



Domestic Homicide Review Executive Summary

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Maria
in September 2018

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Preface

Norfolk's County Community Safety Partnership and the Review Panel wish at the outset to express their deepest sympathy to Maria's family and friends. This review has been undertaken in order that lessons can be learned; we appreciate the support and challenge from families and friends throughout the process.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this murder in a meaningful way and address with candour the issues that it has raised.

The review was commissioned by Norfolk's County Community Safety Partnership on receiving notification of the death of Maria in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

Glossary

DASH	Domestic Abuse, Stalking and Honour based violence risk assessment model introduced to all UK police forces since 2009
DHR	Domestic Homicide Review
EIDA	Employers' Initiative on Domestic Abuse – www.eida.org.uk/
IMR	Individual Management Review – this is a review undertaken by an organisation to look at their interaction with the victim or perpetrator and identify good practice or lessons learned
NCCSP	Norfolk County Community Safety Partnership

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Section One – The Review Process

1.1 Introduction and agencies participating in the Review

- 1.1.1 This summary outlines the process undertaken by the Norfolk County Community Safety Partnership Domestic Homicide Review Panel in reviewing the death of one of its residents. The death occurred in September 2018.
- 1.1.2 The victim was Maria, aged 26, a Romanian national who was killed by her ex-partner at her home. He was a Lithuanian national. He pleaded guilty to her murder in December 2018. At a hearing on 3rd January 2019, he was sentenced to life imprisonment with a minimum term of 19 years 264 days before parole can be considered. His sentence was reduced from 25 years as credit was given for the fact that he had pleaded guilty at the first opportunity.
- 1.1.3 On the day of the incident, Maria completed a shift at 10pm at the local factory where both she and the perpetrator worked. She then cycled home. Unbeknown to her the perpetrator had finished his shift early and was waiting for her in the garage as she went to put her bike away. It was there that he murdered her with a brutal knife attack. The pathologist said that Maria had undergone a ‘sustained and deliberate’ attack which included 25 stab wounds.
- 1.1.4 Maria’s housemate found her lying on floor of the garage still alive. An ambulance was called, and she was taken to the Queen Elizabeth Hospital where she died the next day as a result of blood loss from the multiple wounds.
- 1.1.5 Norfolk County Community Safety Partnership was notified by the death by Norfolk Constabulary six days after Maria’s death. On 13th October 2018, the Chair of the Community Safety Partnership chaired a multi-agency Domestic Homicide Review (DHR) meeting and the decision was taken to undertake a DHR.
- 1.1.6 An independent Chair and Report Author were appointed, and the Review Panel met for the first time on 11th January 2019.
- 1.1.7 The final meeting of the Review Panel was on 5th July 2019 to finalise the report and the findings therein, and consider the actions needed to address the recommendations.
- 1.1.8 It was not possible to complete the review within the six-month timescale set out in the statutory guidance due to pending criminal trial and the time taken to engage with Maria’s family.
- 1.1.9 The following individuals and agencies contributed to the review:
- Access – Supporting Migrants in East Anglia
 - Borough Council of King’s Lynn and West Norfolk
 - Leeway Domestic Violence and Abuse Services
 - Norfolk and Waveney Clinical Commissioning Groups
 - Norfolk Constabulary
 - Norfolk County Council
 - Norfolk Safeguarding Adults Board

- Office of the Police and Crime Commissioner
- Pandora Project – Domestic Abuse Charity
- The employer of both victim and perpetrator
- Maria’s brother (on behalf of her family)
- Work colleague of the perpetrator
- Friend of Maria

1.1.10 Attempts were made to engage with the perpetrator for the purposes of this Review however he did not wish to become involved.

1.2 Purpose and Terms of Reference of the Review

1.2.1 According to the statutory guidance, the purpose of the Domestic Homicide Review 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
- Prevent domestic violence and homicide and improve service responses to all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

1.2.2 The Review Panel agreed that the specific purpose of the Review is to:

- Establish the facts that led to the incident in September 2018 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident in September 2018; suggesting changes and/or identifying good practice where appropriate.
- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

1.2.3 The scope of the Review, as agreed by the Review Panel, is to:

- Draw up a chronology of the involvement of all agencies involved in the Maria to determine where further information is necessary. Where this is the case, Individual Management Reviews will be required by relevant agencies defined in Section 9 of the Domestic Violence, Crime and Victims Act 2004 (revised 2016).
- Produce Independent Management Reviews (IMRs) for a time period commencing 1st January 2014 (being the date that the victim moved to the UK)
- Invite responses from any other relevant agencies, groups or individuals identified through the process of the review.
- Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.
- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of individuals where domestic abuse is a feature.
- Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:
 - guidance from the police as to any sub-judice issues,
 - sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

Section Two – Agency contact and information learnt from the Review

- 2.1 Maria was born in Romania and was 26 years of age at the time of her death. She had lived in this country since 2014 and had four brothers, three of whom were living in the UK. She was the youngest child. Her parents remained in Romania.
- 2.2 The perpetrator was from Lithuania and he was 30 years of age at the time of the incident. He had moved to the UK in 2016 and had no previous criminal convictions.
- 2.3 Maria had been in a relationship with the perpetrator for approximately 12 months and during this time they were both employed locally to King's Lynn. Together they took a number of holidays including visiting Switzerland, Venice and Bali.
- 2.4 On the day of the incident, Maria completed a shift at 10pm at the local factory where both she and the perpetrator worked. She then cycled home. Unbeknown to her the perpetrator had finished his shift early and was waiting for her in the garage as she went to put her bike away. It was there that he murdered her with a brutal knife attack. The pathologist said that Maria had undergone a 'sustained and deliberate' attack which included 25 stab wounds.
- 2.5 Maria's housemate found her lying on floor of the garage still alive. An ambulance was called, and she was taken to the Queen Elizabeth Hospital where she died the next day as a result of blood loss from the multiple wounds.
- 2.6 Maria had little contact with local agencies, short of unremarkable interaction with health services.
- 2.7 **Evidence of domestic abuse**
- 2.8 Even though no reports of domestic abuse were made by Maria we are able to glean a sense of the relationship between Maria and the perpetrator from the accounts given by friends and colleagues and the perpetrator's interview after his arrest. This paints a picture of the perpetrator as an abusive and controlling man.
- 2.9 The perpetrator was a jealous man who sought to isolate Maria from her family, friends and work colleagues. There is evidence of coercion and control in the relationship as well as physical abuse.

Section Three – Key issues arising from the Review

3.1 **What were the barriers to Maria seeking help?**

3.2 Maria had been in a relationship with the perpetrator for a relatively short time and ended the relationship, it is reasonable to assume, when she realised that his behaviour towards her was abusive and she had simply had enough. During the time of their relationship she did seek help from her brothers on a couple of occasions but did not disclose to her family the extent of the abuse. It has been suggested to the review that this might have been because she was concerned about what her brothers might do to protect her. We do not know for certain that this was a factor.

3.3 One of the other issues considered by the Review Panel was whether Maria understood that his behaviour was abusive and unacceptable and whether she knew where to go to get help. The review is convinced that Maria did know that the perpetrator's behaviour towards her was not right and not acceptable. She did what she felt she could to distance herself from him.

3.4 **What part did cultural issues play?**

3.5 The Review Panel was very mindful of the ethnicity of both Maria and the perpetrator and gave considerable consideration to the part that this might played both in the incident and the lack of reporting.

3.6 Having spoken to her family and friends, the review is satisfied that it would not be true to say that there was any cultural issue that would lead Maria to feel that this behaviour was acceptable or that she had to remain in the relationship and the Review Panel is satisfied, as far as it can be, that this situation would not have been any different had the parties been white British.

3.7 **Why did the abuse escalate so quickly?**

3.8 The Review drew on the research of Dr Jane Monckton-Smith of University of Gloucestershire into Intimate Partner Femicide Timeline¹. This research has identified eight stages through which a relationship that ends in homicide is likely to go through. By considering this timeline we can see that, although Maria was in a relationship with the perpetrator for a relatively short period of time, the relationship follows this timeline, and the different stages can be seen.

3.9 The Review noted that Dr Monckton-Smith is clear that the length of time between these stages can vary, with average time between stages 4 and 8 being between two weeks and one month. In some cases, stage 4-8 can take as little as 4 hours but that in others it can take up to 12 months. Therefore, we can see that as this relationship did follow the homicide timeline it is not, therefore, appropriate to suggest that this relatively quick escalation was unusual.

¹ https://www.womensaid.ie/download/pdf/jane_monckton_smith_powerpoint_2018_compatibility_mode.pdf

- 3.10 What we do know, from Dr Monckton-Smith’s research is that, at any point, an intervention could have changed the course of events but unfortunately, there was not the opportunity for this to happen.
- 3.11 **What lessons are there for employers?**
- 3.12 After several attempts at contact, the Agency that had employed both the victim and the perpetrator engaged fully with this Review and they showed themselves to be an organisation open to learning from this tragic event.
- 3.13 The Agency acknowledged that they had previously lacked any detailed information for employees about Domestic Abuse. They are members of Stronger Together and a supporting partner in the charity Unseen, both of which target modern slavery. As a result of their awareness being raised by this Review, they have already joined EIDA² and embraced the Domestic Abuse Toolkit. They aim to build a policy on Domestic Abuse which would be embedded in their business, supporting by training and awareness to their internal staff and to all workers. They aim to deliver this in the same way that they do in other areas, looking to partner with their clients to push the message and raise the awareness. This Review has no doubt as to their intentions.

² Employers’ initiative on domestic abuse – www.eida.org.uk

Section Four – Recommendations

- 4.1 It is recommended that, to build on this good practice, the GP surgery considers engaging in the county wide DA Champions Network.
- 4.2 It is recommended that the Norfolk Community Safety Partnership works with the Office of the Police and Crime Commissioner to build upon the work already undertaken in promoting the EIDA³ Domestic Abuse Toolkit for employers through local business networks. Particular attention should be paid to employment agencies.
- 4.3** It is recommended that Norfolk continues to develop its awareness raising with regards to the contribution that behaviours such as stalking and harassment contribute to the risk of significant harm or homicide following the breakdown of a relationship. Particular regard should be paid to the understanding within Norfolk’s migrant communities.

³ <https://eida.org.uk/>

Section Five – Conclusions

- 5.1 The perpetrator carried out, in the words of the Judge, ‘a brutal sustained attack upon a defenceless woman who was only 26 years old’. It is noted that there were no defence wounds.
- 5.2 The couple lived in a number of different places which meant that little was known about either by any local agency. Their life revolved largely around time together, time with their family and work.
- 5.3 The Review has considered whether sufficient services are available to encourage migrants to become part of the local community and thus access services such as specialist DA provision. It is clear that this particular area of the country has enjoyed the benefit of economic migrants and the role they play in the local economy. Positive provision has been made through groups such as Access and the Pandora project.
- 5.4 The lack of information available through the employment agency as perceived by the family and friends of this victim is disappointing as is their delayed engagement with this Review. More needs to be done with this and other employers to ensure they are aware of the integral role they play in individuals lives.
- 5.5 Whilst, with hindsight, the perpetrator in this case had demonstrated behaviours that were clearly abusive towards this victim, the escalation of violence was unexpected and not predicted by anyone.