Permission has been granted by the Home Office to publish this final report

Safer West Sussex Partnership

Domestic Homicide Review Overview Report

FINAL REPORT INTO THE DEATH OF ADULT A in 2011

Report produced by Councillor David Simmons

Date: 1 February 2012

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Please note that the subjects of this report have been anonymised throughout.

1. INTRODUCTION AND BACKGROUND

1.1. Introduction

This Domestic Homicide review examines the circumstance surrounding the sudden unexpected death of an Adult A in West Sussex. Sussex Police were called at 21.00 hours on 25 December 2011 to an incident where Adult A had received a stab wound, paramedics also attended. Attempts were made to revive Adult A, but these were unsuccessful and he died at the scene. Twelve suspects were initially arrested on suspicion of being connected to the murder. This was due to the large number of people being present, many of whom appeared to be drunk and speaking a foreign language. Eleven of these people were later released and Adult B was charged with the murder of Adult A. Adult A and Adult B were brothers. In September 2012, the jury in the trial of Adult B returned a Not Guilty verdict to charges of murder and manslaughter. There are no other criminal proceedings.

1.2. Reason for conducting the Review

Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. They were established on a statutory basis 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'*

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.

The guiding principles which underpin this review are:

- **Urgency** – agencies should take immediate action and follow this through as quickly as possible
- **Impartiality** – those conducting the review should not have been directly involved with the victim or the family
- **Thoroughness** – all important factors should be considered
- **Openness** – there should be transparency with no suspicion of concealment
- **Confidentiality** – due regard should be paid to the balance of individual rights and the public interest
- **Co-operation** – the agreed procedure and statutory guidance contained within Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011 should be followed.
- **Resolution** – action should be taken to implement any recommendations that arise as soon as possible

1.3. Process of the review

A DHR was recommended and commissioned by the West Sussex Strategic Community Safety Partnership in line with the expectations of Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011. The guidance is issued as statutory guidance under section 9(3) of the Domestic Violence Crime and Victims Act (2004)

The Chair of the West Sussex Strategic Community Safety Partnership (WSSCSP) established Adult A's homicide met the criteria of a subject of a DHR by applying the definition set out in paragraph 3.8 of the guidance.

The trial of Adult B has now concluded with the jury returning a verdict of Not Guilty on the counts of murder and manslaughter. There are no further criminal actions relating to this case.

Agencies and interested parties were notified of the requirement to secure any records pertaining to the homicide to inform the subsequent overview report

The Home Office was notified of the intention to conduct a DHR and the Chair agreed to be Councillor David Simmons.

The process began with an initial meeting on 3 February 2012 to consider the information which had been sought from seventeen different organisations that could have potentially had contact with Adult A and/or Adult B prior to the homicide. The full list of organisations appears at Appendix A.

Only three organisations had any knowledge of Adult A or Adult B prior to the date of the homicide, and IMR's were commissioned from these organisations.

The review panel met a further four times on the following dates:
16 March 2012, 1 May 2012, 4 July 2012 and 24 September 2012.

The DHR Panel comprised:

REP FOR:	**NAME**	**POST**
	Councillor David Simmons	Independent Chair
West Sussex County Council	Sue Cart	Head of Safeguarding
West Sussex County Council	Trish Harrison	Domestic and Sexual Violence Manager
Sussex Police	Carwyn Hughes	Detective Chief Inspector
Arun District Council	Kevin Basford	Head of Environmental Amenities and Community Safety
Surrey & Sussex Probation Trust	Jane Browne	Offender Management Director

REP FOR:	NAME	POST
Sussex Community NHS Trust	Sue Giddings	Deputy Director Operations & Clinical Services
Sussex Police	Danny Dugan	Detective Sergeant
CVS Arunwide	Hilary Spencer	Chief Executive
NHS West Sussex	Stephanie Stockton	Head of Safeguarding
West Sussex County Council	Sonia Knight	MARAC Coordinator
West Sussex County Council- Note taker	Kate Johnson	MARAC Administrator

The DHR Panel requested that the following agencies/bodies secure their records and identify and commission an independent author of sufficient experience and seniority to undertake an Individual Management Review (IMR):

- Arun District Council
- NHS West Sussex
- UK Border Agency

Sussex Police were requested to provide further information to the review relating to criminal activity in Germany.

The authors of the Individual Management Reviews are independent in accordance with the guidance.

The Chair and author of the Domestic Homicide Review is Councillor David Simmons Chair of the West Sussex Strategic Community Safety Partnership. Councillor David Simmons has had no previous involvement with the subjects of the review or the case.

1.4. Time Period

The review began on 3 February 2012 and concluded on 1 December 2012.

The primary focus of the review will be the period 17 February 2008, the date at which family members of Adult A and Adult B were known to be resident in the UK, and 25 December 2011, the date of the homicide.

Adult A is known to have been in the UK from 10 December 2010.
From the information available to the Review Panel it was not possible to establish a date that Adult B came to the UK.

1.5. Terms of Reference

The purpose of the Domestic Homicide Review is to:

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.

- 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

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

In addition the following areas will be addressed in the Individual Management Reviews and the Overview Report:

- Adult A had no known contact with any specialist domestic abuse agencies or services. The review will address whether the incident in which he died was a 'one off' or whether there were any warning signs and whether more could be done in West Sussex to raise awareness of services available to victims of domestic violence.

- Whether family, friends or colleagues want to participate in the review and if so whether they were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide.

- Whether there were any barriers experienced by Adult A or his family/ friends/colleagues in reporting any abuse in West Sussex or elsewhere, including whether he knew how to report domestic abuse should he have wanted to.

- Whether Adult A had experienced abuse in Germany prior to coming to the UK and whether this experience impacted on his likelihood of seeking support in the months before he died.

- Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by the victim that were missed.

- Whether the alleged perpetrator had any previous history of abusive behaviour to a family member or intimate partner and whether this was known to any agencies.

- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Adult A, or Adult B.

- While it is not the purpose of this review to consider the handling of child protection concerns related to the case there may be issues that arise from the review that relate to the safeguarding of children who may be affected by domestic abuse. If this is the case these issues will be raised with the West Sussex Local Safeguarding Children's Board.

- The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the county.

- The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator e.g. Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

- Due regard will be given to the criminal proceedings and any H.M. Coroner's Inquest.

The review will consider any other information that is found to be relevant.

1.6. Individual Management Reviews

The Domestic Homicide Review Panel has received and considered the following Individual Management Review Reports (IMR):

Organisation	Author name	Author title
Arun District Council	Kevin Basford	Head of Environmental Amenities and Community Safety
NHS West Sussex	Stephanie Stockton	Head of Safeguarding
UK Border Agency	Tim Reichardt	Hampshire & Isle of Wight and Sussex Local Immigration Teams

The objective of the Individual Management Review (IMRs) which form the basis for the DHR is to give as accurate as possible account of what originally transpired in an agency's response to Adult A and his family, to evaluate it fairly, and if necessary to identify any improvements for future practice. IMRs also propose specific solutions which are likely to provide a more effective response to a similar situation in the future. The IMRs have also assessed the changes that have taken place in service provision during the timescale of the review and considered whether changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse.

This report is based on IMRs commissioned from professionals who are independent from any involvements with the victim, his family or the alleged perpetrator. The report author has indicated whether there is confidence in the findings of the IMR. The IMRs have been signed off by a responsible officer in each organisation.

The Overview Report's conclusions represent the collective view of the DHR panel, which has the responsibility, through its representative agencies, for fully implementing the recommendations from the review. There has been a full and frank discussion of all the significant issues arising from the review.

Confidentiality

The findings of each review are confidential. Following acceptance of this report by the West Sussex Strategic Community Safety Partnership a confidential "briefing note" encapsulating key messages and agreed recommendations will be circulated to relevant managers in each of the organisations that contributed to this DHR.

Dissemination

Whilst key issues have been shared with organisations the report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group. In order to secure agreement pre – publication drafts of the report were seen by the membership of the review panel (as listed at 1.3) and IMR authors as listed at 1.6.

The content of the Overview report and Executive Summary is anonymised in order to protect the identity of the victim, the perpetrator, relevant family members, staff and others, and to comply with the Data Protection Act 1998. The overview report will be produced in a form suitable for publication with any redaction before publication.
Adult A's family will be briefed about the report and will have access before publication.

1.7. Subjects of the review

Deceased	Adult A
Alleged Perpetrator	Adult B

All subjects of this review are Lithuanian.

1.8 Involvement of family/friends/colleagues

In domestic homicides, members of informal 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 including individuals from both the victims and perpetrators networks in the review process.

Adult A's sister agreed to talk with the DHR.
Adult A's wife agreed to talk to the DHR.
There were no other family members, friends or colleagues who wished to participate in the review.

2. DOMESTIC HOMICIDE REVIEW PANEL REPORT

2.1. Summary of the case

It is believed that Adult A came to the UK from Germany on or before 10 December 2010, which is the earliest date that any agency has a record for Adult A. It has not been possible to establish the date that Adult B came to the UK.

Adult A and Adult B were brothers who have been reported to the review panel as having a long standing and on-going adversarial relationship. This relationship is believed to have included frequent physical violence by both Adult A and Adult B

Neither Adult A nor Adult B was known to any agencies in the context of domestic violence before the homicide on 25 December 2011.

2.2. Analysis of friends/family/colleagues information

It proved challenging to find friends, family or colleagues who wished to talk to the review panel and initially offers were declined. However later in the process the Sussex Police Family Liaison Officer successfully introduced a member of the Review Panel to both the sister and wife of Adult A. It is important to note that the sister was also the sister of Adult B.

There was one face to face meeting which took place in November 2012 at which there was no need for a translator. The information given to the Panel member was that they were aware of the difficult relationship between Adult A and Adult B, but thought that there was nothing that any agency could have done for Adult A or Adult B, before the tragic events of 25 December 2011. The view expressed was that the tragic death had been caused by alcohol and the only thing that they would like agencies to do differently would be to ban alcohol. Nothing else was said by the sister or wife of Adult A.

2.3. Analysis of Individual Management Reviews

The three agencies who were required to complete IMRs all responded with completed IMRs within the required timescale.

None of the agencies had contact which was considered by the DHR Panel to be relevant to any background or relevant to any events which may have led to the death of Adult A, although they did raise issues which may have longer term implications in respect of offender management within the context of immigration. It is the intention of the DHR Panel to bring these matters to the attention of the Minister of State for Immigration.

Arun District Council reported some contact in relation to Housing Benefit and Council Tax Benefit, but these were not considered relevant to this case by the DHR Panel as they were of a routine nature. There was no contact with Adult A or Adult B. Adult A appeared on the benefit forms, Adult B did not appear on the benefit forms.

NHS West Sussex reported Adult A had contact with medical services for minor health issues. There was no significant health input to Adult A.
The minor health input is not considered by the Overview Panel as relevant to this Review.
The author of the report concluded that Adult B had no involvement with local health services.

UKBA reported they had records in relation to an application for a work permit relating to Adult A
The author of the report stated that the subjects of the review were likely to have passed through UK border controls but there is no record available of these movements. This is because the movement of European Economic Area (EEA) nationals is not routinely recorded.

The only other contact the UKBA had with either subject was a worker registration scheme application from Adult A in 2011.

There was no contact or record of Adult B.

With so little information available and none that would naturally lead to any form of enquiry for domestic abuse by any frontline professional, the IMRs did not offer any further insight to the DHR Panel.

3. CONCLUSIONS AND LESSONS LEARNED

3.1. Agencies working together

West Sussex has a long history of successful partnership working in the field of domestic violence. The request for information to be provided to and shared with the Domestic Homicide Review Panel was responded to in a timely and considered manner by all agencies in the partnership.

It was revealed by Sussex Police during the review that both Adult A and Adult B had previous convictions for crime in Germany, but neither was known to the British authorities before the homicide.
The deceased, Adult A had two specific convictions for violent crime, and in Germany on 22 February 2008, he received a seven year prison sentence for causing grievous bodily harm with intent and a 4 year sentence of armed robbery.

The alleged perpetrator Adult B had two theft convictions, one involved violence and he received a one year custodial sentence for this offence.

3.2. Good Practice

West Sussex is one of the best resourced counties in the UK with the following domestic violence services:

- WORTH Services has been established since 2004 and provide an Independent Domestic Violence Advisor (IDVA) 7 days a week across the county. The IDVA Service is available to male and female victims and has assisted over 10,000 victims of domestic violence. IDVAs are based in the Emergency Departments of all major hospitals in the county and also with Sussex Police. The service has 17 IDVAs, 3 of which are male and a further 4 support staff.

- There are four MARACs in West Sussex each meeting monthly and during 2011/2012 over 750 cases were referred to the MARACs.

- There are frequent advertising campaigns to raise the awareness of domestic violence within the community and information is distributed to every household in the county.

- The West Sussex County Council Domestic and Sexual Violence Unit worked with Crime-stoppers to launch a campaign to encourage third party reporting of domestic violence.

3.3. Lessons Learned

Because of the lack of relevant knowledge of Adult A or Adult B in the period since they both entered the UK, there are few specific lessons to be learned.

It is also acknowledged that the Lithuanian community may not understand domestic violence in the way that it is defined and described within the UK and this will be covered more fully in the recommendations in section 4 of this report.

3.4. Conclusions

The Terms of Reference have been considered and the following conclusions made.

- The criminal proceedings concluded in September 2012, with Adult B being found Not Guilty of either murder or manslaughter. There are no further suspects or criminal investigations relating to this case.

- H.M. Coroner has confirmed that she will not be conducting an Inquest.

- The review has been conducted according to best practice, with effective analysis and conclusions related to the case.

- It has been difficult to establish specific lessons to be learned due to the limited and unconnected contact that agencies had with Adult A or Adult B. However it has been established that a better understanding of and working relationship with UKBA should be established.

- The review does not conclude that the incident in which Adult A died was a "one off", as there is a long history of violence between Adult A and Adult B. However Adult A had no known contact with any specialist domestic abuse agencies or services. It would seem that due to this long history of violence that there were warnings signs, but none of these had been brought to or come to the attention of any agency that could have provided intervention.
  From all the information available to the Review Panel it does not appear that any agency could have prevented the homicide.

- There is more that can be done within West Sussex to raise the awareness of domestic violence and the help that is available to the

Lithuanian and other migrant communities and translation of leaflets into a wider range of languages should be a priority.

- The sister and wife of Adult A talked with a member of the Review Panel, they were aware of the history of violence between Adult A and Adult B, but did not think that any agency could have prevented this death.

- The only barriers to Adult A or his friends/family/colleagues reporting the violence were their lack of will to do so and possibly their aversion to doing so, because of the criminal convictions and a sentence that still had not expired. Language had not appeared to be a barrier to accessing other services effectively for matters of housing and benefits.

- It would seem that Adult A and Adult B had both experienced previous violence from each other in Germany and this violence existed before they lived in Germany and had its roots in childhood.

- The panel concluded that there were no missed opportunities to routinely enquire or identify domestic violence, and no opportunities to offer intervention.

- There are no child protection concerns related to this case. The Panel are further satisfied that children's services acted entirely appropriately at the time of the homicide.

- The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the county.

- The panel felt this review has raised significant concerns about the unmanaged risk to public safety in local communities from dangerous and violent offenders entering the country. Although this death arose in a domestic situation it could have occurred between unrelated people.

- Another concern is that the UK Border Force is not aware of this level of intelligence and thus is unable to assess the risk posed to public safety and possibly national security by some people coming into the UK.

- When considering the past criminal records of Adult A and Adult B the Review Panel were astonished at the lack of information sharing between countries.

- The Chair of the Review Panel has written to the Minister of State for Immigration to request a meeting to discuss the matters relating to immigration more fully.

- Best practice in relation to raising awareness of domestic violence within eastern European communities should be identified and used to review and improve current service provision within current resources to assist future engagement with these communities by service providers.

The Panel concludes that all agencies acted appropriately within the context of their contacts with Adult A and Adult B and there was nothing further those agencies could have been expected to have done or to provide to prevent the death of Adult A.

4. RECOMMENDATIONS - Local

4.1. To identify best practice in relation to provision of information about domestic violence and to replicate this in West Sussex and communicate this to Eastern European migrant communities.

4.2. Necessary funding to support 4.1 be identified within partner organisations during 2013/2014.

5. RECOMMENDATIONS – National

5.1. The Home Office urgently review the policies and procedures governing the checking, risk assessment and management of people with criminal histories entering the UK.

5.2. The Home Office develop a strengthened policy around criminality in the EEA context as well as considering whether the production of overseas police certificates can be introduced for both EEA and non-EEA applicants.

5.3. It is acknowledged that there is no general power to allow UKBA to seek the criminal record of an EU national who has not come to the adverse notice of the UK authorities. When connected to the second generation Schengen Information System (SIS 11), by April 2015, they will receive European Arrest Warrants as soon as they are certified. The

Panel recommend that this be reviewed and brought forward and the dissemination of this information should be shared with Police and Probation.

5.4. The Panel recommends that Government ask UKBA to update their administration to include a declaration of overseas criminality and develop and implement an internal checking and risk assessment system using this information to determine whether further action should be taken.

5.5. The Minister of State for Immigration is informed of the concerns of the Review Panel in relation to the fact that known and violent criminals are in the UK without the knowledge of Police and security services.

5.6. A legislative framework is established to ensure better links are developed between criminal courts and enforcement bodies across the European Union, to prevent people entering the UK without notification who have not fully served custodial sentences in other countries.

5.7. The transparency of policy in relation to immigration be reviewed to ensure that relevant information is made available to statutory requirements such as Domestic Homicide Reviews.

5.8. That policies be set in train to allow exchange of such information with Independent Chairs of such reviews without prejudicing national security.

5.9. Processes to vet people entering the UK as either refugees or economic migrants be improved along with referrals of appropriate information to police and enforcement agencies across the UK.

Councillor David Simmons
Independent Chair

1 December 2012

Appendix A

Organisations contacted for information to inform this Review

Organisation	Person	Role
Arun CVS	Hilary Spencer	Chief Executive
West Sussex County Council- Safeguarding	Sue Cart	Head of Safeguarding
West Sussex County Council- Domestic and Sexual Violence Unit	Trish Harrison	Domestic and Sexual Violence Manager
Arun District Council	Georgina Holland	Community Safety Manager
Sussex Police	Carwyn Hughes	Detective Chief Inspector
Arun District Council	Kevin Basford	Head of Environmental Amenities and Community Safety
Sussex Community NHS Trust	Sue Giddings	Deputy Director of Clinical Operations
NHS West Sussex	Stephanie Stockton	Head of Safeguarding
South East Coast Ambulance Service	Jane Mitchell	Safeguarding Manager
Surrey & Sussex Probation Trust	Jane Browne	Director Offender Management
Sussex Partnership NHS Trust	Louise Archer	Head of Social Care
West Sussex County Council – Adult Services	Jenny Daniels	Head of Health & Social Care Practice
RISE	Gail Grey	Chief Executive
Worthing Hospital	Andy Jones	Operations Manager

Carolyn Randall	Area Manager	Crime-stoppers Sussex
Women’s Aid	Lisa Johnson	National DV Helpline Team Leader
UK Border Agency	Tim Reichardt	Hampshire & Isle of Wight and Sussex Local Immigration Teams
UK Border Agency	Duncan Partridge	Area Manager - Detention Services Operations