A Domestic Homicide Review into the death of VB

Overview Author's Report

A report for

The Safer Peterborough Partnership

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December 2013

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1.0 INTRODUCTION

1.1 Case Summary

This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of VB.

VB was a Lithuanian national, aged 29 years, living in Peterborough with her son aged 10 years. She disappeared from her home on or around 12th August 2011. Following her disappearance, her son was accommodated by the local authority.

Cambridgeshire Constabulary initially commenced a missing from home enquiry; the status of which quickly changed to a murder investigation. Subsequently her ex-husband, RB, also a Lithuanian national, was arrested and charged with her kidnapping and murder; her body having been found in Poland in October 2011 but not identified until February 2012.

There had been two previous incidents of domestic abuse reported by the victim to the police in Peterborough post her arrival in the UK in May 2010. On both occasions she identified her ex-husband as the offender.

The trial of RB was held at the Central Criminal Court in London during October and November 2012. He was found guilty of her kidnapping and murder and sentenced to life imprisonment.

The delay in finalising this review is as a result of an active police investigation which continued up to the trial. However, in order to ensure that any urgent learning was identified and to protect other potential victims/service users within the City, an interim overview report was completed and discussed at panel on 25th September 2012. At that time, as a result of the information gained through the process of Internal Management Review (IMR), the overview author suggested one overriding recommendation:

That all agencies should engage without delay in a root and branch review of domestic abuse service provision within Peterborough. This should include clarity around governance, policy, process, supervision, case management and how agencies work together for the benefit of victims within the City.

Whilst this recommendation arose as a result of the DHR process in September 2012; work to review Domestic Abuse provision and services in the City had actually begun in the early part of 2012; this DHR added significant impetus to that process.

The result of the City-wide review was a new governance structure for Domestic Abuse and Sexual Assault under the Chair of an Executive Director of the Council and with senior (director level) buy-in and representation across partner agencies on behalf of the Community Safety Partnership. The review is underpinned by a needs assessment and a detailed development and implementation plan which is appended to this report. It is this multi-agency strategic group which will direct cross-cutting service improvement across the City and oversee the implementation of the multi-agency action plan specifically arising from this review.

As with all in-depth scrutiny of services some agencies have highlighted issues that are important but adjacent to the purpose of this formal DHR. Whilst important for individual service improvement, this report will refrain from addressing those issues, the process of senior management 'sign-off' required by the Statutory Guidance should ensure such issues are recognised and addressed by each agency.

1.2 Reasons for Conducting the Review

Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. They were established under Section 9 of the Domestic Violence, Crime and Adults Act (2004).

The act states that a DHR should be a review '*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by* –

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

In this case the deceased was married to the person subsequently convicted of her murder; there was evidence of previous violence from the perpetrator towards the victim. The criterion for such a review is thus met.

The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.3 Process of the review

On 26th October 2011 Cambridgeshire Constabulary notified the Chair of the statutory 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 of the Safer

Peterborough Partnership determined that in her view a Domestic Homicide Review was appropriate in circumstances.

The Home Office were notified of the decision in a letter from the Chair of SPP on 22nd November 2011.

An initial framing meeting was held on 6th December 2011 under an appointed Independent Chair in order to determine the detail of the review, the breadth of enquiry and from whom IMRs 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 it was the view that the six month time guidance for completion of reviews was unlikely to be appropriate for this case.

The panel decided that IMRs would be commenced to identify lessons learnt but finalisation of the process would be delayed pending the outcome of the police murder investigation and any subsequent judicial proceedings. It was also agreed that the involvement of the deceased's family would be left until after the investigation and any subsequent proceedings had concluded as they were potential witnesses in those pending criminal proceedings.

The Framing Meeting determined that the following agencies/bodies secured their records, identified and 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 Services
The United Kingdom Border Agency (UKBA)
NHS; General Practitioner
The Crown Prosecution Service (CPS)

The following organisations would be asked to check their records to identify whether they had any prior knowledge of the deceased or her family (if they did, a decision would be made subsequently as to whether an IMR was required or not):

NHS Cambridgeshire and Peterborough to cover the Peterborough and Stamford Hospitals Trust
Cambridgeshire and Peterborough Foundation Trust (Mental Health Services and Children's Division)
Peterborough City Council Housing Services

A specific Domestic Homicide Review Panel met on 25th May 2012 comprising:

NAME	**POST**
Felicity Schofield	Independent Chair
Robin Humphries	UKBA
Paul Phillipson	Executive Director, Peterborough City Council
Sue Mitchell	Assistant Director, Peterborough Primary Care Trust
Simon Megicks	Head of Public Protection, Cambridgeshire Constabulary
Marie Southgate	Legal Services, Peterborough City Council (Advisor to the panel)
Gary Goose	Safer Peterborough Partnership, Overview Report Author

Information available at that time led the panel to agree that an IMR was not required of the Cambridgeshire and Peterborough Foundation Trust (provider of mental health services). In addition, written reports covering Health Service involvement of the Family GP and the UKBA would suffice. A request was made to the Crown Prosecution Service for them to assist the review as it appeared from the relevant guidance that the Crown

Prosecution Service cannot be compelled to assist; in the event the CPS have fully engaged in this review.

1.4 Terms of Reference

In addition to the purpose of the Domestic Homicide Review as stated in 1.2 above, the terms of reference for this review determined that the following areas would be addressed in the Individual Management Reviews and the Overview Report:

Requirements of IMR authors

- All agencies are required to provide a detailed chronology from the date of entry into the country.
- All agencies to provide a comprehensive and well structured management review detailing their full involvement with the mother and/or child. Practice at individual and organisational levels should be critically analysed including comments on what might have been different if alternative practices were followed.
- The following areas should be specifically addressed:

    1. Were there any signs of domestic abuse not picked up by agencies involved with the family?
    2. The stresses on new arrivals such as employment, housing, finance and how these may have impacted on the family
    3. The impact the victim's immigration status may have had on access to services
    4. Any cultural issues from the perspective of professionals and family members

- Are there any lessons from this case about the way in which organisations work together to support victims of domestic abuse? Is there any good practice to highlight?

- Recommendations for changes in practice should be clearly identified, measurable and specific.

- An action plan should form part of the report. What outcomes should these actions achieve?

Terms of Reference for the Overview author

1. Provide a genogram.
2. Summarise the relevant information provided by each agency in their IMR
3. Provide a critical analysis of the facts and a strong evaluation leading to conclusions for how and why events occurred and actions or decisions by agencies were or were not taken.
4. Personal details must be anonymised.
5. Develop specific lessons to be learnt supported by achievable recommendations for improving practice.
6. The action plan must be agreed at senior level by each of the participating organisations.

1.5 Subjects of the review

Deceased:	**VB** – D.o.B 15/09/1981 – D.O.D on or around 12/08/2011
Child:	**AB** – D.o.B. 27/09/2000
Ex-husband of deceased:	**RB** – D.o.B 26/03/1965

All of the subjects of the review are Lithuanian nationals, having moved to the UK during 2010.

1.6 Involvement of the family

In domestic violence homicides, members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel considered carefully the potential benefits gained by including individuals from both the victim's and perpetrator's networks in the review process. However, given the ongoing nature of the police investigation and imminent judicial proceedings it was felt that involvement of any family members would be reviewed after the conclusion of those proceedings.

Post proceedings, some family members returned to Lithuania and expressed a wish to hold no further meetings or interviews with organisations in the UK. However, they did wish to ask one question of the review, namely:

- When RB changed his name, his identification and passport numbers remained the same under Lithuanian Law. How was/is it possible for him to evade the authorities when producing identification under his 'new' name?

The victim's brother remained in the UK but moved to another part of the country. The victim's son now lives with him. Earlier this year contact was made with the family both through the police family liaison officer and the son's social worker. The response was that the boy remains very traumatised by the loss of his mother and it would be inappropriate to speak with him. The victim's brother was offered an opportunity to speak to a panel member, which he declined, saying that he simply wished to be kept informed about the progress of the review.

This review report is an anthology of information and facts from seven agencies, all of which were potential support agencies for the deceased or had material involvement in the circumstances that arose prior to her death.

Section 2 : Domestic Homicide Review overview report.

2.1 Family History

The victim (VB) and her ex-husband (RB) are both Lithuanian Nationals. At the time of her 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 VB was 17 and had a child together some 18 months later. Their son, AB (now aged 12) was, at the time of the disappearance of the victim, living with her. The victim and her husband were legally divorced (in Lithuania) in September 2010 although both were resident in the UK at that time.

VB originally came to live in Peterborough in May 2010 in order to work although she had briefly been living temporarily in the UK for about 2 months in mid-2009 staying with members of her family, in particular her brother. Her brother had migrated to the UK in 2006.

She returned home briefly to Lithuania for a family wedding on July 11th 2010 returning to the UK on July 23rd. On this occasion she was accompanied by RB and their son AB; the child had been living with his maternal grandmother in Lithuania. Given the proximity of the divorce it is clear that divorce proceedings were in train during this period and although the couple divorced, they continued to live together.

2.2 Overview summary of the case

There is no record of any agency involvement with the family until the early hours of 25th July 2010 when VB attended a police station in Peterborough to report being violently assaulted by RB the previous evening. 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 but unsuccessful attempts to arrest RB. It appears that RB had made his way out of the

country as soon as the incident had occurred late the previous evening. He was circulated on the Police National Computer as a wanted person.

The incident was referred on to the City Council's Independent Domestic Violence Advocate (IDVA) service who 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 early September after contact between the Service and VB; when the risk was seen to minimise by RB having left the UK.

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 was an oversight.

RB 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 victim. 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 victim.

The IDVA allocated to the case reopened her dialogue and support during this period and subsequently wrote to the Lithuanian Courts in relation to the divorce proceedings.

In September 2010 arrangements began between the City's Education Department and the victim to arrange a school place for the then 10 year old AB.

In October 2010 the victim visited her GP for the first and only time at the Alma Road Doctors Surgery in Peterborough. She complained of a work related wrist injury, nothing further was disclosed and this appears to have been a largely routine and unremarkable interaction with the GP.

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 husband who she said had punched her, threatened to kill her, put his hands around her throat and detained her against her will at their home before she had managed to escape by distracting him. After escaping she made her way to her cousin's home, where her child was but was confronted again by her husband who had tracked her down. There ensued a further incident, some of which happened in the street and some of which 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, took the report and arrested RB.

In interview he again denied any responsibility and in fact suggested that VB had attacked him, reinforcing this by showing the police a mark on his leg. Whilst RB was in custody, a statement was taken from VB with the aid of an interpreter. Subsequently the view of the Crown Prosecution Service was sought as to whether sufficient evidence existed upon which to charge RB. It was the view of the CPS that because of a lack (at that time) of independent witness evidence, the counter allegation and other considerations, further information was needed before an informed decision could be made as to what, if any, charges should be brought. As a result RB was bailed from the police station with conditions not to contact the victim. He was bailed to return on 16/02/11.

The police risk assessed the status of VB, recording her risk level as the highest they could. They made a referral to Children's Social Care outlining that the child had witnessed the incident and to the IDVA service. The referrals outlined the fact that this incident followed a previous one.

On 11th February VB attended the Primary School (that AB was attending) informing them that she had been attacked by RB, that he was dangerous and should not be allowed to collect AB 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.

Further attempts were made in the days between release on bail and his due return date to gather additional evidence. A statement was taken from the cousin, but house to house enquiries revealed no further evidence and attempts to locate another family member who had witnessed the incident proved unsuccessful (this person has never been located even given the later resources available to the murder investigation). No statement was taken from the child.

The matter was further reviewed by the CPS the day prior to RB's due bail return date. It was the view of the CPS that the evidence available would support a charge of common assault against the victim. In the event, RB did not return to the police station and could not be found; it is believed he had once again left the country.

A different IDVA was allocated the case and who, between 14th and 23rd February, made four attempts to contact the victim. She never did speak with VB but on the fourth occasion did speak to AB and asked him to leave a message for her. There were no more attempts to contact the victim. The IDVA service did not immediately link the two incidents together as there had been a slightly different spelling of the names involved and it was only by overheard conversations that the two incidents were eventually linked.

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

There was no further interaction between any of the agencies on this case, each doing their 'own thing'. No agency ensured that this case went to MARAC.

Following the incident in February, VB moved address, again within Peterborough and within the same small geographical area of the City.

On July 23rd 2011 VB attended a local police station to report that she had seen RB near her new home address. He had changed his appearance, and by now we know his

name too, to now include a beard. The officer taking the report checked the status of RB 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. No officer was dispatched specifically to the scene. There was no other action taken.

On 12th August 2011 VB failed to return home from work. Her son raised the alarm with her current partner who subsequently reported her missing to the police. The police launched a missing from home enquiry, swiftly changing its status to a murder enquiry when the full extent of the information available at the time became clear. RB was located in Lithuania and subsequently extradited and charged with her kidnapping and murder, initially without the body having been found. Unbeknown to UK authorities her body had actually been discovered in Poland in late October 2011, this information being made available in February 2012. After various legal arguments relating to jurisdiction the trial took place in November 2012. RB pleaded not guilty and contested the evidence fully. He was however convicted of kidnap and murder and sentenced to life imprisonment.

2.3 The National Context of Domestic Abuse

In *Call to End Violence Against Women and Girls*[1] the difficulty in being able to fully identify the prevalence of violence against women and girls is expressed: it is often a hidden crime. Research however reveals[2]:

- *At least 1 in 4 women in the UK will experience domestic abuse in their lifetime (British Crime Survey 2009/10)*
- *Almost 1 in 5 women will experience sexual assault in their lifetime (British Crime Survey 2009/10)*
- *Almost 1 in 20 women was stalked last year and 1 in 5 women will experience stalking in their lifetime (British Crime Survey 2009/10)*

[1] Call to End Violence Against Women and Girls November 2010. HM Government

[2] Call to End Violence Against Women and Girls November 2010. HM Government

- *The minimum cost of violence against women and girls in the UK is £37.6bn.*

There is also a significant impact on children:

- *At least 750,000 children a year witness domestic violence (Department of Health, 2002).*
- *Children who live with domestic violence are at increased risk of behavioural problems and emotional trauma, and mental health difficulties in adult life (Stanley 2011)* [3]
- *52% of child protection cases involve domestic violence (Farmer & Owen, 1995)*
- *40% to 70% of men who assault their wives or partners are also directly physically or sexually violent to their children, or abuse or threaten the children to increase their control over their mother (Hester and Pearson, 1998, Humphreys, C. and Mullender, A, 2000)* [4]

2.4 The Local Context of Domestic Abuse

Local information on levels of domestic abuse is available from a number of different sources. Currently, the Police record both the robust data on domestic abuse and the highest numbers; however, given that up to a quarter of domestic abuse is not reported to the Police[5], this data only provides a partial picture.

There is work to do to develop the data held by other agencies such as the Independent Domestic Abuse Service, Women's Aid, Children's Services and the Sexual Assault Referral Centre, to ensure that this data is interpreted in a meaningful way.

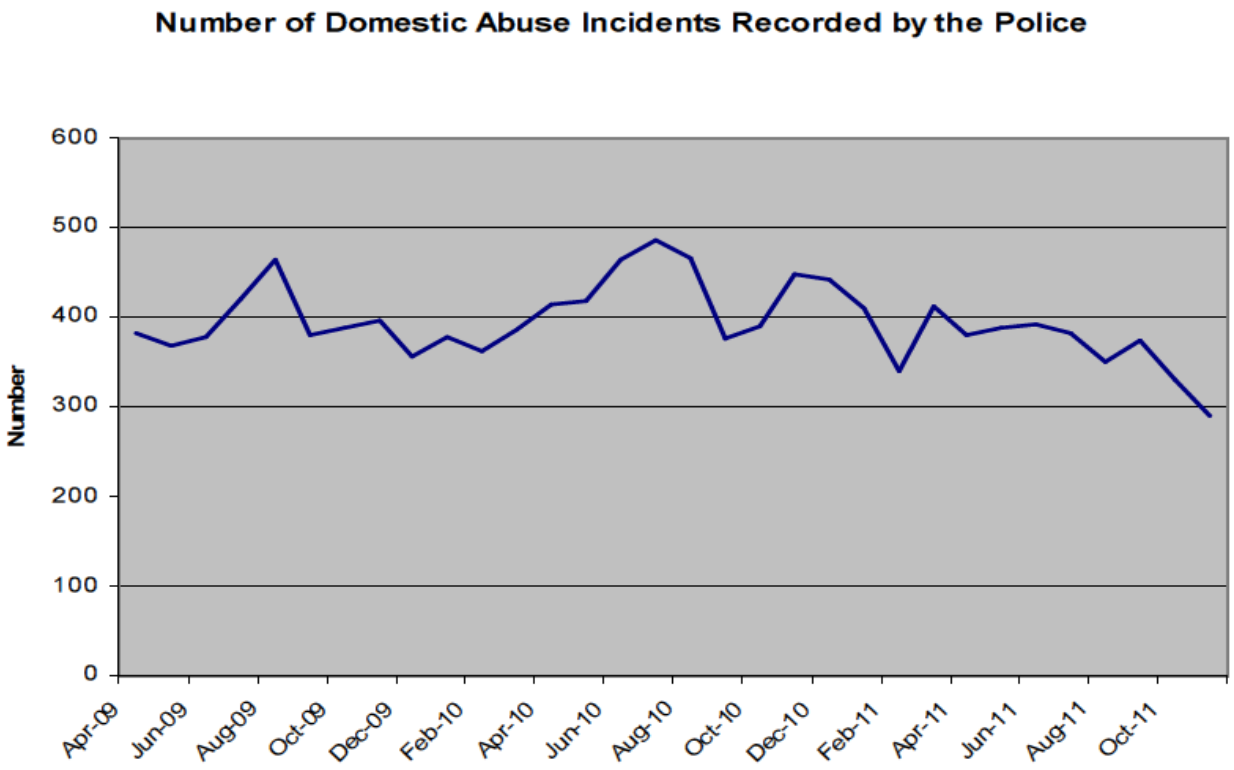
[3] Children experiencing domestic violence: A research review. Research in practice 2011

[4] Hester, M., Pearson, C. and Harwin, N. (2000) Making an impact: A reader, London, Jessica Kingsley. Humphreys, C. and Mullender, A. (2000) Children and domestic violence, Research in Practice Series, Dartington, Devon

[5] Domestic Violence National Delivery Plan

2.4.1 Police Data

When recorded by the Police, domestic incidents and offences are given a domestic marker, which varies dependent on the relationship between the victim and the offender[6]. The graph below shows the trend in domestic incidents and offences reported to the Police between April 2009 and November 2011, which have remained broadly static over the last three years:



For the period May 2011 to April 2012, police data indicates:

	2010-2011	**2011-2012**
Number of Domestic Abuse Incidents	*5073*	*4248*
Number of Domestic Violence Crimes	*1207*	*972*
Number of DV repeat victims	*338*	*263*

[6] That is to say: partner on partner; non partner; ex partner

Number of DV crimes charged	*385*	*305*

For the period May 2011 to April 2012, police data indicates:

- There were 909 victims of a domestic abuse crime in Peterborough,
- Of these 909, there were 820 individual victims[7]
- And 70 victims were a victim more than once

Information on levels of domestic abuse is also recorded by the Independent Domestic Violence Advocacy (IDVA)[8] Service and Women's Aid who receive referrals from a number of different sources. Incident levels from the IDVAs and Women's Aid have increased over the last three years, however since there have been major developments to encourage victims of domestic abuse to seek help and to develop the quality of the services that they may receive, this is not surprising. Referrals from Children's Social Care and Children's Centres have also contributed to the increase in referrals this year.

2.4.2 Migration in Peterborough and Lithuanian attitudes to Domestic Abuse.

Peterborough has long been a centre for significant levels of migration. In recent years a level of migration from Eastern Europe much higher than the national average has continued.

The majority of migrants arrived between 2004-2009 (16,948 people or 9.3% of the current population).

- Peterborough has more migrants than both regional and national comparators a total of –

14,134 from Eastern and central Europe

[7] This is unique victims in terms of they haven't reported twice within the time frame, they may have reported before May 2011

[8] IDVAs work with the most high risk domestic abuse cases

Whilst it remains difficult to identify the specific country of migration, a significant proportion of these numbers are from Lithuania.

This has provided a challenge for authorities. In respect of attitudes towards Domestic Abuse it is relevant to note that only recently has Lithuania developed Domestic Abuse specific legislation.

2.4.3 Victim Profile

The profile of victims of domestic abuse in Peterborough has largely remained unchanged over the last twelve months: victims are generally female, White British and under the age of 50, however there is a peak in the 20-26 age group. White Other victims continue to be over-represented when compared to the population estimates, with victims from Lithuania, Poland, Portugal and Latvia most frequently recorded

Women's Aid and the IDVAs have found increasing numbers of Eastern European women accessing services, with many finding that they have no recourse to public funds.

2.4.4 Offender Profile

The information held on offenders is limited to those offenders who have been charged with an offence. The domestic offences which have resulted in a charge have shown an increasing trend over the last three years, the proportion of offences which resulted in a charge is on average over 30%.

The local offender profile has shown little change over the last year (2010/11). The average offender is generally male (87% of the offending population) and White British. There is no particular peak age group, with most offenders falling in the 20-40 age group. White Other offenders are generally over-represented compared to population estimates (15% of offender population), with the majority of offenders coming from Lithuania, Poland, Portugal and Latvia. Conversely, Asian Pakistani offenders are under-represented compared to the population profile (4% of offender population). White Other offenders are almost all under 50, however this could be a reflection of the population who have come to live in the City.

It is in this context that the incidents described above occurred.

2.5. Analysis of Individual Management Reports (IMRs)

This author has not sought to replicate the entirety of the IMRs within the body of this report. Rather, he has endeavoured to highlight the critical issues that require individual scrutiny and identify practice that is either sound or requires attention across the system as a whole. The authors of all the reports were suitably qualified and independent of the line management arrangements for the case.

2.5.1 Cambridgeshire Constabulary

During the time period covered by this review, Peterborough was a distinct policing Basic Command Unit (BCU). Of particular relevance for this case is that at the time the BCU was responsible for all local crime investigation with the exception of serious and organised crime, homicide investigation and some other complex or sensitive investigations. Domestic Abuse policy was within the remit of the Public Protection Department that sat within the Crime Directorate.

The police first became aware of VB and RB on 25th July 2010 when VB attended a local police station, with a close friend, in the early hours of the morning to report being assaulted by RB late the previous evening.

She reported that she was attacked by the suspect who had been drinking heavily and had taken her mobile 'phone and looked through her contacts, taunting her that she had a lover and then demanding to know who it was. She alleged that this was a prolonged attack as she felt herself going into and out of consciousness on a number of occasions as she struggled to reason with him as he put pressure on her neck and throat by manual strangulation. During the attack she made an effort to escape, but he pulled her back by her hair, kicking her and then continuing as before by manual strangulation. She further alleged that he had threatened to 'bury her in the back garden' before escaping by distracting him.

Once free she contacted a close friend and went back to her home before reporting the incident at the police station. Whether or not her son witnessed the attack remains

unclear; the IMR author reports that in the victim's subsequent statement she says her son was present at the time but this appears to be contradicted later in that same statement.

The officer taking the report at the police station rightly identified and recorded this as a domestic assault. That officer took photographs of the injuries and gathered sufficient information to determine that RB should be arrested for the assault. The officer made a decision that in order to take a full statement of the events from VB an interpreter would be required and given the hour (it was reported at about 1am) that would be best achieved the following morning. However, it is now known that the friend accompanying VB spoke good English and therefore an interpreter was not actually required. This would be in accordance with accepted practice and procedure.

The IMR author points out that this is not likely to have added significant evidential value in this case. The officer acted immediately upon the information he received from VB without waiting for the formal written statement before establishing efforts to arrest RB. However, these were unsuccessful and it seems probable that RB had left the City heading out of the country probably before the matter was even reported to the police.

Information within the crime report suggests that he had spoken on the telephone with the victim the following morning saying he was in Poland, he had also made contact with his ex-partner telling her he would return in about a month and this had also been passed onto RB. It does appear for certain that he was in Lithuania two days later as he called the victim from a Lithuanian landline.

The police risk-assessed VB at the highest level, and thus an electronic referral was made through to the Independent Domestic Violence Advocates (IDVAs) who worked within the Peterborough City Council Community Safety Team at that time.

As a result of the high risk score the matter proceeded to the Multi Agency Risk Assessment Conference (MARAC). A MARAC co-ordinator formed part of the IDVA team and was responsible for arranging these meetings and those cases to appear.

In addition, a Victim Care Contract (VCC) was put in place by the police and the IMR author notes some specific difficulties in this case in relation to the police maintaining contact through Language Line and some confusion with officers over the policy. He does however note that this seems case specific and not something that is reflected in other similar cases. To reinforce that view it seems that the IDVAs did engage successfully with the victim on this case.

However the police failed to notify Peterborough Children's Social Care (PCSC) about this case. It appears that this was an administrative oversight; whilst the original record for the case showed a '9 year old child in the household safe and well', the referral record made by the Force's Central Referral Unit (who deal with all referrals of Child and Domestic Abuse) recorded 'no children'. The lack of support for AB at this time is disappointing especially as it appears to have become known to the IDVAs that RB was possibly using AB as indirect pressure upon VB by calling him and encouraging a return to Lithuania.

A number of contacts were made throughout July and August by both the IDVAs and the police to support VB; including the fitting of a panic alarm. There appears to be a common understanding that RB had declared his intention to return to the UK possibly in September and an appropriate level of support seems to have been put in place.

Given that all attempts to arrest RB had failed the police 'circulated him as wanted'. The police believed that should he be checked at any point by any agency with access to the Police National Computer he could, and should, be arrested. They were under the impression that this included checks at the UK border. This was an error and he should have been circulated via the all ports system in accordance with national protocols.

On the 3rd September RB returned to the UK. He was not detained at a port (the following section detailing the UKBA response will explain why), however he activated an electronic mechanism in a police patrol vehicle whilst travelling through Essex and was duly arrested upon suspicion of assault and transferred back to Peterborough for interview. Upon interview he denied any involvement in any assault upon VB.

The police officers made contact with the Crown Prosecution Service who decided that there were insufficient to prosecute. A variety of reasons are recorded for this decision including the time period that elapsed between incident and arrest, a lack of consistency in the evidence (photographs not being consistent with the reported attack), no direct witnesses and the fact that in some of the contacts between the police victim care officer and the victim the notes suggest she was unsupportive of prosecution and sympathetic for RB.

The net result was that RB left the police station without charge or condition and able to return to VB's home.

The initial response by the police to the incident of 24th July was prompt and professional. However, subsequently they did not interview the son as a potential witness or seek a medical examination of the victim, both of which might have provided more evidence for the CPS and potentially affected their decision not to charge the perpetrator. They did not refer the matter to Children's Services and the circulation of him as wanted lacked additional notification to the ports for the attention of the UKBA.

There was no further interaction between the police and the victim until the second incident on 9th February 2011. On this occasion, 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 at their home before she had managed to escape by distracting him. After escaping she made her way to her cousin's home, where her child was, but was confronted again by her husband who had tracked her down. There ensued a further incident, some of which happened in the street and some of which 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. It seems that it was in a state of panic as to whether AB would or already had been taken by the suspect, that VB telephoned 999 seeking police assistance. Although the call was difficult to understand officers were despatched in an emergency response, however before officers arrived at the scene the suspect had left the area.

The victim was able to provide an initial account to the officers of the assault on her and subsequently they attended the home of the suspect where he was arrested for assault.

The victims' statement was obtained with the assistance of an interpreter the following day whilst RB remained in custody. In providing an account of the incidents she continued to refer to the fact that she considered the suspect to be *"Increasingly unpredictable"* in respect of his behaviour and the final paragraph quotes her as saying, "*He has said that if I do not live with him, I will not live at all".*

Once again RB denied assaulting VB, in fact asserting that she was the aggressor and identifying a mark on his leg to support his account. Given his denial, the police were once again faced with having to seek a CPS decision in respect of charging. Officers spoke with CPS Direct who took the view that further enquiries had to be made before an informed decision could be taken. CPS listed a total of seven further actions to be taken before they could make a final decision.

The CPS standpoint meant that officers had to either seek more time in which to make the enquiries whilst RB remained in custody, or release him with conditions not to contact VB whilst they made those enquiries. They chose the latter after risk assessing the proposed arrangements in the interim period. A short bail date of 6 days hence (16th February) was given to minimise the opportunity for further harm. Bail conditions were imposed which formed part of the risk assessment to protect the victim; there is no evidence that a refuge placement was considered.

This decision is one that exemplifies the difficulties faced by agencies in trying to protect individuals in domestic abuse cases, often where it is one word against another. On the one hand, evidential necessity demanded more information upon before a charge could be considered; on the other, the risk of further offending and harm to the victim was something that must have been recognised and considered carefully. The fact that RB had fled the country following the previous incident must have been a factor but undoubtedly countered by the fact that he returned voluntarily and five months had passed since the previous incident.

Subsequently, and with minimal further material information, the CPS decided that there was sufficient information to charge RB with common assault when he returned to answer his bail. We now know that he did not return and had probably fled back to mainland Europe immediately upon his release.

In relation to the police actions suggested by the CPS on this second incident, post release they carried out house to house enquiries with the result that no-one wanted to get involved, they did take a further statement from RB's cousin but could not find the only other independent witness, the man whose car she had got into and was dragged out from during the attack. They did not interview her son. Once it was clear that RB was failing to answer his bail he was again circulated as a wanted person but again this was only via the PNC and with no ports warning.

The victim was again risk assessed by the police at the highest level and referrals made to both the IDVA service and to Peterborough Children's Social Care Unfortunately names were spelt incorrectly and this resulted in a lack of join-up of cases within the IDVA service. In addition, the case was not referred to MARAC.

A Victim Care Contract was once again instigated and there appears to have been reasonable contact by the police with the victim in the following few months, tailing off after the end of March 2011 when it appears that the victim thought the suspect was again in Lithuania.

Referrals to MARAC were the administrative responsibility of the MARAC co-ordinator, however in this case, there seems to have been a break down in communication. Any agency can refer to MARAC through the coordinator; no agency did. The police were in a better position than anyone to make the links given that the Migrant Impact Funded IDVA working with the other IDVAs was the allocated case officer. That post was managed by a Police Detective Inspector who worked within the Public Protection Department specifically on domestic abuse. However, the connections were not made. The author cannot say why this did not happen; however, there were no checks or balances in place at the time which could have picked this up.

The next and final contact with the police was on 23rd July 2011 when VB attended the local police station saying that she had seen her ex-husband near her home. An officer took the report and made the necessary checks including checking the crime reports to see that he was indeed wanted. He sent an electronic note to the case officer and requested that the details were circulated immediately to Peterborough officers to apprehend if possible. In the event he was not found. There is no record that information was passed to the IDVAs.

On 12th August, just three weeks later, VB failed to return home from work having been kidnapped and subsequently murdered.

AB was left at home by his mother from around 4.30am on the morning of what is now known to have been her abduction, August 12th 2011. He last spoke with his mother late on the previous evening where she asked him to tidy up and vacuum the carpet prior to him going to bed. She was due to arrive home at around midday and they were planning on having lunch together.

The child was not at school as this was the summer holiday. His usual routine would be to walk to school, where his mother would later collect him, or he would walk home with friends. It was not unusual for him to be left alone in the home, which was multi-occupancy, for several hours when his mother was at work.

When his mother did not arrive home as expected, he contacted his mother's boyfriend who went to the address and remained with him for the afternoon. At about 8pm they both went to the police to report her missing as this was out of her character.

The child was able to provide important background information about his mother and her movements and habits. He spoke reasonable English.

He was taken into care (Police Protection) from 8pm on the 13th August 2011. The mother's boyfriend was deemed not suitable by the police and social services. The child was taken into police protection as his safety was unable to be guaranteed with family/relatives due to the possible intentions of the father, who was at large at this time.

A formal interview with an appropriate adult (intermediary) and interpreter was conducted on the 21st August 2011 to ensure that the child's voice was understood and acted upon, both as part of the investigation and for protection purposes.

Analysis of the Police involvement

The operational decision making was sound at the initial report of each incident. The subsequent investigations could have been more thorough, for example the fact that there was no medical evidence sought in relation to the first incident and the lack of clarity about whether AB was present. In addition, the circulation as wanted only on the PNC and not via the UKBA all ports system meant that there was no way RB could have been arrested at the border as the PNC does not automatically link across to the systems utilised by the UKBA. This was an error.

Similarly the failure to refer to the MARAC after the second incident contributed to the poor information sharing across agencies.

Given the high risk rating after the second offence, there should have been a more proactive response when the victim reported in July that he had returned to Peterborough. A third referral should have been made to the IDVA service following the perpetrator's return to Peterborough.

Since April 2012 the police have moved the investigation of domestic abuse into a specialist Domestic Abuse Investigation Unit (DAISU). This is a positive move and recognises the specialist and at times specific difficulties faced by officers attempting to gain enough evidence to support prosecution in the right cases. Whilst this is seen as a positive move I do not believe this should be seen as a criticism of the officers involved in this investigation, more-so a recognition of the difficulties encountered with these types of investigations. The move to the DAISU is a positive move by the Constabulary that should enhance the standard of investigation; for example the necessity and urgency for medical examinations will be uppermost in the minds of specialists rather

than 'on the list of options' for generalists. Specialists are far more likely to be consistent in an approach to risk assessment and conversations with the CPS about risk.

2.5.2 United Kingdom Border Agency (UKBA)

The UKBA have not completed a full IMR but have fully contributed to the DHR by answering a series of questions put to them by the DHR Panel. This was completed in a two stage process; the initial questions put were as follows:

(i) What is the legislation that covers border checks in the UK with a layman's guide to what would happen in the case of Lithuanian nationals passing through UK border ports?

Schedule 2 of the Immigration Act 1971 confers the powers that enable an Officer to undertake checks of persons seeking entry/admission to the UK. All persons are to satisfy an Officer of identity and nationality. All individuals who are not British citizens or EU/EEA nationals, or those who are exempt from control (i.e. Diplomats, etc.) are also required to satisfy an Officer that they meet the criteria of the Immigration Rules under which they seek entry (i.e. Visitor, Student, Worker, etc.)

European Community law bestows on all EU citizens and their family members the right to move freely and reside within the EU. Free movement rights are governed by the Free Movement Directive 2004/38/EC, which all EU Member States are obliged to transpose into domestic legislation. In the UK this takes the form of the Immigration (European Economic Area) Regulations 2006 – more commonly referred to as the EEA Regulations.

Persons coming to the UK who are entitled to free movement do not require leave to enter or remain and are dealt with as persons seeking admission in accordance with the EEA Regulations and not as persons seeking leave in accordance with the Immigration Rules.

Therefore, in accordance with Regulation 11(1) all EEA nationals must be admitted to the UK on production of a valid national ID or passport issued by an EEA state, subject

to considerations of public, policy, health and security. Beyond this an EEA national should only be questioned where there is strong reason to believe there may be reasons to refuse admission on grounds of public policy, public health or public security.

An EEA national can only be refused admission and removed on grounds of public policy, public health or public security.

All EEA nationals seeking admission to the UK will be have their document checked, biometric chip opened (where applicable), a face to photo verification and their details checked against any information held on the Warnings Index (WI)

(ii) What information would appear on any check of European nationals, would this be different in the case of Lithuanian nationals?

The WI can hold varying amounts information. This can include adverse immigration history and criminal convictions. Border Force is reliant on other authorities making this information available and it should not be concluded that simply because an individual has been convicted abroad this information will be available automatically on the WI.

Nationality has no bearing on what or what may not be on the WI.

(iii) Would previous criminal history be known via a simple passport check?

No. As point 2, unless this information had been passed to Border Force or UKBA, via the police or a foreign authority, then it would not be available to an Officer at passport control.

(iv) If someone had a violent history but was not currently wanted in any European country, would they be refused entry into the UK?

A person who constitutes a threat to public policy would normally be a person who has shown a propensity to re-offend, although past conduct alone may

constitute a threat. Where exclusion is considered on public policy grounds the person could be refused admission in accordance with Regulation 11 and 19 of the EEA Regulations. The following factors **must** be considered:

- serious criminal convictions (bearing in mind the propensity to re-offend, "proportionality" e.g. applicant's age, family/economic connections to the UK, other compassionate grounds to be considered);
- refer to the Nationality, Immigration and Asylum Act 2002 (Specification of Particularly Serious Crime) Order 2004, N.B. do not assume the crimes listed merit automatic refusal;
- EEA nationals with a permanent right of residence should not be refused admission except in cases involving serious and imperative grounds e.g. former leader of "extreme political" party;
- facilitation of illegal entry may in itself be sufficient to justify refusal of admission, particularly if the person is engaged in persistent or large scale facilitation;
- national security can fall under this heading as well as under public security.

However, the most important point to re-iterate is that unless Border Force has been made aware of this history and that there may be strong reasons to consider a public policy refusal, then an EEA national cannot be stopped and questioned further, other than of confirming nationality and identity.

(v) In this case specifically, did any of the names relevant to this review appear on any checks with UKBA from May 2010 through to August 2011

The only record UKBA hold relating to this period is on the accused using a different name. The record is of the accused travelling by flight AY0839 from Helsinki to London Heathrow on 30.09.2011- and being arrested upon arrival by the police upon suspicion of kidnap and murder.

However, as this review progressed it became clear to the reviewers that the fundamental question as to how someone 'wanted' by the police and recorded as wanted on the Police National Computer could escape capture when entering the

UK. It was the police belief that the PNC itself was electronically 'matched across' and automatically checked by the UKBA when passports are 'swiped' upon entry. The UKBA officials had also given the reviewers that belief.

As a result additional questions were asked of the UKBA and are set out below:

Question 1

We know that RB returned to the UK from mainland Europe, through the port of Dover, on 2nd September 2010. At the time he returned, the police state that he was marked as a wanted person on the PNC for the offence of assault upon his (now deceased) wife. Please comment as to how a person wanted on the PNC was able to enter the UK without being detained at the point of entry.

Response

When RB arrived in the UK in September 2010 no adverse information was known to border officials, so he was admitted to the UK in line with the guidance on EEA nationals previously provided in the UKBA letter of 30 May 2012. EEA nationals can only be refused entry to the UK or subject to further questioning in very limited circumstances.

Border Force holds details of certain individuals of interest to the police and other government departments, but this is a completely separate system to the PNC. If a police force wishes to flag an individual to Border Force for further action they are able to do so via the National Ports Office in line with existing guidance / Standard Operating Procedures.

Question 2

We know that after leaving Dover he was arrested by Essex Constabulary as a result of his car triggering an ANPR camera in their area. Please comment as to whether ANPR is available at the port and, if so, would a car with a PNC marker trigger the port's system.

Response

The ANPR system is owned and operated by the Police. The data and parameters for generation of an alert for Police related matters on the ANPR system is controlled by the Police and unfortunately I am unable to say whether the port's system was triggered.

Question 3

We know that between 10th February 2011 and 20th July 2011 RB left the UK and then returned. He was, again, marked as wanted on the PNC for a further offence of assault upon his wife. Again, he was not picked up at the port of entry, which is believed to have been Dover. Please comment as to how he was able to enter the UK a second time without being detained at the port.

Response

Again, at the time of his arrival in the UK between 10th February 2011 and 20th July 2011 no adverse information was shared with Border Force. Accordingly RB would have been admitted to the UK in line with the guidance on EEA nationals previously provided in the UKBA letter of 30 May 2012.

Comment

It would be helpful if the UK Border Force would articulate the effect the name and, therefore passport, change in Lithuania would have had upon UK border checks; would a change of name by the Lithuanian authorities effectively render the PNC entry in the original name moot, or is there a means by which the new name would be linked to the previous name in order that UK authorities could see he was wanted?

Response

In this case the name change would not have had any effect. The problem arose because Border Force was not notified that this individual was wanted on warrant. RB was extradited to the UK in September 2011 and became of adverse interest to Border Force only following his conviction for murder in November 2012.

Conclusion

This issue has highlighted a significant level of operational misunderstanding between the police and UKBA.

The **recommendations** following this are as follows:

That Cambridgeshire Constabulary ensure that officers are aware that when circulating individuals as wanted, that the UKBA must be informed separately if there is any suspicion that the individual may attempt to leave, or re-enter, the UK's borders.

That UKBA and Cambridgeshire Police explore current Cambridgeshire Police access to NBTC, and to explore whether or not we could further develop ties between the two organisations – within the relevant national guidelines for such activity.

2.5.3 Crown Prosecution Service

The Crown Prosecution Service have assisted this review with a report outlining their role, criterion for prosecution, the development of their domestic abuse policies and lawyers' experience, and a scrutiny of their specific involvement in this case.

It is clear that the decisions made by CPS in respect of both cases are backed up by detailed notes of their considerations.

The role of the CPS is a difficult balancing act in cases such as these. It is the view of the Senior District Crown Prosecutor for the East of England that in this case each of the decisions made was sound and appropriate and that they can learn nothing from this case. However, the overview report writer and panel are of the opinion that the second incident was serious, that there was sufficient evidence to charge with common assault at the point of arrest and potentially with a more serious charge following further investigation.

2.5.4 Peterborough City Council Domestic Abuse (IDVA) Services

The context in which these services were delivered is relevant to this review. In August 2010, a review of the domestic abuse service was initiated. All posts were placed at risk of redundancy during this process, those posts being 2 IDVAs, 1 IDVA (fixed term contract maternity cover), the MARAC co-ordinator and the Domestic Abuse Co-ordinator. The Domestic Abuse Service Delivery lead post had been vacant for some time and was deleted.

Each of these posts was at risk of redundancy from the end of August 2010 to the beginning of March 2011. During this review period, the DA Co-ordinator left through voluntary redundancy (end of October 2010). The management role during the interim period was filled by the Safer Peterborough Manager. This is the critical period for this review.

On 28th July 2010, the IDVA service received notification from the Police of the incident having occurred on 24th July. The information was entered onto the MODUS computer system operated by the IDVA service. MODUS is a web based software system developed specifically for agencies managing cases of domestic violence. It is also used for MARAC co-ordination. It is a secure system protected by user name and password entry. It is supported and backed up daily on the PCC server.

The referral record gave sufficient details of the incident to begin engagement by the service with VB; it did not show that the victim had a child. The IDVA allocated to deal with the case was an experienced IDVA. The risk assessment identified VB to be of high risk.

The first contact was on either 29th July or 2nd August. A lack of detailed records has resulted in the exact date not being established. The IDVA appears to have established good contact through Language Line and also identified that text messages could be sent via the victim's brother.

There were at the time no written policies within the PCC setting out timescales for the first contact. Upon interview, it appears the IDVAs understood the desired contact range to be within 48 – 72 hours.

During August and September 2010, the IDVA made at least nine contacts with VB. It is recorded that she assisted in a range of issues to improve the quality of life and safety of VB. This included schooling for AB and a letter to the Lithuanian Courts in relation to the divorce.

The IMR author concludes that sensible and practical safety advice was given.

The case went to MARAC on 19th August 2010, the IDVA attended and the MARAC record shows a number of tasks for the IDVA to complete. These tasks were completed and VB was content and reassured that whilst RB was out of the country she was safe and also that he would be arrested upon his return to the UK. On 2nd September the IDVA left a message for VB to inform her that the case was closed, which was appropriate in the circumstances.

Co-incidentally, the following day RB re-entered the UK and was arrested by Essex police and brought to Peterborough for interview. There is no recorded exchange of information between the police and the IDVA at the time of the arrest. It appears that the IDVA probably was not told given that the MODUS records show her next responding to a text received from the victim on 9th September with a reference ‘’re police NFA’, followed by an email to the police officer dealing and a call back to VB explaining the police decision. A follow-up text was sent by the IDVA to VB on 29th September 2010 checking if she was ok. There is no record of any response and no further entries on MODUS.

Whilst the overview author is content that the IDVA offered a good level of support and guidance to VB the lack of detailed record keeping is a concern, as is the fact that the case just seemed to ‘drift’, there was no closure and no record of supervision.

The second incident was referred to the IDVA service again by police. The records do not state what date the referral was received but the first attempts at contact were made by the allocated IDVA on 14th February.

The referral from the police again recorded a 'high risk' posed to the victim. As such the case was picked up by the MIF IDVA who was now in post working alongside the other IDVAs. February 2011 was the time period when the management of the IDVA service was at its most stretched and IDVAs decided amongst themselves who would take what case; albeit the MIF IDVA would take most cases involving Lithuanian nationals when she was available.

The referral detailed AB as being present during the incident and referred to the previous incident. However, the referral had the name of VB spelt differently and also address and telephone numbers had changed; thus it did not immediately link across to the previous record and no link was made by the IDVA. However, the referral form clearly marked a previous incident, so the failure to make any additional enquiries to link the two was an omission.

The IDVA made three attempts to contact VB by telephone; on 14th, 16th, and 21st February. All were resulted as 'no answer'. On or around 23rd February, as a result of an overheard office conversation, the link between the two cases was made. Consequently, the IDVA made a further attempt to contact VB, speaking to AB and leaving a message with him. There is no record of any further contact. The IMR author has identified through interview an informal practice within the IDVA service of 'three attempts and close'. At the time, cases were closed at the workers' discretion with no requirement for a sign off by a supervisor.

There is no evidence of any attempt to clarify whether Peterborough Children's Services were aware of the referral.

The IDVA allocated to this second case decided that she would transfer all of the records from the second case, to that of the first, and delete the second record. There was no written policy or procedure for this and the IDVA thought this expedient. However, as the MODUS record for the previous case had already been closed. The effect of moving this second case on to it had the effect of 'losing' the case. The case file was not re-opened and thus would not show on any review of open cases.

To compound issues, the case should have been referred to MARAC on two counts: firstly it was a high risk victim, and secondly it was a second incident within 12 months involving the same victim. No referral to MARAC was made. This is an error on the part of the IDVA who should have referred this case to the MARAC coordinator.

This second referral demonstrates the need for senior managers to assess and monitor the impact on practitioners and service delivery when services are under review and staff facing an uncertain future and possible redundancy. In addition, it is clear that there was a lack of some basic procedures and practice guidelines in relation to the management of both staff and cases.

2.5.5. Peterborough Children's Social Care

The first referral to Children's Social Care was on 11/02/11 detailing the incident that had occurred on the 09/02/11. A Children's Social Care Referral and Initial Information Record was completed following receipt of a faxed Domestic Abuse Risk Assessment Referral Form from Cambridgeshire Police. This information informed Social Care of a domestic violence (DV) incident involving the Victim and Perpetrator. The Police recorded the risk to the Victim as 'high' and made a reference to a previous incident where the Perpetrator was arrested for assault. No further detail was given. The Police DV referral form identifies that the victim has been subject to strangulation, choking, suffocation or drowning and that the victim is in fear of further injury and violence. The long hand description of facts leading to the referral merely describes a 'hit to the face causing a nose bleed' and does not mention any details to justify the strangulation box being ticked.

A team manager decided that an initial assessment was required 'to consider impact of domestic violence upon the Child and parent's ability to protect, assessment needs to clarify status of parental relationship following recent DV incident'. The spelling of the child's surname is different from the spelling on the original Police referral.

The referral was allocated to TSM1 and SW1. A date for the Initial Assessment was set for 14/02/11. A letter was also sent on the 14/02/11, to Cambridgeshire Police informing

them of the name of the allocated Social Worker and the plan for an Initial Assessment. The spelling of the Child's surname is different from the spelling on the original Police referral, but the same as that recorded on the referral and Information record.

The IMR authors comment: 'It would be reasonable to assume that at this stage the Referral and Initial information Form has been handled by two members of the Initial assessment Team yet no contact has been made with the police to establish the full facts of the circumstances surrounding the previous incident, the victim's fear of further violence and details of the strangulation or choking incident

On 24/02/11 SW1 undertook an unannounced home visit to see the Victim and Child but no one was at home. On 25/02/11 a second home visit by SW1 was undertaken but there was still no response. SW1 made several other unsuccessful visits, eventually leaving a note with her telephone number on with the people at the 'Take Away' shop below the flat.

On 21/03/11 a CSCS Case Recording Summary recorded a phone contact from the Victim to SW1 after the Victim had received the letter left at the 'Take Away' The Victim is recorded to have moved house. A meeting to undertake the Initial Assessment was recorded to have been agreed for 23/03/11

An Initial Assessment completed by SW1 has a start date recorded as 14/02/11 and an end date of 23/03/11 with an outcome of no further action. The social worker made no contact with any relevant agencies, namely the police, the school or the IDVA service, which would be expected as part of an initial assessment. In addition, the victim was not asked about any previous domestic abuse or her current concerns about the risk posed by her ex partner. Instead, the records describe the child's behaviour, which, whilst relevant to a holistic assessment, was not the focus of the referral.

It is also recorded that the son told the social worker that his father had said 'you will be put into a children's home and then I will kill your mother". This statement was never shared with the Police.

PCSC did not clarify any details with the police about the level of violence used; they did not pass information about the threat to kill to anyone else, including the police; they did not alert the school attended by AB as to what was a significant incident that may have affected his development. They did not include the school as part of the initial assessment.

2.5.6 Peterborough Children's Services; Education

On 02/09/10 Peterborough City Council sent a letter to the Victim offering her son a place at a Primary School. The letter advised the Victim to contact the school in order to arrange a visit to discuss admissions arrangements and a start date. The letter was written in English. It is not clear whether PCC knew that English was not the first language of this applicant or whether this applicant was offered the information in Lithuanian. The child's name on the admissions letter was spelt differently from the spelling in the Terms of Reference.

On 12/10/10 an Admissions Meeting was held between the Victim and school and he started Primary School on 18/10/10. On 20/10/10 the school records show that a letter was sent to the Victim with information about the text messaging service used by the school. The letter asked for information from parents about whether their 'child was born in this country or the date they arrived in this country'. The response details the date of arrival into the UK by the Child as 27/07/10.

At 8.30am on 11/02/11 a school record indicates that the Victim attended her son's school and stated that the Victim 'was attacked by her ex husband' the previous night - 10/02/11. There is a second entry which shows a photocopy of a Lithuanian identity card, the entry identified this person as the cousin of the victim and stated 'only mum or cousin to collect - dad very dangerous If mother or cousin not at school the child is to come back into school'. No further detail is recorded.

There is no record of how the Victim presented on 10/02/11. In the interview undertaken with the Office Manager, it was noted that she had not noticed any outward signs of abuse. What had been noticed, but not recorded, was the Victim's anxiety about the

Child's collection arrangements. Apparently the Victim was very clear that the Perpetrator should not collect the Child. The office manager did not explore this with the Victim but did explain to her that what she was requesting was not possible for the school to enforce. She explained that if the Perpetrator turned up at the school there was nothing the school could do to stop him taking the child, as his father, they had no powers to prevent this. In effect, she told the mother that the school could do nothing to protect her child. The school did not share the information with children's social care or seek advice about how they might help the mother and protect the child.

On 20/06/11 an admissions form was completed by the Victim at another Primary School. There were no details noted for any special collection arrangements for the Child. The mode of transport to school was recorded as 'walking' A new address was recorded.

Section 3 : Analysis

3.1 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 by attempting to arrest him and by providing her with support. Once it was known that the ex-husband had left the country, he was listed as wanted on the Police National Computer but unfortunately not via the all ports system. This resulted in his arrest when he returned to the country after triggering an ANPR camera in Essex; he had managed to evade arrest at the point of entry as the all ports system had not been updated.

3.2 It has always been the case that the police have assured the panel that as soon as RB became wanted on both occasions (for the original attack in July 2010 and after failing to answer bail following the second attack in February 2011) that he was circulated as 'wanted' on the Police National Computer. They were aware of his likely flee back through UK borders to mainland Europe. Their view was that this would mean his arrest if the PNC was checked in the UK or indeed upon re-entry into the UK.

3.3 Whilst this initially appeared to be confirmed by officials from the UKBA, when pressed for clarification it has become apparent that entry onto PNC is NOT sufficient. The police needed to additionally inform the UKBA of the fact that the person was wanted and to issue an all-ports warning notice to alert them as to the fact that particular individual was wanted for arrest.

3.4 This was not done in this case with the result that RB passed through the UK border, probably having shown his passport in the normal way, and was granted entry. This scenario explains why he was then picked up by UK police when he triggered an ANPR camera in Essex, as the PNC is automatically checked when ANPR is activated. It also means that the fact that RB changed his name and appearance when returning to the UK on the second occasion was irrelevant. He

was entitled as an EU citizen to enter the UK. Passport control is used to ensure that non – EU citizens did not gain entry.

3.5 The Crown Prosecution Service 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. However, if the police investigation had been more in depth, for example by seeking a medical examination and by interviewing the son, it is possible that their advice would have been different. In addition, the panel remain of the opinion that the second incident was serious, that there was sufficient evidence to charge for common assault at the point of arrest and potentially with a more serious charge following further investigation.

3.6 After the first assault, the case was appropriately referred to the MARAC and good advice and practical support were offered to the victim. By all accounts, she was reassured by this help, especially as her ex-husband was no longer in the country. Although children's social care were not notified, it is unlikely that this first incident would have met their threshold for involvement because it was apparent that the mother was doing her best to protect her son and was receiving appropriate help from the IDVA service. The case was appropriately closed by the IDVA service whilst the ex husband was known to be out of the country.

3.7 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 standpoint resulted in the ex-husband being released on bail with conditions not to contact the Subject. The bail conditions did not include not leaving the country, even though that is what he had done on the last occasion and did 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 and the CPS and that they should have been mindful of the likelihood of RB 'disappearing'.

3.8 Since April 2012 the police have moved the investigation of domestic abuse into a specialist Domestic Abuse Investigation Unit (DAISU). The move to the DAISU is a positive move by the Constabulary that should enhance the standard of investigation; for example the necessity and urgency for medical examinations will be uppermost in the minds of specialists rather than 'on the list of options' for generalists.

3.9 Once it was clear that the ex-husband was failing to answer his bail, he was again circulated as a wanted person. This time, however, he was not picked up on his return to this country for the reasons described previously within this section.

3.10 Following both assaults, the case was promptly allocated to the IDVA service, the second time to a specialist worker who shared the same language as the victim. Several attempts were made to contact the victim on this second occasion and it is unfortunate that these attempts were unsuccessful. However, it was a reasonable decision to stop making further attempts at contact after four tries, especially given that the victim was familiar with the service. However, the IDVA should have referred the case to the MARAC. The reason why this did not happen has not been established but the absence of a clear referral pathway is likely to have been a factor and is a finding from this review.

3.11 This review also identified significant gaps with regard to the need for clear procedures around recording, supervision and decision making in the IDVA service. It is noted that during the period of the review, staff were under considerable pressure as a result of being made 'at risk' with the resulting uncertainty about their future and reduced management capacity.

3.12 Since this review commenced, a Domestic Abuse Governance Board has been created under the Chair of the Executive Director: Operations of the Local Authority. The Board commissioned an independent needs audit, developed a

new and agreed strategy for Domestic Abuse within the City and has now developed an implementation plan to deliver that strategy, restructure services, increase investment together with sustainability and improve services within the City. It is that plan that will pick up the responsibility for ensuring individual agency actions are progressed arising from this DHR, but also that the important cross-cutting themes are moved forward. The Domestic Abuse Development Plan for Peterborough is appended to this report.

3.13 Following the second assault, children's social care undertook an initial assessment and the mother alerted the school about the risk posed by her ex-husband. Both the school and social care failed to appreciate the level of risk posed by the perpetrator, despite it being made very clear by the mother to the school and the son to children's social care. Neither of these agencies made contact with each other or with the police. There was therefore a twofold failure of information sharing, firstly through the failure to re refer to MARAC and secondly on the part of the individual agencies who were informed about the risk. No agency considered a contingency plan should the ex husband return, even though that was an established pattern of his behaviour.

3.14 The school should have responded more proactively to the mother's concerns, even if technically their advice was correct, they should have sought further advice as a matter of urgency. To tell a parent that there is nothing they can do to prevent a child going off in the care of someone the main carer believes to pose a serious risk is unacceptable. If the case had gone to the MARAC, and they had been made aware of that, their awareness might have been heightened but the information they had from the mother should have been sufficient to prompt some action.

3.15 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 six weeks to complete the initial assessment

which is significantly outside the timescales set by the statutory guidance. No action resulted from it, not least because by now the ex husband had left the country and nobody considered what action would be necessary should he return.

3.16 A serious case review 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 of the need 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 a detailed single agency action plan.

3.17 None of the agencies asked VB about her life in Lithuania prior to moving to Peterborough. It was as though her life had begun on the day she arrived in the UK. Had the police or children's social care sought information about VB's life in Lithuania they would have learnt that there had been a series of incidents prior to her arrival in the UK. This information would have informed their risk assessments.

3.18 Similarly, her son's experience of living with domestic abuse and the fear of its recurrence was not given sufficient weight. He was never spoken to by the police or by the school despite witnessing a serious attack on his mother and his mother's expressed fear to the school that he was at risk.

3.19 As soon as the mother realised that her ex husband had returned to this country, she alerted the police. However, even though he had been assessed as high risk at the point of leaving the country, the action taken was unlikely to have lead to a quick arrest, especially as he was reported to have changed his appearance and therefore was unlikely to be recognised. Similarly, the IDVA service was not alerted and on this third occasion no practical support was offered to protect the victim or her son.

Section 4 : Conclusions, Lessons Learned and Recommendations

4.1 Conclusions

4.1.1 The purpose of a Domestic Homicide Review is to establish whether lessons can be learned from the way in which professionals and organisations work individually and together to safeguard victims. Further; to ensure those lessons learned are implemented.

4.1.2 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. A multi agency action plan is attached as an appendix..

4.1.3 It is the view of the panel that given the difficulties in establishing RB'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 VB's tragic death. However, it is acknowledged that different actions at different times could have afforded her greater protection.

4.1.4 The findings from this review have been used to inform a comprehensive review of domestic violence services. In addition the following lessons have been learned

4.1.5 Lessons Learned from this review:

- 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. A risk assessment should be completed for significant change in high risk services such as domestic abuse.
- Multi agency processes must be underpinned by robust procedures, that are understood and implemented by each agency eg 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, (e.g when the school said they couldn't stop the perpetrator collecting the child)
- 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
- 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 how the police national computer links to systems operated by the Border Agency.
- Organisations should carefully consider the capacity required for undertaking detailed domestic homicide reviews, including the financial cost of outsourcing IMR and Overview authors.

4.2 Recommendations

4.2.1 A referral pathway to MARAC must be agreed, implemented and monitored

4.2.2 Procedures, practice standards and supervision requirements for IDVAs must be established and implemented.

4.2.3 Risk assessments across all agencies must include contingency plans if a risk is reduced by a perpetrator leaving the area.

4.2.4 The police must ensure that officers are familiar with the links between the PNC and the Border Agency.

4.2.5 The view of this panel should be brought to the attention of the CPS in relation to the second incident.

4.2.6 Partner agencies 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.

Appendix A: Chronology of events

Date	Agency	Form of Contact
2009	-	Victim lived briefly in the UK for a period of two months
May 2010	-	Victim came to live in Peterborough
August 2010	Domestic Abuse Service	Domestic abuse case officer attempted contact with victim on five separate occasions. Modus record for the case was created
September 2010	-	Victim and suspect were legally divorced in Lithuania
11/07/10	-	Victim returned to Lithuania for a family wedding
23/07/10	-	Victim came back to England, accompanied by the suspect and her son
25/07/10	Police	Victim reported assault by suspect to the Police (assault took place on 24/07/12)
27/07/10	-	Victim received call from the suspect on a Lithuanian landline indicating that he was out of the country
August 2010	Domestic Abuse Service	IDVA post employed as a result of Migrant Impact funded project
19/08/10	Police	Victim was assessed as very high risk and referred to MARAC
03/09/10	Police	Suspect arrested on his return to the UK following activation of a 'marker' on his vehicle registration number by patrolling Essex police officers
03/09/10	Domestic Abuse Service	Domestic abuse case officer left message for victim to inform her that Police's case had been closed
04/09/10	Police	Victim updated that no further action would be taken by the Police following the incident she reported in July
04/02/11	Domestic Abuse Service	Domestic abuse case officer attempted to contact the victim on four occasions – on one occasion managed to speak to victim's son
09/02/11	Police	Victim reported second assault by suspect to the Police
10/02/11	CPS	Decision by CPS that suspect would not be charged but released on bail pending completion of additional enquiries
11/02/11	PCC Children's Social Care	Social Care Referral and initial information record completed following fax from the Police
11/02/11	Abbotsmede Primary School	Victim informed class teacher that if she or her cousin were not at school at home time, child is to come back into school as 'Dad is dangerous'
15/02/11	CPS	CPS made decision to support a charge of battery (common assault) against the suspect
16/02/11	Police	Suspect failed to appear on bail

23/03/11	PCC Children's Social Care	Initial assessment record states that child is recorded as saying that 'he would be given a children's home and then his father would kill his mum'
23/02/11	Domestic Abuse Service	Domestic abuse case officers noted incorrect spelling of victim's name and merged the two cases
24/02/11	PCC Children's Social Care	Home visit to check to see child and victim, no answer
25/02/11	PCC Children's Social Care	Second visit to home address, no answer
01/04/11	Domestic Abuse Service	Management of the service transferred to Peterborough Women's Aid under a 2 year agreement from Peterborough City Council
June 2011	-	Suspect changed his name to that of RV
23/07/11	Police	Victim reported a sighting of the suspect close to her new home address in Peterborough, reported that he had changed his appearance
12/08/11	Police	Victim reported missing by her boyfriend
October 2011	-	Body of victim found in shallow grave in Poland