Safer Peterborough Partnership

A Domestic Homicide Review into the death of VB

Executive Summary

December 2013

1.0 Introduction

1.1 This Domestic Homicide Review (DHR) examines the circumstances surrounding the tragic death of a young woman, aged 29 years. She was a Lithuanian national living in Peterborough with her son, aged 10 years at the time of her death. For the purposes of this report she will be referred to simply as the Subject.

1.2 The circumstances surrounding the Subject's death are that on 12th August 2011 she failed to return home from work. Her son raised the alarm and she was subsequently reported missing to the police. There had been two previous incidents of domestic abuse reported by the victim to the police following her arrival in the UK in May 2010. On both occasions she identified her ex-husband as the offender.

1.3 The police launched a missing from home enquiry, subsequently changing its status to a murder enquiry when the full extent of the information available at the time became clear. The subject's ex-husband was located in Lithuania and subsequently extradited and charged with her kidnapping and murder, initially without the body having been found.

1.4 Unbeknown to UK authorities her body had actually been discovered in Poland in late October 2011, this information being made available in February 2012. The subject's ex-husband was convicted of kidnap and murder and sentenced to life imprisonment in November 2012.

1.5 Following a period in the care of the local authority, the subject's son went to live with his extended family.

2.0 The process

2.1 Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004), which came into force in April 2011. They are reviews of the circumstances when persons over the age of 16 years die as a result of domestic violence by either a person to whom they are related or a member of the same household.

2.2 The purpose of a DHR is to establish what lessons are to be learned regarding the way in which professionals and organisations work individually and collectively to safeguard victims, to apply those lessons to service responses and to prevent future domestic violence

homicides and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

2.3 On 26th October 2011 Cambridgeshire Constabulary notified the Chair of the Community Safety Partnership (known as the Safer Peterborough Partnership (SPP)) that the enquiry into the disappearance of the deceased was being treated as a murder investigation. After further consultation and consideration, the Chair determined that a Domestic Homicide Review was appropriate. The Home Office were notified on 22nd November 2011.

2.4 An initial framing meeting was held on 6th December 2011 under an appointed independent Chair to determine the detail of the review, the breadth of enquiry and from whom agency reports would be required. That meeting also noted that at that time the police investigation was still considered a 'live investigation' (the discovery of the deceased's body at that time not being known to UK investigating authorities), as such that the six month time guidance for completion of reviews was unlikely to be appropriate for this case.

2.5 It was also agreed that the involvement of the deceased's family would be postponed until after the investigation and any subsequent criminal proceedings were finalised because they were potential witnesses in that process.

2.6 The following organisations commissioned an independent author of sufficient experience and seniority to undertake an Individual Management Review (IMR):

Cambridgeshire Constabulary

Peterborough City Council; Domestic Violence Service

Peterborough City Council; Children's Social Care

Peterborough City Council; Education Services

The authors of the IMRs were asked to undertake a comprehensive review of their organisations' involvement and to specifically address:

1. Were there any signs of domestic abuse not picked up by agencies involved with the family?
2. The impact the victim's immigration status may have had on access to services
3. Any cultural issues from the perspective of professionals and family members

Three other organisations, the UK Border Agency, the Crown Prosecution Service and the GP practice were not sufficiently involved to require an IMR but were requested to submit written accounts of their involvement with the Subject.

2.7 The process was overseen by a panel of senior officers comprising those organisations who were involved in delivering services to the Subject and her son. The overview report was compiled by an officer from Peterborough City Council with wide experience of community safety matters and who had no line management responsibility for any of the staff who worked with the Subject.

3.0 Summary of Events

3.1 The Subject and her ex-husband are both Lithuanian nationals. At the time of the Subject's disappearance they had been in a relationship for approximately 12 years; 3 years of which had been as a married couple. They had met in Lithuania when the Subject was 17 years old and had a child together some 18 months later. They were divorced (in Lithuania) in September 2010, although both were resident in the UK at that time.

3.2 The Subject came to live in Peterborough in May 2010, returning home briefly for two weeks in July and returning in the company of her ex-husband and their son, who had been living with his maternal grandmother in Lithuania.

3.3 There is no record of any agency involvement with them in the UK until 25th July 2010.
In the early hours of 25th July, the Subject attended a police station in Peterborough to report being violently assaulted by her ex-husband. The reported assault was of some significant level of severity, including attempted strangulation, kicks and threats to kill her. The police recorded the complaint as a domestic violence related assault and made prompt attempts to arrest the ex-husband, but he had left the country as soon as the incident had occurred. He was circulated on the Police National Computer as a wanted person.

3.4 The incident was referred to the City Council's Independent Domestic Violence Advocate (IDVA) service which made contact with the victim and began a range of supportive calls and actions. The case was risk assessed at the highest level and was taken through the Multi Agency Risk Assessment Conference (MARAC). The case was closed in early September when the risk was seen to have minimised by the ex-husband having left the UK.

3.5 The police did not refer the matter on to the City Council's Children's Services Department despite the couple's child being present at the incident. This has been established as human error.

3.6 The ex-husband returned to the UK on 3rd September 2010 and was arrested by Essex Police after his car details had triggered a wanted notice on police camera systems. He was returned to Peterborough for interview and denied all the allegations of assault made by the Subject. The evidence was placed before the Crown Prosecution Service who determined that there was insufficient evidence upon which to base a charge. He was thus released from custody and it appears went back to living with the Subject.

3.7 During the evening of 9th February 2011, the victim made an emergency call to the police reporting that she had been further assaulted by her ex-husband who she said had punched her, threatened to kill her, put his hands around her throat and detained her against her will. After escaping she made her way to her cousin's home, where her child was but was confronted again by her ex-husband who had tracked her down. There ensued a further incident, some of which happened in the street and was witnessed by the child and others. The victim reported that she escaped again only after her screams brought other people's attention to the incident. The police attended the emergency call and arrested the ex-husband.

3.8 The view of the Crown Prosecution Service was sought as to whether sufficient evidence existed upon which to charge the ex-husband. It was their view that further information was needed before an informed decision could be made. As a result, the ex-husband was bailed with conditions not to contact the victim. He was bailed to return on 16/02/11 but never attended, having already left the country.

3.9 The police risk assessed the status of the Subject as the highest they could. They made a referral to Children's Social Care and to the IDVA service. The referrals outlined the fact that this incident followed a previous one.

3.10 On 11th February the Subject attended her son's primary school informing them that she had been attacked and that her ex-husband was dangerous and should not be allowed to collect their son from the school. The office manager at the school explained that such a request was one which they were unable to enforce. The school did not share this interaction with any other agency or seek further advice about this potentially risky situation.

3.11 A different IDVA was allocated the case and made four unsuccessful attempts to contact the victim. The IDVA service did not immediately link the two incidents together as there had been a different spelling of the names involved.

3.12 Children's Social Care allocated a social worker who, after several unsuccessful attempts, completed an initial assessment on 23rd March 2011. During the assessment the son made comments about the threat made by his father to kill his mother; although recorded, these were not passed on to any other agency.

3.13 On July 23rd 2011 the Subject informed the police that she had seen her ex-husband near her new home address. He had changed his appearance. The officer taking the report checked his status, confirming that he was wanted, passed the details on to the Police Control Room for local observations and passed the details of the sighting to the case officer for information.

3.14 On 12th August 2011 the subject failed to return home from work and was subsequently reported missing to the police. Her body was found in Poland some months later.

4.0 Key issues arising from the Review

4.1 Although relatively new to the UK and speaking little English, the subject made appropriate contact with the police and IDVA service when she was first assaulted by her ex-husband. Those services responded promptly and provided her with timely and appropriate advice and support, including a referral to the MARAC.

4.2 Once it was known that the ex-husband had left the country, he was listed as wanted on the police national computer (PNC). This listing was not sufficient to enable him to be identified at the Border when he re entered the country because there is not an automatic link between the PNC and the Border Agency's database. This was not appreciated by the police. However, it did result in his arrest by a neighbouring police force via car number plate recognition. The fact that he changed his name and appearance when re entering the UK on this second occasion is therefore irrelevant.

4.3 The Crown Prosecution Service have reviewed their decision making concerning their advice not to prosecute and stand by their decision, which was based on a variety of reasons including a lack of witnesses and the passage of time between the incident and the ex-husband's arrest.

4.4 With regard to the second incident in February 2011, this was a serious assault which was said to have been witnessed by more than one person and resulted in physical injuries. Once again the police responded promptly by arresting the ex-husband. Whilst in custody, they sought advice from the CPS who listed a total of seven further actions to be taken before they could make a decision about charging. This advice resulted in the ex-husband being released on bail with conditions not to contact the Subject. The bail conditions did not include remaining in the country, even though he was known to have left the country on the last occasion and, in fact, did so again this time. The conclusion reached by the overview report writer, supported by the DHR panel, was that a more robust approach could have been taken by both the police with regarding to their investigation of the incident and the CPS.

4.5 Once it was established that the ex-husband was failing to answer his bail, he was again circulated as a wanted person on the police national computer, although as before, this would not have been sufficient to alert the UK Border Agency to enable him to be identified when he returned to the UK.

4.6 Following the second assault on the Subject, the case was referred back to the IDVA service; children's social care undertook an initial assessment and the mother alerted the school about the risk posed by her ex-husband.

4.7 The spelling of the Subject's names differed between and within agencies. This was particularly significant because during this period she changed both her address and her mobile number.

4.8 The case was allocated to an IDVA who shared the same language as the Subject and who was familiar with her cultural background. Despite several attempts, the IDVA failed to make contact with the Subject, closing the case after the fourth attempt. The case was not re referred to MARAC. Whilst, the reason why was not established, the lack of a clear referral pathway to the MARAC was a finding of this review.

4.9 The IDVA service was going through a period of significant organisational change. Staff were uncertain about their future and interim management arrangements were in place. There were no agreed procedures within service with regard to case allocation, record keeping or case closures. Supervision arrangements at that time were not sufficiently robust. Subsequently there has been a review of the service and significant changes have been

made which have led to significant improvements in levels of supervision and case management. A domestic abuse governance board has been established to monitor the delivery of actions plans and performance.

4.10 Both the school and social care failed to appreciate the level of risk posed by the ex-husband, despite it being made very clear to them by both the Subject and her son. Whilst the school should have responded more proactively to the mother's concerns, if the case had been re-referred to the MARAC, their awareness might have been heightened. Similarly, as part of an initial assessment, children's social care should have contacted the police, the school and the IDVA service in order to gain more information. In addition, they should have alerted the police and the IDVA service about the information they received about the father's clear threat to kill the mother. It took children's social care 6 weeks to complete the initial assessment which was significantly outside the timescales set by the statutory guidance and no action resulted from it, not least because by now the ex husband had left the country.

4.11 A serious case review which was undertaken by the Peterborough Safeguarding Children Board into the death of a child who died in February 2011 identified similar issues about the quality and timeliness of initial assessments undertaken by children's social care and also about the failure on occasion to appreciate the significance of domestic violence and to alert schools to incidents of domestic violence. The learning from this serious case review has already been implemented and, in addition, children's social care has gone through a significant improvement programme, which is reflected in their single agency action plan.

4.12 None of these three agencies, that is the IDVA service, the school or children's social care, made contact with each other. No agency made any enquiries with the Subject about whether or not she had experienced domestic violence in Lithuania. If they had, they would have discovered a history of similar assaults. No agency considered a contingency plan should the ex husband return, even though that was an established pattern.

4.13 As soon as the mother realised that her ex husband had returned to this country, she alerted the police. However they failed to appreciate the degree of risk that he posed to her. Although some action was taken to alert local officers, it was insufficient, especially as the ex-husband was reported to have changed his appearance and was therefore was unlikely to be recognised. Only more concerted efforts might have led to his arrest. The IDVA service was not alerted on this third occasion.

5.0 Conclusions and Lessons Learned

Many of the lessons learned and subsequent recommendations have already been implemented given the time that has elapsed since the victim's disappearance in August 2011.

It is the view of the panel that given the difficulties in establishing the ex-husband's whereabouts, the fact that he changed his name and physical appearance, together with his clear determination to carry out his attack, that it is unlikely that services could have prevented the subject's tragic death. However, it is acknowledged that different actions at different times could have afforded her greater protection. The lessons learned from the review are set out below:

- Systems and processes need to accommodate the movements of alleged perpetrators in and out of Peterborough, with contingency plans identified for their return.
- Police officers need to understand fully the relationship between the police national computer and the Border Agency, including how to alert the UK Border Agency.
- Organisational change presents a risk to service delivery. Managers must ensure that front line staff are adequately supported and supervised during periods of organisational uncertainty.
- Multi agency processes must be underpinned by robust procedures that are understood and implemented by each agency e.g. referrals to MARAC
- The accurate spelling of names and other data entry is a vital part of record keeping
- Threats to kill must always be taken very seriously and referred to the police
- If an organisation receives information suggesting a child could be at risk then immediate advice must be sought even if their procedures appear to mitigate against taking action.
- Domestic abuse risk assessments must be holistic and require contact with other agencies in order to be fully informed
- A child's 'lived experience' of domestic violence must be considered as part of a risk assessment.

- Risk assessments must include information about past events, including incidents which took place in a different country
- The investigation of domestic abuse remains complex and sensitive, requiring a robust police response. The Panel welcome the move to a specialist Domestic Abuse Investigation Unit within Cambridgeshire to professionalise the response to such investigations.

6.0 Recommendations ongoing actions

1. **A single referral pathway to MARAC must be agreed, implemented and monitored as soon as possible**
2. **Procedures, practice standards and supervision requirements for IDVAs must be established, implemented and SPP board satisfied with its sustainability**
3. **Risk assessments across all agencies must include contingency plans if a risk is reduced by a perpetrator leaving the area.**
4. **The police must ensure that officers are familiar with the lack of links between the PNC and the UK Border Agency**
5. **The view of this panel should be brought to the attention of the CPS, in particular in relation to the second incident.**
6. **All agencies involved in the prevention or investigation of domestic abuse must ensure that practitioners have an opportunity to learn the lessons from this review and especially that:**
    - **Threats to kill must be treated seriously and shared with the police**
    - **Information is sought about previous incidents of domestic violence.**
    - **A child's 'lived experience' is taken into account in risk assessments**
    - **Assessments must be holistic, which necessitates contacting and sharing information with other agencies**
    - **If a member of staff is given information that a child might be at risk, they must refer to their child protection procedures and take some sort of preventive action**
    - **The accurate recording of basic information is a vital part of safeguarding work.**

Felicity Schofield, Panel Chair

Gary Goose, Overview Report Writer July 2013