Bracknell Forest Community Safety Partnership - Domestic Homicide Review TS

Report Author: Jerry Oliver March 2013

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The Chair of the Domestic Homicide Review

1. Campbell Christie CBE was, until recently, a Commodore and Assistant Chief of Staff in the Royal Navy. He was responsible for all naval training and education Policy. He was appointed Principal of Bracknell and Wokingham College in September 2011.

The Report Author

2. Jerry Oliver the Author has occupied positions as Director of Local Authority Adult, Children and Families and Housing Services, PCT Operational Director (Integration), Chief Inspector in Regulation pre CSCI, NSCI AND CQC and more recently Department of Health North West Regional Policy Lead (England).

3. At present Managing Director of Janjer Ltd, a specialist care and health business consultancy providing UK wide advisory services, including risk management services to Insurance Underwriters on risk, claim and loss adjusting. Linked with this a UK wide Assist Service to policy Holders.

The Domestic Homicide Panel

4. This comprised representatives from Thames Valley Police, The Probation Service, Bracknell Forest Council through the Community Safety Manager and Assistant Borough Solicitor.

Introduction

5. This Domestic Homicide review was commissioned by Bracknell Forest Community Safety Partnership (CSP) in response to the death of TS in Bracknell on 27 May 2012. The referral for consideration of a Domestic Homicide Review was made by the Police to the Chair of the Bracknell Forest Community Safety Partnership who is also the Chief Executive of Bracknell Forest Council. The Chair considered the Home Office guidance and concluded that the requirement for such a review was met and a Domestic Homicide Review group was set up chaired by the Bracknell and Wokingham College Principal.

6. TS was aged 43 at time of death. TS was attacked in an underpass under the London Road, A329 in Bracknell. She was stabbed in the neck before being hit with a heavy pair of cutters on at least nine occasions. She was struck with considerable force across the back of her head. There was evidence that she tried to defend herself as bones in her hand were broken. There was evidence from MS's friends that TS was left by MS still breathing when MS left her in the underpass.

7. There was a later report from an individual who heard an argument between a man and a woman in the Basemoors area between midnight and 1am. TS's body was found at 8am in the early hours of Sunday, 27 May 2012.

8. The perpetrator, MS, aged 28 at the time of the crime, was found guilty of murder with a recommendation that he serve 23 years following a trial at Reading Crown Court. MS's defence was that TS provoked him to lose his self-control which was rejected. No independent witness or information to sustain this position was accepted by Court. MS showed no remorse or emotion from the time of his arrest, throughout the extensive interviewing at the police station or at his trial.

9. There were no witnesses to the murder. It was reported by staff at a Ladbrokes shop in Bracknell that TS and MS had spent from 5pm to 10 pm on Saturday 26 May 2012 playing the roulette machines in their shop. It was understood that they lost about £1,000 during this time. During the evening they were seen by the staff of the Ladbrokes shop to have argued on one occasion but left together at 10pm.

10. With no direct witnesses to the murder or more specific information or defence from the perpetrator it is purely speculative as to whether the loss of money at the Ladbrokes shop, or other exchanges between the couple on that night triggered the homicide.

Background

11. TS was born in Thailand and married a German national, RS, in 1994 in Denmark. She became a full German citizen and in June 1997 gave birth to a son, SS. She left RS in October 2010 to move to the UK. In March 2012 RS filed for divorce.

12. DH lived in Germany and was the sister of TS and had regular contact with her by phone. She had spoken with her 5 days before she was murdered and TS had spoken to her family in Thailand the day before. She knew that she was living in Bracknell with MS. They had met at a party in October 2010 and he asked her to live with him. In October 2011 TS told her that she was going to marry MS as she loved him.

13. In 2011 Essex police, together with the UK Border Agency visited a property in Harlow, where they found TS. In interview she claimed to have flown into Aberdeen the week before where she stayed with friends before travelling to London by train and getting a taxi to Harlow to stay with friends.

14. MS was a Pakistani national who on 29th September 2010 applied to come to the UK on a Tier 4 General Student Visa, he entered the UK on 6th November 2010 from Islamabad, Pakistan, and the Visa expired on 18th February 2012. It would appear that MS was attempting to use his relationship with TS to

remain in the UK but at the time of her death she was still legally married to her German husband.

15. MS stated that he had married TS in an Islamic Ceremony in Slough on 31/12/2011) in spite of the fact that TS's divorce was not final.

16. TS and MS arrived in Bracknell in March 2012. TS met MS in Slough in April/May 2011. There is no information on where they lived in Slough. MS told the court how he had married her in an Islamic Ceremony in Slough on 31 December 2011 and that they had applied to Southwark Registry Office to marry under British law but the divorce papers that TS had did not have the correct wording (she was still legally married to her estranged husband in Germany). There was no contact with the Authorities in Southwark.

17. Neither TS or MS had a GP in Bracknell – MS had a GP in Slough - despite a number of enquires with the NHS and Health Authorities, Police were not able to find a GP for TS. This is covered in more detail in this report when discussing Health involvement.

18. The Police's position was that TS did not work; she was financially supported by MS. Information from Police interviews with MS indicated he set up a company called IHM which he described as a virtual university through a computer based approach. He was reportedly assisting overseas students gain places at UK colleges and applying for Student Study Visas.

19. On 28th June 2012 Sky Solicitors representing MS wrote to the Home Office and applied for an Application of European Economic Area (EEA) Residence Card. They were informed that in light of the fact he was being charged on criminal offences the application could not proceed any further. On 13th September 2012 the EEA application was withdrawn. MS remains subject to the Immigration Act 1971, as amended, and as such is liable to deportation or administrative removal from the UK.

20. The Police's view at the time of the trial and derived from interviews with MS was that it did not appear that TS was being exploited. The Crown's case was that this was a relationship mutually convenient to both parties.

21. Discussions with DH the sister of TS confirmed she had regular contact with her sister by phone had spoken with her 5 days before her murder. DH knew that she was living in Bracknell with MS. They had met at a party in October 2010 and he asked her to live with him. In October 2011 TS told DH that she was going to marry MS as she loved him. As indicated later in this report, DH confirmed they were living together and reported that she had been physically abused by MS, about three months before her death and at an earlier occasion he had either pushed her or held her down against her will. The exact details as to whether any physical harm came of this is not known.

22. However their Landlord FN, who saw TS nearly every day as he lived in part of the building he let to them, reported over a sustained period of time, many months, she presented as happy. FN only heard them argue once, she raised her voice, FN asked what was going on and she said 'He hit me'. FN didn't see any marks and her account was that she said she wanted to go out, he tried to stop her by putting his arms around her, she pushed him away, he then slapped her on the face. FN said that TS was beginning to become more independent and MS was controlling, MS would stick to her like glue.

23. The reports from DH the sister did not reveal a history of TS being abused by MS. FN the landlord reported one occasion of reported violence over a period of many months of contact with TS. These two reports on their own would not indicate that there was sufficient information or escalation of violence to expect any of the local agencies should have been alert to or have considered TS as a vulnerable person, or consider any of the local agencies awareness of exploitation was deficient.

Terms of reference for the review

24. This was to:

- Consider the facts that led to the homicide on 27 May 2012 and whether there are any lessons to be learned from the incident about the way in which local professionals and agencies worked together.

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

- Consider the need for a Serious Case Review (SCR) should serious concerns over safeguarding come to light.

- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the homicide in May 2012.

- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process. Domestic homicide reviews are not inquiries into how the victim died or who is culpable. That is a matter for the Police, coroners and criminal courts.

What are Domestic Homicide Reviews

25. Domestic Homicide Reviews are part of the Domestic Violence, Crime and Victims Act 2004 and became law from 13 April 2011. They do not replace, but are in addition to, the inquest or any other form of inquiry into the homicide.

26. The main document to guide the review team was the guidance[1] issued by the Home Office as statutory guidance under section 9(3) of the Domestic Violence, Crime and Victims Act (2004). The act states: "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

    (a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

    (b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

27. It is clear that the death of TS falls within this definition.

28. This review was conducted between November 2012 and February 2013. During this period the Review team met on the 16 November 2012, 13 December 2012, 30 January 2013 and for the last time on the 20 February 2013.

Purpose of Domestic Homicide Review (DHR)

29. The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

[1]http://www.homeoffice.gov.uk/publications/crime/DHR-guidance

Establishing a review Panel

30. A review team was appointed by the Chair of the Bracknell Forest Community Safety Partnership. The Membership followed the statutory guidance and a chair appointed who is the Principal of Bracknell and Wokingham College, to oversee and take forward the Domestic Homicide Review.

31. Core Members of the review panel were; the Local Authority Community Safety Manager, also Legal Services, The Probation Service, and Thames Valley Police.

The Review report itself and what happens to this

32. The methodology is as follows:

    - Background to the DHR
    - Consideration of single agency/individual reports, highlighting lessons learnt and recommendations
    - Key points of note
    - Main recommendations and conclusions.

    An integrated agency Chronology has also been drawn together and this is included as Appendix A to this report.

33. The tendency over the last few years has seen these reports growing in detail and sometimes arguably including detail and complexity of style that does not allow the key issues to surface readily. This report is designed to be concise and pull the lessons learnt for all the agencies involved into a composite document for all interested parties to readily understand the key organisational learning points and corrective actions going forward in order to hold parties accountable for making improvements where these have been acknowledged and agreed.

34. The Home Office guidance states that “Publication of Overview Reports and the Executive Summary will take place following agreement from the Quality Assurance Group at the Home Office and should be published on the local CSP web page.”

35. The Overview Report aims to bring together and draw overall conclusions from the information and analysis contained in the Independent Management Reviews (IMR). The review of these IMRs and ancillary information also raised questions and actions for taking forward during the life of the panel.

36. The Overview Report makes recommendations for future action which the Review Panel has translated into a specific, measurable, achievable, realistic and timely (SMART) Action Plan. This is referenced in Appendix B.

Individual management review reports

37. The Chair of the Review Panel wrote to the senior manager in each of the participating agencies to commission from them an IMR. The IMRs form part of this Report.

38. The aim of the IMR is to allow agencies to look openly and critically at individual and organisational practice and the context within which people were working, to see whether the homicide indicates that changes could and should be made. To also identify how those changes will be brought about and to also identify examples of good practice within those agencies. **The two key judgements are predictability and preventability.**

Point of note

39. There were three meetings of the Domestic Homicide Review group (DHRGroup) running up to the presentation to the panel of the first draft report on 20 February 2013. During these meetings membership continuity and lack of full awareness in responding organisations, of Home Office IMR reporting guidance (although detailed in correspondence) were issues in comparing and answering queries and contrasting reports by the Panel.

Recommendation 1

At a local level organisations required to produce IMRs require a better familiarity with the statutory basis for conducting DHRs and their role and responsibilities in engaging with these activities. The Community Safety Partnership is best placed to consider this matter further.

Recommendation 2

The Home Office is also asked through this report to review how it might best remind key statutory agencies of their responsibilities in engaging with DHRs. Please see recommendation 6 & 7.

Recommendation 3

The key organisations that represent the statutory organisations on the DHR Panel should ensure that the officers they delegate for attendance have sufficient authority to enable the DHR Group to deliver its statutory responsibilities.

Other Authorities involved and contacted

40. As the deceased had also been living in Harlow Essex, enquiries of Essex Police were made.

41. The Police in Thames Valley were also involved and they were able to give information on both the victim and perpetrator.

42. The Crown Prosecution Service was contacted.

43. Public Health and The Probation Service were involved.

44. Due to the recent travel into this country of TS and MS the UK Border Agency was also approached for information due to the immigration status of both the victim and perpetrator.

45. Essex's Community Safety Partnership was also approached for information.

46. Due to the gender of the deceased, the Berkshire Woman's Aid organisation was contacted.

47. The deceased was not subject to a Multi-Agency Risk Assessment Conference (MARAC)[2]and the Perpetrator was not subject to Multi Agency Public Protection Arrangements (MAPPA)[3]

48. As far as the review panel could ascertain the victim did not have any contact with a domestic violence organisation.

49. Consideration was also given as to whether TS was a 'vulnerable adult' – a person "who is or may be in need of community care services by reason of mental or other disability, age or illness; and was or may have been unable to take care of herself, or unable to protect herself against significant harm or exploitation". As there was information from Essex Police of being arrested on suspicion of being involved with prostitution, the subject of exploitation was also considered and Adult Social Care in Bracknell Forest Council were also

[2]**The MARAC** is a victim-focused meeting where information is shared on the highest risk cases of domestic abuse between criminal justice, health, child protection, housing practitioners, IDVAs (Independent Domestic Violence Advocate) as well as other specialists from the statutory and voluntary sectors. A safety plan for each victim is then created.

[3]**Multi-Agency Public Protection Arrangements** (MAPPA) is the name given to arrangements in England and Wales for the "responsible authorities" tasked with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public. The "responsible authorities" of the MAPPA include the National Probation Service, HM Prison Service and England and Wales Police Forces. MAPPA is coordinated and supported nationally by the Public Protection Unit within the National Offender Management Service. MAPPA was introduced by the Criminal Justice and Courts Services Act 2000 and was strengthened under the Criminal Justice Act 2003.

approached for information. No information was held on either TS or MS. No contacts at all are recorded.

Family involvement (general)

50. In domestic violence homicides, members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel therefore carefully considered the potential benefits gained by including and contacting such individuals.

51. Although the deceased's estranged husband lived in Germany it was agreed contact should be made with him.

52. In addition TS had a sister in Germany and she was contacted and gave information.

53. Efforts were made to speak to a friend, WP, in Fleet, Hampshire, who appeared at the perpetrator's trial. Attempts were made to contact twice but did not result in her participation in this review.

54. Although a communication strategy was discussed for keeping the families informed, this had limitations for two main reasons. Firstly TS' birth family lived in Thailand. Secondly it appeared that many of TS' family did not speak English or communication was limited.

55. Further details of the family's position are addressed later in this report.

The family (specific)

56. The deceased's estranged husband, RS, was contacted on 28 January 2013. As he was living in Germany this communication was undertaken by telephone call. Language Line, a telephone interpreting service, was utilised. He was asked whether he had kept in touch with TS and he replied there was no contact between them other than the occasional contact with his son. He did not know where she lived and TS had not reportedly spoken to her son who was living with the Father since 2011.

57. DH, TS' sister, was also contacted on 29 January 2013. The sister reported telephone contacts with TS as recently as 5 days before her death. She was aware her sister was living in Bracknell and living with MS. She confirmed they were living together and reported that she had been physically abused by him, about three months before her death and at an earlier occasion he had either pushed her or held her down against her will. The exact details as to whether any physical harm came of this is not known. The sister advised her to move back to Germany but TS reported her love for MS prevented that occurring. The sister did not think TS would have known about any agencies or

organisations that could have helped her. She also confirmed that her sister did not have a GP.

58. A friend of TS living in Fleet, WP, was approached via her husband by telephone and written to on 1 February 2013. Despite these attempts no contact with this person was possible. In the circumstances it was considered inappropriate to pursue the friend further and the contact details of the officer attempting to make contact were left. However reports of the trial were mentioned in the "Get Bracknell" media[4]. This is mentioned, as the reporter describes WP as a friend and business woman. WP had only known her for three and half weeks before TS' death. However there had been a phone call between them where some sexual behaviours of concern to TS involving a friend of MS were discussed. WP advised TS to leave MS. TS said MS would kill himself or hurt himself if that happened. Also he had her passport. The behaviour of concern, involving MS' friend was denied by the friend in court.

Point of note

59. As the court transcripts related to the trial were not readily available to the author of this report reference to Bracknell media information is second-hand information at best. However it does indicate the importance of information that is in the possession of the police or Crown Prosecution Service (CPS) being discussed with the DHR group and for the DHR Group to understand what can or cannot be accessed and its relevance. This may best be achieved through an invitation to the Police's Senior Investigation Officer at an early point in the meetings of the DHR Group.

Recommendation 4

60. The terms of reference for future DHRs going forward needs to contain mention of relevant background information such as court transcripts, where appropriate. In addition, again where appropriate, an early invitation from the DHR Group to the Police's Senior Investigation Officer is built into the terms of reference of DHRs.

Family - Point of note

61. The sister in Germany did not indicate that the violence reported to her on two occasions was of sufficient cause to action any contacts with the Police. The DHR concluded that there was a likelihood of insufficient information from other family members to add value to the review process. Accordingly no other family members were contacted.

[4] "getbracknel" is the e-version web based arm of the Bracknell Forest Standard.

UK Border Agency

62. Enquiry of this agency was through the Evidence and Data Integrity Directorate. Formal requests for an IMR were responded to on 8 January 2013. This provided a witness statement from an Executive Officer from the Directorate. No formal IMR has been forthcoming.

63. The information describes MS as a Pakistani National who applied to the British Embassy in Abu Dhabi on 27 September 2010. MS entered the UK on 6 November 2010 and was granted general student status to stay until 18 February 2012.

64. On the 3 March 2011 the Home Office received an application for a certificate of approval for marriage on behalf of MS to marry a national of the Slovak Republic (European Economic Area) exercising her treaty rights in the UK. Further correspondence on behalf of MS on 17 February 2012 was received by the Home Office for EEA residence as the unmarried partner of TS, a national of Germany exercising her treaty rights in the UK.

65. Further correspondence from the Home Office in June 2012 confirmed that the application could not proceed on the basis of the charges for criminal offences at that time. Those charges related to the murder of TS.

66. On 13 September 2012 the application was withdrawn. MS has no valid leave to remain or permission to work in the UK. He is currently serving his sentence following being found guilty on 30 November 2012 of the murder of TS.

Point of note

a) The DHR Group was concerned to better understand whether domestic violence was publicised in any way at borders and surrounding passport control areas and if this needed to be further reviewed by the Home Office through the UK Border Agency (UKBA).

b) Despite asking for an IMR from the UKBA, other than information via a witness statement from an Executive Officer, no IMR was provided.

c) The matter of a EEU treaty allowing nationals from the European Union to travel and reside freely whose language skills may not include English is an issue and should be discussed further at the Community Safety Partnership meetings. This will aid better understanding and consideration of any actions in the local community that might publicise more effectively which key organisations can be contacted.

d) The Home Office, by way of this DHR, will be asked to consider (c) above.

e) The UKBA did not identify any lessons learnt, or changes required to their systems and procedures.

Recommendation 5

67. The Home Office will be asked through this review to consider whether information about the services of help for those suffering from Domestic Violence should be further promoted at borders and through the activities of the UKBA.

Recommendation 6

68. Despite asking for an IMR from the UKBA, other than information constructed via a witness statement from an Executive Officer, no IMR was provided. The Home Office will be asked to note that the UKBA did not supply an IMR for this DHR. This is also linked to recommendation 2.

Crown Prosecution Service Essex

69. A formal IMR request was made to the Crown Prosecution Service (Essex). No response was forthcoming to the DHR Group whilst the Review Group was being held. A single page letter was received subsequently. They did not identify any lessons learnt, or changes required to their systems and procedures.

Recommendation 7

70. The Crown Prosecution Service (Essex) did not supply an IMR for this DHR. A single page letter was received subsequently. The Attorney General's Office to be contacted, this may well be best through the Home Office initially. This is also linked to Recommendation 2.

Essex Police

71. Essex Police were formally asked for an IMR. Whilst an IMR was not produced, a good deal of information was provided to the DHR Group. They were unable to provide a full IMR due to the limited contact they had had with TS. The first of two reports indicates she was arrested on 2 March 2011 on suspicion of running a brothel. The search of the premises was jointly conducted with the UKBA. TS was arrested, interviewed and later bailed. She reported having arrived into the UK a week before the arrest.

72. Essex Police confirmed that TS denied the offence as stated. On 26 May 2011 the Crown Prosecution Service decided that there was insufficient evidence to prosecute TS. No other information is held by or known to them.

73. Essex Police confirmed there is no information held on their records with regard to MS.

Point of note

74. Essex Police had to be written to twice to receive formal correspondence indicating the level of contacts they had had with TS and MS.

Summary

75. Essex Police's information response, indicated knowledge of TS only from the arrest on 2 March 2013. The information supplied did not follow the IMR structure however the minimal contact with TS would see the information supplied as meeting the spirit of the IMR request. Essex Police also confirmed that they had no recorded information on MS. Essex Police did not identify any lessons learnt, or changes required to their systems and procedures.

Thames Valley Police (TVP)

76. Thames Valley Police produced an IMR. This contained a factual statement. This statement reported that at 07.58 hours on 27 May 2012 Thames Valley Police received a report of a female body having been located in the underpass by The Brackens in Bracknell. The deceased was subsequently identified to be TS. On 29 May 2012, MS, partner to TS, was charged with her murder.

77. All of the available local and national data bases have been examined by TVP. There are no records held by TVP of any relevance to the review with regard to TS or MS.

78. Enquiries via the Impact Nominal Index (INI) system revealed information held by the Essex Police relating to TS. Essex Police were contacted formally as part of this DHR and their details are referenced earlier in this report.

79. The third DHR meeting on 30 January 2013 was attended by Detective Inspector Michael Squire of Thames Valley Police and information was given in respect to information held by Local Community Policing. This again indicated that no information was held at this local level and the neighbourhood where TS and MS lived was represented by an officer with many years' service in that local community area.

In summary

80. Thames Valley Police did not identify any lessons learnt, or changes required to their systems and procedures. To balance this statement the Police did not have any contact or information on either TS or MS prior to the murder of TS. The Police did confirm that TS had no GP.

Health

81. Health input to the DHR Group was provided by Public Health who did have some access to health records including other NHS data. An IMR was requested. Follow up enquiries with Public Health, and utilising the informatics

team of Berkshire NHS Cluster, revealed no information held on either TS or MS.

82. Initially this position was a concern to the DHR Group as it was felt unlikely that TS would have had no contact at all within the health system and the DHR Group pressed for further clarity on this, especially as an IMR was not forthcoming. This was followed up by the report author on 4 February 2013. This was met with a response on 5 February 2013 confirming that neither TS nor MS had any record of treatment or contact against their given National Insurance numbers.

83. Following the information reported by Essex Police, they had mentioned that, when arrested, TS was using her maiden name. This information was taken back to the informatics team who again formally responded that there was nothing recorded against these details. This occurred on 15 February 2013.

84. Health did not submit an IMR or considered it necessary to attend the DHR Group. They did not identify any lessons learnt, or changes required to their systems and procedures.

Point of note

85. As there was no GP registration for TS, Public Health made enquiries within health data systems for the DHR Group concerning the extent of any possible contacts from TS and MS to health access points in the Bracknell area.

86. It may also be worthwhile, due to the new NHS changes effective from 1 April 2013 (in particular Department of Health and Public Health England), that membership from Health is discussed at the Strategic Community Safety Partnership after 1 April 2013.

Point of note

87. Health were unable to produce an IMR. Again the early searches indicated no information held for either TS or MS and this point should be seen in that context.

Recommendation 8

88. The Community Safety Partnership needs to review, post 1 April 2013, the most suitable strategic partner representative following significant organisational and governance changes concerning the Department of Health and Public Health England.

Recommendation 9

89. It is also recommended that the Health's informatics access arrangements are reviewed in relation to DHRs. This to reach certainty as to whether health access via Walk in Centres, for example, or Accident and Emergency, are recording information that may be relevant to DHR cases and their interface with nationally held data sets.

Berkshire Women's Aid

90. Berkshire Women's Aid was invited to take part in the DHR meetings however did not attend. They did confirm that they would be forwarding an IMR which was not received. However as they indicated formally that they had no contacts with TS, the construction of an IMR would not have added any value. They did not identify any lessons learnt, or changes required to their systems and procedures.

Bracknell Forest Housing (Local Authority)

91. TS whilst in Bracknell lived in the Bullbrook area, in a private end terrace house owned by a landlord, FN, who also lived at the address. He owns several properties in Bracknell and rents out rooms to local people and, as reported by TVP, to a number of EU nationals who have also come to this country to work.

92. FN was contacted and claimed that TS and MS had moved into his property in February 2012 and that he had seen nothing untoward, despite seeing them regularly during their occupation.

93. Bracknell Forest Housing Local Authority indicated they had no information on TS and MS relating to Housing enquiries from either TS or MS. They did not identify any lessons learnt, or changes required to their systems and procedures.

Adult Social Care

94. Adult Social Care in Bracknell was approached for any information they held on TS and MS. This agency has a number of interfaces or contact with organisations that TS and MS may have been in contact with.

95. An IMR was not received and this was not necessary as the organisation had tracked their systems for contact and both parties were not in contact with them. Adult Social Care reported this position formally on 14 January 2013.

96. Adult Social Care did not identify any lessons learnt, or changes required to their systems and procedures.

Conclusions

97. The aim of the IMR is to allow agencies to look openly and critically at individual and organisational practice and the context within which people were working, to see whether the homicide indicates that changes could and should be made. To also identify, how those changes will be brought about and to identify examples of good practice within those agencies. The two key issues of predictability and preventability being considered as the underpinning theme.

98. TS and MS had only been living in Bracknell for approximately 12 weeks. Both this fact and their lack of any contact with statutory based organisations or registration with a GP have meant there was no opportunity for any of the agencies in the Bracknell area to have predicted the course of events leading to the murder of TS by MS. Neither is it considered that this domestic homicide could have been prevented.

99. The Police in Essex who were the first known statutory authority to come in contact with TS, although concerned that she may have been involved with prostitution, did not prosecute nor was there any information for them at that early contact stage to consider she was vulnerable or being exploited. She had only been in the country a few days, there was no other history for them to consider in the context of vulnerability.

100. The reports of DH, the sister did indicate that TS had discussed with her concerns around being assaulted by MS approximately three months before her death. However DH in a telephone conversation 5 days before TS's murder did not raise any concerns about his conduct at that time.

101. The Landlord who lived in a private part of the accommodation connected to and leased to TS and MS, reported he would see TS every day and over a number of months she appeared happy. There was only one discussion between TS and the Landlord where she raised concerns about MS behaving in a reportedly abusive manner. The Landlord saw more of TS and MS in close proximity to their personal environment than any other party. He heard no arguments or concerning behaviour otherwise.

102. The Crown's case was that this was an unusual joining of two people. It appeared that if TS married MS he would give her some money and he would obviously obtain residency as she was a German Citizen. They did appear to have a shared love of gambling. They did appear to have lived and slept together as a couple. DH, the sister of TS, indicated that this was a loving relationship as indicated that TS said that she loved MS. There was no evidence of TS being exploited.

103. It is therefore concluded by the DHR Panel that there was no information to indicate that TS was vulnerable or being exploited and what information was known by the Landlord and TS's sister DH, was not communicated to any statutory authorities involved in this DHR. Neither would DH or the Landlord have been expected to report their concerns prior to TS's death, as the incidents were isolated, not directly observed, forming any pattern or reaching any reasonable thresholds for reporting to the Authorities.

104. However the DHR did through the process of its review identify a number of lessons to be learnt which are covered separately in this report.

Lessons learned

105. There were three meetings of the DHR panel running up to the presentation of the first draft report on 20 February 2013. During these three meetings membership continuity and lack of full awareness in responding organisations, of Home Office IMR reporting guidance (although detailed to them in correspondence) were issues in comparing and answering queries and contrasting reports by the DHR Panel. This was Bracknell's first DHR Panel review concluded under the Council's statutory obligations related to Community Safety Partnership arrangements. This has a bearing on the first three recommendations arising out of the review.

106. The court transcripts related to the trial were not readily available to the author of this report. However it does indicate the importance of information which is in the possession of the Police or Crown Prosecution Service (CPS) being discussed with the DHR panel and for the panel to understand what can or cannot be accessed and its relevance. This may best be achieved through an invitation to the Police's Senior Investigation Officer at an early point in the meetings of the DHR Panel.

107. The DHR Panel was concerned to better understand whether domestic violence was publicised in any way at borders and surrounding passport control areas and if this needed to be further reviewed by the Home Office through the UK Border Agency.

108. It is suggested that the matter of nationals from the European Union being allowed to travel and reside freely is an issue for discussion at the Community Safety Partnership. This will aid better understanding and consideration of any actions in the local community that might publicise more effectively which key contact organisations can be contacted.

109. As there were no GP registration details for TS, Public Health made general enquiries initially within health data systems for the DHR Panel

concerning the extent of any possible contacts from TS and MS to health access points in the Bracknell area. No information existed. Further enquiries revealed that data quality across local health outlets was not sufficiently developed to establish whether TS may or may not have visited the numerous health outlets that exist in major towns such as Bracknell.

110. This point linked to the NHS changes effective from 1 April 2013 (in particular Department of Health and Public Health England) further indicates that appropriate membership from Health is discussed at the Community Safety Partnership after 1 April 2013.

Main Recommendations in summary

8.1 Multi Agency recommendations

Recommendation 1: At a local level, organisations required to produce IMRs, require a better familiarity with the statutory basis for conducting DHRs and their role and responsibilities in engaging with these activities. The Community Safety Partnership is best placed to consider this matter further.

Recommendation 2: The Home Office is also asked through this report to review how it might best remind key statutory agencies of their responsibilities in engaging with DHRs. Please see recommendation 6 & 7.

Recommendation 3: The key organisations that represent the statutory organisations on the DHR Panel should ensure that the officers they delegate for attendance have sufficient authority to enable the DHR Panel to administer its statutory responsibilities appropriately.

Recommendation 4: The terms of reference for future DHRs going forward need to contain mention of relevant background information such as court transcripts, where appropriate. In addition, again where appropriate, an early invitation from the DHR to the Police's Senior Investigation Officer is built into the terms of reference of DHRs.

8.2 Single Agency recommendations

Home Office

Recommendation 5: The Home Office will be asked through this review to consider whether the support services for victims of domestic violence should be further promoted at borders and through the activities of the UKBA.

Recommendation 6: The Home Office will be asked to note that the UKBA did not supply an IMR for this DHR. However a witness statement was produced. This is also referred to in Recommendation 2.

Recommendation 7: The Crown Prosecution Service (Essex) did not supply an IMR for this DHR. A one page letter was received subsequently. The Attorney General's Office to be contacted, this may well be best through the Home Office initially.

Health Bracknell

Recommendation 8: The Community Safety Partnership needs to review, post 1 April 2013, the most suitable strategic partner representative following significant

organisational and governance changes concerning the Department of Health and Public Health England.

Recommendation 9: It is also recommended that Health's informatics access arrangements are reviewed in relation to DHRs. This to reach certainty as to whether health access via Walk in Centres, for example, or Accident and Emergency are recording information that may be relevant to DHR cases and their interface with nationally held data sets.

Appendix A Chronology

Chronology of the events leading up the murder of TS by MS on 27 May 2012.

Date	Event	Source
27/09/2010	MS applied for Entry Clearance to UK as Tier 4 Student in Abu Dhabi	UKBA witness statement by CW
29/09/2010	MS granted Entry Clearance to UK	UKBA witness statement by CW
October 2010	TS enters UK	Ex-husband, RS via DS L by e mail
6/11/2010	MS arrives in UK	UKBA witness statement by CW
02/03/2011	TS arrested in Harlow Essex on sus. of managing a brothel. She is placed on bail. TS claimed to Essex police to have arrived in the UK a week before.	Essex Police IMR (BW, Review Officer)
30/03/2011	Application from MS to marry a Slovak national in UK	UKBA witness statement by CW
April / May 2011	MS met TS in Slough	DCI Y TVP/ DS L
26/05/2011	TS released from her bail. Essex CPS decide NFA	DCI M Essex Pol. Letter dated 16/08/2012
29/6/2011	TS leaves UK via Heathrow	DS L e mail (19/11/2012)
17/9/2011	TS re-enters UK via Heathrow	DS L e mail (19/11/2012)
31/12/2011	MS & TS marry in an Islamic ceremony in Slough	DCI Y TVP/ DS L
17/02/2012	Application from MS for an EEA Residence Card as the unmarried partner of a European national, TS	UKBA witness statement by CW
March 2012	MS and TS arrive in Bracknell	DCI Y TVP/ DS L
Feb (poss. March) 2012	MS and TS arrive in Bracknell	FN, Landlord in interview with IB
Poss. March 2012	FN says that TS complained of being assaulted by MS. (Imprecise date). TJ's sister, DH also said that TS disclosed to her that she had been assaulted by MS at about this time	Notes taken from interviews with FN (20/02/2013) and DH (sister) (29/01/2013
27/05/2012	Murder of TS	
28/01/2013	Phone call via language line between IB and TS's ex-husband RS. Revealed no recent contact	Notes from IB
01/02/2013	Letter sent to WP, friend of TS, inviting her to respond re DHR. No reply received	Letter sent by IB

Appendix B Action Planning

Bracknell Community Safety Partnership: TS/MS Domestic Homicide Review March 2013 - Action Plan

Recommendation	Scope of Recommendation i.e. Local National	Action to take	Lead Agency	Key Milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
1. At a local level organisations required to produce IMRs require a better familiarity with the statutory basis for conducting DHRs and their role and responsibilities in engaging with these activities. The Community Safety Partnership is best placed to consider this matter further.	Local – Community Safety Partnership (CSP)	Bracknell CSP to agree the best way of ensuring local organisations, including statutory partners, understand the statutory basis for conducting Domestic Homicide Reviews and as a consequence improve their responsiveness to these responsibilities.	Local Authority as Chair of the Community Safety Partnership	To be compiled by the agencies involved	July 2013	
2. The Home Office is also asked through this report to review how it might best remind key statutory agencies of their responsibilities in	National – Home Office	The Home Office is asked to review how it might best remind key statutory agencies of their responsibilities in engaging with a DHR.	Home Office	To be updated following the Home Office's consideration of this matter	To be established	

Recommendation	Scope of Recommendation i.e. Local National	Action to take	Lead Agency	Key Milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
engaging with DHRs. Please also see recommendation 6, & 7.						
3. The key organisations that represent the statutory organisations on the DHR Panel should ensure that the officers they delegate for attendance have sufficient authority to enable the DHR Panel to administer its statutory responsibilities appropriately.	Local - CSP	Linked with recommendation 2 The Community Safety Partnership to consider and agree the best course of action locally to ensure key local organisations delegate individuals for attendance that have sufficient knowledge & authority. The CSP to discuss and agree actions to improve these issues.	Local Authority - CSP	To be compiled by the CSP	July 2013	
4. The terms of reference for future DHRs going forward needs to contain	Local - CSP	Initial meetings of the DHR Panel needs to consider using other relevant background	Local Authority as Chair of the Community Safety	To be actioned, as part of the next DHR.	Next DHR	

Recommendation	Scope of Recommendation i.e. Local National	Action to take	Lead Agency	Key Milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
mention of relevant background information such as court transcripts, where appropriate. In addition, again where appropriate, an early invitation from the DHR to the Police's Senior Investigation Officer is built into the terms of reference of DHRs.		information such as court transcripts In addition, an early invitation to attend the DHR by the police's Senior Investigation Officer is built into the future terms of reference of DHRs where appropriate.	Partnership			
5. The Home Office will be asked through this review to consider whether the support services for victims of domestic violence should be further promoted at borders and through the activities of the UKBA.	National Regional – Home Office – UK Border Agency	The Home Office is asked, through this review, to consider whether domestic violence support services are sufficiently promoted at UK borders.	Home Office – UK Border Authority	To be compiled by the agencies involved	To be established	
6. The Home Office will be asked to note	National – Home Office – UK Border	The Home Office is asked to note that the	Home Office – UK Border Agency	Going forward an IMR is received for any	To be established	

Recommendation	Scope of Recommendation i.e. Local National	Action to take	Lead Agency	Key Milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
that the UKBA did not supply an IMR for this DHR. However a witness statement was produced. This is also referred to in Recommendation 2.	Agency	UK Border Agency did not supply an IMR for this DHR. This is also referred to in Recommendation 2.		future DHRs.		
7. The Crown Prosecution Service (Essex) did not supply an IMR for this DHR. A one page letter was received subsequently. The Attorney General's Office to be contacted, this may well be best through the Home Office initially. This is also linked to Recommendation 2.	Regional	The Home Office is asked to note that the CPS (Essex) belatedly, supplied a letter with some details however they did not supply an IMR for this DHR. This is referred to in Recommendation 2.	Home Office –CPS (Essex)	Going forward an IMR is received for any future DHR's.	To be established	
8. The Community Safety Partnership needs to review, post	Local	The Community Safety Partnership reviews when it next	Local Authority - CSP	Appropriate representation achieved for DHRs	July 2013	

Recommendation	Scope of Recommendation i.e. Local National	Action to take	Lead Agency	Key Milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
1 April 2013, the most suitable strategic partner representative following significant organisational and governance changes concerning the Department of Health and Public Health England.		meets post the 1 April 2013 the most suitable strategic partner representation from Health. This further to recent legislative NHS reforms.		post 1 April 2013		
9. It is recommended that Health's informatics access arrangements are reviewed in relation to DHRs. This to reach certainty as to whether health access via Walk in Centres, for example, or Accident and Emergency are recording information that may be relevant to DHR cases and their interface with	Local	The Community Safety Partnership reviews, when it next meets post the 1 April 2013, the degree to which informatics held in various Health services locally can be accessed to benefit DHRs	Local Authority - CSP	Future DHRs are provided with more certainty as to whether Domestic Homicide victims have used Health Services so that this information can be analysed and utilised to inform the DHR Panel deliberations regarding predictability and preventability judgements.	July 2013	

Recommendation	Scope of Recommendation i.e. Local National	Action to take	Lead Agency	Key Milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
nationally held data sets.						

Home Office

Safeguarding & Vulnerable People Unit
2 Marsham Street
London
SW1P 4DF

T **020 7035 4848**
F **020 7035 4745**
www.homeoffice.gov.uk

Timothy Wheadon
Chief Executive of Bracknell Forest Council
Chair of the Bracknell Forest
Community Safety Partnership
Easthamspstead House,
Town Square
Market Street
Bracknell
Berkshire
RG12 1AQ

23 April 2014

Dear Mr Wheadon,

Thank you for submitting the revised Domestic Homicide Review (DHR) report from Bracknell Forest Community Safety Partnership (Case TS) to the Home Office Quality Assurance (QA) Panel. I apologise for the delay in getting back to you.

The QA Panel would like to thank you for conducting this review and providing them with the final report. In terms of the assessment of DHR reports the QA Panel judges them as either adequate or inadequate. It is clear that a lot of effort has gone into revising this report, and I am pleased to tell you that it has been judged as adequate by the QA Panel.

The revised documents provide clarification and amendments on most of the points we raised in our previous response to you. However, the Panel felt the reference at paragraph 65 to "...charges for criminal offences at that time" would benefit from additional text to clarify who was charged, and what the offences were, or alternatively to note if this was not clear to the DHR Chair, before you publish the final report.

We do not need to see another version of the report, but I would ask you to include this letter as an appendix to the report when published.

Yours sincerely,

Christian Papaleontiou, Acting Chair of the Home Office Quality Assurance Panel

Head of the Interpersonal Violence Team, Safeguarding and Vulnerable People Unit