CROYDON COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the death of Victoria

March 2016

Independent Chair and Author of Report: Mark Yexley

Associate Standing Together Against Domestic Violence

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1. Preface

1.1 Introduction

1.1.1 On an evening in March 2016, the London Ambulance Service (LAS) received an emergency phone call from a man stating that his girlfriend had been stabbed. He gave the address of a house in Croydon. An ambulance attended and found the body of Victoria inside. She had died from multiple stab wounds. Victoria's boyfriend, Grzegorz, was found in his car by officers from the Metropolitan Police Service (MPS). Grzegorz had wounds to his chest and stated that he had been in a fight with his girlfriend. The MPS commenced a homicide investigation. Grzegorz was arrested and charged with the murder of Victoria. He was later convicted of Victoria's murder.

1.1.2 As Victoria was in an intimate relationship with Grzegorz at the time of her death the incident was considered a domestic homicide. Croydon Community Safety Partnership (CSP) commissioned a Domestic Homicide Review (DHR) as required by Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.1.3 This report provides an overview of the DHR process. The review process examined the experience of Victoria, together with interaction with agencies and support provided to her as a resident of Croydon prior to her murder at her home in March 2016.

1.1.4 The review considered agency contact or involvement with Victoria and her partner Grzegorz over a two-year period, from March 2014 to the date of Victoria's death in 2016.

1.1.5 In addition to agency involvement, the review also examined the past to identify any relevant background information or trail of abuse before the homicide. This included whether support was accessed within the community and whether there were any barriers to accessing support. In examining as much information as possible the review sought to find ways of making the future safer for others.

1.1.6 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for learning to be developed as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such crimes happening in the future.

1.1.7 This review process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

1.1.8 The Review Panel expresses its sympathy to the family, friends and colleagues of Victoria for their loss and thanks them for their contributions and support for this process. In the circumstances of this case, where there was little agency contact, the support was vital to the review.

1.1.9 The panel would also like to make special mention of the bravery of Victoria. She took steps alone to protect herself in an effort to leave an abusive and controlling partner. The panel considered the tragic circumstances that led to her death and aim to use the recommendations of this review to provide additional improvements to the response given to people like Victoria in the future.

1.2 Timescales

1.2.1 The Croydon CSP commissioned this DHR in accordance with the March 2013 Multi-Agency Statutory Guidance for the Conduct of DHRs. The Home Office were notified of the decision in writin by the CSP.

1.2.2 Standing Together Against Domestic Violence (Standing Together) was commissioned to provide an independent chair for this DHR in August 2016. Whilst the review was conducted in accordance with the 2013 Guidance, the revised Home Office guidance was published in December 2016. Wherever possible, this report considers the revised guidance. The completed report was handed to the Croydon Community Safety Partnership on 26th March 2018.

1.2.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. There was an initial delay in the commissioning process. Standing Together, from the point of being commissioned, also had to allow agencies sufficient time to search and secure their records and the first panel meeting was held in October 2016. It was apparent at an early stage that there had been very limited contact with statutory agencies and local domestic abuse services. The panel considered that the involvement of family members and the perpetrator was important to gain a better understanding of Victoria's life. As those parties were also crucial to the criminal trial process, it was agreed with the prosecuting authorities that the witnesses would not be approached until after the trial. The trial concluded on 7 April 2017. The chair maintained contact with the family through the Victim Support (VS) Homicide Worker. After the trial, there was a period when there was no VS worker allocated to the family. This resulted in the chair directly approaching the victim's family and this added a further delay to the process. Interviews with the family representative revealed that it was essential to speak to friends and colleagues. Finally, the chair needed to ensure adequate time was provided to family and friends to review and comment on the final report before submission to the CSP.

1.3 Confidentiality

1.3.1 The findings of this report are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. Information is available only to participating officers/professionals and their line managers.

1.3.2 This review has been suitably anonymised in accordance to the 2016 guidance. The specific date of death has been removed, and only the independent chair and Review Panel members are named.

1.3.3 To protect the identity of the victim, the perpetrator and family members, the following anonymised terms have been used throughout this review:

1.3.4 The victim: Victoria

1.3.5 The perpetrator: Grzegorz

1.3.6 The victim's maternal cousin: Magdalena

1.3.7 The victim's friend: Paulina

1.3.8 The victim's manager: Peter

1.3.9 The pseudonym for the victim was suggested by her next of kin and all names used have been agreed upon, so as not to cause any further upset or distress.

1.4 Equality and Diversity

1.4.1 In conducting the review, the Chair of the Review and the Review Panel considered all the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

1.4.2 There were no local area protected characteristics identified by the panel.

1.4.3 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.

1.4.4 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.

1.4.5 Sex should always require consideration in DHRs and this is particularly important in this case for two reasons:

- Sex is considered a risk factor because the overwhelming majority of victims of domestic violence and abuse are female, with perpetrators being overwhelmingly male. Research has also shown that intimate partner homicides are disproportionately perpetrated by men upon women (ONS, 2014).
- Recent case analysis of intimate partner homicides has been consistent with research. STADV and the London Metropolitan University[1] noted that the majority, 23 out of 24 of intimate homicides had a female victim and a male perpetrator. This finding is consistent in the Home Office recent analysis of intimate partner homicides.[2] The Review Panel provided special consideration to these issues throughout this review to determine if responses of agencies were motivated or aggravated by these characteristics.

1.4.6 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. It was agreed that Refuge would be commissioned by the CSP to join the DHR panel. The panel would like to express thanks to the expertise and advice provided to the panel and the chair.

1.5 Terms of Reference

1.5.1 The Terms of Reference are included in **Appendix 1**. This review aims to identify the learning from this death, and for action to be taken in response to that learning:

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[1] Sharp-Jeffs, N. and Kelly, L. (2016) *Domestic Homicide Review (DHR) Case Analysis: Report for Standing Together*, London: Standing Together Against Domestic Violence and London Metropolitan University

[2] Home Office (2016) *Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews*, London: Home Office

with a view to preventing homicide and ensuring that individuals and families are better supported. The Terms of Reference were drafted and agreed under the 2013 Home Office guidance.

1.5.2 The Review Panel comprised of agencies from the London Borough of Croydon, as the victim and perpetrator were living in that area at the time of the homicide. Agencies were contacted as soon as possible after the review was established to inform them of the commencement of the DHR process, their participation and the need to secure their records.

1.5.3 The review also established that the victim and perpetrator had lived in the London Borough of Lambeth when their relationship first started. The time spent in Lambeth fell outside the period under close examination. Consideration was given to whether there had been any historic incidents in Lambeth. The panel ensured that enquiries were made in that area to establish whether there had been any contact with Victoria or Grzegorz. It was determined that there had been no contact. Lambeth agencies were not invited to take part in the review. The panel extends thanks to the Community Safety team in Lambeth for their support in this review.

1.5.4 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved. As a result of this enquiry, it was agreed that the time period to be reviewed would be from March 2014 to the date of the homicide in March 2016. Agencies were asked to summarise any relevant contact that they had with Victoria or Grzegorz outside of these dates. At the initial meeting, it was established that the only contact with agencies had been through routine GP appointments. The couple had been in an intimate relationship and in the UK before the time period covered by the review, but there was no further information presented to the panel that would indicate that a review period beyond two years would be required.

1.5.5 This review was set up under the Home Office Guidance of 2013 and the Review Panel considered the “generic issues” as set out in 2013 Guidance. The issue of the victim and perpetrator’s nationality, and experience as migrants to the UK, was considered from the outset. During the review, it became apparent that an application for personal mail to be redirected by Victoria was a catalyst for the attack by Grzegorz resulting in her death. The redirection of mail was an issue of concern for Victoria’s family and friends. Interviews with family and friends also established that there were concerns over Grzegorz use of cannabis.

1.5.6 In order to give due consideration to the specific circumstances, Refuge were invited to be part of the review. Refuge provided expertise on services provided for Eastern European women and domestic abuse.

1.5.7 Whilst the issue of mail redirection was known at the outset of the review, the significance of this issue to the family and friends of Victoria became very apparent

after the criminal trial process. As a result, the chair made direct contact with the Royal Mail. It was agreed that the Royal Mail would not be part of the panel, but the recommendations of the review would be considered in partnership with the Royal Mail.

1.5.8 The issue of substance misuse was not apparent at the outset of the review. However, the panel did include the locally commissioned substance misuse service as a standing member.

1.6 Methodology

1.6.1 Throughout the report, the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-government definition of domestic violence and abuse as issued in March 2013 and included in the Terms of Reference for the review at **Appendix 1**.

1.6.2 This review has followed the 2013 statutory guidance for Domestic Homicide Reviews issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. This review commenced before the revised 2016 Guidance was implemented. On notification of the homicide, agencies were asked to check their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with the victim or perpetrator. A total of 15 agencies were contacted to check for involvement with the parties concerned with this review. Of all the agencies contacted, 13 agencies confirmed that they had had no contact with either party. The police provided a letter stating that there had been no contact. The police letter also outlined the circumstances of the homicide. The GP was the only agency to submit an IMR and chronology.

1.6.3 As the review progressed, the Refuge Eastern European Advocacy Service provided details of several other services. These were services providing help to Eastern European Women. The services included: Eastern European Advice Centre, Polish Domestic Violence Helpline, and Polish Free Counselling for Croydon Residents. Other smaller organisations and individuals providing services for Polish women were also identified. All were contacted by the panel and it was established that none of these services had contact with the persons identifying themselves as Victoria or Grzegorz. These services were not formally included in the DHR process but a written record is retained of all contact. Refuge also checked the records of the National Domestic Violence Helpline (NDVHL) and there was no record of contact with the victim or perpetrator.

1.6.4 *Independence and Quality of IMRs:* The IMR was written by an author independent of case management or delivery of the service concerned. The IMR received was comprehensive and enabled the panel to analyse the contact with the victim. Where the chair had also sent specific questions to the IMR author on behalf of the panel, these were considered in the IMR. There were no recommendations made in the IMR.

1.6.5 *Documents Reviewed:* In addition to the IMR, documents reviewed during the review process have included a report from the Metropolitan Police Service, previous Croydon DHR reports, and Standing Together and HO DHR Case Analysis. Care Quality Commission (CQC) reports referred to in the GP IMR were also examined.

1.6.6 *Interviews Undertaken:* The Chair of the Review has undertaken three interviews during this review. This has included a telephone interview with a member of the victim's family, and face to face interviews with a friend of the victim and the victim's work manager. Towards the end of the review process, a further meeting was held with the Human Resources section of the victim's employers. The chair is very grateful for the time and assistance given by the family, friends and colleagues who have contributed to this review.

1.7 Contributors to the Review

1.7.1 The following agencies were contacted, but recorded no involvement with the victim or perpetrator:

- 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
- Refuge - Eastern European Advocacy Service

- South London and Maudsley NHS Foundation Trust (SLaM)
- Victim Support

1.7.2 The following agencies contributed written reports to this review:

- GP practice for victim - IMR
- Metropolitan Police Service - Letter on circumstances of death

1.7.3 In addition to the agencies taking part in the review, the chair also contacted the Royal Mail. The Consumer Data Services department assisted the chair with information concerning the process for the redirection of mail.

1.8 The Review Panel Members

1.8.1 The review panel members are listed below

Agency represented	**Review Panel Members**
Community Rehabilitation Company - Probation	Cassie Newman Lucien Spencer
Croydon CCG	Rachel Blaney
Croydon Health Services NHS Trust	Estelene Klaasen Dr Shade Alu
Croydon Recovery Network – Substance Misuse Services	Jude Unsworth
Family Justice Centre - Commissioned provider of Domestic Abuse Services for Croydon	Alison Kennedy
London Borough of Croydon - Adult Social Care	Sean Oliver Pauline Swan
London Borough of Croydon - Community Safety	Andy Opie

London Borough of Croydon - Community Safety Partnership	Carl Parker
London Borough of Croydon - Housing	Mark Meehan Yvonne Murray
Metropolitan Police Service	Gary Castle Helen Rendell
NHS England	Jemma Sharples
Refuge – Eastern European Advocacy Service	Julia Dwyer Julia Kulak
South London and Maudsley NHS Foundation Trust (SLaM)	Lucy Stubbings
Standing Together Against Domestic Violence (Independent Chair)	Mark Yexley
Victim Support	Caroline Birkett

1.8.2 *Independence and expertise*: The agencies represented were represented on the panel by persons with appropriate levels of experience and expertise. The only agency to have personal contact with the victim or perpetrator before the homicide was the GP. The GP was represented by the CCG on the panel, ensuring independence.

1.8.3 The Review Panel met a total of three times, with the first meeting of the Review Panel taking place on 25 October 2016. There were two subsequent meetings on 3 February 2017 and 30 August 2017.

1.8.4 The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review

1.9 Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

1.9.1 Initially, the Croydon CSP notified the family of Victoria in writing of their decision to undertake a review on 27 September 2016. The Chair of the Review and the Review Panel acknowledged the important role Victoria's family could play in the

review. From the outset, the Review Panel decided that it was important to take steps to involve the family, friends, and work colleagues.

1.9.2 Consideration was initially given to approach the victim's mother as her nearest next of kin. Victoria's mother was residing in Poland with the victim's brother, and her father was deceased. The formal notification of the review had been sent by the CSP to the victim's mother. The family in Poland had previously nominated Victoria's cousin, Magdalena, to represent the family on all matters related to the homicide. Victoria's cousin lives in the UK and had been the family link to the police throughout the criminal investigation. After consulting with the police Family Liaison Officer (FLO), Senior Investigating Officer (SIO) and VS Homicide Worker, the panel decided that it was most appropriate that Magdalena should also be the main family representative for the DHR process.

1.9.3 Magdalena had grown up with Victoria in Poland and had supported her moving to the UK. Magdalena spoke excellent English and there were no barriers to communication.

1.9.4 The chair initiated contact with Magdalena through the VS Worker. Magdalena was provided with a letter from the chair, together with Terms of Reference for the review, the Home Office leaflet for families, and information on Advocacy After Fatal Domestic Abuse (AAFDA). Contact was initially maintained through the VS Worker. The chair was informed that Magdalena would be happy to support the DHR process but would prefer to wait until after the criminal trial, as she was finding it extremely stressful.

1.9.5 After the trial had completed, the VS worker left the service and was not immediately replaced. After delays in a new worker being allocated to the case, the chair made direct contact with Magdalena. Magdalena was informed that the panel would value her insight into the case and offered to be as flexible as possible in conducting an interview. Magdalena stated that she would prefer to be interviewed by phone. After the interview had taken place, a written record of the interview was sent to Magdalena and she confirmed accuracy of the record.

1.9.6 Following the interview with Magdalena, it was apparent that friends and colleagues could contribute to the review. Magdalena facilitated an introduction to Victoria's childhood friend and ex-housemate, Paulina. Arrangements were also made to interview Victoria's work manager. During the interview with Paulina, it transpired that Victoria had more recent contact with a male cousin in Poland. That cousin was due to visit the UK in August 2017. It was planned that the chair would meet with this cousin; however, his trip to the UK was cancelled. Enquiries were made with the SIO and it was confirmed that the male cousin had not offered any information on disclosures by Victoria and was not a witness in the case. Paulina stated that the

male cousin had not informed her of any disclosures. There are no plans to interview the male cousin at this stage.

1.9.7 Consideration was also given to interviewing Victoria's work colleagues, other than her manager. The interview with the manager had already highlighted ways in which employers and managers could support victims of domestic abuse, if disclosures were made in the workplace. It was not considered proportionate to this review to conduct a series of further interviews.

1.10 Involvement of Perpetrator

1.10.1 The Review Panel appreciates the value that gaining an understanding of the perpetrator's view can add to a DHR. Wherever possible, the chair would try to engage with perpetrator to formally contribute. Steps were taken to encourage Grzegorz to take part in the review.

1.10.2 On 28 April 2017, Grzegorz was sent a letter from the chair, via the prison governor. The letter explained the purpose of the review and that the views of Grzegorz would be considered in the DHR process. The letter included the Home Office leaflet explaining DHRs and an interview consent form to sign and return to the chair.

1.10.3 The perpetrator sent the consent form back to the chair indicating that he did not wish to take part in the DHR process. The perpetrator did add a comment to the consent form, stating that he was not a violent person.

1.11 Parallel Reviews

1.11.1 *Criminal trial:* The Homicide Investigation was conducted by the MPS SCO1 Homicide Command. The SIO attended the first meeting of the DHR panel and provided a briefing on the circumstances of Victoria's death. The SIO was consulted on the drafting of the Terms of Reference. The chair also offered to work directly with the police Disclosure Officer on any issues arising from the DHR. The panel agreed that interviews, to support the review, would not be conducted with any witnesses until after the criminal trial process had concluded.

1.11.2 The criminal trial concluded in April 2017. After pleading 'Not Guilty' to Victoria's murder, Grzegorz was convicted of murder and sentenced to life imprisonment with a recommendation that he serve 23 years.

1.11.3 *No parallel reviews:* 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.

1.12 Chair of the Review and Author of Overview Report

1.12.1 The Chair and author of the review is Mark Yexley, an Associate DHR chair with Standing Together. Mark has received Domestic Homicide Review Chair's training from Standing Together. Mark has chaired and authored ten DHRs. Mark is a former Detective Chief Inspector with 33 years' experience of dealing with domestic abuse. He was the head of service-wide strategic and tactical intelligence units combating domestic violence offenders, head of cold case rape investigation unit and partnership head for sexual violence in London. Mark was also a member of the Metropolitan Police Authority Domestic and Sexual Violence Board and Mayor for London Violence Against Women Group. Since retiring from the police service he has been employed as a lay chair for NHS Health Education Services in London, Kent, Surrey, and Sussex. This work involves independent review of NHS services for foundation doctors, specialty grades and pharmacy services. He currently lectures at Middlesex University on the Forensic Psychology MSc course.

1.12.2 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.

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

1.12.4 *Independence:* The chair 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.

1.13 Dissemination

1.13.1 The following recipients will receive copies of this report:

- Family members and friends of Victim
- Workplace of Victim

- London Borough of Croydon CSP
- Panel members
- Royal Mail Consumer Services
- STADV DHR Team

Once approved by the QA Panel, it will be published on Croydon CSP website.

2. Background Information (The Facts)

2.1 The Homicide

2.1.1 *Homicide:* At the time of her death, Victoria was living with her boyfriend in a rented room in a multi-occupancy house in Croydon, South London. It is known that, in the week before her death, Victoria was planning to leave her boyfriend. 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.

2.1.2 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 to her home, Victoria did return home.

2.1.3 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. During the telephone call, Grzegorz stated that his girlfriend was bleeding and he gave their address. The ambulance crew arrived within fourteen minutes of the initial call. They found blood in the hallway of the house and Victoria was in the living area having 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.

2.1.4 The ambulance crew called the police and a homicide enquiry was commenced by the MPS. Grzegorz was later found by police in his car. He had two wounds to his chest and he told officers that he had a fight with his girlfriend. He was arrested on suspicion of murdering Victoria, but due to his injuries was taken straight to hospital. Grzegorz had a stab wound that had nicked his heart and he was admitted to hospital. He was discharged into police custody eight days later. 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.

2.1.5 *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'.

2.1.6 *Criminal trial outcome*: Grzegorz appeared before the Central Criminal Court and indicted for Victoria's murder. A first trial took place in September 2016, however the trial was adjourned, part heard, and the judge discharged the jury. A second trial was held and Grzegorz was convicted of Victoria's murder in April 2017. He was sentenced to life imprisonment, with a recommendation to serve 23 years.

2.2 Background Information on Victim and Perpetrator (prior to the timescales under review)

2.2.1 *Background Information relating to Victim:* Victoria was 29 years old as the time of her death. She was born in France to Polish parents and raised in a small town in Poland. She was a white European, Polish National, and her faith is not known. Victoria has a younger brother who lives in Poland. Her mother still lives in Poland and her father died in 2004. Victoria spent her childhood and college years in Poland. Victoria came to the UK in 2007 at the invitation of friends and family living here. When she arrived in the UK, Victoria shared a house with a childhood friend Paulina, in South London. Victoria's cousin Magdalena helped her obtain employment with a large restaurant chain, in a South London branch. Victoria worked with the same restaurant company until her death and was employed as an assistant manager.

2.2.2 *Background Information relating to Perpetrator:* Grzegorz was 33 years old when he killed Victoria. He was a Polish National and his faith is not known. It is believed that Grzegorz's father was a police officer in Poland. Nothing more is known about his family. Grzegorz is known to have a previous conviction for an offence of theft in Italy in 2005. Grzegorz came to the UK from Poland in 2008. Grzegorz's employment, at the time of his arrest, was recorded by the police as being a self-employed painter and decorator.

2.2.3 *Synopsis of relationship with the Perpetrator:* Grzegorz met Victoria about six months after he arrived in the UK. They met through family contacts and initially were housemates with separate rooms in a shared house in Lambeth. They started an intimate relationship within months and started to share a room in the same house. The house was rented by Victoria's friend Paulina and the couple paid Paulina for their room. After living in the house for some time they eventually moved out of Paulina's house and Victoria rented a terraced house in Croydon. They lived together in the house until Victoria's death in 2016. They had been together between seven and eight years.

3. Chronology

3.1 Chronology from March 2014 to March 2016

3.1.1 The DHR process identified only one contact with an agency during the period under review. The contact comes from a routine appointment that Victoria had with her General Practitioner (GP).

3.1.2 Medical records show that Victoria registered with her GP in December 2012. There was only one contact with the GP between the time of her registration and her death in 2016. This was in May 2015 when Victoria was invited to attend her GP as part of the NHS cervical smear screening programme.

3.1.3 The GP practice where Victoria was registered do not make routine enquiry as to whether a new patient or a woman attending a cervical smear screening appointment has been subject of domestic abuse.

3.1.4 Consideration was given to the relevance of the medical records held on the perpetrator. Grzegorz refused to cooperate with the review and he did not consent to his medical records being examined by the review panel.

3.1.5 There was no information arising from the criminal trial process to suggest that there would be any medical records held confidentially that could assist this process. There was no defence raised by the perpetrator that referred to any mental health issues. In light of this information, the panel did not believe that it was proportionate to consider asking the CCG to examine the records without consent.

4. Overview

4.1 Summary of Information from Family, Friends and Other Informal Networks

4.1.1 The main information on this case comes from the police report and interviews conducted with family and friends during the DHR process.

4.1.2 *Interview with family:* Victoria's cousin Magdalena was interviewed by the chair on the telephone in May 2017. Magdalena gave an account of Victoria's background, family and her relationship with Grzegorz.

4.1.3 Magdalena is the daughter of Victoria's mother's sister. Magdalena described herself as having been 'inseparable' with Victoria since childhood. Victoria and Magdalena also had a close friendship with Paulina since their teens. When the two friends, Magdalena and Paulina, came to the UK to work, Victoria stayed in Poland to study. Victoria studied politics at university.

4.1.4 After Victoria had completed her studies, Magdalena and Paulina supported Victoria coming to the UK. Magdalena helped her cousin get a job with a restaurant chain and Paulina provided accommodation for her.

4.1.5 Victoria met Grzegorz around six to nine months after she came to the UK. Magdalena stated that at first, Grzegorz was charming and social. After a few months, he started to talk to Magdalena about Victoria in a way that was not nice. He also excessively smoked 'weed'. Magdalena expressed her concerns about Grzegorz to Victoria, but Victoria then told Grzegorz what her cousin had said about him.

4.1.6 Magdalena said that Grzegorz became very controlling of Victoria. When Victoria went out socially with friends, Grzegorz would criticise her clothing telling her she 'looks like a slut'. When Victoria was away from him, Grzegorz would ask her to send him photos of her location by phone to prove where she was. Magdalena expressed her concerns about Victoria's relationship to her family in Poland, but was advised to let them be.

4.1.7 Magdalena witnessed one incident of domestic abuse in which Grzegorz had been violent to Victoria. On a day, believed to be in 2012, Magdalena was present with her partner, Grzegorz and Victoria, at a barbeque at Paulina's house. Grzegorz was drinking and playing loud music. A neighbour came out and told them to turn the music down. Grzegorz became angry and threw garden furniture at the neighbour. The neighbour called the police. The police attended the incident. Victoria tried to calm Grzegorz and he argued with her and pushed her down a

small set of stairs. Victoria did not want to make a fuss about the incident because it took place in Magdalena's house whilst she was out. The police were not informed of the assault.

4.1.8 Magdalena tried to persuade Victoria to leave her boyfriend, but Victoria was in love with him. Grzegorz ignored the fact that Victoria's father had died and then used the death of his parents to bring her closer. He said that he only had her in his life and she could not leave him. Magdalena became distant from her cousin in the last couple of years.

4.1.9 Magdalena described Grzegorz as being financially dependent on his girlfriend. He could not hold down a permanent job and worked one to two days a week. They lived in a room in Victoria's name. Victoria had told friends that Grzegorz owed her £5000.

4.1.10 Magdalena believed that the event that triggered Victoria's death was her application for mail to be redirected from their home. Magdalena said, 'That makes me most upset and it prompted him to do what he did'. Magdalena also stated that Victoria was most concerned that if she sought help from friends that Grzegorz would harm them. Magdalena believed that Victoria spoke to younger friends and that a more mature person giving advice could have helped her. Victoria had spoken to her boss at work and he said he would take her to the police but Victoria declined. Victoria planned to move away from Grzegorz and not involve anyone else.

4.1.11 Magdalena was asked about Victoria's cultural links to Polish Groups or support networks. Victoria was described as having excellent use of the English language. There was no reason for her to use Polish organisations.

4.1.12 In considering what could have helped Victoria, her cousin felt that people in the workplace need to take things more seriously. They should be trained or have information on how to flag problems. She did say that Victoria's employers were a good company, 'like a big family'. Magdalena felt the biggest issue in the case was the mail redirection.

4.1.13 Victoria was described as the 'life and soul of the party'. She was a person who loved to travel and never wanted to stay at home. Victoria loved swimming and had saved her cousin from drowning as a child. She dreamt of living in a country with beaches. She was described as friendly and would never want to get someone else into trouble.

4.1.14 *Interview with Friend:* The chair also contacted Victoria's childhood friend and housemate, Paulina. Paulina agreed to be interviewed face to face. The interview was conducted in July 2017 and the Standing Together DHR Manager took notes at the time.

4.1.15 Paulina had known Victoria since she was 15 or 16 years old in Poland. Paulina came to the UK when she was 19. Victoria remained in Poland at University. They remained in contact during this time. Victoria had a relationship with a man in Poland. They were together for three years before they parted. Paulina suggested to Victoria that she should come and live in the UK. Victoria came to the UK with another female friend and they shared Paulina's room in a house.

4.1.16 Paulina later decided to rent a house in Lambeth and share with her friends. The women moved into the house and all had separate rooms.

4.1.17 Grzegorz was the cousin of Paulina's ex-boyfriend. Paulina was told that Grzegorz had problems with the police in Poland and had to leave the country. Grzegorz's father was a police officer in Poland and it was suggested that Grzegorz was getting in trouble and having his record 'wiped clean'. Grzegorz was believed to have been involved in a fight with a knife. He was also believed to have had fights with his brother and father.

4.1.18 Paulina described how Victoria met Grzegorz. They met a few days after Grzegorz arrived in the UK. Victoria was initially very keen on Grzegorz. Grzegorz was rude about Victoria to Paulina behind her back. Paulina said that Grzegorz made sexually offensive remarks about Victoria. Paulina said that he was seen by others as a nice boy and Victoria fell in love with him. Victoria and Grzegorz got together after a few months. Whilst Paulina could see her friend was happy with Grzegorz, she had seen a different side to him. Grzegorz moved into the shared house in Lambeth and after three months Victoria started to share a room with Grzegorz. They all lived together in the house rented by Paulina, for about three years.

4.1.19 Paulina experienced several problems with Grzegorz living in the shared house. There were constant arguments between Paulina and Grzegorz over his failure to pay bills. Grzegorz smoked 'weed' in the house and Paulina was scared that they would get in trouble with the police. Grzegorz also exhibited strange behaviour, such as putting knives in the fridge. Paulina attempted to get Grzegorz to leave but Victoria said she would leave with her boyfriend if they had to go and she did not want Victoria to have nowhere to live. The couple stayed on in the house.

4.1.20 Paulina also experienced abusive behaviour from Grzegorz. He once had an argument with Paulina and pushed her into a mirror. Grzegorz also sent threatening text messages to Paulina. When Paulina went on holiday, Grzegorz would send her text messages. She felt that this was a deliberate act by Grzegorz to spoil her holiday.

4.1.21 Grzegorz exhibited controlling behaviour towards Victoria at home. Paulina described how she had found Victoria very upset with Grzegorz, just before they were due to go to a party. Victoria was crying and Grzegorz was seen holding her shoulders. It later transpired that Grzegorz had told Victoria that she could not go

to the party because her skirt was too short. Paulina also described other occasions when Victoria would be out with friends and Grzegorz would be texting her instructions not to drink.

4.1.22 On another occasion, a friend had told Paulina that she had seen Grzegorz screaming at Victoria in the airport when they had been travelling to Poland. She said that Grzegorz had not realised that he was being observed by the friend.

4.1.23 Paulina eventually asked Grzegorz to leave and Victoria went with him. Paulina described an incident when several thousand pounds was stolen from her house in Streatham. Paulina said that she had her suspicions on who had stolen the money and she reported it to the police. She suspected Grzegorz was involved in the theft. She believes this took place between 2011 and 2012. Paulina lost contact with Victoria after this. Grzegorz texted Paulina but she replied that she knew what he did. All contact ceased between Paulina and Victoria. Victoria 'blocked' Paulina on Facebook. Victoria did maintain contact by text with a male cousin in Poland. This cousin gave Paulina positive messages about Victoria, stating that she was in love but not happy in the UK. They were planning to get married and return to Poland. Paulina believed the messages may have changed shortly before Victoria died.

4.1.24 Paulina was asked if there was anything that could have helped Victoria. She said that the redirected mail was a factor. She felt that Victoria tried to deal with the situation on her own and she was too scared to go to the police. Paulina was asked if the experience of police in Poland would have impacted Victoria's view of British police. She said that she did not think so and that Poland was different. She said that they grew up in an environment where women lived in fear of their husbands and would not go to the police for help. Paulina was not 100% sure of the situation between Victoria and Grzegorz but she knew that something was wrong between the couple. If she had recognised it as domestic abuse then, she would have done anything to help Victoria. Paulina did know that there were domestic abuse agencies in the UK, but did not know how to look for them. It was established that Victoria had no known contact with any agencies for Polish people living in the UK.

4.1.25 Paulina described Victoria as a very calm person who had lots of friends. She was often the sensible one who could be cautious about doing new things. Victoria enjoyed life and was never one to sit at home.

4.1.26 *Interview with work manager:* The chair contacted Victoria's Manager at her former place of work, Peter. Peter agreed to be interviewed face to face. The interview was conducted in July 2017 and the Standing Together DHR Manager attended and took notes.

4.1.27 Victoria was employed by a large restaurant chain with branches across the country. She worked as an assistant manager in a South London branch. Peter had been working for the company for 12 years and took charge of Victoria's branch about a year before she died.

4.1.28 When Peter arrived at the branch, Victoria told him that she was seeking to leave the company and work elsewhere. He did not develop a strong relationship with her because he thought Victoria would be leaving the company soon. She was a person who loved to travel and socialise with people outside work. She never missed a work social event. Peter was not aware that Victoria had any problems at home. He said that he had heard Victoria's partner had problems with police in Poland. He had never met Victoria's partner.

4.1.29 In March 2016, Peter decided to have a meeting with Victoria to discuss her future. This was about a week before her death. It had been a year since Victoria mentioned that she intended to leave the company and Peter wanted to know what her plans were. Victoria told Peter that she wanted to transfer to another restaurant; she wanted to 'run away'. She then told Peter that her boyfriend was abusive towards her. He would lock her in a room and shout at her. Victoria did not mention physical assaults. Peter asked if there was physical abuse, but he could not remember what Victoria said. She described constant 'psychological abuse'. Her boyfriend would shout at her and not allow her to leave a room until Victoria agreed with what he wanted. She wanted to separate from him but he would not let her go. She told Peter that she had changed her address.

4.1.30 Peter asked Victoria if she wanted him to go to the police with her or if he could get involved in any other way. She said 'No, I don't want to get him in trouble'. Peter told her that she could have an immediate transfer at work if she wanted it. Victoria did not mention the transfer again.

4.1.31 Victoria continued working at the branch for a week. On the date of her death, there was a manager's meeting. Victoria attended the meeting and she was scheduled to start work the next day at 07:00. At 13:00 the next afternoon, Peter received a call from the branch informing him that Victoria was not at work. Peter phoned Victoria and when the call was not answered he called the police. Peter was informed by the police that Victoria had been killed the evening before.

4.1.32 After Victoria's death, Peter discovered that friends at work knew that she was having problems with her boyfriend. They knew that Grzegorz was abusive and he would come to work and ask about her schedule. Peter said that there were lots of signs she was a victim of abuse at work, but he was never told about them. It was said that others had advised Victoria on what to do, but after she ignored their advice, they gave up on her. Peter was not made aware of Victoria's situation when he became her manager or in the year leading to her death.

4.1.33 Peter was asked if he was aware of any domestic abuse agency, other than the police. He stated that he was only aware of the police.

4.1.34 Following Victoria's death, all staff at the branch who knew her were supported. All were given immediate paid leave and staff from other branches covered their shifts. Peter said that he felt supported by his senior managers.

4.1.35 Victoria was described by Peter as 'shy and introverted'. He said that she was a nice person. She was sometimes seen as 'too nice' as she would not say 'no' to staff when required.

4.2 Summary of Information from Perpetrator

4.2.1 In conducting DHRs, the views of the perpetrator can provide a valuable insight. The chair of the DHR made a formal request to Grzegorz inviting him to be interviewed, and contribute to the review. Grzegorz declined to take part in the DHR process. However, he did make a written comment on the consent form sent to him. He stated "It was proven during the trial that I wasn't violent towards Victoria! It happened suddenly, I was never violent. I don't agree to take part in it".

4.3 Summary of Information known to the Agencies and Professionals Involved

4.3.1 There was no information held by any statutory or non-statutory agencies that would suggest that Victoria was subject to abuse by Grzegorz. The only contact with an agency was when the victim was subject to a routine medical appointment.

4.3.2 Whilst the DHR panel was not privilege to Grzegorz's medical records, it is highly likely that any medical or mental health concerns of the perpetrator would have been mentioned during the criminal trial process. The perpetrator was not known to be registered with a GP service.

4.3.3 The MPS did not complete an IMR as they held no information relating to contact with Victoria or Grzegorz before the homicide. As a result of interviews with Magdalena and Paulina, the MPS were asked to check records concerning the contact with police.

4.3.4 Police records show a report of theft made by Paulina and her fiancé in January 2012. Both Victoria and Grzegorz were named as suspects. The theft was said to have taken place between November and December. The investigation showed that the theft took place after Victoria and Grzegorz had left the house and locks had been changed. No further action was taken by the police.

4.3.5 The police held no records of the call in relation to Grzegorz's violent behaviour towards the neighbour during the barbeque. It should be noted that the violent behaviour towards Victoria by Grzegorz was not reported to police at the time.

4.4 Any other Relevant Facts or Information

4.4.1 At an early stage in this review, it became apparent that the victim's application to redirect her mail was a contributory factor to her death. The process of mail redirection is linked to the separation of partners. Separation is known to be a key factor in elevating the level of risk of domestic abuse. The impact of the mail redirection was a cause of concern for family and friends involved in this review. As a result of these concerns, the chair made enquiries with the Royal Mail. The Head of Royal Mail, Consumer Data Services provided information to assist this review. She was already aware of the circumstances of this case.

4.4.2 The mail redirection process was outlined. An application to redirect mail to a new address is accessed through an online Royal Mail process or in person at a Post Office. After an application for mail redirection is made, the Royal Mail send out two letters. A confirmation letter is sent to the customer at their old or new address, depending on the date they move. This letter confirms the redirection details, including the addresses, names of recipient and start dates. Customers can choose to withhold their new address in this letter. A second 'security letter' is sent to the old address, addressed 'Dear Occupier'. The letter is a fraud defence and does not show the new address. It is believed that in this case the confirmation letter was sent to the new address and the 'security letter' was sent to the house where Victoria and Grzegorz lived. The letter was then opened by Grzegorz at the shared old address.

4.4.3 Since the death of Victoria, the Royal Mail have updated their online application to emphasise that they will be sending two letters, including one to the original address. An update to the paper process is due at the next reprint. The Royal Mail suggested that customers could decide to delay the redirection process until they have moved out of the old address. This would mean that a letter would arrive after the person had left, but it would not show the new address. The Post Office will be making customers aware of the process in branches when they apply in person.

4.4.4 The Royal Mail are considering stopping the confirmation letter process for online applications. The letter would be replaced with a confirmation email. The security letter will still be sent to the old address.

4.4.5 The Royal Mail do have a process of suppressing all letters to the old address in 'individual special circumstances' such as a person moving to a refuge. This is managed by the Customer Experience Team and requires confirmation from the

police. This process is not published. The Royal Mail state that there need to be tight controls in place to avoid the process being used by fraudsters.

4.4.6 The chair discussed the process with the Royal Mail. It was agreed that the removal of the security letter in general applications could also facilitate stalking activity or controlling domestic abuse. If the security letter was not in place it could allow a partner or stranger to effectively divert a person's mail without their knowledge.

4.4.7 The Consumer Data Services head stated, 'We are keen to ensure we protect our customers and maintain the integrity of their mail and I am open to any ideas on how to we can further improve our service'. The Royal Mail agreed that they would be happy to review the recommendations of this DHR and assist where possible.

4.4.8 An enquiry was made of the Metropolitan Police Service and they were not aware of the unpublished Royal Mail process, whereby the 'security letter' could be withheld if supported by the police.

5. Analysis

5.1 Domestic Abuse/Violence and Victoria

5.1.1 The circumstances of Victoria's death and the conviction of her boyfriend for murder clearly show that she was subject of domestic abuse when she died. From interviewing family and friends, it is clear that Victoria had been experiencing domestic abuse leading up to her murder. Whilst friends and colleagues knew of an abusive relationship, it was not apparent to any statutory agency or non-government agency at the time.

5.1.2 The DHR review process allowed the panel to look at Victoria's experience from the view of her friends, family and colleagues. It is clear from the interviews carried out that Victoria was subject to coercive and controlling abuse by her boyfriend Grzegorz. Victoria had reported to her work manager that she was being shouted at and locked in a room by her boyfriend.

5.1.3 Victoria's family and friends felt that she was being isolated from them by the controlling behaviour exhibited by her boyfriend. Long established friends and informal networks of support were lost to Victoria in the years before her death. It is suggested by family and friends that Victoria cut off contact with her closest friends because they were telling her things about her relationship that she did not want to hear. Victoria did disclose her boyfriend's controlling behaviour and psychological abuse to her work manager. Whilst there has been relatively new legislation to cover coercive and controlling behaviour, agencies dealing with domestic abuse have long recognised the impact of controlling behaviour and the impact on levels of risk in personal relationships.

5.1.4 It was apparent that Victoria was subject to financial abuse by Grzegorz. It was certainly felt by friends and family that Grzegorz was reliant on Victoria financially. He had an unstable employment record and it appeared that he was heavily dependent on Victoria for accommodation and owed her money. Arguments over Grzegorz's failure to meet his financial obligations were a factor in them leaving accommodation with friends.

5.1.5 The issue of substance misuse has been considered by the panel. Whilst friends have commented on Grzegorz's use of cannabis, Victoria did not express any views of this to friends. There was no information arising from the police investigation or defence case that would indicate that substance misuse was a factor, and there was no known contact with substance misuse agencies.

5.2 Analysis of Agency Involvement

5.2.1 A key purpose of a DHR is to look at the way in which local professionals and organisations work to safeguard victims. In this case, there was only one agency that is known to have had contact with the victim or perpetrator: the GP practice.

5.2.2 *GP Practice:* There was one contact with a GP during the period under review. Victoria saw her GP because of an invitation to attend the practice under the Cervical Screening Programme. It is appreciated that the involvement of a screening test that is of an intimate nature can sometimes raise concerns for victims of domestic abuse and may lead to disclosures. Previous DHRs have highlighted the need for routine enquiry on domestic abuse on registration and on the conduct of some medical examinations. The circumstances of this case do not deem it appropriate to make further recommendations in that area. It is clear that the GP Practice have systems and processes that consider the possibility of disclosure of abuse. All staff are trained at the appropriate levels of Safeguarding. There are clear referral protocols for cases of domestic abuse and the practice use the local CCG pathway for referral of cases of domestic abuse. It should also be noted that a June 2016 independent CQC inspection noted that all staff were shown to be Safeguarding trained. There was no evidence of the need for the GP to make any other referrals or to communicate with other agencies.

5.2.3 It should be considered that the only contact with a statutory agency during the review period was for the Cervical Screening Programme. Medical examinations of an intimate nature can lead to disclosure of domestic and sexual violence. Guidelines for good practice in conducting cervical screening alert professionals to the possibility of disclosure. This requires healthcare professionals to be prepared to provide appropriate advice and referrals during such examinations. Training for screening at Victoria's practice was provided by an outside agency and there was no specific focus on domestic abuse during the training. It should again be noted that all nurses at the practice had undergone specific domestic abuse training, although not directly linked to the cervical screening examination. Whilst opportunity to spend time alone with a healthcare professional can provide an opportunity to disclose abuse, it did not happen in this case.

5.2.4 *Substance Misuse:* The review has revealed that the perpetrator was involved in the misuse of substances. This included references by friends about his regular use of 'weed'. The police investigation also provided information that there was cannabis at Grzegorz and Victoria's home when the homicide took place. There is no clear evidence that this misuse was a contributory factor in the domestic abuse. There was no record of Grzegorz being referred to any substance misuse agency and it was not a factor in his criminal trial.

5.3 Involvement of private companies

5.3.1 The consideration of the work of private companies does not fall within the statutory guidance for DHRs. However, raising awareness of domestic abuse and the need for a partnership approach in society is vital if we aim to reduce violence and prevent harm.

5.3.2 This review highlighted the interactions with others in Victoria's life that could possibly have helped her or prevented harm. Raising awareness of domestic abuse in the private sector could improve service responses, support a coordinated approach to identifying abuse and prevent harm.

5.3.3 *Royal Mail:* A key contact in this case was the Royal Mail. Whilst there are other methods of delivering letters, the Royal Mail is the key delivery service for all households in the UK. In considering cases of domestic abuse, the Royal Mail is integral to many processes that would contribute to victim's safety. Those processes would include communication with solicitors, courts, medical services and the police. Whilst there is a growth in electronic communication, the provision of hard copy letters is essential for some matters.

5.3.4 If a person is in an intimate or familial relationship, there can be an opportunity for the abusive party to open and read letters addressed to the other. The separation or the attempted separation of a domestic abuse victim from her abusive partner is identified as a high-risk factor in domestic abuse. If an abusive partner sees that they are about to lose control of their victim, they can take extreme steps to stop them escaping that relationship or seeing anyone else. At that time of risk, there needs to be assurances that private communications remain secure. The need for a victim to ensure that her mail is redirected safely is essential to their right to privacy and personal safety.

5.3.5 In this case, it is believed by the police, family, friends and colleagues that Grzegorz's discovery of Victoria's active plans to separate was the cause of conflict and ultimately her death. Grzegorz discovered Victoria was moving after opening the Royal Mail 'security' letter that stated her post was being redirected. On the date of discovery, there were text message exchanges between Grzegorz and Victoria. She was afraid to go home. After she returned home, Victoria was murdered.

5.3.6 The need for the Royal Mail to send a security letter is understandable. The Royal Mail would consider the process essential to combat fraud. In considering domestic abuse and stalking behaviour, it is essential to have processes in place to stop a perpetrator from intercepting mail using the redirection service.

5.3.7 The Royal Mail do have a process for withholding the security letter. This process requires consultation with the police. This process does not consider victims who do

not wish to report to the police. It should also be of note that the MPS were not aware of this process.

5.3.8 Victoria had told her manager that she intended leave home but did not require support from the police. When she took the steps to move home and redirect mail, it would seem highly unlikely that Victoria understood that a 'security' letter would be sent to her home whilst she was still living there.

5.3.9 The provision of a mail service that considers the needs of customer's safety as an element of the mail redirection process is essential.

5.3.10 *Employers:* This review has also revealed that Victoria's manager and colleagues were aware that she was living in an abusive relationship. There was a clear disclosure by Victoria that she was being emotionally abused and controlled a week before her death. Victoria's manager was immediately supportive of her and offered to help her report to the police. He also offered help in an immediate transfer to another branch. It is also apparent that the company that Victoria worked for was supportive to all of their staff on discovery of Victoria's murder.

5.3.11 Victoria's manager was not aware of any other agencies who could support his staff members. It is not possible to know whether Victoria would have made different decisions had she been referred to a non-police domestic abuse agency or helpline by her boss. It can be said that if contact had been made, she would have been better informed on the services and options available to her in seeking protection.

5.3.12 It was not apparent that the consideration of domestic abuse and possible disclosures at work have been addressed in any training or induction for new managers. Victoria's manager was not aware of any domestic abuse policy being in place. It is appreciated that the DHR process cannot hold private companies to account for recommendations made in reviews. This case does provide an excellent opportunity to develop links with private companies to promote a wider understanding of domestic abuse. This will ultimately have a positive impact on the safety and wellbeing of employees, and benefit employers having a healthy supported workforce.

5.4 Equality and Diversity

5.4.1 The Review Panel identified the following protected characteristics of Victoria as requiring specific consideration for this case; Polish nationality and sex.

5.4.2 In considering the nationality of both Victoria and Grzegorz, the panel has taken on expert advice from Refuge. The panel have also extended the scoping of agencies over a wide area to check whether either party had contact with services in the UK

for Polish people. There was no known engagement with any services checked. From discussions with Victoria's family, it is apparent that she felt fully integrated in British society, had an excellent understanding of English, and would have had no need to engage with services for Polish people. The panel concluded that her nationality had no impact on the services received.

5.4.3 Consideration was given to Victoria as a Polish woman and an immigrant to the UK, and whether she would access services herself. When interviewing Victoria's friend and manager, it was clear that there was a perception that in Poland, women could experience abusive and controlling behaviour and not report or take action. It needs to be appreciated that the same could be said for many women living in the UK. Victoria's cousin, friend and manager living in the UK knew that a person could report domestic abuse to the police. They did not know that a victim could access support without reporting a matter to the police. It was clear that Victoria feared others would be harmed if she reported to the police. It is not known with certainty that her experience as a Polish woman would have influenced those views. Given the views and experience of childhood friends, it is a strong possibility that it could have.

5.4.4 The panel considered that the length of time that a person lives in a country can greatly influence a person's knowledge of specialist support, civil, and criminal justice options available to victims of crime. The panel included a member with experience living in Poland and now working in the UK. Young people being raised, educated and subject to national media and popular culture in the UK tended to be aware of the services linked to domestic abuse. It was considered that the concepts of refuges, arrest, injunctions and civil orders were more likely to be known by persons who had lived in the UK for longer periods.

6. Conclusions and Lessons to be Learnt

6.1 Conclusions (key issues during this Review)

6.1.1 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. Those friends have expressed concerns about processes that need to change.

6.1.2 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.

6.1.3 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.

6.1.4 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.

6.1.5 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.

6.1.6 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.

6.1.7 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 (victims, and 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.*

6.2 Lessons To Be Learnt

6.2.1 This case does not highlight any new lessons to be learned from the contact between Victoria and the GP practice, the only agency represented at the DHR to have contact with before her death.

6.2.2 In this case, 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.

6.2.3 The chair has discussed this case with the Head of Royal Mail Consumer Business Development. The Royal Mail are keen to provide service improvements as soon as possible and the panel is taking immediate action to develop new processes.

6.2.4 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.

6.2.5 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 and abusive 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 in.

6.2.6 As part of this process, Standing Together facilitated a meeting between Victoria's former employers and the Employers' Initiative on Domestic Abuse (EIDA) (eida.org.uk). EIDA are a network of more than 170 companies and public-sector organisations that exchange information and good practice, to encourage and promote action to help staff who are experiencing domestic abuse. In October 2017, the chair of this review, Standing Together DHR manager and EIDA met with senior representatives of Victoria's former employers. It was agreed by all that employers needed to learn lessons from Victoria's death and it is planned that EIDA will share good practice and policies from other employers.

6.2.7 Victoria's experience as a Polish woman living in the UK was 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.

7. Recommendations

7.1 IMR Recommendations (Single Agency):

7.1.1 **There were no single agency recommendations identified in the IMR.**

7.2 Overview Report Recommendations:

7.2.1 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. The panel considers that whilst the homicide took place in the Borough of Croydon, the victim was employed in another area and the recommendations should have an impact on National Strategy as well as local initiatives.

7.2.2 **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*).

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

7.2.4 **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.

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

7.2.6 **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.

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

7.2.8 **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)

Appendix 1: Domestic Homicide Review Terms of Reference

Domestic Homicide Review Terms of Reference: Case of Victoria

This Domestic Homicide Review is being completed to consider agency involvement with Victoria and Grzegorz following the death of Victoria in March 2016. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

1. Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.

2. To review the involvement of each individual agency, statutory and non-statutory, with Victoria and Grzegorz during the relevant period of time March 2014 – March 2016. To summarise agency involvement prior to March 2014.

3. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.

4. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.

5. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.

6. The Independent Chair will:
   a) chair the Domestic Homicide Review Panel;
   b) co-ordinate the review process;
   c) quality assure the approach and challenge agencies where necessary; and
   d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

7. To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.

8. On completion present the full report to the Safer Croydon Partnership.

Definitions: Domestic Violence and Coercive Control

9. The Overview Report will make reference to the terms domestic violence and coercive control. The Review Panel all agree that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The Review Panel understand and agree to the use of the cross-government definition as a framework for understanding the domestic violence experienced by the Victim in this DHR.
   The cross-government definition of domestic violence and abuse (amended March 2013) definition states that domestic violence and abuse is:
   "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; and emotional.
   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 a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

Ethnicity, Equality and Diversity

10. The Review Panel will consider all protected characteristics of both Victoria and the Grzegorz (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any local area protected characteristics to consider (e.g. armed forces, carer status and looked after child).
11. The Review Panel identified the following characteristics of Victoria and of Grzegorz as requiring specific consideration for this case; Polish Nationality.
12. The Review Panel will invite a suitable representative for issues affecting Polish nationals to the panel as an expert/an advisory member to the chair to ensure they are providing appropriate consideration to the identified characteristics.

Membership

13. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Agency representatives must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge.

14. The following agencies are to be on the Panel:
    a) Clinical Commissioning Group
    b) Community Health Services (e.g. health visiting)
    c) General Practitioner for the victim and [alleged] perpetrator
    d) Hospital
    e) Local Authority Adult Social Care Services
    f) Local Authority Community Safety
    g) Local Authority Housing services
    h) Local domestic violence specialist service provider e.g. Women's Aid / IDVA
    i) Mental Health Trust
    j) NHS England

k) Police (Borough Commander or representative, Senior Investigating Officer (for first meeting only) and IMR author)
l) Probation Service
m) Substance misuse services
n) Victim Support

15. Expertise: The Review Panel recognise that the particular issues in this case are substance misuse and therefore Turning Point will act as experts on this area to advise the panel.

16. Parallel Reviews: If there are other investigations or inquests into the death, the panel will agree to either:
    a) run the review in parallel to the other investigations, or
    b) conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.

17. Role of Standing Together Against Domestic Violence and the Panel:
    STADV have been commissioned by the Croydon CSP to independently chair this DHR. STADV have in turn appointed their Associate Mark Yexley to chair the DHR. The STADV DHR team consists of two Administrators, a Manager and Senior Coordinator. A STADV DHR team Administrator will provide administrative support to the DHR and the STADV DHR Team Manager and Senior Coordinator will have oversight of the DHR. The STADV Manager and Senior Coordinator may at times attend a panel meeting as an observer. The STADV DHR team will quality assure the Overview Report before it is submitted to the CSP. STADV DHR team will liaise with the CSP around publication. The contact details for all on the STADV team will be provided to the panel. Standing Together will also consider the dissemination of learning from the panel in consultation with the CSP.

Collating evidence

18. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

19. Chronologies and IMRs will be completed by the following organisations known to have had contact with Victoria and Grzegorz during the relevant time period. The agency is also required to produce an Individual Management Review (IMR):
    a) General Practice

20. Further agencies may be asked to complete chronologies and IMRs if their involvement with Victoria and Grzegorz becomes apparent through the information received as part of the review.

21. Each IMR will:
    a) set out the facts of their involvement with Victoria and/or Grzegorz and critically analyse the service they provided in line with the specific terms of reference
    b) identify any recommendations for practice or policy in relation to their agency
    c) consider issues of agency activity in other areas and review the impact in this specific case
    d) Ensure that the IMR is quality assured before submission to the panel

22. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Victoria and Grzegorz in contact with their agency.

Analysis of findings

23. In order to critically analyse the incident and the agencies' responses to Victoria and/or Grzegorz, this review should specifically consider the following points:
    a) Analyse the communication, procedures and discussions, which took place within and between agencies.
    b) Analyse the co-operation between different agencies involved with Victoria / Grzegorz [and wider family].
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d) Analyse agency responses to any identification of domestic abuse issues.
    e) Analyse organisations' access to specialist domestic abuse agencies.
    f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.

As a result of this analysis, agencies should identify good practice and lessons to be learned. The panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.

Development of an action plan

24. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the Safer Croydon Partnership on their action plans within six months of the review being completed.

25. Safer Croydon Partnership to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Liaison with the victim's family and [alleged] perpetrator

26. Sensitively attempt to involve the family of Victoria in the review once it is appropriate to do so in the context of on-going criminal proceedings. The chair will lead on family engagement with the support of Police and Victim Support Homicide Service.

27. Invite Grzegorz to participate in the review, following the completion of the criminal trial.

28. Co-ordinate family liaison to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

Media handling

29. Any enquiries from the media and family should be forwarded to the Safer Croydon Partnership who will liaise with the chair. Panel members are asked not to comment if

requested. The Safer Croydon Partnership will make no comment apart from stating that a review is underway and will report in due course.

30. The Safer Croydon Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

31. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

32. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

33. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Documents to be password protected.

Disclosure

34. Disclosure of facts or sensitive information may be a concern for some agencies. We manage the review safely and appropriately so that problems do not arise and by not delaying the review process we achieve outcomes in a timely fashion, which can help to safeguard others.

35. The chair will liaise directly with the police disclosure officer, if appropriate.

36. The sharing of information by agencies in relation to their contact with the victim and/or the [alleged] perpetrator is guided by the following:
    a) Human Rights Act: information shared for the purpose of protecting right to life (domestic abuse and domestic homicide), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).

b) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:
   i) It is needed to prevent serious crime
   ii) there is a public interest (e.g. prevention of crime, protection of vulnerable persons)

Appendix 2: Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
What is the over-arching recommendation?	*Should this recommendation be enacted at a local or regional level (N.B national learning will be identified by the Home Office Quality Assurance Group, however the review panel can suggest recommendations for the national level)*	*How exactly is the relevant agency going to make this recommend ation happen?* *What actions need to occur?*	*Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendati on?*	*Have there been key steps that have allowed the recommendation to be enacted?*	*When should this recommendation be completed by?*	*When is the recommendation and actually completed?* *What does the outcome look like?*
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**	National and Local		Police Croydon CSP	1. The Chair of Croydon CSP writes to Royal Mail Consumer Services – providing a copy of the draft report. Requesting they review current practice and engage with police and domestic abuse agencies at a strategic level to change practice.	30 April 2018	Completed.

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*).				2. MPS representative on NPCC to present this case and establish plan to review and change practice.		
Recommendation 2: **That the Home Office promote the work of bodies such as the Employers' Initiative on Domestic Abuse.**	National		Home Office Employers' Initiative on Domestic Abuse	Report to be shared with Employers' Initiative on Domestic Abuse	Once published, report will be shared.	
Recommendation 3: **That the Home Office consider campaigns to raise awareness of**	National			To be decided by the Home Office		

coercive and controlling behaviour and the availability of Domestic Abuse Services (local and national) to Non-UK Nationals.						
Recommendation 4: **That the Home Office provide financial support to National Domestic Violence Helpline to establish links with services for Eastern European women.**	National			To be decided by Home Office		
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.**	Local			To be decided by the CSP		
Recommendation 6: **Croydon CSP work with local employers to ensure that consideration is given to**	Local			To be decided by CSP		

supporting employees who are subject to domestic abuse.						
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)**	Local			To be decided by CSP		

22 November 2018

Home Office

Public Protection Unit

2 Marsham Street

London
SW1P 4DF

Anthony Lewis
Head of Community Safety
6D Bernard Weatherill House
8 Mint Walk
Croydon
CR0 1EA

Dear Mr Lewis

Thank you for submitting the Domestic Homicide Review (DHR) report for Croydon ('Victoria') to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 26 September. I am sorry for the delay in providing the Panel's feedback.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this is a well written, compassionate and thorough report that has made good use of interviews with family, friends and wider networks. This helps a reader appreciate the victim as a person and see events through her eyes. The lessons are well articulated and the Panel particularly commended the positive action that has resulted from the meeting between the Employer's Initiative on Domestic Abuse and the victim's employer on workplace domestic abuse policies. The Panel also highlighted the good practice in following up recommendations with Royal Mail regarding their redirection policy.

There were, however, some aspects of the report which the Panel felt may benefit from additional comment, further analysis, or be revised, which you will wish to consider:

- To give more context, the narrative in the executive summary could include additional examples of the perpetrator's controlling and coercive behaviour;
- The recommendations in the action plan are missing outcomes;
- It would aid transparency if the chair could include the period of time since he retired from the police service;
- There are a small number of typing errors in both reports which should be corrected before publication.

The Panel does not need to review another version of the report, but I would be grateful if you could email us at DHREnquiries@homeoffice.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the Mayor's Office for Policing and Crime for information.

Yours sincerely

Hannah Buckley

Chair of the Home Office DHR Quality Assurance Panel