Bracknell Forest Community Safety Partnership

Executive Summary

Domestic Homicide Review

Victim Female TS - Died May 27th 2012

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March 2013

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Executive Summary Domestic Homicide: - Female TS

1. Case Summary

1.1 This DHR was commissioned by Bracknell Forest Community Safety Partnership (CSP) in response to the death of TS in Bracknell on 27 May 2012.

1.2 At 07.58 hours on 27 May 2012 Thames Valley Police received a report of a female body having been located in the underpass by The Brackens in Bracknell. The deceased was subsequently identified to be TS. On 29 May 2012, MS, partner to TS, was charged with her murder.

1.3 TS was aged 43 at time of death. TS was attacked in an underpass under the London Road, A329 in Bracknell. She was stabbed in the neck before being hit with a heavy pair of cutters on at least nine occasions. She was struck with considerable force across the back of her head. There was evidence that she tried to defend herself as bones in her hand were broken.

1.4 The perpetrator, MS, aged 28 at the time of the crime, was found guilty of murder with a recommendation that he serve 23 years following a trial at Reading Crown Court. MS's defence was that TS provoked him to lose his self-control which was rejected. No independent witness or information to sustain this position was accepted by Court. MS showed no remorse or emotion from the time of his arrest, throughout the extensive interviewing at the police station or at his trial.

1.5 There were no witnesses to the murder. It was reported by staff at a Ladbrokes shop in Bracknell that TS and MS had spent from 5pm to 10 pm on Saturday 26 May 2012 playing the roulette machines in their shop. It was understood that they lost about £1,000 during this time. During the evening they were seen by the staff of the Ladbrokes shop to have argued on one occasion but left together at 10pm.

1.6 With no direct witnesses to the murder or more specific information or defence from the perpetrator it is purely speculative as to whether the loss of money at the Ladbrokes shop, or other exchanges between the couple on that night triggered the homicide.

1.7 TS was born in Thailand and married a German national RS, in 1994 in Denmark. She became a full German citizen and in June 1997 gave birth to a son SS. She left RS in October 2010 to move to the UK. In March 2012 RS filed for divorce.

1.8 TS and MS arrived in Bracknell in March 2012. TS met MS in Slough in April/May 2011. He told the court how he had married her in an Islamic Ceremony in Slough on 31 December 2011 and that they had applied to Southwark Registry Office to marry under British law but the divorce papers

that TS had did not have the correct wording (she was still legally married to her estranged husband in Germany).

1.9 The Police's view at the time of the trial and derived from interviews with MS was that it did not appear that TS was being exploited. The Crown's case was that this was a relationship that was mutually convenient to both parties.

1.10 The Police's position is that TS did not work; she was financially supported by MS.

1.11 Information from Police Interviews with MS indicated he set up a company called IHM which he described as a virtual university through a computer based approach. He was reportedly assisting overseas students gain places at UK colleges and applying for Student Study Visas.

1.12 What is perhaps a little unusual, although explained by the short period of time resident in Bracknell was that the differing agencies contributing to this DHR established that no contact or records of information or events with TS the victim or MS the perpetrator were held about them whilst they were residing in the Bracknell Forest area.

2. Establishing the Domestic Homicide Review

Decision Making

2.1 The referral for consideration of a DHR was made by the Police to the Chair of the Bracknell Forest Community Safety Partnership who is also the Chief Executive of Bracknell Forest Council. The Chair considered the Home Office guidance criteria for a DHR as defined in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews April 2011 (the Guidance) and concluded that the requirement for such a review was met and a DHR panel was set up chaired by the Bracknell and Wokingham College Principal.

2.2 There were three meetings of the Domestic Homicide Review group (DHR Group) running up to the presentation to the group of the first draft report on the 20 February 2013.

Domestic Homicide Review Panel

2.3 The review team was appointed by the Chair of the Bracknell Forest Community Safety Partnership. The Membership followed the statutory guidance and a chair appointed, Campbell Christie the Principal of Bracknell and Wokingham College, to oversee and take forward the Domestic Homicide Review. An Independent Author was also appointed.

Purpose of a DHR

2.4 The purpose of a DHR is to:

2.5 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;

2.6 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result;

2.7 Apply these lessons to service responses including changes to policies and procedures as appropriate;

2.8 Prevent domestic violence homicides and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working. Source: Paragraph 3.3 The Guidance.

The DHR Panel comprised:

- Campbell Christie (Chair)
- Diane Brown: Berkshire Women's Centre
- Detective Insp Mike Squire: Thames Valley Police
- Louise Mellish: Thames Valley Probation Service, Bracknell.
- Simon Bull: Assistant Borough Solicitor.
- Sophie Wing-King: Domestic Abuse Co-ordinator, Bracknell Forest Council
- Justin Whitlock: Offender Manager Bracknell Forest Council
- Detective Chief Inspector (DCI Protecting Vulnerable People) Linda York: Thames Valley Police
- Ian Boswell: Bracknell Council Community Safety Manager

Specific Terms of Reference for this Domestic Homicide Review

2.9 This was to:

- Consider the facts that led to the incident on 27 May 2012 and whether there are any lessons to be learned from the incident about the way in which local professionals and agencies worked together.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Consider the need for a Serious Case Review (SCR) should serious concerns over safeguarding come to light.
- Establish whether the agencies' or inter agency responses were appropriate leading up to and at the time of the incident in May 2012.
- 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. Domestic homicide reviews are not inquiries into how the victim died or who is culpable. That is a matter for the Police, coroners and criminal courts.

Time Period

2.10 The time period under this review was initially not specified as the early information from the agencies represented on the DHR Panel were indicating no information or contact records to generate any certainty regarding how long TS and MS had been living in the Bracknell area.

2.11 Agencies were asked to exercise their professional judgement and include any information relevant to the terms of reference that pre-dated the death of TS on 27 May 2012.

2.12 The target date for completing the review was the end of March 2013 - which was achieved.

Agencies involved

- As the deceased had also been living in Harlow Essex, enquiries of Essex Police were made.
- The Police in Thames Valley were also involved and they were able to give information on both the victim and perpetrator.
- The Crown prosecution service in Essex was contacted.
- Public Health and Probation were involved
- Due to the recent travel into this country of TS and MS the UK Border Agency were also approached for information due to the immigration status of both the victim and perpetrator.
- Essex's Community Safety Partnership was approached for information.
- Due to the gender of the deceased the Berkshire Woman's Aid organisation was contacted.
- The deceased was not subject to a Multi-Agency Risk Assessment Conference (MARAC)[1]and the Perpetrator was not subject to Multi Agency Public Protection Arrangements (MAPPA)[2]

[1]**The MARAC** is a victim-focused meeting where information is shared on the highest risk cases of domestic abuse between criminal justice, health, child protection, housing practitioners, IDVAs (Independent Domestic

2.13 As far as the review panel could ascertain the victim did not have any contact with a domestic violence organisation.

2.14 Consideration was also given as to whether TS was a 'vulnerable adult' – a person "who is or may be in need of community care services by reason of mental or other disability, age or illness; and was or may have been unable to take care of herself, or unable to protect herself against significant harm or exploitation". As there was some indication from Essex Police of being arrested for suspicion of being involved with prostitution the subject of exploitation was also considered and Adult Social Care in Bracknell Forest Council were also approached for information. Consideration as to whether TS was vulnerable is covered again, later in this report.

Agencies requested to provide Individual Management Reviews (IMRs) and whether received

- Thames Valley Police: Submitted.
- UK Border Agency: Not submitted limited information received.
- Essex Police: Not submitted limited information received.
- Public Health Bracknell: Not submitted limited information received.
- Crown Prosecution Service Essex: Not submitted limited information received.

3. Notification and involvement of TS Family and others close

3.1 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 DHR Panel therefore carefully considered the potential benefits gained by including and contacting such individuals especially as there had been contacts by the Police running up to the trial of MS, the perpetrator.

3.2 Although the deceased's estranged husband lived in Germany it was agreed contact should be made with him.

3.3 TS had a sister in Germany and she was contacted and gave information.

Violence Advocate) as well as other specialists from the statutory and voluntary sectors. A safety plan for each victim is then created.

[2]**Multi-Agency Public Protection Arrangements** (MAPPA) is the name given to arrangements in England and Wales for the "responsible authorities" tasked with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public. The "responsible authorities" of the MAPPA include the National Probation Service, HM Prison Service and England and Wales Police Forces. MAPPA is coordinated and supported nationally by the Public Protection Unit within the National Offender Management Service. MAPPA was introduced by the Criminal Justice and Courts Services Act 2000 and was strengthened under the Criminal Justice Act 2003.

3.4 Efforts were made to speak to a friend, WP, in Fleet who appeared at the perpetrator's trial. Attempts were made to contact here twice but did not result in her participation in this review.

3.5 Other than the individuals described, the victim's birth family lived in Thailand and there were very few family and friends to contact. This was reinforced by considering the information held by the Police who also had reason to contact family and friends as part of the trial following TS' death.

3.6 The deceased's estranged husband, RS, was contacted on 28 January 2013. As he was living in Germany this communication was undertaken by telephone call. Language Line, a telephone interpreting service, was utilised. He was asked whether he had kept in touch with TS and he replied there was no contact between them other than the occasional contact with his son. He did not know where she lived and TS had not reportedly spoken to her son who was living with the Father since 2011.

3.7 DH, TS' sister, was also contacted on 29 January 2013. The sister reported telephone contacts with TS as recently as 5 days before her death. She was aware her sister was living in Bracknell and living with MS. She confirmed they were living together and reported that she had been physically abused by him, about three months before her death and at an earlier occasion he had either pushed her or held her down against her will. The exact details as to whether any physical harm came of this is not known. The sister advised her to move back to Germany but TS reported her love for MS prevented that occurring. The sister did not think TS would have known about any agencies or organisations that could have helped her. She also confirmed that her sister did not have a GP.

3.8 TS and MS's Landlord FN, who saw TS nearly every day, (as he lived in part of the building he let to them), reported over a sustained period of time, many months, she presented as happy. FN only heard them argue once, she raised her voice, FN asked what was going on and she said 'He hit me'. FN didn't see any marks and her account was that she said she wanted to go out, he tried to stop her by putting his arms around her, she pushed him away, he then slapped her on the face. FN said that TS was beginning to become more independent and MS was controlling, MS would stick to her like glue.

3.9 The reports from DH the sister did not reveal a history of TS being abused by MS. FN the landlord reported one occasion of reported violence over a period of many months of contact with TS. These two reports on their own would not indicate that there was sufficient information or escalation of violence to expect any of the local agencies should have been alert to or have considered TS as a vulnerable person, or consider any of the local agencies awareness of exploitation was deficient.

3.10 A friend of TS living in Fleet WP was approached via her husband by telephone and written to on 1 February 2013. Despite these attempts no contact with this person was possible. In the circumstances it was considered inappropriate to pursue the friend further and the contact details of the officer initially contacting were left.

4. Synopsis of events

Prior to March 2012 - TS and MS arrival in Bracknell

4.1 TS entered the UK in October 2010 according to her estranged husband. This is at variance to the accounts of the Essex Police who indicate from an interview with her that she arrived in the UK in late February 2011.

4.2 She came to the attention of the Police in Essex at the beginning of March 2011 on suspicion of running a brothel in Harlow at that time. This was denied by TS and no prosecution occurred.

4.3 Information from the UK Border Agency indicates MS entered the UK on 6 November 2010 and was granted general student status to stay until 18 February 2012. There was no connection with TS at this point.

4.4 The first mention of a linkage with TS was on 17 February 2012 when the Home Office was approached by MS for EEA residence as the unmarried partner of TS, a national of Germany exercising her treaty rights in the UK.

4.5 Information from TS' sister report TS and MS meeting in Slough in April/May 2011.

4.6 March 2012 is the first time records indicate that TS and MS are living in the Bracknell area. This is further confirmed by the landlord of the premises they lived at up until the time of TS' death in May 2012.

4.7 Interviews with the landlord were important to conclude and understand, as the landlord also occupied part of the premises where TS and MS rented. He did not report any abuse or violent or concerning behaviours occurring in the relationship.

March 2012 – May 2012

4.8 TS and MS arrived in the Bracknell area in March 2012. As described earlier in this report the lack of any contact with any of the agencies/organisations involved in this review made it very difficult to be clear whether TS suffered any serious, sustained or frequent domestic abuse and emotional harm at the hands of MS.

4.9 Contacts with TS' sister with whom TS had by all accounts fairly regular contact, indicated some physical restraint and pushing behaviour by MS about three months before her death but nothing of note before this time. These reports by TS' sister never came to the attention of any authorities.

4.10 TS had no contact with health or any other statutory agency whilst residing with MS in the Bracknell area which might have led to any health professionals linking any presenting mental or physical difficulties to possible abuse.

4.11 There was no registration with a GP for either TS or MS during their short time in Bracknell. Other searches of health records for other health contacts from TS, such as a walk in centre or dentist also found no traces of contact during the twelve or so weeks she resided in Bracknell with MS.

4.12 The landlord did not indicate any concerns other than some shouting on an occasion and nothing to alert him to concerns warranting contact with other organisations such as the Police.

4.13 The Community police who were active in the neighbourhood were never alerted to any concerns or knew of any such concerns.

5. Conclusions

5.1 The aim of the IMR is to allow agencies to look openly and critically at individual and organisational practice and the context within which people were working, to see whether the homicide indicates that changes could and should be made. To also identify how those changes will be brought about and to identify examples of good practice within those agencies. The two key issues of predictability and preventability being considered as the underpinning theme.

5.2 TS and MS had only been living in Bracknell for approximately 12 weeks. Both this fact and their lack of any contact with statutory based organisations or registration with a GP have meant there was no opportunity for any of the agencies in the Bracknell area to have predicted the course of events leading to the murder of TS by MS. Neither is it considered that this domestic homicide could have been prevented.

5.3 The Police in Essex who were the first known statutory authority to come in contact with TS, although concerned that she may have been involved with prostitution, did not prosecute or was there any information for them at that early contact stage to consider she was vulnerable or being exploited. She had only been in the country a few days, there was no other history for them to consider in the context of vulnerability.

5.4 The reports of DH, the sister did indicate that TS had discussed with her concerns around being assaulted by MS approximately three months before her death. However DH in a telephone conversation 5 days before TS's murder did not raise any concerns about his conduct at that time.

5.5 The Landlord who lived in a private part of the accommodation connected to and leased to TS and MS, reported he would see TS every day and over a number of months she appeared happy. There was only one discussion between TS and the Landlord where she raised concerns about MS behaving in a reportedly abusive manner. The Landlord saw more of TS and MS in close proximity to their personal environment than any other party. He heard no arguments or concerning behaviour otherwise.

5.6 The Crown's case was that this was an unusual joining of two people. It appeared that if TS married MS he would give her some money and he would obviously obtain residency as she was a German Citizen. They did appear to have a shared love of gambling. They did appear to have lived and slept together as a couple. DH, the sister of TS, indicated that this was a loving relationship as indicated that TS said that she loved MS. There was no evidence of TS being exploited.

5.7 It is therefore concluded by the DHR Panel that there was no information to indicate that TS was vulnerable or being exploited and what information was known by the Landlord and TS's sister DH, was not communicated to any statutory authorities involved in this DHR. Neither would DH or the Landlord have been expected to report their concerns prior to TS's death, as the incidents were isolated, not directly observed, forming any pattern or reaching any reasonable thresholds for reporting to the Authorities.

5.3 However the DHR did, through the process of its review, identify a number of lessons to be learnt which are covered separately in this report.

6. Lessons learned

6.1 There were three meetings of the DHR panel running up to the presentation of the first draft report on 20 February 2013. During these meetings membership continuity and lack of full awareness in responding organisations, of Home Office IMR reporting guidance (although detailed to them in correspondence) were issues in comparing and answering queries and contrasting reports by the DHR Panel. This was Bracknell's first DHR Panel review concluded under the Council's statutory obligations related to Community Safety Partnership arrangements. This has a bearing on the first three recommendations arising out of the review.

6.2 The court transcripts related to the trial were not readily available to the author of this report. However this does indicate the importance of information which is in the

possession of the Police or Crown Prosecution Service (CPS) which is discussed with the DHR panel and for the panel to understand what can or cannot be accessed and its relevance. This may best be achieved through an invitation to the Police's Senior Investigation Officer at an early point in the meetings of the DHR Panel.

6.3 The DHR Panel was concerned to better understand whether domestic violence was publicised in any way at borders and surrounding passport control areas and if this needed to be further reviewed by the Home Office through the UK Border Agency.

6.4 It is suggested that the matter of nationals from the European Union being allowed to travel and reside freely is an issue for discussion at the Community Safety Partnership. This will aid better understanding and consideration of any actions in the local community that might publicise more effectively which key organisations can be contacted.

6.5 As there were no GP registration details for TS, Public Health made general enquiries, initially within health data systems for the DHR Panel concerning the extent of any possible contacts from TS and MS to health access points in the Bracknell area. No information existed. Further enquiries revealed that data quality across local health outlets was not sufficiently developed to establish whether TS may or may not have visited the numerous health outlets that exist in major towns such as Bracknell.

6.6 This point linked to the NHS changes effective from 1 April 2013 (in particular Department of Health and Public Health England). This further indicates that appropriate membership from Health is discussed at the Community Safety Partnership after 1 April 2013.

7. Good practice

7.1 Thames Valley Police were particularly helpful in this review; in particular the information they generated and ensuring queries of local community policing were represented at the DHR to cover specific community lines of enquiry.

8. Recommendations

8.1 Multi Agency recommendations

Recommendation 1: At a local level organisations required to produce IMRs require a better familiarity with the statutory basis for conducting DHRs and their role

and responsibilities in engaging with these activities. The Community Safety Partnership is best placed to consider this matter further.

Recommendation 2: The Home Office is also asked through this report to review how it might best remind key statutory agencies of their responsibilities in engaging with DHRs. Please see recommendation 6 & 7.

Recommendation 3: The key organisations that represent the statutory organisations on the DHR Panel should ensure that the officers they delegate for attendance have sufficient authority to enable the DHR Panel to administer its statutory responsibilities appropriately.

Recommendation 4: The terms of reference for future DHRs going forward need to mention relevant background information such as court transcripts, where appropriate. In addition, again where appropriate, an early invitation from the DHR to the Police's Senior Investigation Officer should be built into the terms of reference of DHRs.

8.2 Single Agency recommendations

Home Office

Recommendation 5: The Home Office will be asked through this review to consider whether the support services for victims of domestic violence should be further promoted at borders and through the activities of the UKBA.

Recommendation 6: The Home Office will be asked to note that the UKBA did not supply an IMR for this DHR. However a witness statement was produced. This is also referred to in Recommendation 2.

Recommendation 7: The Crown Prosecution Service (Essex) did not supply an IMR for this DHR. A one page letter was received subsequently. The Attorney General's Office should be contacted, this may well be best through the Home Office, initially. This is also linked to Recommendation 2.

Health Bracknell

Recommendation 8: The Community Safety Partnership needs to review, post 1 April 2013, the most suitable strategic partner representative following significant organisational and governance changes concerning the Department of Health and Public Health England.

Recommendation 9: It is recommended that Health's informatics access arrangements are reviewed in relation to DHRs. This to reach certainty as to whether health access via Walk in Centres, for example, or Accident and Emergency are recording information that may be relevant to DHR cases and their interface with nationally held data sets.

End of Executive Summary

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