CROYDON COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Executive Summary of the report into the death of Victoria in March 2016

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1. Executive Summary

1.1 The Review Process

1.1.1 This summary outlines the process undertaken by Croydon Community Safety Partnership (CSP) Domestic Homicide Review (DHR) Panel in reviewing the murder of Victoria.

1.1.2 The process began with an initial meeting on 25 October 2016 of all agencies that potentially had contact with the victim, Victoria and the perpetrator, her boyfriend, Grzegorz, prior to the point of death.

1.1.3 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the period to be reviewed would be from March 2014 to the March 2016 which was the month of the homicide.

1.1.4 The Review Panel for this DHR comprised the following agencies:

- Community Rehabilitation Company
- Croydon Clinical Commissioning Group (CCG)
- Croydon Health Services NHS Trust – Community Health Services
- Croydon Health Services NHS Trust – Croydon University Hospital
- Croydon Recovery Network – Substance Misuse Services
- Family Justice Centre
- London Ambulance Service (LAS)
- London Borough of Croydon - Adult Social Care
- London Borough of Croydon - Community Safety
- London Borough of Croydon – Housing
- Metropolitan Police Service
- Refuge - Refuge Eastern European Advocacy Service
- South London and Maudsley NHS Foundation Trust (SLaM)
- Standing Together Against Domestic Violence
- Victim Support

1.1.5 Agencies were asked to complete Individual Management Reviews (IMRs) and Chronologies of their contact with Victoria and Grzegorz prior to the homicide. Where there was no involvement or insignificant involvement, agencies advised accordingly. Each agency's report covers the following:

- A Chronology of interaction with the Victoria, Grzegorz and their family; what was done or agreed;
- Whether internal procedures were followed; and conclusions and recommendations from the agency's point of view.

1.1.6 All nominated agencies responded.

1.1.7 The following four agencies reviewed their files and notified the DHR Review Panel that they had no involvement with Victoria or Grzegorz and therefore had no information for an IMR:

(a) Community Rehabilitation Company

(b) Croydon Health Services NHS Trust – Community Health Services

(c) Croydon Health Services NHS Trust – Croydon University Hospital

(d) Croydon Recovery Network – Substance Misuse Services

(e) Family Justice Centre

(f) London Ambulance Service (LAS)

(g) London Borough of Croydon - Adult Social Care

(h) London Borough of Croydon - Community Safety

(i) London Borough of Croydon – Housing

(j) Refuge - Refuge Eastern European Advocacy Service

(k) South London and Maudsley NHS Foundation Trust (SLaM)

(l) Victim Support

1.1.8 Chronology and IMR or reports were requested from two agencies:

(a) Croydon Clinical Commissioning Group (CCG) – IMR and Chronology

(b) Metropolitan Police Service – Report on the homicide investigation

1.2 Outline of circumstances that led to a DHR

1.2.1 Victoria was 29 years old at the time of her death. She came to the UK from Poland in 2007 to live with a friend already in the UK. Grzegorz came to the UK, from Poland, the following year. He was 33 when he murdered Victoria. The couple met in the UK and started a relationship. At the time of Victoria's death, the couple had been living in a rented house in Croydon. They had been together between seven and eight years.

1.2.2 At the time of her death Victoria was actively planning to leave Grzegorz. She had told colleagues about his controlling behaviour. Victoria had made an application to the Royal Mail for her personal post to be redirected from her home to a new address, in anticipation of moving. Victoria had also requested a transfer to another area from her manager at work.

1.2.3 On the date of her death in March 2016, the security letter from Royal Mail, confirming redirection of post, arrived at Victoria's home. Grzegorz opened the letter whilst Victoria was out. He discovered Victoria was having her mail redirected. Victoria was out of the house at the time and there was an exchange of texts between Victoria and Grzegorz. Although fearful of going back, Victoria did return home.

1.2.4

1.2.5 On her return home that evening, neighbours heard arguing at the house. Shortly after this arguing was heard, Grzegorz phoned 999 and asked for an ambulance. He informed the LAS ambulance call handler that his girlfriend had been stabbed with a knife. The ambulance crew arrived and found

Victoria had been stabbed. Victoria was in cardiac arrest and the ambulance crew attempted to save Victoria's life until a Helicopter Emergency Medical Service (HEMS) arrived to assist. Victoria died at the house.

1.2.6 A homicide enquiry was commenced by the MPS. Grzegorz was later found by police. He had two wounds to his chest and he told officers that he had a fight with his girlfriend. Grzegorz was interviewed but gave no account for his actions, refusing to answer all questions. He was charged with the murder of Victoria and remanded in custody.

1.2.7 *Post Mortem*: A post mortem examination was conducted by a Home Office Pathologist. Victoria was found to have suffered multiple stab wounds and the cause of death was recorded as 'a stab wound to the chest'.

1.2.8 *Criminal trial outcome:* Grzegorz appeared before the Central Criminal Court and indicted for Victoria's murder and he was convicted of Victoria's murder in April 2017. He was sentenced to life imprisonment, with a recommendation to serve 23 years.

1.2.9 The Review Panel expresses its sympathy to the family and friends of Victoria for their loss.

1.3 Parallel Reviews

1.3.1 The Coroner decided no investigation was required and therefore, no inquest was held. Consequently, following the completion of the criminal investigation and trial, there were no reviews conducted contemporaneously that impacted upon this review.

1.4 Chair of the DHR and author of the Overview Report

1.4.1 The chair and author of the review was Mark Yexley, an associate DHR chair with Standing Together. Mark has received DHR Chair's training from Standing Together. Mark has chaired and authored ten DHRs. Mark is a former Detective Chief Inspector with 33 years of experience with dealing with domestic abuse at strategic and operational levels. In addition to his work on DHRs, Mark works for NHS Health Education England and Middlesex University.

1.4.2 Standing Together is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.

1.4.3 Standing Together has been involved in the DHR process from its inception, chairing over 50 reviews, including 41% of all London DHRs from 1 January 2013 to 17 May 2016.

1.4.4 The Chair of this DHR has no current connection with the London Borough of Croydon or other agencies mentioned in the report. Whilst serving in the MPS, he was never posted to Croydon Borough.

1.5 Equality and Diversity

1.5.1 The nine protected characteristics as defined by the Equality Act of 2010 have all been considered within this review. (They are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation). It was considered that domestic abuse is a gendered crime and the majority of victims are female.

1.5.2 Domestic abuse is a gendered crime. Most victims are female, and the majority of perpetrators are male. Consequently, in domestic homicide reviews sex should always require special consideration.

1.5.3 Victoria was 29 years old at the time of her death and Grzegorz was 33. Both were heterosexual. They were not known to have any disabilities. The religious beliefs of either party were not known and there was no information revealed in the review to show that religion had an influence on the relationship.

1.5.4 Victoria and her boyfriend, Grzegorz, were both Polish nationals and they entered the United Kingdom eight years prior to her death. The Review Panel gave special consideration to the nationality of both parties and whether their status as migrant workers in the UK affected contact with agencies. Consideration was also given to the overlap between Victoria's status as a Polish national in the UK and her sex. At the initial meeting and throughout the process, panel members were asked to provide information on any formal or informal links to services for Eastern European women living in the London Borough of Croydon. The panel were unable to provide any contacts. As there were no local options known, Standing Together proposed that the domestic abuse charity, Refuge, be approached. Refuge provide expertise in the provision of services to Eastern European women experiencing abuse.

1.6 Involvement of family, friends, work colleagues, neighbours and wider community

1.6.1 The panel acknowledge the important role that families and friends can play in a DHR. In this case Victoria's family have been supportive throughout the DHR process and have help shape the recommendations. Victoria's colleagues and employers have played a valuable part in this review and have demonstrated that they are willing to improve processes that support disclosure of abuse.

1.7 Involvement of perpetrator

1.7.1 No information was received from the perpetrator for this review despite attempts made in writing by the Independent Chair of the Review to contact the perpetrator in prison.

1.8 Overview of agency information:

1.8.1 The agency involvement in this case amounted to one routine appointment for Victoria with her GP. There was no other agency involvement and the review has not found any contact that would have revealed that Victoria was the victim of abuse.

1.9 Lessons learnt from the review

1.9.1 This case does not highlight any new lessons to be learned from the contact between Victoria and statutory agencies. The areas for learning come from Royal Mail procedures and how employers respond to disclosures of domestic abuse from employees.

1.9.2 The key lesson to be learnt is around the Royal Mail process for redirecting mail. Whilst the Royal Mail is a private company, it is essential that a strong multi-agency partnership is developed to ensure the future safety of victims of domestic violence moving away from an abuser. The mail redirection process should have a clear section where the applicant is able to indicate that they are moving address because of personal safety reasons and this should link to services for persons experiencing domestic abuse. The process should consider the safety of a person who does not wish to report to police and highlight other services for persons experiencing abuse.

1.9.3 This DHR has also shown the importance of private businesses understanding domestic abuse. Domestic abuse impacts on staff welfare, retention, productivity and safety. It is important that the role of non-police agencies and third-party police reporting are promoted to businesses. The training of businesses on the impact of domestic abuse could have positive benefits for many and improve public safety.

1.9.4 In this case, the establishment of Domestic Abuse Policies and Procedures in the workplace could have helped. At the time that Victoria reported her partner's controlling abusing behaviour to her manager, the only known options to him were to help her report to the police and provide a safer place for her to work.

1.9.5 Victoria's experience as a Polish woman living in the UK was a consistent factor in this case. Victoria had no problems with the English language. Her close friends and family were also from Poland and had no knowledge of the support services that were available to victims of abuse, other than reporting to the police. The family also expressed concerns that in Poland, there is a different cultural view of domestic abuse, and this could make a person less likely to make a formal report.

1.10 Conclusions from the review (Key Issues)

1.10.1 This review has demonstrated that there are people living with domestic abuse who do not have any significant contact with the statutory agencies and organisations who are key to the DHR process. Even though there are no formal contacts, failures in procedures or referral protocols, this review has shown the value in looking at the case from the perspective of family, friends and colleagues.

1.10.2 The mail redirection process was a key concern for the initial panel meeting and it was a concern of each person interviewed by the chair. It could be considered that the Royal Mail is not a named body in the DHR process. However, in the daily management of domestic abuse, the mail service is involved at all stages. The police, NHS, courts and legal services will often send important information by mail and we need to ensure that the information gets to the intended recipient safe and secure. The separation or attempted separation of a domestic abuse victim from her abusive partner is identified as a high-risk factor in domestic abuse. The Domestic Abuse Homicide, Stalking, Harassment and Honour Based Violence (DASH) risk assessment framework, used across domestic abuse agencies, includes separation as a high-risk indicator. It will usually involve the redirection of mail for one party, abuser or victim. It is essential that the current service is improved for the safety of all, whilst ensuring that abusers cannot exploit the service.

1.10.3 The contribution of Victoria's, family, friends and work colleague have been essential to this review. In discussing the case in hindsight with friends it is clear to see that Grzegorz was exhibiting coercive and controlling behaviour towards Victoria. It is also known that Victoria made a clear disclosure of abuse to her manager a week before she was murdered. The review has also shown that none of the people interviewed were aware of services for victims of abuse, other than the police.

1.10.4 Whilst it can be considered that family would not have been aware of the availability of support services, there is an issue on the identification of abuse. The relatively new legal recognition of coercive and controlling behaviour as a form of domestic abuse will be a new concept for those raised in the UK from an early age. Whilst her Polish friends and family recognised that Victoria's relationship with Grzegorz was unhealthy, they were not aware of how they could take further steps to gain support for her by considering this was domestic abuse that could be reported to supportive agencies.

1.10.5 It was also established that when Victoria reported abuse to her manager, he had not received any training from his employers on domestic abuse. He was also not aware of any domestic abuse policies within his company. The company was entirely supportive to Victoria from her initial disclosure, have supported their staff in the aftermath of Victoria's death and have shown themselves to be a caring employer.

1.10.6 When we know there are ways that private companies can change practice and improve safety, there is a duty for statutory agencies to work in partnership to make things better. Domestic abuse harms the whole of society including friends, families, loved ones and colleagues. The whole of society can help make things safer for people like Victoria.

1.10.7 The key issues revealed in this case have been shown to be

(a) Royal Mail redirection procedures not clearly providing advice for victims of domestic abuse.

(b) Employers and members of the public (friends and families of victims) not having information on ways to report domestic abuse and support victims of domestic abuse.

(c) Experience of Polish woman in the UK.

1.11 Recommendations from the review

The recommendations below should be acted on through the development of an action plan, with progress reported to the Croydon CSP within six months of the review being approved by the partnership.

1.11.1 **Recommendation 1:** That the National Police Chief's Council (NPCC), Domestic Abuse NGOs, and Royal Mail, work in partnership to review the current process around mail redirection to ensure that procedures are in place to consider the safety of victims of Domestic Abuse changing address. It should be considered that in applications for mail redirections there should be a routine question on whether the redirection is for means of personal safety. This process should take place in consultation with National Domestic Abuse agencies (*NB: Given the timescales and the risks involved it is considered that this action be discussed by the NPCC and Royal Mail at the earliest opportunity and before this report is published*).

1.11.2 **Recommendation 2:** That the Home Office promote the work of bodies such as the Employers' Initiative on Domestic Abuse.

1.11.3 **Recommendation 3:** That the Home Office consider campaigns to raise awareness of coercive and controlling behaviour and the availability of Domestic Abuse Services (local and national) to Non-UK Nationals.

1.11.4 **Recommendation 4:** That the Home Office provide financial support to National Domestic Violence Helpline to establish links with services for Eastern European women.

1.11.5 **Recommendation 5:** That Croydon CSP develop awareness campaigns to promote awareness of domestic violence within the local Eastern European Community and support the development of local services.

1.11.6 **Recommendation 6:** Croydon CSP work with local employers to ensure that consideration is given to supporting employees who are subject to domestic abuse.

1.11.7 **Recommendation 7:** That Croydon CSP promotes domestic violence and abuse awareness and education amongst local businesses. This should include examination of HR Guidance and Protocols on domestic abuse with particular emphasis on local and national referral pathways for victims and perpetrators of domestic abuse. (The CSP may consider working in partnership with Victoria's employer and the Employers' Initiative on Domestic Abuse to pilot this process)