Working for a safer Wycombe

Domestic Homicide Review
Executive Summary

REPORT INTO THE DEATH OF ADULT B ON 19th September 2016

DOMESTIC HOMICIDE EXECUTIVE SUMMARY

1. Introduction

This Domestic Homicide Review (DHR) examines the agency responses and support given to Adult B, a resident of High Wycombe prior to the point of her death in September 2016. In addition to agency involvement, the review also examines the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

2. The review process

This summary outlines the process undertaken by the Domestic Homicide Review Panel in reviewing the murder of Adult B. It was commissioned by the Wycombe Community Safety Partnership in response to the death of Adult B on 19th September 2016

3. Terms of Reference

Purpose of the review
The purpose of the review is to:

- Establish the facts that led to the homicide on 19th September 2016 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked individually and together to safeguard the victim and any dependent children.
- Identify 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. Apply these lessons to services, including changes to policies and procedures as appropriate.
- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the homicide in High Wycombe.
- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes resulting from the review.

Specific issues to address:

- Was there evidence of a risk of serious harm to the victim or perpetrator/s that was not recognised or identified by the agencies in contact with the victim and/or perpetrator?
- Family, friends, neighbours and work colleagues:

  - Whether family or friends want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour towards the victim, prior to the homicide.
  - Whether, in relation to family, friends, work colleagues and neighbours there were any barriers experienced in reporting abuse.
- Could improvements in any of the following have led to a different outcome for Adult B, considering:
  - Communication and information-sharing between services. Was information or were any opportunities available that might have identified that there was a serious risk of harm to either the victim or perpetrator that was not shared with other agencies?
  - Information-sharing between services regarding the safeguarding of adults and children. If information or opportunities were available and shared were they acted upon in accordance with the agencies' recognised best professional practice?
  - Communication within services.
  - Communication to the public and non-specialist services about the role of the police and the availability of specialist support services in Bucks.
  - Sharing/reporting of information about incidents involving victim or perpetrator by businesses/companies including, if appropriate, guidelines and procedures that exist to safeguard customers/users
- Immigration and nationality considerations
  - Whether decisions made at the time of the perpetrator's entry into the UK, were consistent with the then Border Agency's procedures and protocols and whether correct procedures were carried out in trying to trace him after his immigration status was confirmed as being illegally in the UK.
  - What impact did the immigration status of those involved have and were agencies aware of their status?
  - Were there any language or communication barriers which might have had an impact on the victim contacting agencies? Are agencies able to provide suitable translation services in a quick and effective way?
- Post Incident communication between agencies following the death of Adult B
  - How is information shared about a death? Where does the responsibility lie for sharing information once a death is confirmed?
- Does the homicide appear to have any implications or reputational issues for any of the agencies or professionals?
- Does the homicide suggest that national or local procedures or protocols may need to be changed or are not adequately followed or understood?

Contributors to the Review
The following agencies and contributors were involved in the review:

- Thames Valley Police provided a chronology and a report. This was not a full Individual Management Review as there had been no significant involvement by Thames Valley Police with any of those involved in the homicide. The only involvement had been with Adult C in a couple of unrelated incidents.
- Bucks Healthcare Trust (BHT) provided a short report in respect to their involvement, mainly concerning Health Visitor information in respect to the child and pre-review period.
- South Central Ambulance Service provided a short report which related to attendance at the incident. There had been no previous engagement with those involved in the review.
- Buckinghamshire County Council Children's Services provided brief information in respect to the child but this related to the pre-review period.
- The Borders Immigration and Citizenship Agency provided information in respect to the immigration status of Adult C and Adult D.
- Wycombe District Council provided a short letter with information about both Adult B, her partner, and Adult C in respect to housing benefit, council tax and electoral register information. A short note was also provided by Licensing in respect of taxi driver responsibilities and training.
- Reports were received relating to the GPs for Adult B and Adult C.
- Victim Support provided a short summary of involvement, but this was in respect of unrelated incidents involving Adult C.
- An interview took place with the CCTV (closed circuit television) Manager of a local private CCTV service.

The subjects of the Review were not known to any other services.

All the information and reports provided were given by staff who were not involved with the subjects of the review or have any direct management of staff who had previous links with the subjects.

Process
All agencies that had been involved with the family over previous years were asked to contribute to the review and where appropriate to provide chronologies and Individual Management Reviews if required.

Chronologies and Individual Management Reviews IMRs
Reports, but not full IMRs, were requested from South Central Ambulance Service (SCAS), Thames Valley Police (TVP), Buckinghamshire County Council (BCC) Children's Services, Wycombe District Council (WDC) Licensing and Revenue and Benefit Services. The Border Immigration and Citizenship Agency was requested to

provide immigration status information on the subjects. The doctor's surgeries for Adult B and Adult C were requested to undertake an assessment of their involvement. Bucks Healthcare Trust provided a report of the Health Visitor engagement with the family. Midwifery Services were requested to provide a report on their involvement with the family when the child was born.

Chronologies were also completed by Victim Support, BCC Adult Mental Health Services and Oxford University Hospital NHS Trust. For Victim Support, their involvement had only been with Adult C and was unrelated. Both Mental Health and Oxford University Hospitals sole involvement had been post incident in treating and assessing Adult C.

Panel Members

The members of the Panel are as follows:

Organisation	Name	Post
Lime Green Consultancy Service Ltd.	Gillian Stimpson	Independent Chair of Panel, Director
Thames Valley Police	Gill Fox Simone Marples Graham Hadley	Inspector Detective Inspector Chief Inspector
Buckinghamshire County Council	Julie Puddephatt	Head of Safeguarding Adults and Deprivation of Liberty Safeguards
Wycombe District Council	Elaine Jewell Sarah McBrearty	Head of Community Community Safety Team Leader
South Central Ambulance NHS Foundation Trust	Anthony Heselton	Head of Safeguarding
Thames Valley Probation Service	Charlie Walls	Senior Probation Officer
Wycombe Women's Aid	Lis Harvey	Chief Executive Officer
Bucks Healthcare Trust	Nuala Wade	Lead Nurse for Safeguarding Adults
Chiltern Clinical Commissioning Group	Victoria Gray Tania Atcheson	Safeguarding Manager Safeguarding Manager

Independent Chair

The Domestic Homicide Review has been chaired by Gillian Stimpson of Lime Green Consultancy Service Ltd. Gillian has had previous experience as a Police Officer in the Metropolitan Police from 1978 to 1987 and as Community Safety Manager for Wycombe District Council, from 1993 to June 2015. Gillian currently has no

connection to the Community Safety Partnership other than in the undertaking of the Domestic Homicide Review.

Summary of chronology

In this case there was very little agency involvement, either statutory or voluntary, in the year before the homicide. The key contacts with the family are from the time that Adult B first came to the attention of Bucks Healthcare Trust; GPs and Children's Social Care (Children's Services). The chronology also includes information from Borders Immigration and Citizenship; Thames Valley Police; and a local CCTV Service.

May 2011 - Borders Immigration and Citizenship - Adult C was issued a visa to study in the UK and was legally here as a student with leave to remain until 30 August 2014.

March 2013 - The first contacts of any sort date from 2013. At that time Adult B came to the attention of Children's Social Care and Bucks Healthcare Trust. Aged 16, she was pregnant and had been considering adoption.

Adult B had a supportive boyfriend, both were Polish speakers and were sharing a room in the paternal father's flat. The Health Visitor reports that they both spoke good English and agreed that they would say if they did not understand anything at any time.

Good support was given to the young couple during this time until the baby was born at Stoke Mandeville Hospital.

Following discussions with the parents it was agreed that both Adult B and her partner now wanted to keep the baby, but that they would need some support. Children's Social Care purchased equipment for the baby.

During the next couple of months, the family were supported by the Health Visitor and were provided with equipment, clothes and toys, along with suitable advice. It was noted that both Adult B and her partner dealt well with the baby and were loving and supportive.

July 2014 - Borders Immigration and Citizenship - Adult C applied for leave to remain as partner/spouse of an EEA (European Economic Area) national (married 17 March 2014 to a Slovakian national) but withdrew that application before it was resolved.

November 2014 - Borders Immigration and Citizenship - Adult C applied for leave to remain outside of the immigration rules on compassionate grounds based on marriage.

January 2015 - Information was received by Thames Valley Police that Adult C had been involved in a sham marriage. This intelligence was shared with the immigration Office on 29/1/15. The review has been unable to have sight of information substantiating the sham marriage.

February 2015 - Borders Immigration and Citizenship - Application refused with no right of appeal

April 2015 - Borders Immigration and Citizenship - The case was passed into Capita's contact process as Adult C had no further leave to remain in the UK. (Capita are the service provider for contacting those who are UK immigration offenders). No contact was made (the service now knows that Adult C travelled to Ireland at some point)

May 2015 - Borders Immigration and Citizenship - Applicant made a claim in the ROI (Republic of Ireland); (UK were not informed until 22-Jun-2015). There is no evidence as to when he left the UK or how.

November 2015 - Borders Immigration and Citizenship - The Home Office agreed to accept the case back for consideration in the UK under the terms of the Dublin Agreement and a formal 'Take Charge Request', was received from the ROI on 25 November 2015, which was accepted on 22 December 2015. The Republic of Ireland (ROI) had 6 months from this date to transfer the subject.

September 2016 - At 05.16, SCAS (South Central Ambulance Service) EOC received a 999 call from Adult D, stating that Adult C had cut his wrists. At 05.31, SCAS telephoned TVP and requested assistance at the home address of Adult C as, on arrival, the paramedic found Adult B deceased in a bedroom. Both men were present with her in the room. Adult C had cut his wrists and was taken to hospital. At 10.06 he was arrested on suspicion of the murder of Adult B and was subsequently charged with her murder.

4. Feedback from Family and Friends

Adult B's partner has moved with his child to live with her mother, who lives abroad. The family are Polish speaking and so letters and leaflets, including the Home Office DHR leaflet and Advocacy Leaflets from Advocacy After Fatal Domestic Abuse (AAFDA), translated into Polish, were sent to the family offering our condolences for their loss and asking if the family would be willing to be involved with the Domestic Homicide Review. The communication with the family has been through the Police Family Liaison Officer (FLO). Despite several requests the family to date has not wanted to have any direct engagement with the process.

The family has been offered the opportunity to meet with the Panel, or to engage with us through whatever medium they wanted, including email, phone call, direct meeting or through an advocate. The Panel has also requested that the Police FLO requests that, if the family do not want to engage with the Panel, they seek permission to share the family impact statements and any other relevant information that they have provided to the Police as part of the investigation. The response has been a firm rejection of any involvement and confirmation that they are keen to get on with trying to re-build their lives.

5. Lessons to be Learned

The review has established that there were several areas of good practice. These included:

- The use of an interpreter who was fluent in English and Polish to translate for Adult B at appointments with the GP.
- The Social Worker reassured them of the adoption process in the UK as Adult B explained that when you offer a baby for adoption in Poland the baby is removed, the mother will not see or hear from the baby again. Adult B was pleased to know that she could have contact with the baby once born and the option of using a foster carer was also discussed. The Panel consider this was good practice and gave suitable assurance to Adult B and her partner about what would happen in the UK. In addition, the Social Worker provided a Moses basket, bedding, bottles, sterilizer, baby grows, and vests, again providing appropriate and timely support to the young family.
- There was also good practice evidenced in respect of support to the family by the Health Visitor, who, when finding out that Social Care was unable to support a request for money for Adult B to get a taxi to the hospital when she went into labour, sourced a donation by a local charity. The Panel consider this to have been good practice as the HV made the efforts to find a suitable charity to support Adult B at an important time.
- The Panel also considers that CCTV Operator 'A' acted appropriately and that what he did was good practice. His Manager confirmed that the actions he took were appropriate and correct in this case, stating that the incident had been recorded and actioned appropriately. The manager considered that going out to check on the welfare of Adult B was very good practice.The areas where there are lessons to be drawn from the case relate, in the main, to post incident.
- There is learning identified regarding how key agencies are advised of a death. This was identified as Adult B's GP surgery was not immediately made aware of her death. Indeed, the only way they found out was because of the domestic homicide review taking place. There is no clear procedure as to which agencies should be notified of a death.
- There are three areas of learning regarding immigration services. The first regards the flow of information between the Employers Checking Scheme and Immigration Enforcement and UK Visas and Immigration, and forms a recommendation. The second area of learning has been identified because of the early release of Adult D, following his 'not guilty' finding. As he had already been served with the necessary papers in September 2016, he should have been held until reporting restrictions, prior to his removal, could be put into place. This process has been improved since this case.
- Thirdly, there has been an issue in requiring the Borders Immigration and Citizenship Agency to undertake an IMR. This caused a delay to several stages in the Review process. Indeed, there seemed to very little

understanding within the agency of Domestic Homicide Reviews. Whilst the review did eventually get a report from the agency, followed up by a second update report with responses to some additional questions raised by the Panel, these were only provided following numerous approaches and chases. Once a representative of the service was identified communication was excellent.

- Research by a simple 'Google Search' revealed there are several reviews which have had immigration as an area to review. In these cases, it was noted that there was a mixed response from the Borders Agency. There were two examples found within the first page of results which also had significant issues in gaining the information required.
- It is inevitable that there will continue to be links with immigration status in some DHRs undertaken, as we live in a very diverse country which is attractive to migrants, be they here legally or illegally. Immigrants may find it more difficult to contact a variety of agencies because of language difficulties or indeed may feel they are unable to contact services, including support services, because of their immigration status. In this case Adult C was in the UK illegally and so the question of why he was not arrested, detained and deported was raised. It is important that Domestic Homicide Reviews can easily access information and request IMRs from the service. The learning from these reviews may lead to significant improvements in the Service which may, in the long-term, help to prevent a homicide.

6. Conclusions

The Review has not identified any significant issues in the lead up to the death of Adult B.

Adult B was very young when she fell pregnant, at 16 years, giving birth when she was 17. All the evidence produced showed they cared well for the child and were supported during this important time and were provided with a variety of baby equipment and clothing as they had very little in the early days.

Language was an issue initially as both parents had come from Poland and had limited English. This improved over time. Support with translation was provided in the early days when required by health services and health visiting.

Adult B, over the last few months of her life, started to go out in the evening. The review has established that she met Adult C during one of these evenings out and started to see him regularly and formed a strong relationship with him. However, Adult C became very possessive and this concerned Adult B. The police report that she shared texts with a friend in Poland expressing that she wanted to end the relationship as he was too possessive. Adult B did not seek any support during this period and it is possible that she never perceived herself to be in the sort of relationship where she might need to seek support or advice.

Adult C started to follow her, but it appears she was not aware that he was doing this. The stalking was seen by a CCTV operator of a private system in the town centre, although the Operator had thought he might be trying to steal her handbag. The operator acted diligently, ensuring the incident was recorded and he went outside to ensure that Adult B and her male companion were ok. He correctly followed the CCTV procedures and sent information to the Area Intelligence Team for TVP; he notified the High Wycombe Business Improvement District Company and informed a couple of named officers who dealt with young people. He was unable to determine the age of Adult C and thought he may be a young offender about to steal a handbag. He had not thought it was a stalking incident. He didn't feel it was appropriate to call the police as there are incidents happening every day and so some degree of proportionality for calling the police to incidents must be exercised.

On the day of her death Adult C deceived her into thinking they were going to a party. He deceived her by buying a sim card and using it in his phone to send himself messages, so it looked as though they were from another person arranging a party. He took her to a disused kebab shop where he murdered her by asphyxiating her with a net curtain around her neck and using packing tape and cling film to prevent her from breathing. He removed these and then took her lifeless body in a taxi to his home address. The review considered the role of the taxi driver but Adult C lied to him too, telling him she was drunk. This was not challenged by the taxi driver. Future training in respect to CSE is being planned for taxi drivers and so the Panel has already requested that this includes the reporting of possible safeguarding issues for potentially vulnerable passengers.

The Panel considered whether Adult B was subject to exploitation. A lengthy discussion was held with Police SIO who did not think she was exploited. There was obviously concern about the final incident as it appears that Adult C tricked Adult B into going with him to the kebab shop. The SIO feels this was not exploitation but was part of the plan around getting her to go with him, where they would be alone. Adult C was asked about control when the Chair met with him. The Chair was happy that other than the final incident, there does not appear to have been any other suggestion that he controlled or exploited Adult B.

With very little engagement with any services, other than a GP whom she had very little need to consult with, there were no identified chances or opportunities for any agency to have noticed any changes in behaviour or provide advice.

Adult C was in the UK without a valid visa.

It may be considered that if he had been detained or deported, then the relationship could not have taken place. Despite this, it is unlikely that it would have been perceived that, by not detaining a person who was illegally in the UK, a murder might have been preventable outcome.

Following the death of Adult B, the Review has established that there was a lack of communication between agencies in respect of the notification of Adult B's GP. The Surgery was not aware of her death for a few weeks and so did not contact the family to offer support. The Health visitor was not aware and so did not make early contact to ensure the well-being of the child.

7. Recommendations

Panel Recommendation
The Panel recommends that Wycombe District Council's Licensing Department Taxi Driver training to raise awareness of Child Sexual Exploitation, is enhanced by adding safeguarding and the reporting of suspicious activity or concerns which extend, not just to children but, to adults who may appear vulnerable.

Panel Recommendation
Her Majesty's Government add the notification to a GP and Health Services (by using the NHS Number) to the 'Tell Us Once' list, following the death of a person.

Panel Recommendation
Agencies, which will include local NHS Trust services, Clinical Commissioning Groups, Police and Coroner's Office establish a policy/procedure which will address the appropriate notification of key agencies following a death.

Panel Recommendation
Her Majesty's Government (Home Office) review the legislation and guidance for Domestic Homicide Reviews (Section 9(3) of the Domestic Violence, Crime and Victims Act 2004) and add Borders Immigration and Citizenship to the list of statutory agencies required to participate in a domestic homicide review when relevant

Immigration Recommendation
Immigration Enforcement (IE) and United Kingdom Visas and Intelligence (UKVI) will review the information flow between the Employers Checking Scheme (ECS) and Immigration Enforcement intelligence to improve the process.