A Domestic Homicide Review of the death of 'Justina'

July 2019

Final draft

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Section 1: Introduction

1.1 The commissioning of the review

1.1.1 This Domestic Homicide Review has been commissioned by the Safer Peterborough Community Safety Partnership following the murder of 'Justina' which occurred in July 2019. Justina is a pseudonym which will be used throughout this overview report in order to protect the victim's identity.

1.1.2 The appointed Independent Author is Mr Mike Cane of MJC Safeguarding Consultancy Ltd. He is completely independent of the Safer Peterborough Community Safety Partnership and has no connection to any of the organisations involved in the review. He is a former senior police officer where his responsibilities included homicide investigation, safeguarding and tackling organised crime. He has extensive experience as an author and panel member for Domestic Homicide Reviews and is a former member of Teesside's Safeguarding Vulnerable Adult Board, the Domestic Abuse Strategic Partnerships and the Local Safeguarding Children Boards. During his police career he was Force lead for domestic abuse, child protection and vulnerable adults. He chaired the MARAC meetings across Teesside for several years. He has previous experience of conducting Domestic Homicide Reviews, Safeguarding Adult Reviews and Child Safeguarding Practice Reviews as both an Independent Chair and Independent Author.

1.1.3 This overview report will examine life 'through the eyes of the victim.' The purpose of the review is not to judge 'Justina' but to better understand her circumstances, so we may appreciate how or why she made certain decisions. It is also important to understand the involvement of several agencies in this case, to examine the professional's perspective within that context and to avoid hindsight bias. This will ensure that any learning is captured and acted upon.

1.1.4 The death of any person in these circumstances is a tragedy and the family are still coming to terms with their loss. Justina's family have been consulted during the review process and their views are reflected in this document. The overview report author is grateful for their contribution and the information obtained during these discussions. The family are of course still grieving, and we extend our deepest condolences to them for their tragic loss.

1.1.5 The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of reports and chronologies. Individual Management Reviews (IMRs) have been requested and supplied. Following careful consideration by the Review Chair and Panel, it was

agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided for the overview author. The following organisations were required to produce an Individual Management Review:

1.1.6

- Cambridgeshire and Peterborough Clinical Commissioning Group
- East of England Ambulance Service
- Cambridgeshire Constabulary
- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- North West Anglia NHS Foundation Trust
- Children's Social Care
- Education Safeguarding Team (Cambridgeshire and Peterborough Councils)
- Refuge (Domestic Abuse Outreach Services)
- Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation Company (BeNCH CRC)

Additional chronologies were also provided from:

- Lincolnshire Police
- 'Change, Grow, Live (CGL) Peterborough Aspire'
- Housing Enforcement Service
- Cambridgeshire and Peterborough IDVA service

1.2 The Review Panel

1.2.1 The Chair of the Review Panel is Mr Mike Cane, who was also appointed as the Independent Author for the review.

1.2.2 The Domestic Homicide Review panel is comprised of the following people:

- Mike Cane - Independent Chair and Author

- Joanne Proctor, Head of Service: Cambridgeshire and Peterborough Safeguarding Partnership Boards (Children and Adults)
- Jo Curphey, BeNCH CRC Deputy Director and Head of Cambridgeshire Local Delivery Unit
- Wendi Ogle-Welbourn, Executive Director; People and Communities, Cambridgeshire and Peterborough Councils
- Superintendent Andy Gipp, Area Commander for Northern, Cambridgeshire Constabulary
- Rob Hill, Assistant Director; Public Protection, Cambridgeshire and Peterborough Councils
- Deirdre Reed, Operational Manger; Cambridgeshire and Peterborough IDVA Service
- Annette Chandler, Senior IDVA, Peterborough
- Carol Davies, Designated Nurse, Safeguarding Adults Team, Cambridgeshire and Peterborough Clinical Commissioning Group
- Linda Coultrup (from second panel meeting) Cambridgeshire and Peterborough Clinical Commissioning Group
- Mandy Geraghty, Service Manager; Refuge
- Helen Scrivner, Safeguarding Lead, Education Safeguarding Team, Cambridgeshire and Peterborough Councils
- Donna Phipps, Designated Nurse, Cambridgeshire and Peterborough Clinical Commissioning Group.
- Shalina Chandoo, Quality Assurance Lead, Children's Social Care, Peterborough Council.

1.2.3 The local agency responsible for providing substance misuse support was consulted during the review. They researched their database. The perpetrator had been referred on one occasion to their service. However, he did not take up the offer. The substance misuse support agency were invited to the DHR panel. As they had no direct contact with any of the subjects, and due to resource implications, the agency could not commit to this.

1.2.4 The Domestic Homicide Review panel actively considered the involvement of the Lithuanian community to advise on Eastern European culture. However, the view of the majority of panel members was that the subject matter was very sensitive and it was not proportionate to do so when noting potential ongoing tensions within the local area. The view was that although this may have provided some benefit, this was outweighed by the wish to protect the information held about the victim, perpetrator and wider family.

1.2.5 None of the panel members had any direct dealings with the subjects of the review nor had management responsibilities to any front line worker involved with any of the subjects.

1.3 Reason for conducting the review

1.3.1 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of a person where domestic abuse forms the background to the homicide and to determine whether a review is required. In accordance with the provisions of Section 9 of the Domestic Violence, Crime and Victims Act 2004 (amended 2013), a Domestic Homicide Review should be:

"*A review of the circumstances in which the death of a person aged 16 years 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."

1.3.2 For this review, the term domestic abuse is in accordance with the agreed cross-government definition of domestic abuse:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- *Psychological*
- *Physical*
- *Sexual*
- *Financial*
- *Emotional*
- *Coercive control*

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is an act or pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim."

1.3.3 The overarching reason for the commission of this review is to identify what lessons can be learned regarding the way local professionals and organisations work individually and collectively to safeguard victims.

1.4 Purpose of the review

1.4.1 The Safer Peterborough Partnership identified that in this case the death met the criteria of the Domestic Violence, Crime and Victims Act 2004 and commissioned a Domestic Homicide Review.

1.4.2 The statutory guidance states the purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

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

- Apply those lessons to service responses including changes to policies and procedures as appropriate.

- Articulate life through the eyes of the victim, to understand the victim's reality; to identify any barriers the victim faced to reporting abuse and learning why interventions did not work for them.

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

1.5 Terms of Reference

1.5.1 The following terms of reference were agreed by the Review panel with regards to the death of Justina:

- The date parameters under consideration would be from 1st January 2011 to July 2019. (Based upon dates of entering the UK).

- Were practitioners sensitive to the needs of the victim and the perpetrator? Were they knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

- Did the agency have policies and procedures for domestic abuse, stalking and harassment? Were risk assessment and risk management

processes for domestic abuse victims or perpetrators correctly used in the case of this victim and perpetrator? Were these assessment tools effective?

- Was the victim subject to a MARAC or other multi-agency fora?

  MARAC is the Multi-Agency Risk Assessment Conference; where local professionals meet to exchange information and plan actions to protect the identified highest risk victims of domestic abuse.

- Was the perpetrator subject to MAPPA, MATAC or any other perpetrator intervention programme?

  MAPPA is the Multi-Agency Public Protection Arrangements. These are statutory processes to manage sexual and violent offenders. The 'Responsible Authorities' (police, National Probation Service and HM Prison Service) all have statutory responsibilities to protect the public under national MAPPA guidelines).
  MATAC is Multi-Agency Tasking and Coordination. It is a scheme currently being rolled out in many areas across the UK to specifically manage serial and repeat perpetrators of domestic abuse.

- Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

- Were appropriate services offered or provided, or further relevant enquiries undertaken, in the light of the assessments made?

- Were correct procedures followed in compliance with multi-agency child protection arrangements?

- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

- Had the victim disclosed to any practitioners or professionals and, if so, was their response appropriate? Was this information recorded and shared where appropriate?

- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

- Were senior managers of the agencies and professionals involved at the appropriate points?

- Did any staff make use of available training?

- Did any restructuring during the period under review have any impact on the quality of service delivered?

- How accessible were the services for the victim, perpetrator or children?

1.6 The subjects of the review

1.6.1 The subject of this review is the victim; 'Justina'. This is a pseudonym and will be used throughout the review to protect her identity. On the date of her death she was 42 years old.

1.6.2 The perpetrator is identified by the pseudonym 'Matis'. He is the husband of Justina and was 46 years old at the time of the homicide.

1.6.3 There are three other subjects to this review:

(1) The adult daughter of the victim and perpetrator. She lived in the same household and was 22 years old at the time of her mother's death.
(2) The sister of the perpetrator. She was also attacked with a knife during the incident which led to the homicide.
(3) The nephew of the perpetrator. He was a young child at the time of the homicide. He was also stabbed several times during the incident but survived.

1.6.4 Any relevant addresses will be referred to only in general terms to protect the anonymity of those involved. The family lived at 'Address A' from June 2012 to June 2018. The tenancy for 'Address B' was signed in December 2018. However, the first call to the ambulance service to Address B was actually in June 2018. The family still resided there at the time of the homicide. Both addresses are in the city of Peterborough. Further checks

conducted as part of this Domestic Homicide Review suggest Matis may have lived separately (either with wider family, friends or renting his own room) for several months before moving back in with Justina and their close family later in 2018.

1.7 Confidentiality

1.7.1 The content and findings of this review will be 'confidential', with information available only to those participating officers and professionals and where appropriate their organisational management. It will remain confidential until the review has been approved for publication by the Home Office Quality Assurance Panel.

1.7.2 The victim Justina and the perpetrator Matis were both Lithuanian nationals residing permanently in the UK. The other adults subject to this review were also Lithuanian nationals residing permanently in the UK. The child was born in the UK.

1.8 Parallel Reviews and timescales

1.8.1 The decision to undertake a Domestic Homicide Review was taken by the Independent Chair of the Safer Peterborough Partnership on 3rd July 2019. This decision followed a detailed notification of the case provided by Cambridgeshire Constabulary. The Chair considered the circumstances and was satisfied that the information available suggested this murder had been perpetrated by the husband of the victim. The couple were still married at the time of the victim's death and so the death meant a Domestic Homicide Review was required. At that time, the criminal investigation and trial were still progressing but have since been concluded.

1.8.2 The aim of the DHR panel was to deliver the review as soon as practicable but also recognising the delay in the criminal trial which pushed back some of the initial deadlines. Nevertheless, the DHR panel Chair is confident the review maintained focus and the final report was completed in good time.

1.8.3 The inquest into Justina's death was opened and adjourned pending the criminal court process.

1.8.4 A child was seriously injured during the incident that led to the domestic homicide. Consultation took place locally between the Chair of the Safer Peterborough Partnership and the Chair of the Cambridgeshire and Peterborough Safeguarding Childrens Partnership Board. The agreement was the Domestic Homicide Review would be progressed. There was no

requirement for a Child Safeguarding Practice Review, but specific terms of reference linked to child protection issues would be included within the Domestic Homicide Review. Senior officers from Children's Social Care formed part of the Domestic Homicide Review panel and there has been learning identified relating to child protection matters.

1.8.5 The final panel and the presentation to the Community Safety Partnership were conducted remotely due to the Covid-19 pandemic. Additional time was given to panel members to consider the final version of the overview report but delays were kept to an absolute minimum.

1.9 Background

1.9.1 For the year to March 2019 there were 2.4 million adults who experienced domestic abuse (1.6 million women and 0.8 million men).[1] Nationally, the police recorded 746,219 offences linked to domestic abuse. This is a 24% increase on the previous year. However, all independent experts acknowledge this significant increase is due to much improved police recording practices. Nevertheless, these figures demonstrate just how widely domestic abuse affects society.

1.9.2 The Home Office homicide index also provides further data. For the year to March 2019, 38% of all female victims of homicide (a total of 79 women) were killed by their current or former partner.

1.9.3 Cambridgeshire Constabulary recorded the following level of domestic abuse incidents in recent years:

Year	2016	2017	2018	2019
Number of domestic abuse incidents	13271	13226	13398	14027

[1] The Crime Survey of England and Wales 2019

1.9.4 For recorded domestic abuse related crimes the data is:

Year	2016	2017	2018	2019
Domestic abuse related crimes	6067	7460	7674	9818

The sharp rise in recorded crimes between 2018 and 2019 is due to a change in recording criteria. This is matched in the national data and should be viewed as a positive step to ensure the right vulnerable victims are identified.

1.9.5 The killing of Justina is the fourth domestic homicide in Peterborough since the introduction of legislation mandating Domestic Homicide Reviews in 2011. The previous domestic homicides occurred in October 2011, May 2012 and June 2015. Of these four homicides, three have involved a Lithuanian female victim. This is a significant concern and will form part of the analysis and recommendations from this Domestic Homicide Review.

Section 2: The Facts

2.1 Case specific background

2.1.1 The victim, Justina, was born in 1976 in Lithuania. She was 42 years old at the time of her death. She left Lithuania in 2010 and came to the UK alone to look for work. She initially lived in Lincolnshire with her husband's extended family. Her husband and adult daughter joined her in the UK in 2011 and 2012 respectively.

2.1.2 The perpetrator, Matis, was born in 1973 in Lithuania and was 46 years old at the time of the homicide. He travelled to the UK in 2011 to join his wife (the victim) and other members of his family who had already settled here. (Though he appears to have visited the UK intermittently before settling here). He and Justina (together with their adult daughter when she arrived in the UK in 2012) all worked in the food processing industry.

2.1.3 There are no official records in Lithuania of any domestic abuse incidents between Justina and Matis. However, it should be recognised that the level of service from the authorities in Lithuania regarding domestic violence is well below the standards of recording, investigation and support that occurs in the UK. Enquiries made during the criminal investigation following Justina's death suggest there were unreported domestic abuse incidents between the couple in Lithuania.

2.1.4 By the middle of 2012, the family had moved to Cambridgeshire. They lived in a rented property in Peterborough (Address A). There were several incidents reported to police from this address over the following five and a half years. These included domestic abuse and other incidents of violence.

2.1.5 Other agencies also had contact with Justina, Matis and their extended family. This related to their health, offender management, child protection and housing.

2.1.6 Matis suffered from a number of health problems linked to his epilepsy and alcoholism.

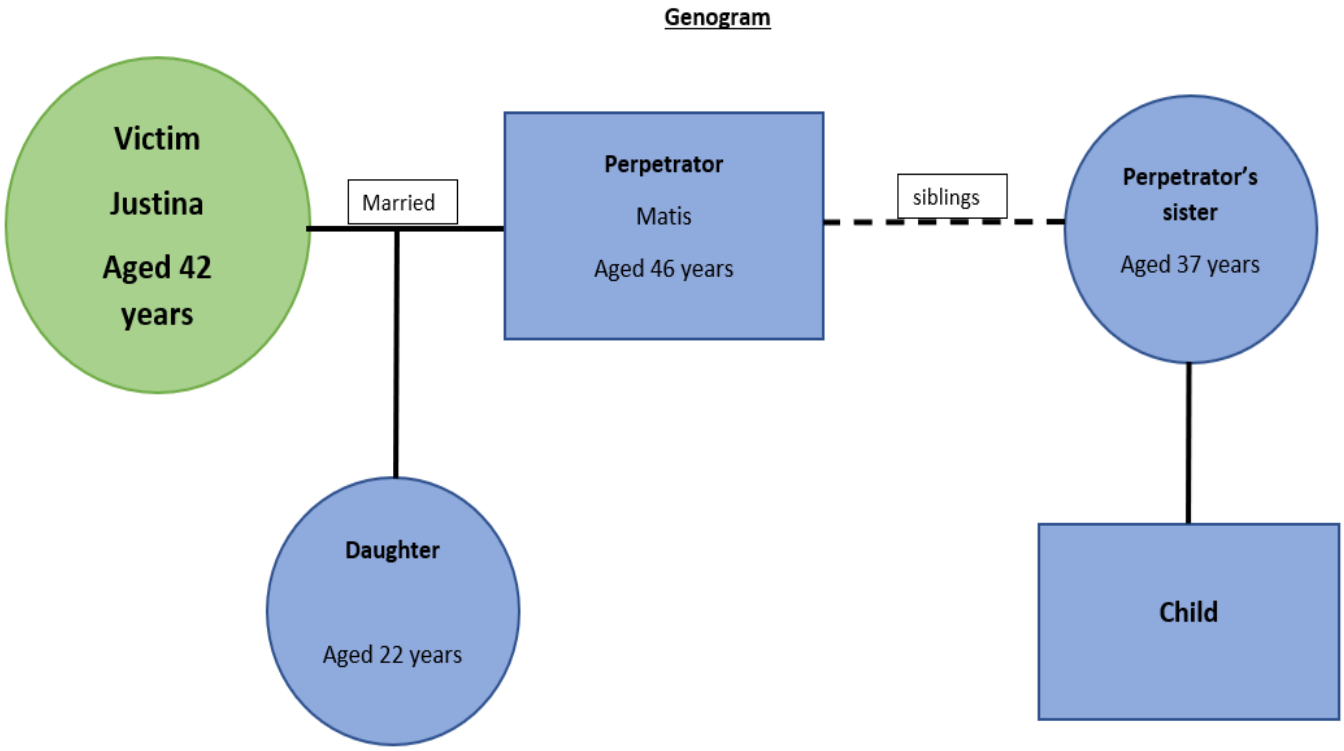
2.1.7 There were several safeguarding concerns raised relating to the welfare of Justina and Matis' nephew.

2.1.8 In early July 2019, a disturbance took place at the family home at Address B. Matis attacked Justina with a knife and a hammer. When his sister tried to intervene he stabbed her, and she fled from the house. Matis armed himself with more knives. His young nephew had been awoken by the noise and saw what was happening to his aunt. Matis then stabbed the child several times inflicting serious wounds. When Matis turned his attention back to Justina, the child escaped from the house. Police were called and when they entered the property they found Justina in the main bedroom. She had catastrophic injuries. Paramedics were called to the scene, entered the bedroom and declared her deceased. She had suffered multiple stab

wounds and significant head injuries during what was later described as a ‘frenzied’ attack. Matis was found hiding in an outbuilding. He was arrested and later charged with murder, attempted murder and causing grievous bodily harm.

2.1.9 Matis appeared at Cambridge Crown Court in February 2020. He pleaded not guilty but was convicted by the jury of the murder of his wife and the attempted murder of his nephew. For the murder of Justina he was sentenced to life imprisonment with a minimum term of 28 years. He was also sentenced to 14 years imprisonment to run concurrently in relation to the attack on the child.

2.2 Genogram



2.3 The Individual Management Reviews and chronologies

2.3.1 As part of this Domestic Homicide Review, reports were compiled and submitted by 13 agencies. These comprised of chronologies of the organisation's involvement with Justina, Matis or their family members who were also part of this review. In the majority of cases, the agency also drafted an Individual Management Review (IMR) which examined their organisation's actions and decision-making. The IMR authors had no direct involvement with any of the subjects of the review and are therefore independent. Each agency's involvement is summarised:

Lincolnshire Police

2.3.2 Although the homicide occurred in Cambridgeshire, initial scoping revealed the family had lived in Lincolnshire from around 2010. Lincolnshire Police were able to provide some background information which summarises events prior to the date parameters set by the Domestic Homicide Review panel.

2.3.3 On 31st January 2010, a '999' call was made to Lincolnshire Police. The anonymous caller stated they could hear loud banging at an address in Boston and that a male was chasing a female and possibly attacking her. The female was screaming. The caller also believed there was a young child at the premises. The caller did not know the names of the people involved but did believe they were all foreign nationals. Lincolnshire Police graded the call as an 'urgent response'. The attending officers established that the two people involved were Matis and his adult sister. The house was quiet. There was no apparent damage and no person had any visible injuries. The officers noted this had been a verbal argument between the brother and sister over a lack of money. Other persons present included Justina (Matis' wife) and their nephew (then aged 2 years). A domestic abuse risk assessment form was completed, and the incident was assessed as 'standard risk'. Officers recorded no child protection checks were required as the child had not witnessed the incident and he was not the child of those involved (though when checking the dates of birth the child was indeed the son of Matis' sister who was seriously injured several years later during this domestic homicide).

2.3.4 A Road Traffic Collision was reported to Lincolnshire Police on 21st November 2012. The circumstances are not directly relevant to this review, but it can be noted that by this date, Matis gave his address to police as 'Address A' in Peterborough.

2.3.5 On 12th August 2013, Lincolnshire Police received a report of a postman slumped in the caller's neighbour's garden. Police attended and established

the postman was Matis who was working for an agency. Officers confirmed he was okay but Matis spoke very little English. The officers confirmed his identity with the manager at the local sorting office who confirmed this had happened before. The manager believed it was because Matis was exhausted with working excessive hours.

2.3.6 There were no further incidents involving any subjects of this review and Lincolnshire Police after this incident in 2013.

GP Practice

2.3.7 All of the subjects of the review (the victim, the perpetrator, their adult daughter, the perpetrator's sister and her child) were all eventually registered at the same GP practice in Peterborough.

2.3.8 Justina registered at a local GP Practice on 3rd September 2012. Matis was registered there on 10th April 2013. His sister transferred to the same practice on 15th November 2013. Her child had initially been registered with a separate GP Practice in Peterborough but he transferred to the same Practice on the same day as his mum. Justina and Matis' daughter registered there in May 2015.

2.3.9 There are no entries relating to the adult daughter of Justina and Matis recorded in her GP notes that are relevant to this review.

2.3.10 There is one entry relating to Matis' sister which is worthy of note. On 4th August 2017, she attended her GP reporting low appetite and poor sleep pattern. She was crying and stated her problems were due to 'family social problems'. The GP notes do not record any details about the context of the family problems nor whether advice was offered.

2.3.11 For the victim, Justina, there are 13 entries in the GP records spanning from 2013 to 2017 relating to back pain. The records are of GP visits and referrals to other services such as physiotherapy or orthopaedics. In October 2013, the notes state 'when asked about anxiety/depression patient replied, "I am not anxious or depressed".'

2.3.12 The final GP record for Justina is on 27th June 2018 and is a change of address. The entry confirms she has moved from Address A to Address B but remains in the Peterborough area.

2.3.13 There are no references to any form of domestic abuse suffered by Justina in any of her GP records. Nothing was disclosed in this regard.

2.3.14 The first entry to note relating to the child (Justina and Matis' nephew) is on 11th January 2013. This was an enquiry from a social worker after the child (then aged preschool) had been found wandering in the street.

2.3.15 The next entry of note is on 11th October 2014 when a hospital letter was received at the GP Practice. There had been a two week delay in seeking medical treatment for the child following a fall. The child's mother and stepfather gave conflicting accounts and the child had a bruise near their right eye.

2.3.16 On 14th November 2017, there was further contact from Children's Social Care. The child had been present when Matis was arrested for assaulting Justina. The GP notes also make reference to Matis self-harming the day before the domestic abuse incident.

2.3.17 The perpetrator, Matis, had extensive contact with his GP. Between May 2012 and June 2019, there are 78 entries on the GP records relating to him.

2.3.18 The first GP note for Matis, on 8th May 2012, relates to him taking time off work as a precaution after fainting in the workplace. There was a follow up with ECG and bloods but no direct reason for the fainting was established.

2.3.19 On 11th August 2014, he attended after another collapse at work. Two days later, he re- attended and bloods were taken. He stated he was 'under stress at home' and feared he might have epilepsy. He was waiting for an appointment with an optician and informed the GP he was feeling anxious but had never suffered with depression. The GP records 'advice and treatment given'. Subsequent actions in the following weeks included a chest x-ray (all normal). The GP notes raised a query if the dizziness could be a reaction to co-codamol.

2.3.20 On 9th September 2014, Matis again attended his GP. He was suffering back pain and wanted a fit note for work to restrict him having to perform heavy lifting tasks. The GP formulated a plan to refer to neurology if there was no improvement in the dizziness after two months. Two days later, he returned to the GP following the onset of severe headaches and visual disturbance. He was sent for a scan and for a spinal x-ray but nothing abnormal was found.

2.3.21 On 24th October 2014, the GP Practice was asked to provide a report for Matis' solicitors regarding criminal charges against him; this entry appears to relate to an assault and racial abuse he perpetrated towards two Asian men who had tried to intervene when they saw Matis arguing with two unidentified women.

2.3.22 On 2nd December 2014, Matis' MRI scan reported back to the GP 'some non-specific, small white matter changes, may be related with small vessel disease/migraine'.

2.3.23 During 2015, Matis had seven contacts with his GP. These all relate to contacts elsewhere with other health professionals. He had several visits to Peterborough City Hospital for alcohol related symptoms. The issues were blackouts and seizures. There are references to referrals to 'Drinksense' (an alcohol support service commissioned within Peterborough until March

2016; the service was provided by 'CGL Peterborough Aspire' from April 2016).

2.3.24 His hospital attendances continued regularly during 2016. The entry on 4th March 2016 states 'arrested by police after domestic yesterday – had been drinking heavily (1 bottle of vodka), fell downstairs'.

2.3.25 On 16th September 2016, he attended the GP practice complaining of dizziness and feeling weak. He stated he had epilepsy until the age of 10 years and that he was struggling to find words and was bothered by bright lights. The GP noted he did not have normal power and tone in all four limbs. Matis was advised not to drive and to keep a diary of any seizures. He was referred to neurology.

2.3.26 On 19th December 2016, Matis had a review of his medication at the GP practice. There had been an improvement in his epilepsy. He told the GP he had stopped drinking alcohol.

2.3.27 On 25th January 2017 he attended again. He reported having a fit the day before and four fits in the last two months. His medication was reviewed, and a sick note issued.

2.3.28 Matis' next appointment was on 14th March 2017. He stated he suffered an epileptic fit the week before and several in the preceding weeks. He complained of back pain. He asked for another sick note and had not been at work in the last four months.

2.3.29 At a further appointment on 28th April 2017, he reported he had stopped drinking alcohol three months earlier, but he seemed confused about the epilepsy drug doses. A message was sent to the CPFT epilepsy nurse to contact him.

2.3.30 On 27th July 2017 (following two more incidents of seizures/headaches) his epilepsy medication dose was increased.

2.3.31 On 11th August 2017, during a GP appointment, Matis reported he was having fewer fits but they were now more severe. He was also suffering with insomnia.

2.3.32 On 15th September 2017 he attended to report falling in the street following an epilepsy attack. He had lower back pain and was feeling depressed about not working. The GP noted he had difficulty in talking and was 'stuck for words'. Matis was referred to the Speech and Language Therapy service (SALT).

2.3.33 On 11th December 2017, the GP notes record Matis was taken to hospital recently for self-harm and had attacked his family (referring to an incident on 15th November). The GP entry states, 'no suicidal or harmful thoughts, no alcohol'. There were subsequent referrals made to the epilepsy service, neurology and a counselling service but no mention of any risk assessment

or further gathering of information relating to the 'attack' on his family. We know that Matis' wife (Justina) was registered at the same GP practice.

2.3.34 There are 24 entries on Matis' GP record made during 2018. Most record issues with seizures or falls. On 20th April 2018, the notes state he feels he has hallucinations as a side effect of his medication, leading to self-harm and aggression with his family. He told the doctor he had a number of criminal matters pending but that he cannot remember the incidents.

2.3.35 On 30th July 2018 he reported an increase in the number and duration of his seizures. He stated he was unhappy about not working and his wife having to provide for him. His medications were reviewed.

2.3.36 On 15th August, Matis attended for a follow-up appointment with his GP (relating to his recent attendance at the Accident and Emergency Department at the Peterborough City Hospital). Matis was feeling very low due to his illness and believed his seizures and medication were affecting his mental health. He had consumed a full 1 litre bottle of vodka and then had a seizure. He was living on his savings. He thought he may have to move out of the family home but could not go to his brother's as his brother was worried about 'the impact on his children'. The GP plan was to make a referral to Primary Mental Health Care Service (PRISM).

2.3.37 On 10th September 2018 he attended his GP following another hospital visit. He stated he had been in severe pain and had drank washing detergent. He went on to say he had felt suicidal at the time of the incident but was not suicidal now. He told the doctor his 'family have deserted him' due to his illness but that his daughter is a protective factor.

2.3.38 At an appointment on 24th September 2018, Matis informed the GP he was now living in a rented room. No further details are shown.

2.3.39 On 21st December 2018 he reported a recent A and E attendance following a seizure. He had fallen downstairs and suffered lacerations, a nasal bone fracture and some amnesia. He reported he had not drunk alcohol for the last eleven months. (This is not true as he was admitted to hospital four months earlier when he confirmed he had drunk a 1 litre bottle of vodka).

2.3.40 On 7th February 2019, he attended the GP practice with a complaint of ongoing knee pain. He stated he was now having counselling (the notes do not give details of who was providing this counselling).

2.3.41 On 19th March 2019, Matis requested an extension of his sick note and asked for 'depression tablets'.

2.3.42 At his GP appointment on 7th June 2019, he reported he had gone 36 days without suffering a seizure but then had one after meeting his psychiatrist. It is not clear from the GP notes who was providing the psychiatrist service.

Housing Enforcement Service

2.3.43 When reviewing the 'selective licensing' applications it appears Justina was named as the tenant at Address A in Peterborough from June 2012. The property is listed as a two-storey, three bedroomed terraced property. It was owned by a private landlord. It appears there were at least six people living here; Justina, Matis, Matis' sister and her partner, the child (Matis' nephew), and Justina and Matis' adult daughter.

2.3.44 There do not appear to be any records at the Housing Enforcement team of a move to another property. However, there was an 'Assured Short Term Tenancy' signed for at Address B from 25th December 2018. Again, this was a three bedroomed terraced property and was owned by a private landlord. The tenants are shown as Justina and Matis. No other person is shown on the documentation, but it appears again there were at least six people living at the house. The homicide occurred at Address B on 2nd July 2019. Information gathered elsewhere during this review suggests that Justina may have moved into Address B in the summer of 2018. Matis was probably living on his own in a flat elsewhere in Peterborough at that time (though the exact address is unknown). He may have visited Address B regularly and then it appears he joined the rest of the family living at Address B late in 2018.

East of England Ambulance Service

2.3.45 There were 15 calls to the Ambulance Service to either Address A or Address B between September 2013 and prior to the tragic events of 2nd July 2019. One call was related to Justina; on 23rd September 2013, she requested an ambulance due to back and leg pain. Her daughter was present who appears to have assisted with translation. Justina eventually decided to take a taxi to hospital instead. There was no suggestion of any assault or domestic related incident. One call related to the child (Justina and Matis' nephew); on 2nd December 2016, a '999' call was made after the young child had been suffering abdominal pain for three weeks. It appears the child's mother had not been giving pain relief medication. The ambulance crew gave advice about 'Calpol' and referred the mother to their GP.

2.3.46 The other 13 calls to the Ambulance Service during this timeframe all related to Matis.

2.3.47 The first of these was on 11th September 2014 and was for a fall following a convulsion. He stated it had also happened three weeks earlier. He was taken to Peterborough City Hospital for further checks.

2.3.48 The next call was not for a further two years. Matis had a head injury following a fall. He could not remember falling over or falling downstairs.

Details were provided by his adult daughter. Matis told the crew he did have alcohol problems but that he had not drunk alcohol for three weeks. He was conveyed to Peterborough City Hospital.

2.3.49 There were three calls to Address A during 2017: the first two related to headaches and convulsions. The third call, on 14th November 2017 stated the 'patient was running around the house with a knife. Family are scared and so are in another room. Police in attendance'. Matis had lacerations to the side of his neck and four marks on his left wrist. He stated he had not slept for two days. He denied any drug or alcohol use and was conveyed to Peterborough City Hospital.

2.3.50 A call on 23rd June 2018 relating to a convulsion was cancelled by Matis' daughter as he had made an appointment to see his GP instead. This was the first call to Address B.

2.3.51 There were four further calls for an ambulance during 2018; all related to convulsions or falls.

2.3.52 On 15th January 2019, Matis' sister called an ambulance but Matis was reluctant to speak with the crew. He confirmed he had epilepsy and had not worked for two years. Matis had a large quantity of cash with him which he tried to throw away in a clinical waste bin. The crew stopped him from doing so and handed the cash to hospital staff. This was the last ambulance call prior to the homicide in July 2019.

<u>Peterborough City Hospital (North West Anglia NHS Foundation Trust).</u>

2.3.53 The victim, Justina, did have cause to attend Peterborough City Hospital several times. However, when reviewing the reasons, there does not appear to be anything directly relevant to this review and so her privacy will be respected. One pertinent issue is that Justina did not speak fluent English and her daughter translated for her.

2.3.54 Likewise, Matis' sister only had rare attendances and these were not relevant to this review.

2.3.55 The child (Matis and Justina's nephew) had two attendances of note: On 11th October 2014 he was brought to the hospital with chest pain resulting apparently from a fall two weeks earlier. A safeguarding concern was raised due to the time delay in seeking medical advice and for an unexplained bruise near the child's eye (though Children's Social Care did not receive a referral about the bruising to the eye. They did receive the referral about the chest bruising and lack of timely intervention).The second occasion of note was on 1st December 2014; the child had ear pain, but a safeguarding concern was raised as the child was very quiet and the 'stepfather' appeared

to be very controlling (it has been confirmed this male was not Matis but was the child's mother's new partner).

2.3.56 The subject with the most frequent contact with the city hospital was Matis. He attended the hospital many times during the time period of this review. These visits included initial attendances to the Accident and Emergency Department and then to subsequent specialist clinics when required.

2.3.57 During 2014 and 2015, Matis received treatment at the Peterborough City Hospital. After attending the Emergency Department he was referred to a number of specialist services. These included an x-ray of the spine (result was normal vertebral body alignment), CT head scan (result was normal brain scan with no acute findings), a chest x-ray (result was normal), ophthalmology outpatients, MRI scans (reported as normal back to the GP) and a liver clinic (this followed an Emergency Department attendance where Matis disclosed he had drunk a half to a full bottle of vodka every day for several days).

2.3.58 On 3rd March 2016, he was taken to the Emergency Department after being arrested by police. The notes state 'arrested by police after domestic yesterday – had been drinking heavily (1 bottle of vodka), fall downstairs, is there a cranial bleed?' Matis was sent for a CT head scan. The findings were normal- no haemorrhage or skull fracture. Later during this visit he was diagnosed as suffering from alcohol withdrawal.

2.3.59 He attended the hospital again on 20th June 2016. He had suffered injuries during an assault and was heavily under the influence of alcohol. He was referred to follow-ups with a fracture clinic and to Addenbrookes neurosurgeons for an investigation on neck discomfort.

2.3.60 Matis attended again on 15th September 2016 following a fall downstairs. He stated he had given up alcohol three weeks previously. He received a CT scan for the head and the spine and both results were normal.

2.3.61 On 14th October 2016 he attended the neurology outpatients clinic. The clinician noted he had suffered epilepsy as a child but had not taken any medication for some years. Matis described multiple episodes of loss of consciousness. Epilepsy medication was prescribed.

2.3.62 Matis attended a further three times to the Emergency Department in November 2016 (all relating to falls or seizures).

2.3.63 There were four further attendances to the Emergency Department during 2017 for similar reasons. Each visit triggered further referrals to specialist support services. In addition he also attended the 'Minor Injuries and Illness' unit (MIIU) on 11th October 2017 following a reported epileptic fit. He was advised to attend the main Emergency Department if there were any further episodes. Following an incident in November 2017, he was brought to the hospital by police. He was so violent (spitting, biting and re-opening his wounds caused by self-harm) that police officers had to handcuff him to the

bed/trolley rails. After being sedated, he was admitted to the Critical Care Unit for 18 days. While in police custody he had been breathalysed which showed a moderate level of alcohol in his body. Medical staff recorded the most likely prognosis was use of illicit drugs. It was not until 4th December that police were informed his condition had sufficiently improved for him to be moved out of the Critical Care Unit to a ward.

2.3.64 There were seven attendances at the Emergency Department during 2018. Again, these visits resulted in further referrals to specialist services at the hospital as already described. During one visit on 8th August 2018, he had been brought to the hospital by ambulance following a seizure when he had been found on the floor. Matis told staff he had not drunk alcohol for 12 months but had drank vodka all that day. He also stated he was 'having trouble with his wife' and that he was depressed and wanted to end his life. He was referred to 'Change, Grow, Live Aspire' (an integrated drug and alcohol treatment service for adults and young people).

2.3.65 He had four attendances at the Emergency Department between January and February 2019. These all related to chest pain. Staff noted he was acutely intoxicated with drink or drugs. Subsequent examinations found no evidence of any problems of a cardiac nature.

2.3.66 On 9th June 2019, Matis attended the Emergency Department with a headache post seizure. He was in a shop at the time and the incident was reported by staff in the shop. He did not seem in any distress and told staff he lived with his partner and children. He stated he had stopped drinking alcohol approximately two years previously. He attended a subsequent physiotherapy appointment four days later. This was his last contact with the Peterborough City Hospital prior to the death of Justina.

<u>Cambridge & Peterborough NHS Foundation Trust (CPFT)</u>

2.3.67 The Cambridge and Peterborough NHS Foundation Trust provide a number of services that were accessed by people who are subjects of this review. These include two relating to the child (the nephew of Matis and Justina who was seriously injured at the time of the domestic homicide);the Health Visiting Service and the School Nursing Service (now known as 0-19 universal services). They also include several services that supported Matis: namely mental health services (PRISM), Liaison and Psychiatry, Neurological Conditions Service Epilepsy (NCSE) and adult Speech and Language Therapy (SALT).

2.3.68 The 0-19 years universal services had several contacts with the child subject of this review. These contacts related to four separate safeguarding concerns.

2.3.69 The child was found wandering alone in the street on Christmas Day in 2012 (he was preschool age). Health Visiting were alerted via the Multi-Agency Support Group (MASG). The initial assessment by Children's Social Care was shared with partners on 30th January 2013. This was the first involvement by Health Visiting Services in Peterborough after the family had moved there from Lincolnshire. There does not appear to have been any formal handover between the two localities. The Health Visitor made a home visit and mother and child were seen (though we should note the victim of the domestic homicide is not the mother of the child but is their aunt).

2.3.70 On 11th October 2014, a 'cause for concern' was shared by Peterborough City Hospital. The child had a delayed presentation to the Emergency Department following a fall two weeks earlier. Records indicate that conflicting accounts were given by the mother and stepfather. The child had an unexplained bruise near their right eye.

2.3.71 On 1st December 2014 a further 'cause for concern' was received by the School Nursing team from Peterborough City Hospital. The child had attended with ear pain. They were noted to be very clingy to their mum and the stepfather was very controlling.

2.3.72 On 14th November 2017, a Domestic Abuse risk assessment form was received from the police. It was graded as 'medium risk.' The perpetrator (Matis) had physically assaulted Justina and threatened her. He had then assaulted police officers and paramedics. The child was living in the house at that time. Further information on the risk assessment also indicates that Matis had kicked his nephew two or three years earlier.

2.3.73 Matis accessed numerous specialist services provided by CPFT:

2.3.74 He was referred to Neurological Conditions Service Epilepsy (NCSE) on 21st November 2016 following recent seizures. MRI brain scan and CT head scans were performed. The notes indicate that the seizures relate to drinking alcohol, but that he has since stopped drinking. NCSE reviewed Matis three months later (February 2017). He was taking Epilim as prescribed. Matis was not working and so was anxious and not sleeping. The medical notes suggest he was to be reviewed monthly. On 12th February 2018, the notes record he had a possible reaction to medication (topiramate). He had hallucinations and thought he was cutting meat with a knife but was in fact self-harming. The notes give further detail that Matis had drunk a whole bottle of wine in one sitting. His last appointment with NCSE was on 4th March 2018. He was then subject to yearly reviews and remains on their case load.

2.3.75 The SALT (Speech and Language Therapy) service provides assessment, diagnosis and treatment for adults with acquired communication, voice, fluency and swallowing disorders. Matis had been referred by his GP on 3rd October 2017 due to his speech difficulties. An interpreter was present during his appointment. He described how he was under stress and strain at

home. He had limited finances and limited support from his wife. He stated he was “bottling everything up and feels he will explode”. Matis did agree to counselling but the practitioner noted they were unsure if he fully understood the concept. During his next appointment three weeks later it was noted his speech had improved. The SALT practitioner was concerned that Matis expressed anger and stated he ‘wanted to thump walls’. He told the health professional he is not normally angry. He also stated his relationship with his wife had worsened. He was keen to access counselling and therefore a referral to counselling services was made on 30th October 2017. At his appointment on 8th November 2017, Matis appeared tired and unshaven. He said he was contacting his wife mainly by text. He also said former workmates were now ignoring him. He told the SALT practitioner he felt ‘angry, fearful, negative and shameful’ and that his memory and cognition were ‘fuzzy’. He did not attend his next SALT appointment on 20th November 2017 (he was admitted to hospital at this time) and on 9th July 2018 he was discharged from the SALT service as there had been no contact from him.

2.3.76 Matis had been referred to the Liaison Psychiatry Service from the Emergency Department at Peterborough City Hospital on 14th November 2017. This followed his attendance for feeling suicidal and also when he had been arrested for a domestic violence incident, together with other assaults on police officers and medical staff. He was so violent he was restrained by police in handcuffs and leg restraints. Matis spent a long period in critical care. His assessment took place on 5th December 2017 and he was accompanied by a Lithuanian interpreter. The practitioner recorded the patient had no recollection of events but that there were also inconsistencies in his account. He stated he has a wife, daughter, sister and his sister’s child all living in the same house. The practitioner was aware there was an incident at the house prior to Matis being brought to hospital. He referenced not being allowed back there due to bail conditions. It was noted Matis did not have suicidal ideation. He was future focused and was keen to leave hospital. The Liaison Psychiatry notes state there was ‘no evidence of risk to self or others at this time and no evidence of a mental health issue that needed crisis team input or psychiatric admission’. This information was passed to his GP and the case was subsequently finalised as ‘no further action’.

Cambridgeshire Constabulary

2.3.77 Cambridgeshire Constabulary had ten separate contacts with the family during a period spanning over five years. These incidents were for a variety of reasons and include domestic abuse, violence, child protection and mental health issues.

2.3.78 On 21st July 2012, Matis and Justine had been out drinking with Matis' sister and other members of the family. It is reported that Matis consumed a considerable amount of alcohol and that on their return home they all continued drinking (at Address A). Matis was drinking very strong volume alcoholic drinks. The atmosphere changed and Matis made several inappropriate remarks about Justina. He attempted to punch her but missed. He then threw a laptop computer at his wife, breaking it. He was restrained by other family members. The police were called and Matis was arrested for assault and criminal damage. He was charged with a number of offences and bailed with conditions not to return to the family home. Justina and their daughter returned temporarily to Lithuania. In the meantime, Matis did return to the family home in breach of his bail conditions (though this was not known to Cambridgeshire Constabulary at that time). It was a month later (after her return from Lithuania) when officers could make contact with Justina. She declined to support a prosecution against Matis. There was no other supporting evidence and the case was discontinued.

2.3.79 On 13th July 2013, there was an abandoned '999' call made from Address A. Officers were sent to the address and spoke to a man who stated he had made the call (though the message does not identify the male). It is not clear what had taken place and officers could not get any more information from the people at the property. The incident was closed with no further action and it was not coded as a domestic related incident.

2.3.80 On 12th November 2013, Matis was named on a child protection referral. The actual enquiry did not involve Matis and the incident was not at Address A. He was only named as the child's uncle and as one of the carers for the child while his mother (Matis' sister) was at work.

2.3.81 On 15th September 2014 Matis was seen arguing with two women. He was in a garden outside Address A and the women were inside the house. The two women were not spoken to and so their identities are not confirmed (though only Justina and her adult daughter were living at Address A at that time). A male passing by attempted to intervene and asked Matis if he was alright. Matis then assaulted the male, punching him about the head and using racial abuse. A second male attempted to intervene, and he too was assaulted by Matis. The police were called and Matis arrested. As he was complaining of chest pains, Matis was taken to Peterborough City Hospital. There, he was also racially abusive to the doctor in the Emergency Department. Matis later claimed he could not remember the incidents. He was subsequently convicted of three counts of racially aggravated common assault. There was no attempt to speak to the two women in the house and this incident was not recorded as a domestic related occurrence.

2.3.82 On 22nd November 2014, a neighbour reported a disturbance and 'possible fighting' at Address A. The event was a birthday party at the house. No details were taken of the people who were present, but it is likely this was Justina and Matis' daughter's 18th birthday party.

2.3.83 On 2nd March 2016, Matis returned home drunk and started an argument with Justina, their adult daughter and his sister. He picked up a chair and raised it above his head as if he was going to strike his sister. The police attended but Matis had already left. None of the other family members would provide a statement about what had happened. A DASH risk assessment was completed by the officers with his sister named as the victim on this occasion. No further action was taken against Matis as no one would assist the police with gathering evidence.

2.3.84 On 31st August 2016, a neighbour reported loud music coming from Address A. Officers did not attend but Control Room staff gave advice to the neighbour about contacting the Local Authority Environmental Health department.

2.3.85 On 3rd November 2016, police were called to Address A relating to what was believed to be a domestic related incident. The call related to Matis and was made by his sister. There were some issues with language to establish what had happened. Matis was in the kitchen and he was seen by the officers to be behaving irrationally. He was detained to prevent a breach of the peace. However, when he complained of chest pains he was taken to the hospital and no further action taken against him. This incident was not coded as a domestic abuse matter. It is not clear what the nature of the incident actually was. It may have been concerns for Matis, but it could also have been domestic related. Officers did not submit a DASH risk assessment, but they recorded on the Force Control Room system that they would be submitting a 'form 102' which is an 'Adult at Risk' form. Such documentation is used to share the concerns with multi-agency colleagues for adults who may require further help and support. However, although the intent to submit the form 102 is recorded, the actual form itself was never submitted or shared with partner agencies.

2.3.86 On 13th June 2017, a silent '999' call was made from Address A. There were also sounds of a disturbance in the background. Due to previous incidents at that address the location was 'flagged' on police systems as historical domestic abuse incidents taking place and so the call was graded for an immediate response. In the interim, the caller was contacted by the Force Control Room and they established an ambulance was required for a medical emergency but that police were not required. A cross referral was made to the Ambulance Control Room who confirmed an ambulance had been despatched. No police officers attended the address on this occasion and the incident was not coded as a 'domestic' incident.

2.3.87 There were two calls to police from Address A on 14th November 2017. The first incident was just after 1.00am and officers attended in support of the Ambulance Service to a report of a man armed with a knife who was self-harming. The male was Matis and he had wrist and neck injuries. He was taken to hospital by ambulance. He was not arrested and there was no suggestion he had threatened or harmed other people. A second call was

received at 6.00pm that day (i.e. 17 hours after the first call). Matis had locked himself in the bathroom and started talking about 'needing to shave his body in order not to have epileptic fits'. After over an hour, Justina and their adult daughter knocked on the bathroom door asking him to come out. Matis began to argue with them. At one point he even telephoned his mother in Lithuania. She could be heard on the phone telling him to calm down. Matis then spat at his wife and daughter and threatened to 'split Justina's skull open'. He then slapped Justina around the face and grabbed hold of her. Their daughter intervened and pulled them apart. They then went to the bathroom and locked themselves inside. Matis' sister remonstrated with him and he then grabbed hold of her and pulled her hair. As Justina and his daughter were trying to leave the house he grabbed his daughter's hand and bent it backwards causing an injury. They managed to call the police from outside. When police arrived, all three members of the family made allegations of assault. Officers arrested Matis but he became extremely violent. He assaulted several officers both during his arrest and while he was at hospital. He also assaulted a paramedic and a doctor in the Emergency Department.

2.3.88 Due to his medical issues, Matis remained in hospital for several weeks. He had been extremely violent when transported to the hospital (with several officers injured and Matis restrained by police in handcuffs and leg restraints). He needed to be sedated by medical staff. He was then admitted to the Critical Care Unit for 18 days. He transferred to a main ward on 4th December and was seen by a professional from Liaison Psychiatry the following day. Matis was discharged from the hospital on 16th December 2017. Officers could not locate him immediately. He did attend for a voluntary interview in January 2018. Justina indicated to police that she did not want him prosecuting for assaulting her. She feared if he was convicted he would be deported. Matis was reported for summons in relation to the six counts of assaulting a police officer. Due to negotiations over Defence pleas, the case was not heard at Court until November 2018.

2.3.89 There were no further contacts with Cambridgeshire Police after 2018 until the tragic death of Justina in July 2019. Cambridgeshire Police did not receive any calls to Address B prior to the 2nd July 2019.

<u>Cambridgeshire and Peterborough IDVA service</u>

2.3.90 There was only one incident involving the Cambridgeshire and Peterborough Independent Domestic Violence Advocacy service during the timeframes of this review. This was on 11th March 2016 and related to a referral from Cambridgeshire Constabulary for an assault by Matis on his sister which had occurred at Address A. His sister had declined to support a prosecution. The IDVA service attempted to make contact with the victim but she did not

respond. As the case did not meet the MARAC threshold (high risk), the case was closed on 25th April 2016.

Education Safeguarding Team

2.3.91 There were several contacts with the child (nephew of Justina and Matis) from an education safeguarding perspective. The child had attended two primary schools in Peterborough.

2.3.92 There was an early concern over the contents of their packed lunch in October 2013. This was resolved by the teacher discussing the concerns directly with their mum (and assisted by the support of a Lithuanian interpreter).

2.3.93 On 11th November 2013, the child disclosed to a teaching assistant that their stepfather punched him, and the young child demonstrated the action of punching. Three small round bruises were seen on the child's arm. The matter was reported via the school's designated safeguarding lead to Children's Social Care and police who carried out a joint home visit.

2.3.94 On 7th May 2014, the child showed a family support worker some red spots on their arm which he said were caused by mum hitting them with a nettle because they wouldn't go to bed. Any subsequent actions taken are not recorded.

2.3.95 There were two incidents in October 2014. The first was an injury to the child's eye. However this was confirmed to have taken place in school when they bumped into a post in the school hall and so was not raised as a safeguarding issue. The second was on 14th October in relation to some bruising to the child's chest for which they had attended the Accident and Emergency Department at the hospital. The concern was of the delayed presentation and school assisted the Social Services enquiry by checking the first aid register.

2.3.96 On 1st December 2014, an Inclusion Officer shared information with Children's Social Care due to the young child not achieving age related expectations. The discussion followed a talk with the child's mother who had a perceived lack of parental warmth and lack of engagement when she was informed about her child being involved in several altercations (pushing/biting) with their peers.

2.3.97 On 23rd May 2015 a teaching assistant noted that the child (only Reception Class age) came to school alone. The adult who collected the child that afternoon was challenged and advised about this.

2.3.98 There were several incidents (between September 2017 and May 2018) reported via the school of the child disclosing they were watching or playing

with inappropriate video games and horror films (aged 18+ and 15+). The mother was approached directly about these concerns.

2.3.99 The child's school had never been informed about any domestic abuse incidents taking place in their home.

Refuge (Domestic Abuse Outreach Service)

2.3.100 The Refuge Service in Peterborough provides both safe accommodation for victims of domestic abuse and also provides an outreach service. The service had only one contact with the victim, Justina, during the timeframe of this review. This followed a police referral in November 2017. On 17th November, an outreach worker contacted Justina to offer practical and emotional support. Justina stated she had not yet heard if her partner had been released from police custody. The outreach worker provided her with the telephone number for the National Centre for Domestic Violence in order to apply for a non-molestation order. The worker agreed to contact Justina the following week. The outreach worker made four calls the next week but did not receive a reply despite leaving a voicemail. The case was then closed.

CGL (Change, Grow, Live) Peterborough Aspire

2.3.101 CGL Aspire is an integrated drug and alcohol treatment service; commissioned to provide services to adults and young people in Peterborough since April 2016. They received one contact from Peterborough City Hospital on 10th August 2018 relating to Matis. He had been admitted to hospital following a seizure. Matis had disclosed a historic alcohol problem but stated he had abstained for over a year. He had drunk a bottle of vodka prior to his admission. He told the CGL Liaison professional he was not aware of the risks associated with alcohol use. During the brief assessment, Matis did not disclose any contact with children. He declined a referral to CGL in order to access alcohol treatment. However, he did accept details of how to self-refer to the service in future. Matis did not subsequently contact CGL for help.

Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation Company (BeNCH CRC)

2.3.102 The BeNCH CRC was responsible for supervising Matis on two occasions. The first was between 29th October 2014 and 12th January 2015. The second was between 13th November 2018 and 10th July 2019. The domestic homicide took place during the second period of supervision.

2.3.103 The first supervision period followed the incident when in September 2014 Matis had assaulted and racially abused two males who attempted to intervene when Matis was arguing with two women in a house. Matis was in the front garden of the house. When arrested by the police he was taken to hospital after he had received injuries while being restrained. He then also assaulted and racially abused the doctor at the hospital.

2.3.104 When interviewed at Court by the National Probation Service, Matis stated he could not remember the incidents. The interviewing officer did not raise any issue about who the two women were in the house. Nor did they request a copy of previous police call-outs. Matis was assessed as posing a 'medium risk of serious harm to the public'. He was not identified as posing a risk of harm to his wife or daughter. The interviewing officer did not believe there were underlying issues to Matis' behaviour which required probation intervention, they therefore proposed a purely punitive requirement of unpaid work without any rehabilitative requirements. The Probation Officer did identify that Matis had a 17 year old daughter and conducted a check with Children's Social Care, who replied to advise that the family was not known. Matis was sentenced to a 12 month Community Order with a single requirement of 80 hours unpaid work. His order was allocated to BeNCH CRC, who supervised him and he completed his unpaid work without any problems.

2.3.105 The second period of probation service supervision was related to the incident on 14th November 2017 when Matis had attacked his wife, adult daughter and sister at their home. He had also assaulted several police officers, a paramedic and a doctor at the hospital. There had been a delay of nearly a year before Matis had been convicted of the assaults on police and medical staff as he initially pleaded not guilty to the offences. The Court eventually accepted Matis' basis of plea in which he attributed his violent and aggressive behaviour to the side effects of his epilepsy medication. He was not charged with any of the assaults on his family as they had all declined to provide witness statements.

2.3.106 On 19th October 2018, when interviewed at Court by the National Probation Service, Matis stated his epilepsy was diagnosed in 2016, triggered as a result of a car accident in 2012 when he had sustained a head injury. He stated that prior to the incident he was having hallucinations and had argued with his family. He maintained what he had told the police; that he could not remember any details of the incident. The interviewing officer subsequently reported to the court that although Matis had no formal diagnosis of mental

illness, they believed Matis may need more support than he was currently receiving due to him having expressed suicidal tendencies in the past. Matis had also admitted to using alcohol in the past although he said he had not drunk in the previous six months.

2.3.107 The interviewing officer assessed Matis posed a risk of serious harm to the public, criminal justice staff, medical staff and known adults, namely his wife, his adult daughter and his sister. The interviewing officer expressed concern that Matis was potentially very vulnerable if he received a custodial sentence. They also stated he was not suitable for further unpaid work as he was unfit for employment due to his epilepsy. The interviewing officer recommended a 25 day rehabilitation activity requirement.

2.3.108 The Court sentenced Matis to 12 weeks custody suspended for two years with a 35 day rehabilitation requirement. The Order was allocated to BeNCH CRC to manage.

2.3.109 Matis attended his induction appointment at BeNCH CRC on 21st November 2018. He stated he had been reunited with his wife and daughter at a new address (this was at Address B). During his next appointment the following week, a detailed assessment of Matis' needs and risks was conducted by his Probation Officer. The Probation Officer assessed that 'accommodation, relationships, emotional well-being, thinking and behaviour and attitudes' were all linked to both risk of harm and risk of reoffending. The Probation Officer did identify a history of domestic abuse.

2.3.110 In their risk of harm summary, the Probation Officer concluded Matis posed a medium risk of serious harm to the public, known adults, staff and children. In relation to children, the officer assessed Matis did not currently live with children, but that if this changed, he could present a risk of harm to them if they witnessed his abusive behaviour towards adults in the family home. The officer then created a sentence plan and risk management plan which included working with Matis on anger management, thinking, behaviour, monitoring alcohol and drug misuse, mood and compliance with medication. The plan was to see Matis weekly for the first 12 weeks of his order. A Lithuanian interpreter was required to support Matis at every appointment.

2.3.111 On 3rd December 2018, Matis attended a further appointment with his Probation Officer. He was asked to clarify his current accommodation. Matis stated he now lived with his wife, adult daughter, his sister and her child. They also discussed alcohol use and medication.

2.3.112 At his next meeting on 10th December 2018, the officer thought Matis 'looked poorly'. He was not focused and was struggling with his words. Matis showed the officer a video on his phone apparently of him having a seizure. The Probation Officer's summary of this meeting is that Matis presented with multiple problems, low mood and feelings of depression. During subsequent meetings in December 2018 and January 2019 most of the discussions

seem to be around Matis' health as this was considered to be the most significant risk factor for Matis.

2.3.113 On 4th February 2019, Matis' Probation Officer's Line Manager added a 'management oversight' entry on Matis' file, - to reflect that a 12-week review had been conducted by the Probation Officer. They noted Matis' attendance had been good and that he engaged very well. However, the engagement was impacted by him needing an interpreter at every session. Matis' Probation Officer believed that the fact Matis' epilepsy was being treated and better managed meant that his offending-related needs and risks had reduced and Matis could be reduced to fortnightly appointments to reflect the lack of any further risk related incidents and also perceived improved stability in the case.

2.3.114 A home visit was planned for 3rd April 2019, Matis was introduced to his new Probation Officer (the previous officer was moving to another location). Matis' sister was present and assisted in the interpretation.

2.3.115 Matis' probation meetings continued through May and June. His last appointment prior to the domestic homicide was on 26th June 2019. Matis stated there was no change in his circumstances. He reported a positive change in his health with no further seizures. The Probation Officer set him the task of maintaining compliance with his medication.

Children's Social Care

2.3.116 The first involvement with Children's Social Care in Peterborough was on 27th December 2012. An email was received from the police stating a very young (preschool) child (Justina and Matis' nephew) had been found wandering on a busy road alone. Their mother (Matis' sister) had told officers she had been working night shifts and while she slept the child must have left the house. The case was opened for assessment. No concerns were identified and the child's mother agreed to ensure they did not leave the house alone again. The case was closed to Children's Social Care on 15th January 2013.

2.3.117 On 12th November 2013, Children's Social Care received a referral from the child's school. The youngster had bruising to their arm, allegedly caused by their stepfather. Following a strategy meeting with police and the school, a S.47 enquiry was commenced. This assessment was concluded on 2nd January 2014. The child was living with their mother and other close relatives (including Aunt Justina and Uncle Matis). It was unclear who caused the injury and the child was placed on a Child in Need plan for a period of support. After further home visits, no safeguarding issues or concerns were noted and no new concerns raised by other professionals. The case was closed on 25th March 2014.

2.3.118 On 12th October 2014, Children's Social Care received a telephone call from a doctor advising that the child had been admitted to a children's ward at the hospital due to a chest injury. They appeared to have fallen but the concerns were in relation to their late presentation. The case was opened for assessment. No fractures or bruising were found. The explanation of events was consistent with the injury. The assessment included the child being seen away from the family (while in school). There were some issues identified (linked to a need for dental and optician appointments) but there was no role for Children's Social Care at that time and the case was closed.

2.3.119 On 10th March 2016 contact was received from the police. The child had witnessed a domestic violence incident in the family home eight days earlier. The uncle (Matis) was intoxicated and had been verbally abusive to his wife and had attacked his sister (the child's mother). Matis had been arrested. The day after the referral a social worker telephoned the child's mother and spoke with her via an interpreter. The mother advised she had no concerns as her brother (Matis) had stopped drinking after the incident. The social worker decided on taking no further action after recording Matis had just been visiting the family home.

2.3.120 On 16th November 2017 there was a contact from the police reporting concerns for Matis' mental health and his aggressive behaviour which included cutting his own wrists and cutting at his neck. On 13th November Matis had threatened to split his wife's skull open, had slapped his wife and injured his adult daughter when she tried to escape. The social work team manager noted this was not the first time Matis had been aggressive in the family home and that the child needed to speak with someone at school on a regular basis to share any concerns. A letter was sent to the child's mother and the records indicate that Matis, Justina and their adult daughter all shared the home with the child and his mother. No further action was taken.

Section 3: Family involvement and analysis

3.1 Family Involvement and perspective

3.1.1 The victim's family were contacted by the Independent Author as part of this review. Although there were several telephone conversations, the family decided they did not wish to take any further part in the Domestic Homicide Review and declined to meet with the Independent Author.

3.1.2 Sadly, there has been tension within the family following Justina's death and the family are struggling to come to terms with what had happened. The next of kin for Justina is her adult daughter. She has been supported both before and after the criminal trial by police Family Liaison Officers and by professionals from the Victim Support Service. The Independent Author has spoken with the Victim Support Services. Through them, Justina's daughter stated she did not wish to be involved any further as she was finding such discussions a great strain. She has already had to listen to many details she was unaware of during the trial.

3.1.3 The Independent Chair will arrange for a copy of the Domestic Homicide Review to be hand delivered to Justina's daughter by kind assistance of the Victim Support Services. The Author fully accepts the pressure on Justina's daughter and so the family privacy will be respected.

3.2 Analysis

3.2.1 Justina and Matis had been married for over 20 years. They lived together in Lithuania before travelling (separately) to the UK to find work. They were accompanied by their daughter and other members of the extended family from Lithuania. Justina had limited contacts with services here. Matis had extensive contacts with a large number of agencies.

3.2.2 This analysis will focus on the terms of reference set by the Domestic Homicide Review panel to help to understand the considerations, decisions and interventions of the many agencies involved in this case.

3.2.3 There were incidents of domestic abuse in Lithuania (though it is unclear whether or not they were reported to the authorities there). This information was not known to agencies in the UK prior to Justina's death. There were also reports of domestic abuse taking place in the UK. The purpose of this Domestic Homicide Review is not about apportioning blame but is to look for any missed opportunities, anything that could have been done differently, any themes that are emerging and ultimately to what lessons can be learned from Justina's tragic death.

3.2.4 This analysis will form the basis of conclusions and learning applicable to this particular case. However, there are wider issues which are also identified. Justina's death was the fourth Domestic Homicide in Peterborough since the process of reviewing such deaths became a statutory requirement in 2011. In three of the four homicides, the victims were Lithuanian women. This presents a challenge to all agencies in Peterborough to review their processes and procedures to ensure they are fit for purpose in protecting this particular group of vulnerable victims.

TERMS OF REFERENCE

The terms of reference were agreed at the initial Domestic Homicide Review Panel on 13th September 2019:

Were practitioners sensitive to the needs of the victim and the perpetrator? Were they knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

3.2.5 The first contacts with the family were when they lived in Lincolnshire. On 31st January 2010 police were called to an address after a neighbour reported a disturbance. However, the recorded victim during that incident was Matis' sister. Justina was present in the house but does not appear to have been involved. The incident was assessed using the national 'DASH' method as a standard risk. When reviewing the circumstances, this appears to have been the correct risk assessment.

3.2.6 Cambridgeshire Constabulary were called to the family home on ten occasions between July 2012 and January 2018. Eight of these calls were either coded as 'domestic abuse' at the time of reporting, or information gathered following the incidents suggests they were probably related to domestic abuse. Of those incidents, only two named Justina as the victim and on both occasions the police took positive action and Matis was arrested. The first of these incidents (in July 2012) involved Matis attempting to punch Justina and then throwing a laptop computer at her. During the second incident (in November 2017) he physically assaulted Justina by slapping her across the face and spitting at her. He also threatened to 'split her skull open'. Matis also assaulted his daughter and sister during the

second incident. Both incidents were assessed by the police as 'medium risk' using the national DASH model. This was the correct assessment in July 2012. In November 2017, the circumstances could have led to an assessment of 'high risk' of serious harm. The 'score' on the DASH model risk assessment was 13 which is at the very upper level of what would define a medium risk event. The DASH assessment itself gives further rise for concern when Justina's replies confirmed the abuse getting worse, (she actually tells officers 'this is the worst time'), that he had used weapons to hurt her, he had previously carried knives, he had mental health issues and he was an alcoholic. The DASH system does encourage professionals to also use their professional judgement to assess domestic abuse incidents. However, after the attending officer's assessment, the form was reviewed within the MASH (Multi-Agency Safeguarding Hub) which confirmed the assessment as a 'medium' risk incident. The agreed definition of a medium risk incident is:

There are identifiable indicators of serious harm but is unlikely unless there is a change in circumstances

At the time of the risk assessment, Matis had been arrested and a criminal investigation was being carried out. These mitigating factors may have influenced the risk assessment. It was only later that Justina felt unable to proceed and withdrew the allegations.

There are nationally agreed protocols between the police and the Crown Prosecution Service on domestic abuse cases. However we should note that a case must still meet an 'evidential threshold' irrespective of any prosecution policy. In this particular case, the police did not consult with the CPS. The national guidance to CPS prosecutors states:

"Prosecutors should ensure they are familiar with the Government definition of domestic abuse and the impacts and dynamics of how abuse may be perpetrated.

Prosecutors should work closely with the police from the outset to ensure effective gathering and collation of evidence to build the strongest prosecution cases:

- *all cases should be built primarily using evidence other than that provided by the victim - however, in doing so, prosecutors should be careful to not undermine the victim*
- *police and prosecutors should use the Joint DV Evidence Checklist as a matter of routine to ensure that all evidential opportunities have been taken*

- *effective information sharing with other agencies and support organisations may assist prosecutors and police in case building*
- *police and prosecutors need to work closely to ensure that a complainant's safety needs are addressed through receipt of informed risk assessments and risk identification*

We know that this was a serious case due to the circumstances given in the risk assessment. In addition, Matis had become extremely violent upon arrest and assaulted a number of police officers and medical staff. When Justina, her daughter and Matis' sister withdrew their allegations the only summons issued was for the assaults on the police officers. We know there was a '999' call recorded in the police control room and there may have been initial disclosures from the victims noted by the police. There may have been 'body worn' camera evidence from officers plus any unsolicited comments from Matis. The guidance to CPS prosecutors includes specific advice around domestic abuse cases when the allegations are withdrawn:

'Retractions of allegations and withdrawal of support will require sensitive handling by prosecutors - compelling a complainant to attend court to give evidence should be a last resort option after all other avenues have been explored. The safety of the complainant and any children or other dependents should be the primary consideration.'

Such cases are complex and require a balance to protect the victim but also be mindful about the result of compelling a victim to attend court. However, a 'gatekeeper' (supervising officer) within Cambridgeshire Constabulary recorded there was insufficient evidence to proceed without the testimonies of Justina, her daughter and Matis' sister. There is no suggestion that the gatekeeper requested any intervention by third parties (e.g. an IDVA) to speak with Justina and express the professional's concerns for her safety or to explain the trial process. In particular, we cannot be fully satisfied that (due to language or previous cultural experiences in Lithuania), Justina had all the facts at her disposal to make an informed choice about withdrawing the allegation. This case should have been passed to the CPS for consideration if the 'evidential test' had been met.

3.2.7 At no point did Justina ever disclose domestic abuse directly to her GP. There were references in Matis' GP records to him 'attacking his family'. When family members are patients at different GP surgeries it can prevent a holistic approach to family issues. But from 2013, Justina, Matis, his sister and her young son were all registered at the same GP practice. However,

discussions at the Domestic Homicide Review Panel following Justina's death, confirmed that even when partners are treated at the same GP Practice, there is no automatic sharing of risk based information between patients.

3.2.8 In October 2014, Matis' GP practice were asked by his solicitor to provide a letter of support due to 'criminal charges'. However, although these charges were for violence they related to attacking two men in the street and not to domestic abuse.

3.2.9 An opportunity was missed in December 2017 when Matis was mentioned in a letter to the GP from the Peterborough City Hospital. The notes refer to him 'attacking his family'. Matis himself was referred to neurology, epilepsy and counselling services. But no consideration was made about protecting his family. Justina was a patient at the same GP practice, as was the young child (their nephew). It would be difficult for a GP to intervene directly with another patient but a consideration of the circumstances and potential information exchange with other agencies may have been useful in establishing the full family 'picture'. A similar note is contained in the GP records in April 2018 when Matis was seen following hallucination, self-harm and 'aggression with his family'.

3.2.10 Matis received an excellent service from a variety of medical services in the Peterborough area over several years. These included those organisations already listed; Peterborough City Hospital and Cambridge and Peterborough NHS Foundation Trust. He was treated for epilepsy, physical injuries following falls or assaults, scans, neurology services, liaison psychiatry and alcohol support services. Staff dealt with him professionally in very difficult circumstances including while being racially abused or physically attacked by Matis. Despite the challenging circumstances he received first class care. The only issue that may have been taken forward would be to have reviewed his attendances at the hospital. He was clearly a 'frequent attender'. From a safeguarding perspective, such a review would reveal that although Matis himself is being cared for or treated, there were wider issues that meant his behaviour was having an impact on his family. During his most violent episodes, he was accompanied by police. But the onus is on all agencies to consider the impact of domestic abuse. There was no 'High Intensity User Group' operating within North West Anglia NHS Foundation Trust at the time of Justina's death.

Did the agency have policies and procedures for domestic abuse, stalking and harassment? Were risk assessment and risk management processes for domestic abuse victims or perpetrators used in the case of this victim and perpetrator? Were these assessment tools effective?

3.2.11 Peterborough City Hospital does have a Domestic Abuse Policy. However, there were some missed opportunities relating to 'think family' concerns emanating from Matis' repeated attendances at the hospital. No risk assessment procedures in relation to domestic abuse were ever carried out.

3.2.12 Cambridge and Peterborough NHS Foundation Trust provided many of the support services accessed by Matis following his attendance at the main hospital plus provides the 0-19 child services for his nephew. The CPFT does not have a stand-alone domestic abuse policy but guidance around domestic abuse is contained within the Trust's safeguarding policy. There were no risk assessments conducted by CPFT staff in relation to domestic abuse even though some professionals involved in his care were aware of violence he had perpetrated towards his family.

3.2.13 The East of England Ambulance Service NHS Trust did not have a stand-alone domestic abuse policy at the time of the homicide. The Trust does have a Safeguarding Adults Policy and there is a specific section in that policy relating to domestic abuse. At one of their many attendances to Matis, there was an opportunity to complete a risk assessment. There were two calls in 24 hours in November 2017. The first was of a male hallucinating. The caller went on to say they were 'scared of him' and the 'patient is running with the knife around the room'. Police were called by ambulance staff due to the possession of the knife. Matis was arrested but it appears the information about the caller being scared was not shared with the police. Matis spent several weeks in hospital after this incident and the extra information plus an ambulance service risk assessment may have assisted in the case.

3.2.14 The police were aware of domestic abuse taking place at the home address as far back as 2012. Their systems had a 'flag' to make attending officers aware of this. The ambulance service does not have such a 'flagging' system in place and there is no doubt such information would have been of benefit to the crews attending to the many calls relating to Matis and his falls /seizures. A flag would have alerted the ambulance crew to consider any domestic abuse implications within the home.

3.2.15 The GP practice does have a Domestic Abuse Policy. There does not appear to have been any direct opportunities for a risk assessment as Justina never disclosed any domestic abuse. None of her GP appointments

related to domestic abuse. Information regarding Matis attacking his family could have been considered, but the GP practice were also aware police were already involved in that case.

3.2.16 Cambridgeshire Constabulary has a comprehensive Domestic Abuse Policy, and this was recently updated. The Force uses the national DASH risk assessment method and there is clear evidence that officers are experienced at using this risk assessment. The assessments are routed via an integrated Multi-Agency Safeguarding Hub (MASH). They took action in full compliance with their domestic abuse policies once domestic abuse was identified. This then led to positive action to protect the victim. There is an ongoing national trial within policing linked to the new DARA risk forms. This pilot is still at an early stage.

3.2.17 However there were some gaps when it was the identification itself which was a problem. On one particular incident, the officers did not comply with their policies on attendance at domestic abuse incidents: A 'silent 999' call was made from Address A on 13th June 2017. There was the sound of a disturbance in the background. Due to good practice of 'flagging' previously known domestic abuse addresses, the officers were sent to the house graded as an 'immediate response'. However, before they arrived, the Force Control Room staff managed to speak with the original caller who stated they did not require police but needed an ambulance for a medical emergency. Once the Force Control Room confirmed with the Ambulance Control Room that an ambulance was on route then the police officers were stood down and did not attend. This is not in compliance with Force policies and could have put the victim at further risk of harm. Even if the immediate danger had passed, officers missed the opportunity to speak with the occupants and establish if any offences had taken place.

3.2.18 The child's primary school has a Safeguarding and Child Protection Policy in place. There is no stand-alone Domestic Abuse Policy, but actions required regarding domestic abuse are contained within the safeguarding policy.

3.2.19 The Peterborough Local Authority departments all adhere to the countywide Domestic Abuse Strategy for Cambridgeshire.

3.2.20 The Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation Company (BeNCH CRC) has a Domestic Abuse Policy included in their range of policies and procedures related to risk assessment and risk management, safeguarding children, safeguarding adults at risk of abuse and working with domestic abuse perpetrators. Matis' risk to his family formed part of the CRC risk assessments.

Was the victim subject to a MARAC or other multi-agency fora?

3.2.21 Justina was never identified as at 'high risk' of harm and so no incident was ever referred to the MARAC for further intervention.

Was the perpetrator subject to MAPPA, MATAC or any other perpetrator intervention programme?

3.2.22 Matis was never subject to MAPPA, MATAC or any other domestic abuse perpetrator programme. However, he was subject to two periods of supervision by the Community Rehabilitation Company (a private Probation Service provider formed after a national privatisation programme within the Ministry of Justice).

3.2.23 His sentences at the courts did not warrant his consideration as a 'violent offender' under the MAPPA system.

3.2.24 MATAC (Multi Agency Tasking and Coordination) is a method used in many localities to proactively manage repeat or serial perpetrators of domestic abuse. It is not a national system though does operate in many areas across the UK. Cambridgeshire has not yet adopted the MATAC system.

3.2.25 Matis was supervised from October 2014 through to January 2015 following a conviction for assaulting two males and being racially abusive and again from November 2018 through to July 2019 following a conviction for assaulting several police officers. He was still under the second period of supervision when he murdered Justina.

3.2.26 On the face of it these convictions do not appear to be domestic abuse related. However, the first conviction followed an incident when two male 'passers-by' had been assaulted by Matis after they attempted to intervene when he was standing in the front garden of his house and was shouting at two females inside (we now know these two females were his wife and daughter). The second conviction was for assaulting six police officers, but this was after he had already attacked his wife, daughter and sister in the family home.

3.2.27 The pre-sentence report for the first conviction was carried out by the National Probation Service (NPS).The interviewing officer had a copy of the circumstances of the incident (including Matis standing outside his house and shouting at two women inside) but does not appear to have enquired if this could be domestic abuse. Matis told the interviewing officer there were no issues between him and his wife. The officer did not request a copy of previous police call-outs which would have shown an incident of domestic

abuse at the family home several years earlier. The interviewing officer proposed to the Court that Matis be sentenced to a punitive disposal of stand-alone unpaid work as part of a Community Order because there were no links made to the domestic abuse offences.

3.2.28 Information was shared with the NPS directly from the police in March 2016 which confirmed Matis had been arrested for a domestic related matter. He had been verbally abusive to his wife while drunk and threatened his sister with a chair. No further action had been taken after the women declined to make a statement. It should be noted that Matis was not under any form of supervision either by NPS or CRC at that point. Nevertheless, the circumstances of the incident of domestic abuse was recorded on their files.

3.2.29 Prior to his second period of supervision (November 2018), a pre-sentence report was compiled by the NPS. Details of this are already documented in this overview report. We should note that the interviewing officer from NPS made specific reference to the similarities of Matis' behaviour prior to both of his current and previous offences. They noted that both incidents had been preceded by alleged aggressive behaviour in the family home. The officer expressed their concerns that Matis posed a risk to his wife and that this relationship should be closely monitored. Matis had a formal diagnosis of epilepsy but no diagnosis of a mental illness.

3.2.30 Details of the second period of supervision have already been documented. The CRC officer was thorough in their assessments and proactive in encouraging and supporting Matis regarding his rehabilitation activity requirement set by the Court. They requested a check on police call-outs which did not reveal the 2012 incident, but they were aware of the circumstances of other incidents in 2016 and 2017. The original CRC 'Probation Service Officer' also shared concerns with their team manager about Matis' entrenched misogynistic attitudes and domestic abuse history. This led to positive action and Matis being re allocated to a fully qualified Probation Officer. This is good practice.

3.2.31 The subsequent risk management plan created by the Probation Officer included working with Matis on anger management, monitoring alcohol and drug misuse and compliance with medication. The Probation Officer also planned to make at least one home visit during the first 12 weeks of Matis' supervision. The officer noted that when Matis was arrested for offences he cited his epilepsy or medication as the cause and did not take responsibility for the assaults he had perpetrated.

3.2.32 Much of the work carried out by CRC was well thought out and took a holistic approach. But the planning was not always matched by action. When reviewing the actions taken and in particular the accounts of conversations

during Matis' appointments with his Probation Officer it does seem as though Matis was discussing events in previous weeks (e.g. having a seizure or attending the hospital) but the officer never verified his account with medical professionals (there was an exception when the officer received a text from the Ambulance Service but even then this did not follow with a full discussion). Matis would also show photos of family trips and again there was no follow-up action to check Justina's recollection of events. The best approach would have been to seek Matis' consent to contact his GP and establish a fuller picture of his medical history and alcohol use. Professional curiosity was required.

3.2.33 Even though there were some identified shortcomings during the period of his supervision, this should be balanced by the fact that there were no calls to police of any domestic abuse incidents during this time and remembering that Matis had never been convicted of a domestic abuse related offence.

Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information sharing protocols?

3.2.34 Although a Multi-Agency Safeguarding Hub exists to coordinate actions around domestic abuse the information does not always appear to have been shared with all partners. For example, Operation Encompass is a means of informing a child's school if there has been a police 'call-out' for domestic abuse to an address where a child is part of that household. The school were not informed of the incidents witnessed by Matis and Justina's nephew. However, there was good exchange of information with both the IDVA service (in relation to an incident when Matis assaulted his sister) and the Refuge service (following an incident when Matis assaulted Justina).

3.2.35 There is no evidence that Domestic Violence Protection Notices (DVPNs) were considered by officers attending domestic abuse incidents involving Justina and Matis. This review does not make a judgement on individual police call-outs but DVPNs are seen by all agencies as an effective tool and their use is now monitored across police forces in England and Wales by Her Majesty's Inspectorate of Constabulary, Fire & Rescue Services (HMICFRS). Force policy within Cambridgeshire Constabulary confirms that such an option should be considered (even when the perpetrator is not in police custody, i.e. hospital or elsewhere) and especially when no charges have been brought.

3.2.36 Cambridgeshire completed 35 DVPNs in 2016, 21 in 2017, 28 in 2018 and 21 up to the end of November 2019. When comparing these figures to

similar sized police forces, Cambridgeshire Constabulary are in the lower third nationally. (Source: HMICFRS DA inspection report). The Home Office defines a DVPN (and a Domestic Violence Protection Order – DVPO, which are granted after successful application to the Magistrates courts):

'A civil order that provides protection to victims by enabling police (or subsequently the courts through a DVPO) to put in place protective measures in the immediate aftermath of a domestic violence incident.'

3.2.37 A DVPN (authorised by a police Superintendent) lasts for 48 hours and gives a victim 'space' to consider options available. They do not require a victim's consent. In Justina's case, they may have afforded professionals time to speak with her in depth about her problems, previous experiences with authorities outside the UK and her expectations. If police apply to the courts within 48 hours, then a DVPO can last up to 28 days. Prohibitions include the perpetrator staying away from the family home or not contacting the victim. This provides a window of opportunity for domestic abuse support services to intervene.

3.2.38 It is not clear what the local protocols are for making referrals about domestic abuse from non-police agencies. There was no incident recorded when Justina disclosed abuse by Matis to anyone other than police. However, several Health agencies and the Community Rehabilitation Company were aware of Matis' domestic abuse related behaviour. None of these referred to another agency for support. On some occasions this may have been that the professional knew the police were already involved but without a protocol it is difficult to see how a practitioner would have the knowledge and confidence to make such a referral.

What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

3.2.39 There was some effective decision making evidenced by several agencies. This included assessments of risk which matched national standards and agency policies. However, there were some missed opportunities. Not all of the information made available to this Domestic Homicide Review was available to practitioners at the time of the original incidents and so we must be careful not to engage in hindsight bias.

3.2.40 Cambridgeshire Constabulary were called to an incident at Address A in November 2016. The original call was coded as a domestic abuse

occurrence. When officers arrived, there may have been both language issues and some reluctance from victims or witnesses to give full accounts. Officers found Matis behaving irrationally and he appeared to have some mental health problems. He was initially arrested to 'prevent a breach of the peace' but was released and taken to hospital when he stated he was suffering from chest pains. Officers did not revisit the property and obtain the full details, which would have been good practice as it could potentially have established facts from the victim's perspective. Following Justina's murder, her adult daughter confirmed that on that occasion, Matis has been abusive to her mother to the extent she had locked herself in the bathroom. If officers had spoken to Justina she may have disclosed this information. But once Matis was taken to hospital he was treated as a patient with chest pains (not a suspect for an offence) and the original reason for the call was not investigated.

3.2.41 Another missed opportunity occurred in September 2014 when Matis was arrested by police following an assault on two males in the street. Matis had also racially abused these men. The original message from neighbours outlines a male (Matis) in the front garden of a house and arguing with two women inside the house. The property was Address A and the only women there at that time are believed to have been Justina and her daughter. Officers took positive action by arresting Matis, but they did not visit the house itself, so we do not know what the argument was about or whether any domestic related offences had taken place.

3.2.42 On 7th January 2019 Matis had a scheduled appointment with his Probation Officer. This was planned as a home visit (the only one in his first 12 weeks of his supervision requirement). However, the officer was delayed in the office and so this was downgraded to a telephone conversation. Matis' adult daughter (i.e. one of his previous victims) acted as the interpreter on the telephone. Postponing the home visit meant that the officer missed an opportunity to observe family dynamics and verify if Matis' accounts were truthful about relationships with his family. However, the officer did make a point of speaking to Matis' daughter directly to verify Matis' account that there had been an improvement in his well-being. His daughter commented that he was 'fine' and that all of the family thought he was improving. The officer also sought to verify Matis' account of a recent family outing to a museum in London, which his daughter confirmed had happened, and commented that all of the family had a 'good time'. The initial assessment had included a risk to his wife but the home visit which subsequently took place was not arranged for a time when it was known that Justina would be present and the officer only saw and spoke to Matis' sister. This meant that there was no direct observation of Matis' interaction with his wife by CRC officers.

Were appropriate services offered or provided, or further relevant enquiries made in light of the assessments made?

3.2.43 During the incident already referred to in November 2016 when Matis was taken to hospital by police after complaining of chest pains, officers did indicate they intended to submit a 'form 102' which is an 'adult at risk form'. This was effective thinking by the officers. They could not establish exactly what had taken place but realised that through a multi-agency referral then perhaps the right services could be considered for Matis given his irrational behaviour displayed in the home. However, although the police control room message indicates a form will be submitted, there is no trace of such a form ever being completed and referred. Therefore other agencies were not alerted to the police concerns.

3.2.44 The DASH referrals following domestic abuse incidents were routed through the MASH (Multi-Agency Safeguarding Hub) which facilitated a review of risks and circumstances and shared information with other agencies when appropriate. However, the MASH was not fully integrated at the time of the earlier incidents involving Matis and Justina. It has evolved over time and now has representation from Cambridgeshire Constabulary, Local Authorities and Health. There were gaps as already mentioned with Operation 'Encompass' (schools notification). This initiative was launched in 2014 in Peterborough. However, due to resource implications, it was suspended during 2016 when such notifications would have been helpful in this case. The operation re launched in 2018.

3.2.45 As has been noted already, Matis received access to a variety of professional medical services. More could have been done to consider the wider aspects and 'think family'.

When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victims should have been known? Was the victim informed of options/ choices to make informed decisions? Were they signposted to other agencies?

3.2.46 Justina did not speak English as her first language. On several occasions, she relied on her daughter to provide translation to emergency services. This created difficulties for staff who were trying to establish what had taken place, sometimes in a volatile environment and with emotions running high. Police officers and paramedics attended the family home on many occasions

and dealt with incidents professionally. Even after making allegations of assault or abuse, Justina did withdraw such allegations. We do not judge her for this. For any victim of domestic abuse there are many factors for the victim to consider and relationships are complex. However, in such matters, professional advice is crucial if vulnerable victims are to see a way through their difficulties. This is hard enough, but when language barriers or other cultural experiences with authorities elsewhere are considered then such decisions become even more difficult for the victim.

3.2.47 Justina had only one contact with a domestic abuse support service. This followed an incident when the police had been called in November 2017. An outreach worker from 'Refuge' rang Justina to offer practical and emotional support. Justina asked about when Matis would be released from custody. The outreach worker gave Justina a national telephone number for the National Centre for Domestic Violence, if she was thinking about applying for a non-molestation order. There is nothing wrong with this advice. But with only limited English language and with what appears to be poor experiences of domestic abuse interventions in Lithuania it was never likely that Justina would take up such advice. This was exacerbated by a fear that any conviction of Matis would result in his deportation. Face to face contact with Justina and locally applied resolutions may have worked more effectively.

Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate? Was this information recorded and shared, where appropriate?

3.2.48 On some occasions, Justina could have been afforded a greater opportunity to make full disclosures and there does appear to have been some incidents where a re-visit to the home after Matis had left may have meant a fuller disclosure. However, this hypothesis should be balanced by some of the good positive action that was taken to arrest and remove Matis from the home. On all occasions this happened, Justina subsequently withdrew her allegation. The initial response was firm and effective and protected her, but the subsequent referrals or contacts needed a more cohesive approach to ensure she was properly cited on options available to her.

3.2.49 Referrals were made from the police to specialist support services (e.g. Refuge service or IDVA service). But existing protocols, which can work well for English speaking victims, can be much more difficult with a language barrier (e.g. telephone contact). Likewise, to really understand the victim's perspective and previous life experiences, support workers need to build up a relationship of trust. It is recognised that resources are limited but such

considerations are vital if agencies are to protect foreign born nationals who have made their home in the UK.

Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

3.2.50 One of the biggest issues in identifying learning from this review is linked to cultural and linguistic identity. This is explored throughout this Domestic Homicide Review and will be subject to further comment with the 'conclusions, learning and recommendations' sections.

3.2.51 Although Matis suffered from a number of medical problems there is no recorded disability for him. He did access a number of services. At crisis points (either through police call outs or hospital attendances) staff managed the process with the resources at their disposal. In a more controlled environment (e.g. during his appointments with his Probation Officer) he was accompanied by a Lithuanian interpreter.

Were senior managers of the agencies and professionals involved at the appropriate points?

3.2.52 In those organisations where escalation was necessary, there is evidence that senior managers were involved when required.

Did any staff make use of available training?

3.2.53 A variety of training has been accessed by staff from a number of agencies. This review will make recommendations applicable to improving training.

Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?

3.2.54 Restructuring did not have an impact on this case.

How accessible were the services for the victim, perpetrator or children?

3.2.55 This is a theme running through the Domestic Homicide Review and so will be considered during the 'conclusions and learning' section.

Were correct procedures followed in compliance with multi-agency child protection arrangements?

3.2.56 In addition to the murder of Justina, a child was also seriously injured during the same incident when they were repeatedly stabbed by Matis. This child was the nephew of Justina and Matis (his mother is Matis' sister who was also attacked during the incident).

3.2.57 Several agencies had contact with the child and had raised safeguarding concerns for a variety of reasons. The first of these was in January 2010 when the child was still living in Lincolnshire. Lincolnshire Police had received a '999' call to a domestic abuse incident in Boston. There had been an altercation between Matis and his sister (the child's mother). Although a domestic abuse risk assessment form was completed by the police, they did not identify the child as needing any additional referrals as 'they are not the child of the persons involved.' This raises two concerns: firstly this information is not correct. Officers established the whole family lived at the address (including Justina, Matis, Matis' sister and the child). They confirmed an altercation (with no physical injuries) had taken place between Matis and his sister but then did not link the child to one of those adults (i.e. his mother). Secondly, the comments appear to suggest that if the child is not the dependent of the couple involved, then no referral would be necessary. Clearly a child living in a household which features domestic abuse is at risk irrespective of which particular members of the family are involved. This incident took place over ten years ago and Lincolnshire Police have since updated their domestic abuse policies. However, the issue of a child living in a multi-occupancy household continues to feature throughout this review.

3.2.58 The child had been born in Lincolnshire after their mother had moved to the UK from Lithuania. Later they moved to Peterborough. However, when an early child safeguarding concern was raised (they had been found wandering alone in the street on Christmas Day in 2012), part of the assessment included checking information held by other agencies. At this point Cambridge and Peterborough NHS Foundation Trust (0-19 services) became aware the child's records had not been transferred to them from Lincolnshire.

3.2.59 The S. 47 child protection enquiry in November 2013 (bruising to their arm) was thorough. All relevant agencies were contacted for information held and the assessment (closed in March 2014) was sound in its determination that no further support was required.

3.2.60 There were several incidents at the family home attended by Cambridgeshire Police. Some of these were correctly established as domestic abuse and positive action taken. However, in some instances (coded as 'disturbances' or 'mental health issues') the issue of domestic abuse was not identified. This meant no domestic abuse risk assessment and subsequently no referral of a child present at an incident of domestic abuse.

3.2.61 In October 2014, there were two incidents resulting in separate injuries to the child. One related to bruising to their chest and the other a bruise to the eye. Both injuries were considered by staff at Peterborough City Hospital. However, the referral to Children's Social Care only mentioned the chest injury. This could have meant a significant gap in information as the social care assessment related only to the delayed presentation of the child for a chest injury (and subsequently recorded there was no role for social care established). However, in this particular case, the child's school were able to confirm that the eye injury had in fact been caused in school and so was not a safeguarding concern.

3.2.62 The child was present during an incident of domestic abuse attended by the police in March 2016. Matis was arrested and the police correctly referred the incident to Children's Social Care. The assigned Social Worker used the services of an interpreter when contacting the child's mother (Matis' sister) to discuss the incident. However, there was no home visit and the conversation took place on the telephone. The child's mother informed the Social Worker that Matis did not live at the house and had just been visiting. Some of this may have been lost in translation (i.e. Matis had been removed when arrested) or it may have been a case of the mother not wanting further intrusion from the authorities. In any event, once Children's Social Care were satisfied that Matis no longer lived in the home then no further action was taken.

3.2.63 In November 2017, police submitted a referral to Children's Social Care following a serious incident in the family home. Matis had cut his own wrists and neck. He had assaulted his wife (Justina) and made further threats. He had then assaulted several police officers and paramedics before being taken to hospital. The social care records state the Social Work team manager noted this was not the first time Matis had been aggressive with his family. This is good that the repetition has been identified. A letter offering support to the child's mother was sent out but no other action was taken. This was not an adequate response. The child had been present in a household when knives had been used, the male (the child's uncle) had been arrested and had been extremely violent and Children's Social Care

knew this was not the first time Matis had behaved in this way when the child was in the house. We must pose the question if the assessment would have been much more holistic if the child had been the dependent of Matis and his wife? They were living in a violent household and the intervention should have been much more robust, irrespective of who his parents were.

3.3 Equality and Diversity

3.3.1 Neither the victim nor the perpetrator were registered with a disability. The perpetrator did suffer from epilepsy, but this was managed by medical professionals and he received an excellent service. He was never diagnosed with a mental illness. It is apparent that the perpetrator used his epilepsy as an evasion tactic. This may have prevented investigations taking place as he was treated as a victim of a medical condition and not always as a perpetrator of domestic abuse.

3.3.2 Other protected characteristics have been considered: there were no issues relating to age, gender, gender reassignment, marital status, race, religion/belief, pregnancy or sexual orientation. There are lessons to learn regarding culture and language, but these are not listed within the Equality Act 2010 as 'protected characteristics.'

3.3.3 Immigration issues and particularly language barriers did affect the behaviour of both the victim and perpetrator. The whole issue of immigration status may have prevented the victim from assisting with any prosecution for earlier incidents that she and the family suffered. These are fully explored and considered within the analysis section of this review.

Section 4: Dissemination

4.1 The following organisations/people will receive a copy of the report after any amendment following the Home Office's quality assurance process.

- The victim's family
- The perpetrator's Offender Manager, National Probation Services
- Peterborough Council Children's Services
- Safer Peterborough Partnership

Section 5: Conclusions and recommendations

5.1 Conclusions

5.1.1 The victim had experienced domestic abuse in her home country of Lithuania. It is highly likely that her experiences there affected her decision-making following the reports of domestic abuse in the UK. The pattern was of calling the police or ambulance following a 'crisis' episode but then withdrawing any subsequent allegations. We do not judge her for this. Any person would want emergency action taken to protect them from serious harm. But once the immediate danger had passed there was a reluctance to engage with professionals. Services need to adapt if they are to gain the trust of victims of domestic abuse that have made the UK their new home. This includes personal rather than telephone contact together with the support of independent interpreters when necessary. Risk assessments should be reviewed in the days after a crisis episode (with support of an interpreter when required) to ensure the full risks are captured and acted upon. This includes a review if the victim has withdrawn the allegation as this may impact on the level of risk.

5.1.2 On several occasions, the perpetrator in this case was detained for crime or disorder issues. However, due to physical or apparent mental health concerns he was often taken to hospital and no subsequent action was taken regarding the reported incidents. He was treated as a patient but not as an offender. His illness and medical treatment meant there was a lack of focus on him as a potential perpetrator.

5.1.3 The perpetrator was a frequent hospital attender. He received excellent health care. However, there was no consideration of other environmental factors, i.e. the impact of his behaviour on his family.

5.1.4 Although all members of the family were registered at the same GP Practice, there was no exploration of the domestic abuse within the household nor consideration of potential interventions.

5.1.5 The perpetrator suffered from alcoholism. He gave repeated and inconsistent accounts of his excessive drinking to professionals. He was referred to alcohol support services but chose not to access these.

5.1.6 The majority of police actions were effective at protecting the victim and positive action was taken. However, on several occasions domestic abuse was not correctly identified which hampered further options for action.

5.1.7 Use of DVPNs and DVPOs could be more effective and need to be seen as an option to protect victims and facilitate further interventions. To quote HMICFRS: 'Many Forces are still not using DVPNs/DVPOs as widely as they could, and opportunities to use them are continuing to be missed.' DVPNs and DVPOs could be especially helpful when creating 'space' for dialogue and engagement with victims who originate from outside the UK.

5.1.8 The case (in November 2017) was not passed to the Crown Prosecution Service for consideration. The case was halted by a supervising police officer after Justina and others declined to provide witness statements. There were other evidential avenues that a lawyer trained in domestic abuse protocols could have explored. There was no consideration of the victim being seen by an Independent Domestic Violence Advocate before the case was discontinued.

5.1.9 There was some good work carried out by the perpetrator's probation officer. However, some aspects of the work lacked sufficient intrusion and challenge to the perpetrator's assertion that his domestic abuse towards his wife, daughter and sister were isolated incidents and solely attributable to his health problems and side effects of prescribed medications. The Probation Officer did recognise that the perpetrator's mental and physical health was a critical risk factor and was often concerned about the perpetrator's poor presentation during appointments. This meant that the focus of many of their discussions was the perpetrator's degree of self-care and progress in achieving stability in his medication regime. A home visit was carried out but was later than was originally planned; and there were no discussions with medical professionals to verify his account that he was attending all of his appointments and complying with his medication regime. There were no discussions with his partner even though domestic abuse had been identified. Conversations with family are not currently part of CRC protocols.

5.1.10 A Multi-Agency Safeguarding Hub is in operation in Peterborough. However, it is not clear what local procedures are in place for non-police agencies to refer incidents of domestic abuse which fall outside the scope of MARAC.

5.1.11 There was a missed opportunity to intervene in terms of child protection. In November 2017, a referral was closed prematurely. The child was identified as living in a violent household and had been present during an incident

when a knife had been used and several police officers assaulted. Even though there had been previous incidents, there was no full assessment by Children's Social Care. This may be linked to the multi-occupancy living arrangements and that the boy was not the biological child of the victim or perpetrator of the domestic abuse.

5.2 Recommendations

5.2.1 **Recommendation 1:**

Significant proactive work is required with the Lithuanian community in Peterborough. With three Domestic Homicides of Lithuanian women in the city in the last eight years it is clear this is a particularly vulnerable group. Data suggests only 4% of the local population originate from Lithuania yet 75% of the Domestic Homicides are Lithuanian females. Some good work is already underway (e.g. use of Health Care Assistants fluent in Eastern European languages) but a complete multi-agency working group should be established to ensure Lithuanian voices are heard and services adapted to meet their needs. Themes running across previous homicides include regular exposure to violence, poor experience of authorities in their home country, lack of trust, lack of clarity in communication and issues linked to significant alcohol abuse.

5.2.2 **Recommendation 2:**

Many agencies taking part in this review have comprehensive safeguarding policies in place. However, several do not have a stand-alone domestic abuse policy. Given the prevalence of domestic abuse in society and the impact on services, the drafting of specific policies linked to domestic abuse would provide a focus and clarity in relation to identification and initial actions required when dealing with a victim or perpetrator of domestic abuse.

5.2.3 **Recommendation 3:**

The Community Safety Partnership should seek assurance that all agencies involved in the safeguarding of vulnerable people have training in place for initial identification of domestic abuse and conducting subsequent risk assessments to protect the victim. Such training should be regarded as mandatory with staff required to attend regular refresher training.

5.2.4 **Recommendation 4:**

GP Practices should review their procedures for exchange of information following a disclosure of domestic abuse. The disclosure could be from a victim or perpetrator. This links with recommendation 6 on 'Information Sharing Protocols' so that professionals have confidence in balancing patient confidentiality with risk of serious harm. Such procedures may also include increasing knowledge on referral pathways to local domestic abuse support.

5.2.5 **Recommendation 5:**

Each individual agency should explore the feasibility of creating a 'flagging' marker for domestic abuse cases on their internal systems. Such considerations should balance any potential improved service to victims against an organisation becoming overwhelmed with information.

5.2.6 **Recommendation 6:**

The Community Safety Partnership review its Domestic Abuse Information Sharing Protocol (ISP) to ensure multi-agency professionals are confident in the effective and early use of information exchange. Any revised procedures to be circulated as widely as possible.

5.2.7 **Recommendation 7:**

Cambridgeshire Constabulary review its processes for the application of DVPNs / DVPOs. All staff to be aware of the value of these tools and create a culture of proactive consideration of such interventions in all domestic abuse incidents. Such considerations should be the default position.

5.2.8 **Recommendation 8:**

The Community Safety Partnership consider the adoption of a MATAC system for multi-agency proactive management of repeat and serial perpetrators of domestic abuse.

5.2.9 **Recommendation 9:**

All agencies should review their protocols for dealing with vulnerability in multi-occupancy households. Such households are not uncommon within the Eastern European community that have chosen to settle and make their home in the UK. Such protocols must put a child at the centre of the considerations of all professionals dealing with that extended family or

household; irrespective of whether or not the child's biological parents are directly involved in the incident.

5.2.10 **Recommendation 10:**

The Community Safety Partnership explore opportunities for proactive engagement with families who may not have 'leave to remain' in the UK. This is a national issue but there are clear indications from this review that such family concerns can prevent victims having confidence to report crimes or to prosecute offenders.

5.2.11 **Recommendation 11:**

The Community Safety Partnership should review arrangements for accessing interpreters. There are several examples throughout this review of professionals being unclear of events due to language problems. The use of family members is not always appropriate as they may display misguided loyalties to loved ones.

5.2.12 **Recommendation 12:**

Cambridgeshire Constabulary should ensure its internal systems of management and supervision have checks to ensure all multi-agency referrals (in this case a 'form 102 adult at risk' form) are submitted to partner agencies when required.

5.2.13 **Recommendation 13:**

North West Anglia NHS Foundation Trust reviews their procedures for 'high intensity users' of its services. These procedures to consider holistic (i.e. medical and environmental) approaches.

5.2.14 **Recommendation 14:**

The Community Rehabilitation Company reviews its protocol for contact with partners and family members when staff are managing cases that may be linked to domestic abuse.

5.2.15 **Recommendation 15:**

The Community Safety Partnership should review policies and procedures in place for inter-agency referrals of medium and standard risk cases of domestic abuse.

5.2.16 **Recommendation 16:**

Cambridgeshire Constabulary should reflect on the learning identified linked to a lack of follow-up action when the perpetrator had been admitted to hospital. Although offences had been committed, there was a lack of coordination to ensure robust subsequent investigations. The police should ensure systems are in place that prompt such follow-up enquiries even if there has been a delay from the reporting of the initial incident to the suspect being declared medically fit.

References:

Multi-agency statutory guidance for the conduct of domestic homicide reviews (Home office 2016)

Domestic Homicide Reviews 'Key findings from analysis of domestic homicide reviews' (Home Office 2016)

'The Social Worker's Guide to The Care Act 2014.' (Pete Feldon 2017)

'A Practical Guide to the Mental Capacity Act 2005.' (Matthew Graham and Jakki Cowley 2015).

'Working together to safeguard children' (HM Government 2015, revised 2018)

'Advice for victims and professionals' (Paladin national stalking advocacy service)

MAPPA guidance (Ministry of Justice 2012)

PEEL Inspections into domestic abuse (HMICFRS November 2017)

Office for National Statistics (ONS) data 2015-2019 (HM government)

Joint national protocol CPS/ police for prosecution of Domestic Abuse cases (revised 2018)