement processes. The review should examine issues relating to client consent and client engagement. The review should consider the extent to which the service is achieving the CAADA standard of engagement with clients: 70-75% of referrals. The review should also consider the need for specific protocols for encouraging client engagement – **Recommendation 2.**

3.4 The implementation of the MASH should be accompanied by awareness training for all relevant staff in all partner agencies to emphasise the need to greater efforts in information gathering and sharing in relation to DV matters. This awareness training should also be offered to those agencies (notably the CPS, HMC&TS and Judiciary) which are necessarily independent from the CSP to ensure they are aware of the enhanced capabilities and responsibilities within the borough – **Recommendation 3.**

3.5 This review has identified that there is currently no means for the criminal justice agencies to access an individual's history of compliance with conditions of bail imposed on him/her. This case illustrates the fact that despite the inquisitorial role played by judicial decision makers when considering bail, they may be required to make decisions in ignorance of such information. It is therefore recommended that a feasibility study be commissioned into the incorporation of bail compliance histories into the Police National Database – **Recommendation 4.**

3.6 Enforcement of bail conditions imposed by the courts is the responsibility of police officers. Adequate, up to date, information on bail conditions is not currently accessible for front line officers. It is therefore recommended that the MPS pursues this aspect in its current update of the Emerald Wanted Management System, which forms part of the overall MPS IS/IT programme – **Recommendation 5**.

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Independent Chair & Report Author