NCCSP
Norfolk county community safety partnership

Domestic Homicide Review Report

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

Review into the death of Maria
in September 2018

Report Author: Christine Graham
September 2019

Format of the Report

This Overview Report has been compiled as follows:

Section 1 will begin with an **introduction to the circumstances** that led to the commission of this Domestic Homicide Review and the process and timescales of the review.

Section 2 of this report will **set out the facts** in this case **including a chronology** to assist the reader in understanding how events unfolded that led to Maria's death.

Section 3 will provide **overview and analysis of the information** known to family, friends, employers, statutory and voluntary organisations and others who held relevant information. It will specifically address the issue of identifying any **domestic abuse** that existed within couple's the relationship.

Section 4 will address **other issues** considered by this review

Section 5 will provide the **conclusion** debated by the Review Panel and will consolidate **lessons learned and the recommendations that arise.**

Appendix One provides the **terms of reference** against which the Review Panel operated

Where the review has identified that an opportunity to intervene has been missed, this has been noted in a text box.

Preface

Norfolk's County Community Safety Partnership, and the Domestic Homicide Review Panel wishes at the outset to express their deepest sympathy to Maria's family and friends. This review has been undertaken in order that lessons can 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 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 – Introduction

1.1 Summary of circumstances leading to the Review

1.1.1 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.

1.1.2 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.

1.1.3 During the attack, the perpetrator sustained injuries to his fingers and went to the hospital. Whilst there he presented himself to the ambulance that had taken Maria and said he was responsible. When police arrived, he was arrested. He was charged with murder and remanded in custody. He subsequently pleaded guilty to murder in December 2018.

1.1.4 At a sentencing 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 pleaded guilty at the first opportunity.

1.2 Reasons for conducting the Review

1.2.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.2.2 The review must, according to the Act, 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'.

1.2.3 In this case, the perpetrator has been found guilty of the murder of Maria. Therefore, the criteria have been met.

1.2.4 The purpose of the Domestic Homicide Review (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
- 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

1.3 Process and timescales for the Review

1.3.1 Norfolk County Community Safety Partnership were notified on 28th September 2018.

1.3.2 A partnership meeting was held on 15th October 2018 and this meeting was chaired by the Chair of the Partnership and the decision was taken to appoint an independent chair and report author and proceed with a DHR.

1.3.3 The Independent Chair and Report Author were appointed in October 2018.

1.3.4 The Home Office were notified of the decision to carry out a DHR on 16th October 2018. The family were notified of the intention to hold a DHR.

1.3.5 The first Review Panel meeting was held on 11th January 2019. The following agencies were represented at this meeting:

- Access – Supporting Migrants in East Anglia
- Borough Council of King's Lynn and West Norfolk
- Leeway – providers of specialist domestic abuse services within Norfolk
- Norfolk and Waveney Clinical Commissioning Groups
- Norfolk Constabulary
- Norfolk County Council
- Office of Police and Crime Commissioner

1.3.6 At this first meeting, the Review Panel considered its composition and agreed that it brought together the relevant expertise in relation to the circumstances of this case.

1.3.7 It was agreed that reports would be requested from:

- Norfolk Police
- Borough Council of King's Lynn and West Norfolk
- Health agencies

There had been little prior agency involvement.

1.3.8 The Review Panel met three times and the review was concluded in September 2019.

1.4 Confidentiality

1.4.1 The content and findings of this Domestic Homicide Review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until

such time as the DHR has been approved for publication by the Home Office Quality Assurance Panel.

1.4.2 To protect the identity of the deceased, their family and friends, Maria will be used as a pseudonym to identify the deceased hereafter and throughout this report. This pseudonym was chosen by the victim's family. The person who killed her will be known as 'the perpetrator'.

1.5 Dissemination

1.5.1 The following individuals/organisations will receive copies of this report:

- Maria's family
- Norfolk Police and Crime Commissioner
- Chief Constable, Norfolk Police
- Chief Executive, Borough Council of King's Lynn and West Norfolk
- Chief Executive, Norfolk County Council
- Chief Executive, Leeway
- Chief Executive Officer, Norfolk and Waveney Clinical Commissioning Group
- Chair, Norfolk Health and Wellbeing Board
- Independent Chair, Norfolk Safeguarding Adults Board
- GP practice for Maria
- Senior Coroner for Norfolk

1.6 Methodology

1.6.1 Norfolk County Community Safety Partnership was advised of the death by Norfolk Police six days after the death. This was a timely notification and demonstrated a good understanding by the police of the need for a referral at the earliest opportunity.

1.6.2 In response to the notification, a partnership meeting was held on 13th October 2018. This was chaired by the Chair of the Community Safety Partnership. At this meeting, the police provided a summary of the incident and those partners present shared the initial information that they held in relation to Maria and the perpetrator. At this meeting it was clear that very little was known about either the victim or perpetrator by partner agencies.

1.6.3 Having heard the contributions from the partners present, the Chair took the decision to hold the Domestic Homicide Review because it was clear that, given the information available at the time, there would be learning from this case. The Home Office was informed of the decision to undertake the review. This decision demonstrates a good understanding by the Chair of the Partnership of the issues surrounding domestic abuse and a willingness to welcome external scrutiny of the case in order that lessons could be learnt.

1.6.4 Gary Goose and Christine Graham were appointed in October 2018 to undertake the review and the Review Panel met for the first time on 11th January 2019. The Panel met three times and the final meeting of the Panel was on 5th July 2019.

1.6.5 At the meeting on 11th January 2019 all members of the Review Panel were present. At this meeting, the process of the Domestic Homicide Review was explained to the Panel with the Chair stressing that the purpose of the review is not to blame agencies or individuals but to

look at what lessons could be learned for the future. Prior to this meeting, the Chair had met with the police's senior investigating officer (SIO) to ensure that Section 9 of the statutory guidance was adhered to in relation to disclosue and criminal proceedings.

1.6.6 Agencies were asked to secure and preserve any written records that they had pertaining to the case. Agencies were reminded that information from records used in this review were examined in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the Domestic Homicide Review is to prevent a similar crime.

1.6.7 At this meeting the Terms of Reference were agreed subject to the family being consulted. It was agreed that the Chair and Overview Report author would make contact with the family with an introduction via the police family liaison officers.

1.6.8 The Independent Chair met with the victim's brother and he was made aware of the support that AAFDA (Advocacy After Fatal Domestic Abuse) were able to provide. The Report Author met with friends and colleagues of Maria.

1.6.9 A copy of the report has been shared with the family and left with them to read as and when they wished. The family were specifically offered the opportunity to have the report translated into Romanian, they declined. They were met again prior to publication to talk about any feedback that they had to give; they were content that the Review captured what was known about their loved one.

1.7 Contributors to the Review

1.7.1 Those contributing to the DHR do so under Section 2(4) of the statutory guidance for the conduct of DHRs and it is the duty of any person or body participating in the review to have regard for the guidance.

1.7.2 All Review Panel meetings include specific reference to the statutory guidance as the overriding source of reference for the review. Any individual interviewed by the Chair or Report Author, or other body with whom they sought to consult, were made aware of the aims of the Domestic Homicide Review and referenced the statutory guidance.

1.7.3 However, it should be noted that whilst a person or body can be directed to participate, the Chair and the Review Panel do not have the power or legal sanction to compel their co-operation either by attendance at the Panel or meeting for an interview.

1.7.4 The following 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[1]
- The employer of both victim and perpetrator

1.7.5 The following individuals contributed to the review:

- Maria's brother (on behalf of her family)
- Work colleague of the perpetrator
- Friend of Maria

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

1.8 Engagement of family, friends, colleagues and employers

1.8.1 Family and friends are integral to any Domestic Homicide Review and therefore extensive effort has been made to engage with those who knew Maria and the perpetrator. The Independent Chair and Report Author record their thanks to the officers of Norfolk Police who have greatly assisted the review in engaging the family, friends and employers of both Maria and the perpetrator.

1.8.2 Maria's brothers were written to by the Chair and this letter was delivered by the Family Liaison Officers to explain the review to them. When no response was received, a further letter was sent, and the Family Liaison Officers visited again. After a further approach by the Family Liaison Officer, Maria's brother agreed to meet with the Independent Chair and released his Victim Impact Statement to the review.

1.8.3 The family were given the Home Office leaflet about Domestic Homicide Reviews and AAFDA[2], both of which had been translated into Romanian.

1.8.4 Letters were delivered by the police to all the colleagues and friends that had given evidence to the investigation. Those who chose to engage were met by the Report Author.

1.8.5 Maria and the perpetrator were both employed by the same employment agency and placed at the same local firm. Both the employment agency and employing firm were contacted by the Chair with a view to meeting them. When no response was received, a further letter was sent and this was followed up by a personal visit to the employment agency by the Chair of this Review. Both the site at which they were employed and the Agency itself subsequently engaged with the Review.

1.9 Review Panel

1.9 The members of the Review Panel were:

Gary Goose MBE	Independent Chair	
Christine Graham	Overview Report Author	
Emma Humphrey	Manager	Access – Supporting Migrants in East Anglia

[1] https://www.pandoraproject.org.uk/
[2] Advocacy After Fatal Domestic Abuse

Andy Nederpal	Anti-Social Behaviour Manager	Borough Council of King's Lynn and West Norfolk
Margaret Hill	Community Services Manager	Leeway Domestic Violence and Abuse Services
Gary Woodward	Adult Safeguarding Lead Nurse	Norfolk and Waveney Clinical Commissioning Groups
Lewis Craske	Detective Inspector	Norfolk Constabulary
Alix Wright	Detective Inspector	Norfolk Constabulary
Jon Shalom	NCCSP Business Lead	Norfolk County Council
Walter Lloyd-Smith	Business Lead for Norfolk Safeguarding Adults Board	Norfolk County Council
Zoe Harding	Domestic Abuse Change Coordinator	Norfolk County Council
Amanda Murr	Senior Policy Officer, Vulnerability	Office of the Police and Crime Commissioner for Norfolk

1.10 Domestic Homicide Review Chair and Overview Report Author

1.10.1 Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector, his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary served on the national Family Liaison Executive and led the police response to the families of the Soham murder victims. From 2011 Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

1.10.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. Christine also delivers Partnership Healthchecks which provide an independent view of partnership arrangements. Christine is also a Lay Advisor to Cambridgeshire and Peterborough MAPPA which involves her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews.

1.10.3 Working together, Christine and Gary have completed four reviews, with twenty-seven reviews (excluding this one) currently in progress. In addition, Gary has completed six reviews working alone.

1.10.4 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[3]

1.10.5 Both Christine and Gary have:

[3] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

- Completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports
- Completed DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse)
- Attended the AAFDA Annual Conference (March 2017)
- Attended training on the statutory guidance update in 2016
- Undertaken Home Office approved training in April/May 2017
- Attended the AAFDA Annual Conference (March 2018)
- Attended Conference on Coercion and Control (Bristol June 2018)
- Attended AAFDA Learning Event – Bradford September 2018
- Attended AAFDA Annual Conference (March 2019)

1.11 Parallel Reviews

1.11.1 An inquest was opened and adjourned pending the criminal trial but, following this, the Coroner did not feel it necessary to reopen the inquest.

1.11.2 There were no other reviews undertaken.

1.12 Equality and Diversity

1.12.1 Throughout this review process the Review Panel has considered the issues of equality in particular the nine protective characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

1.12.2 Women's Aid state '*domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family*'.[4] Women are more likely than men to be killed by partners/ex-partners. In 2013/14, this was 46% of female homicide victims killed by a partner or ex-partner, compared with 7% of male victims.[5]

1.12.3 Both Maria and the perpetrator were from Eastern European countries. Maria was from Romania and the perpetrator was from Lithuania. Throughout the review, the Review Panel has sought to question whether the circumstances of this case were impacted by the nationality of both parties. Discussions were held with specialist local agencies and the family and friends of Maria. There was no indication that this case was adversely impacted by their ethnicity.

4 (Women's Aid Domestic abuse is a gendered crime, n.d.)
5 (Office for National Statistics, Crime Statistics, Focus on Violent Crime and Sexual Offences, 2013/14 Chapter 2: Violent Crime and Sexual Offences – Homicide, n.d.)

Section Two – The Facts

2.1 Introduction

2.1.1 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.

2.1.2 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.

2.1.3 Maria had been in a relationship with the perpetrator for approximately 12 months and during this time they were both employed locally. Together they took a number of holidays including visiting Switzerland, Venice and Bali. At the time of her death, Maria had separated from the perpetrator.

2.1.4 A full chronology of events and a summary of information known by family, friends and agencies will follow within this report.

2.2 Chronology

2.2.1 **Background information**

2.2.2 Very little information is known about either Maria or the perpetrator. It is thought that they had been in a relationship since the autumn of 2017 whilst they were both working at the same factory. They had lived together for some time before their relationship ended and Maria had moved a few weeks before her death to the property where she was killed.

2.2.3 Although their relationship had ended, it is known that they were still in some contact with each other. For example, the perpetrator helped Maria to move into her new property and they appeared to be selling items together on Ebay. This interaction will be explored in more detail later in the report.

2.2.4 **Chronology**

2.2.5 In 2014 Maria moved to England with her partner who she later married in Romania.

2.2.6 On 14th April 2015 Maria registered with her GP practice. She gave her main spoken language as being English and had no chronic conditions listed.

2.2.7 At some point in 2016 Maria and her husband separated but did not divorce.

2.2.8 On 27th July 2017 she presented at her GP following a toe injury that had occurred on 26th July. Following an x-ray taken at the local hospital, it was confirmed that she had a fracture of her toe. It was noted by the GP that this was a traumatic injury which Maria attributed to having stubbed her toe against furniture and the mechanism of the injury was in keeping with this account.

2.2.9 In September 2017 Maria and the perpetrator began a relationship.

2.2.10 Maria attended her GP on 18th January 2018 complaining of lower back pain. She stated that this had not been caused by a traumatic injury and it was diagnosed as a muscular skeletal problem, attributed to her manual labour job in a factory.

2.2.11 In April 2018 the perpetrator registered with a GP and listed his main spoken language as Lithuanian. No chronic conditions were listed.

2.2.12 In May 2018 Maria and the perpetrator went on holiday to Bali for a month. When they returned, the perpetrator's luggage had been lost by the airline, so they stayed in Luton for a few weeks whilst they waited for its return in a hotel paid for by the insurance company.

2.2.13 On 2nd July 2018 Maria went with the perpetrator to Lithuania for a week. Upon her return to England, Maria was collected by her brother and went to stay with him for a while.

2.2.14 In August 2018 Maria moved to the house where she died. After moving she continued to work at the same factory in King's Lynn until her death.

2.2.15 **The evening of the incident**

2.2.16 Maria worked from 2pm to 10pm when she cycled home.

2.2.17 The perpetrator arrived for his shift at 5pm. This shift, as a cleaner, was due to last until 7.30pm. He then signed in at 8pm when he would work as a caretaker and signed out at midnight. (There is no automated clocking machine; attendance is just written down and so there is no confirmation that this is accurate).

2.2.18 The electronic door pass recorded that the perpetrator last opened a door at 8.03pm and the site CCTV showed him leaving the main entrance at 8.05pm.

2.2.19 At 8.32pm a taxi driver picked up a booked customer from a local gym and dropped him at the perpetrator's address at 8.37pm. This man matched the description of the perpetrator. The perpetrator was then collected by a taxi at 9.45pm and dropped off 50 metres beyond Maria's address.

2.2.20 At 9pm and 10pm the perpetrator made his hourly call to his employer (as part of their lone working policy) even though he was no longer at work.

2.2.21 The perpetrator then hid in the 'lean-to' where Maria would park her bike until she arrived home. Upon her arrival, he stabbed her with a kitchen knife that he had brought with him. He was disturbed by a housemate, who had heard Maria's cries, and he then left the property.

2.2.22 The housemate alerted neighbours who called for emergency services. Maria was taken to hospital.

2.2.23 A photo album containing photographs of the holiday in Bali was found on the bonnet of the car in the lean-to garage. The relevance of this is not known.

2.2.24 It is thought that the perpetrator intended to return to work and continue as if he had never left. However he had cuts to his hands that needed attention and so he went to the hospital where he approached the back of the ambulance, at the hospital, that had conveyed Maria

and said, 'I think you are looking for me I didn't know where else to go'. The perpetrator had cuts to his hands and was treated by the ambulance staff and when the police arrived, he was arrested.

2.2.25 Maria was pronounced dead at 6.24 am the next morning.

2.2.26 The perpetrator was arrested and charged with murder. At the sentencing hearing he was given a life sentence with a minimum of 19 years 264 days to be served before he was eligible to apply for parole.

Section 3 – Overview and analysis

3.1 Information known to family and friends

3.1.1 The Review Panel is very grateful to those who have contributed to the review.

3.1.2 Maria was very family orientated and close to her four brothers. Her father describes his five children as 'a fist, unbreakable'. He says that now that the little finger is missing, he can no longer make a strong fist. Her brother says that she was the bond that kept them close in the UK. She would organise the family gatherings and she loved nothing more than to have her family together. All of her brothers loved her and listened to her.

3.1.3 She often phoned her parents in Romania and was a wonderful aunt who played an active part in her nieces and nephew's lives. Everyone spoken to described Maria as always happy with a smile on her face.

3.1.3 She was described as being, 'in some ways just an ordinary person who lived an ordinary life'. She enjoyed watching movies, listening to music and travelling. She was described, by her brother, as being 'gentle and humorous, strong and independent with a smile from ear to ear'. She was 'not only beautiful on the outside but also on the inside'.

3.2 Evidence of domestic abuse

3.2.1 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 intensely jealous, abusive and controlling man.

3.2.2 One of her housemates reported that often Maria and the perpetrator could be heard arguing. This person saw her crying a number of times during these arguments.

3.2.3 **Jealousy**

3.2.4 There is evidence of the jealousy that the perpetrator felt if he suspected that others were showing an interest in Maria or she was, as he considered, 'encouraging' them. A number of work colleagues have said that he was jealous if other men spoke to her. He would watch her at work and if he saw her talking to a manager or colleague he would come over. Maria told her friend that it was working together in the factory that caused the problem but if they left there, everything would be OK.

3.2.5 One work colleague described an incident when, as a joke, he put his arm round Maria. This caused the perpetrator to act aggressively and push this colleague. He then pushed back, and they had to be separated by colleagues. Maria pulled him away and told him he would lose his job.

3.2.6 A colleague said that the perpetrator had agreed that he was jealous and justified this by saying 'I love her'. He would stare and look unhappy if she talked to other men at work.

3.2.7 The Review was also told that, whilst they were on a visit to the perpetrator's family in Lithuania, he accused one of his brothers of being too interested in Maria and the police had to be called. The Review has been unable to gain any additional information regarding this.

3.2.8 **Isolation**

3.2.9 Friends of Maria have said that when she met the perpetrator she changed, stopped socialising and would sit on her own with him. She was described as becoming withdrawn and stopped 'being happy'. She was not, it has been said, allowed by him to socialise with colleagues and would ignore people.

3.2.10 One colleague, who spoke to the review, described how when the couple worked in different buildings, Maria would always come over in her break to sit with the perpetrator. If she did not appear at the expected time, he would pace up and down outside the door to her work area.

3.2.11 Maria's Facebook account became more private when she started her relationship with the perpetrator, and she was no longer posting photos'.

3.2.12 The family felt that Maria seemed reluctant to bring the perpetrator to meet the family.

3.2.13 **Coercion and control**

3.2.14 In May 2018 Maria and the perpetrator went on holiday for a month to Bali and whilst there Maria phoned her brother and told him that 'this man is eating my life' and 'suffocating her' and would not let her go anywhere. She asked for help to get a ticket home. The next day, however, she said that everything was OK. When they returned to this country the couple did not appear, to her brother, to be getting on but she did not talk much about her relationship.

3.2.15 During the time that they were staying in Luton, Maria left the perpetrator and went home to Romania for a break. When she came back, she stayed with her brother and whilst she was there, the perpetrator sent her a text saying, 'wherever you go I will find you'.

3.2.16 Maria told a colleague that she could not smile because the perpetrator was jealous.

3.2.17 In the days leading up to her death, Maria told a friend that he would not leave her alone.

3.2.18 Physical abuse

3.2.19 In July 2018 Maria phoned one of her brothers and told him that the perpetrator was aggressive and hitting her. When another brother phoned her to ask about this, she said that she was fine but that he had grabbed her wrist and broken her bracelet. Her brother then went and collected her.

3.2.20 In September 2018 Maria's brother spoke to the perpetrator's brother who told him that the perpetrator had been aggressive and hitting Maria when they were on holiday in Lithuania.

3.2.21 Whilst Maria and the perpetrator were staying in the hotel in Luton, one of her brother's asked another brother to go and collect her, as he feared the perpetrator would kill her.

3.2.22 A friend told of an incident when, at work, the perpetrator was seen to grab Maria and push her. When asked if she was OK, she replied that the perpetrator was jealous. On another occasion, he pushed her, and she started crying and walked out.

3.2.23 The perpetrator has been portrayed by those who knew him as a jealous man and when he met the paramedics at the hospital, he told them that 'my girlfriend is having romantic relations with another male'. He then went on to say that he 'had a moment of passion and lost control and stabbed her'. However, we know that he planned his exit from work and rang on two occasions to give the impression that he was still there. He then took a taxi to Maria's home and waited in the lean-to with a knife that he had taken from home. This was not a spur of the moment loss of control, as the perpetrator would have us believe, it was a pre-meditated act. The doctor who had carried out his mental assessment, commissioned by his defence team, said that there was no mental illness but stated that the perpetrator showed remorse and regret and whilst in police interview the perpetrator did say that he loved her and his view was 'if I can't have her nobody else will'. There is no other evidence of any remorse and his comments mentioned in the preceding sentence illustrate that it was not 'love' it is better described as a jealous obsession

3.2.24 **Stalking and harassment**

3.2.25 Stalking involves a person becoming fixated obsessed with another. It is a pattern of unwanted attention that leaves an individual feeling pestered, frightened, scared, anxious or harassed. It is not just physical – stalking can be psychological. There are some examples that suggest stalking. For example, when they returned from holiday and Maria went to her brother's home, the perpetrator texted her to say, 'wherever you go I will find you'. In the workplace he would come out of his location and watch for Maria to come out on her break. Finally, and most chillingly, he broke into her garage on the night of the murder and waited for her to return.

3.3 Detailed analysis of agency involvement

The chronology sets out in Section 2 details about the information known to agencies involved. This section summarises the totality of the information known to agencies, albeit that this is minimal.

3.3.1 Norfolk Constabulary

3.3.1.1 The Constabulary had no contact with either party prior to the incident.

There are no recommendations for the Norfolk Constabulary

3.3.2 Borough Council of King's Lynn and West Norfolk

3.3.2.1 The council had no contact with either party

There are no recommendations for the council

3.3.3 General Practitioner

3.3.3.1 On 14th April 2015 Maria registered with her GP practice. She gave her main spoken language as being English[6] and had no chronic conditions listed.

3.3.3.2 On 27th July 2017 she presented at her GP following a toe injury that had occurred on 26th July. Following an x-ray taken at the local hospital, it was confirmed that she had a fracture of her toe. It was noted by the GP that this was a traumatic injury which Maria attributed to having stubbed her toe against furniture and the mechanism of the injury was in keeping with this account.

The GP surgery has ensured that all of its staff, both clinical and non-clinical, have been trained by a specialist domestic abuse agency and the review notes that the GP considered whether the injury was likely to have occurred in the way described. This is an example of good practice and demonstrates an understanding of domestic abuse and the need to consider the account given by a patient.

Recommendation

It is recommended that, to build on this good practice, the GP surgery considers engaging in the countywide Domestic Abuse Champions Network.

3.3.3.3 Maria attended her GP on 18th January 2018 complaining of lower back pain. She denied that this had been caused by a traumatic injury and it was diagnosed a muscular skeletal problem, attributed to her manual labour job in a factory.

3.3.3.4 In April 2018 perpetrator registered with his GP and listed his main spoken language as Lithuanian. No chronic conditions were listed. He made no further contact with his GP.

[6] The review is aware that in all interactions with agencies by Maria and her family, they would always use English as their preferred means of communcation

Section Four – Other issues considered

4.1 What were the barriers to Maria seeking help?

4.1.1 Maria had been in a relationship with the perpetrator for a relatively short time – less than one year – 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.

4.1.2 The review has been told that on a number of occasions Maria was advised to call the police but that she would not do this. We cannot know why this was, although information from her family and friends suggests that she said, 'she did not want to bother them'.

4.1.3 There is a sense that Maria thought that she had ended the relationship and had moved on. We know that she was in the early stages of a relationship with another man. However, evidence compiled by the police from her mobile phone, indicates that she was still in contact with the perpetrator. He had, we are led to believe, helped her move into her new home and they were jointly selling items on Ebay. This raises the question about why she might have done this. Whilst the Review Panel acknowledged that many people, at the end of a relationship, will stay in contact and gradually distance themselves other possibilities were considered. Perhaps she thought they could have a relationship as friends in the future, perhaps she thought, in practical terms, that she just needed to complete this unfinished business with him or, more concerningly, perhaps she felt that if she kept contact with him she would know his plans and would feel that she could 'manage' his behaviour towards her. Only Maria knows the answer to this question.

4.1.4 One of the other issues considered by the Review Panel was whether Maria understood that the perpetrator's 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. Maria was advised on more than one occasion to report the behaviour of the perpetrator to the police, demonstrating that she knew that she could go to them for help.

4.1.5 Norfolk has, over the past few years, undergone a major change programme which has seen the establishment of a network of Domestic Abuse Champions from a wide range of agencies which has seen frontline professionals and community organisations having training in the barriers to reporting, particularly for vulnerable and minority groups.

4.1.6 Whilst it is true that more can always be done, Norfolk has sought to learn from previous Domestic Homicide Reviews and make information available to the people of Norfolk about domestic abuse and support that is available.

4.2 What part did cultural issues play?

4.2.1 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 have played both in the incident and the lack of reporting.

4.2.2 The Report Author took the opportunity when speaking to one of Maria's friends who was also from Romania about the part that her culture might have played in Maria reporting the abuse she was experiencing. He was adamant that domestic abuse is as abhorrent in Romania as it is in the UK and that Maria would not have thought that it was something that she had to tolerate. He also said that Maria would not have had a negative view of the police that would have prevented her from approaching them.

4.2.3 The Review Panel considered that Maria had a protective family in the UK and probably did not realise the possible consequences of domestic abuse (if she recognised his behaviour as this) and how far the perpetrator would actually go.

4.2.4 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.

4.3 Why did the abuse escalate so quickly?

4.3.1 In order to understand how this relationship escalated in a relatively short length of time to the brutal attack that led to Maria's death, the Chair and Report Author have sought to speak to the perpetrator, but he has not chosen to engage with the review.

4.3.2 The analysis here draws on the research of Dr Jane Monckton-Smith of University of Gloucestershire into Intimate Partner Femicide Timeline[7]. 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.

4.3.3 **Stage One – Pre-relationship history**
We do not have the information about the perpetrator prior to this relationship to know if there was a previous history of domestic abuse.

4.3.4 **Stage Two – Early relationship behaviours**
We can, from the information that we have, see that there was an early commitment to the relationship with Maria and the perpetrator living together in a relationship that lasted only a year. We do not have the information to know if there were other indicators at this stage.

4.3.5 **Stage Three – Relationship warning signs**
We can see, from the earlier analysis in this report, a number of the warning signs of domestic abuse and control identified by the research. For example, violence (even low level

[7] https://www.womensaid.ie/download/pdf/jane_monckton_smith_powerpoint_2018_compatibility_mode.pdf

pushing and shoving), possessiveness, jealousy and isolation of the victim from family and friends.

4.3.6 **Stage Four – Trigger warning signs**

The research shows that the biggest trigger for domestic homicide is separation or the threat of separation. We know that Maria had ended the relationship and moved into her own place. The perpetrator will have lost control of Maria as a result of this.

4.3.7 **Stage Five – Escalation warning signs**

At this point, the research says, there will be evidence of an escalation in the warning signs such as the concerning behaviours becoming more frequent or more serious. Although we are not able, due to the limited information we have about the relationship, to specifically reference examples of this we can see, through what the perpetrator said to the police, that he used language identified in the research as a warning sign. He said, 'if I can't have you, no-one can'.

4.3.8 **Stage Six – Change of thinking – warning signs**

One of the warning signs identified is a new relationship for the victim. We know that Maria was in the early stages of forming a new relationship. We cannot know for certain, but it is likely given that Maria and the perpetrator worked together, that the perpetrator knew about this, or at the very least, suspected it was happening. We also know that in the time leading up to her death, Maria ceased responding to the perpetrator when he made contact by text. The last time that she had contact with him by phone was 8th September. He continued to text her until 19th September (three days before her murder), despite not receiving any response. This continued contact without a response could also be described as stalking and this, along with the lack of response by Maria are further warning signs at this stage in the timeline. Given that the perpetrator went on to plan the attack, we know that he had changed his thinking towards Maria.

4.3.9 **Stage Seven – Planning warning signs**

We know, from the actions of the perpetrator on the night of the incident, that he had planned to take Maria's life. He had prepared a photo album which he left at the scene and had booked two taxis in preparation for his staged exit from work and his departure from her address. There was nothing about this, as the judge said, that was on the spur of the moment.

4.3.10 **Stage Eight – Homicide characteristics**

The homicide timeline identifies the most common characteristics of the intimate partner femicide timeline as a clear homicide with confession, which features in this case.

4.3.11 In conclusion, the review notes 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.

4.3.12 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.

4.4 What lessons are there for employers?

4.4.1 The Review Panel reflected on the work that is undertaken in Norfolk to raise awareness of domestic abuse and how successful this has been in penetrating local businesses with this information. The Panel acknowledged that, given what we have been told about the perpetrator's abusive behaviour to Maria evident in their workplace, this had probably not been as successful as hoped.

4.4.2 The police commented to the Review Panel that both employers had been very helpful with the investigation. The police wondered if there was more that they could have done, as they closed the investigation, to raise awareness of appropriate domestic abuse policies for these employers. The Panel felt that it needed to be very careful about taking an 'easy' approach of recommending that the police take this on. They are the first point of contact and it is easy to load too much on them.

4.4.3 After several attempts at contact, the Employment 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.

4.4.4 The Employment 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 EIDA[8] 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.

4.4.5 The Review Panel considered how awareness might be raised with employers in the county. It was acknowledged that it would be relatively easy to provide leaflets and posters to companies, but these need to be kept up to date. It is also a possibility that training is provided to companies at no cost to them, but local agencies would need to be resourced to undertake this work.

4.4.6 Most companies will be well acquainted with their legal health and safety responsibilities which, according to the Health and Safety Executive, means making sure that workers and others are protected from anything that may cause harm, effectively controlling any risks to injury or health that could arise in the workplace[9]. The Review Panel discussed employers knowledge and awareness of domestic abuse, and the responsibilities placed upon them at length. It was accepted that some employers may still not understand the benefit of investing in domestic abuse awareness. The Panel felt that more work is to be done with employers to help them understand that they *will* have staff who are affected by domestic abuse, and that this is likely to impact upon their absenteeism or productivity. Thus there is a financial imperitive as well as a human imperitive in so investing.

[8] Employers'initiative on domestic abuse – www.eida.org.uk\
[9] https://www.hse.gov.uk/workers/employers.htm

4.4.7 The Panel also acknowledged that it would be easy to point the finger at private sector companies. However, it is also true that public sector organisations, (many of whom will have well developed policies for dealing with clients or service users who are victims of domestic abuse), can find it much more difficult to address these issues when their own staff are involved.

4.4.8 The Review Panel felt that work in this area was best directed through the Human Resources departments of companies and that there is perhaps a place for their professional bodies.

4.4.9 The Review Panel was made aware that, through Norfolk's Domestic Abuse & Sexual Violence Board, the Office of the Police and Crime Commissioners for Norfolk raised this issue in January 2019 to highlight and recommend to all partners, as best practice, the opportunity to review their own workplace domestic abuse policies utilising the EIDA Domestic Abuse toolkit.

4.4.10 One of the important questions for the Review Panel was whether Maria would have identified the behaviour of the perpetrator as stalking, harassment and abuse when the abuse that we know about often occurred in their workplace.

4.4.11 The Review Panel also considered how an employer deals with a situation where behaviour of this nature is taking place in the workplace between two employees.

Recommendations

It is recommended that the Norfolk County Community Safety Partnership work with the Office of the Police and Crime Commissioner to build upon the work already undertaken in promoting both the EIDA Domestic Abuse Toolkit for employers and Hestia 'Everyone's Business' through local business networks. Particular attention should be paid to employment agencies

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.

Section Five – Recommendations

5.1 In line with Norfolk's thematic learning framework, which has been drawn from a number of reviews – Domestic Homicide Reviews, Safeguarding Adults Reviews and Serious Case Reviews – the recommendations will be grouped under the following headings:

- Professional Curiosity
- Information Sharing and Fora for Discussion
- Collaborative Working, Decision Making and Planning
- Ownership, Accountability and Management Grip

5.2 **Professional curiosity**

5.2.1 It is recommended that, to build on this good practice, the GP surgery considers engaging in the county wide DA Champions Network.

5.3 **Information Sharing and Fora for Discussion**

No specific recommendations

5.4 **Collaborative Working, Decision Making and Planning**

5.4.1 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 EIDA[10] Domestic Abuse Toolkit for employers through local business networks. Particular attention should be paid to employment agencies.

5.4.2 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.

5.5 **Ownership, Accountability and Management Grip**

No specific recommendations

[10] https://eida.org.uk/

Section Six – Conclusions

6.1 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.

6.2 Given that the couple lived in a number of different places meant that little was known about either by any local agency. Their life revolved largely around time together, time with their family and work.

6.3 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 domestic abuse 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 who actively reach out to the migrant community.

6.4 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.

6.5 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.

Appendix One - Terms of reference

Terms of Reference for the Domestic Homicide Review into the death of Maria

1. Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by the Norfolk County Community Safety Partnership in response to the death of Maria which occurred in September 2018.

1.2 The review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

1.3 The Chair of the partnership has appointed Gary Goose MBE and Christine Graham to undertake the role of Independent Chair and Overview Author for the purposes of this review. Neither Christine Graham nor Gary Goose is employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

2. Purpose of the review

The purpose of the review is to:

2.1 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 Maria.

2.2 Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

2.3 Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

2.4 Additionally, 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.

2.5 Contribute to a better understanding of the nature of domestic violence and abuse

3. The review process

3.1 The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

3.2 This review will be cognisant of, and consult with the process of inquest held by HM Coroner.

3.3 The review will liaise with other parallel processes that are on-going or imminent in relation to this incident in order that there is appropriate sharing of learning.

3.4 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

4. Scope of the review

The review will:

4.1 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 Act.

4.2 Produce Independent Management Reviews (IMRs) for a time period commencing 1st January 2014 (being the date that the victim moved to the UK)

4.3 Invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

4.4 Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.

4.5 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.

4.6 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.

5. Family involvement

5.1 The review will seek to involve the family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

5.2 We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

5.3 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews avoiding duplication of effort and without increasing levels of anxiety and stress.

6. Legal advice and costs

6.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

6.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then Norfolk County Community Safety Partnership will be the first point of contact.

7. Media and communication

7.1 The management of all media and communication matters will be through the Review Panel, escalating to the CSP Chair as necessary.

Gary Goose and Christine Graham
Independent Chair and Overview Author