Bracknell Forest

Community Safety Partnership

Domestic Homicide Review

Overview report into the death of Andrius in September 2013

October 2014

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Introduction

1. This Domestic Homicide Review (DHR) was commissioned by Bracknell Forest Community Safety Partnership (CSP) in response to the death of Andrius in Bracknell in September 2013.

2. Andrius was a resident of Bracknell Forest prior to his death. This Review will focus on the period from Andrius' arrival in the UK at the end of 2012 until his murder in September 2013. It will consider the contact and involvement of relevant agencies with Andrius and the perpetrator, Illya.

3. The intention to undertake this review was notified to the Home Office on 3 February 2014 by the Chair of the Bracknell Forest CSP.

4. The key purpose for undertaking DHRs is to learn lessons where a person has been killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to understand fully what happened, and most importantly, what needs to change in order to reduce the risk of such tragedies happening again.

Confidentiality

5. The Overview Report and Executive Summary are made publically available. Individual Management Reports are not. Published documentation is anonymised to protect the identity of the victim, perpetrator, relevant family members, staff and others and to comply with the requirements of the Data Protection Act 1998.

The Chair of the Domestic Homicide Review and the Report Author

6. Martin Gocke worked as a Chief Officer of Bracknell Forest Borough Council working in education and children's services until May 2010. He presently works as an independent consultant and has extensive experience of chairing similar reviews, conducting investigations and the preparation of reports. He was nominated for the role by the Chair of the Bracknell Forest Community Safety Partnership and appointed by the Domestic Homicide Review Panel at its first meeting in May 2014.

7. The Community Safety Manager for Bracknell Forest Council, Ian Boswell provided support to the Chair.

The Domestic Homicide Review Panel

8. This comprised representatives from Thames Valley Police; Bracknell Forest Council through the Community Safety Manager and the Head of Housing Needs; Berkshire Women's Aid; Victim Support, Bracknell; and Bracknell Forest Community Mental Health.

Background to the homicide

9. Andrius was aged 24 at the time of his death. He died late in the evening of 20 September 2013, in a rented property in Bracknell. A post mortem examination established that the cause of death was a single stab wound, 13cm deep, which had pierced his heart.

10. Also resident in the property at the time of the homicide was the perpetrator, Illya and two other male tenants. Andrius and Illya had only recently moved to this property (4 August 2013) and subsequently spent approximately five weeks abroad together. They were not well known to the other tenants.

11. Illya and Andrius first shared a property from sometime in June 2013 (precise date unknown).

12. Illya, aged 31 at the time of the crime, was found guilty at Reading Crown Court and sentenced to life imprisonment with a minimum term of fifteen years on 14 February 2014. Throughout his trial Illya continued to maintain that Andrius had committed suicide. Prior to sentencing, Illya's defence counsel stated, in mitigation, that he was in a state of emotional crisis, compounded by excessive alcohol consumption, aware that a relationship was about to end. The defence counsel stated that Illya had been the dominant partner in the relationship and that he had both helped, and cared for Andrius.

13. Andrius had very limited contact with any agency, and these contacts were not related to the homicide. Illya had significant contact with health and police: the root cause of all of these contacts was alcohol related.

14. 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 Panel was established with an Independent Chair. The DHR Panel (the Panel) met on three occasions between May and late August 2014.

15. With no direct witnesses to the murder or more specific information and defence from the perpetrator it is purely speculative as to exactly what triggered the homicide on 20 September 2013.

Domestic Homicide Reviews

16. The rationale underpinning Domestic Homicide Reviews is set out in the Domestic Violence, Crime and Victims Act 2004. It became a legal requirement for reviews to be conducted from April 2011. They do not replace, but are in addition to, the inquest or any other form of inquiry into the homicide.

17. The main document to guide the review team is the guidance[1] issued by the Home Office as statutory guidance under section 9(3) of the Domestic Violence,

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

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.

18. It is clear that the death of Mr AV falls within both parts of this definition.

Purpose of Domestic Homicide Review (DHR)

19. The purpose of a Domestic Homicide Review is to:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted 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.

The Review report itself and what happens to this

20. The format of the report 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.

21. This report is designed to consolidate the lessons learnt for all the agencies involved into a composite document. It allows all interested parties to readily understand the key organisational learning points and any corrective actions. It is also designed to hold parties accountable for making improvements where these have been acknowledged and agreed.

22. Home Office guidance states *'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.'

Background

23. Victim and perpetrator were both non-UK nationals. The victim, Andrius, was Latvian and the perpetrator: Illya was Lithuanian. They lived transitory existence. Neither had family in the UK. Attempts have been made by the Panel to contact the family of the victim in Latvia but no response has been received. The Panel has received information from the landlords of properties in which both are known to have lived but has been unable to gather reliable information about any friends or work colleagues that might help in establishing the true nature of the relationship between them and any informal history that might have enabled the tragic events of 20 September 2013 to have been predicted and prevented.

24. More can be established about the perpetrator, Illya, than the victim. The former had been in the UK for a longer period, had had contact with statutory services, and his recent employment and housing history have been slightly easier to establish. He has also revealed his history in interviews with a number of health service professionals in particular, and a picture of his time in the UK can be broadly established and corroborated with agency records.

25. Almost nothing is known of Andrius. His movements are not traceable before December 2012. There are no records of his entry to and exit from the UK or detail of accommodation and employment before that date. There are no health records that have come to light as a result of the work of the Panel. There is some involvement with the criminal justice system that occurred on previous visits to the UK, and there is some background information that has been provided by the perpetrator.

26. A chronology highlighting key events leading to the homicide has been drawn together and this is included as Annex A to this report.

Andrius

27. Andrius was born in Latvia in January 1989. This review has been able to uncover very little information about him and his life. According to his brother, with whom the police investigation team had some contact prior to the trial, he first came to the UK when he was 19 (in approximately 2008).

28. In a conversation with his landlord, in September 2013, Andrius stated that he went home once per year to visit. Of note, in this conversation, he referred to his girlfriend in Latvia with whom he had a three-month-old daughter (birth date approximately May/June 2013) and he was communicating with this girlfriend on Skype in early September.

29. Andrius had contact with the criminal justice system in 2008 when he was charged with sexually touching a six-year-old female and slapping her, causing minor cuts. He was found not guilty at Snaresbrook Crown Court (North East London). He received a caution in Sussex in 2009 for attempted theft.

30. There is no employment history available that would enable his movements to be traced in the UK, nor is there any information regarding accommodation prior to December 2012 available to the Panel. There are no records held by the UK Border Agency that enable entry and exit to the UK to be tracked. He had no family in the UK. No friends have been identified.

31. According to his brother, he came to the UK again in January 2013. Employment records in Bracknell indicate that this may have actually have been December 2012 and this ties in with information from private landlords locally and information provided by himself to Bracknell Forest Council Housing Services.

32. It is not possible to confirm why he came to Bracknell or if he had been here before. In an interview conducted by a Forensic Psychiatrist in September 2013, Illya stated that he had been in a relationship with Andrius for approximately a year[2] and that Andrius had been brought over to the UK by a gang from Lithuania and was 'in crisis' – no job, no money. There is a suggestion in the police report of an incident in Bracknell in May 2012 that Andrius was present but this is not based on contemporaneous information and is a supposition arising out of the TVP IMR based on erroneous information, later retracted.

33. From December 2012, Andrius was employed at [redacted] distribution centre in Bracknell through [redacted] employment agency. Illya also worked here and it is possible that he provided Andrius with an introduction to this employment.

34. At that time Illya and Andrius were living in separate addresses in Bracknell, albeit in close proximity to each other. Both were living in properties with other east European nationals and it is likely that they shared a group of acquaintances within this community.

35. The first record of them living together in the same property is in June 2013, when Andrius moved to 25 [redacted], shortly joined by Mr IS.

Illya

36. Illya was born in Lithuania in 1982. He has given various accounts of when he first came to the UK – according to information provided to East London Mental Health Trust, it was early 2011, according to information provided to Berkshire Healthcare Foundation Trust it was during 2008/9. It is possible that he entered and exited but no records are available to substantiate this from UKBA. It is most likely that he first entered around 2008/9 and remained after that due to his self reported relationship history.

37. He describes himself as a 'gay' man, but in his interviews with health professionals he clearly struggles with this concept. He describes a relationship

[2] It should be noted that there are frequent discrepancies in time periods and dates in Illya's various statements. His ability to communicate in English and his reportedly excessive alcohol consumption, plus the instability of his lifestyle in the UK are undoubtedly contributory factors in this.

that lasted for two years in London, until his partner committed suicide by jumping in front of a train in early 2012.

38. He self reported that he was involved in a number of unskilled jobs in London, but there are clearly periods of unemployment and homelessness whilst he was living there.

39. He had limited contact with the criminal justice system prior to the murder. He received two cautions for being drunk and disorderly and for unacceptable behaviour on the railway in December 2011 (both London), a conditional discharge for theft in 2012 (London), and received a not guilty disposal for handling stolen goods in April 2012 (North London Magistrates Court).

40. He has had other contact with the police in London, mostly relating to excess alcohol consumption and has been involved in two incidents where police attended his home address in Bracknell after May 2012.

41. His alcoholism and associated suicidal thoughts have led to frequent contact with health services.

42. In March 2012 he attended the Royal London Hospital A&E. He was treated and discharged. Two days after this discharge he presented at a police station with suicidal thoughts and was taken to the City and Hackney Centre for Mental Health (CHCFMH). He was a patient here for a period of seven days, discharged on 29 March 2012. He was taken again to Royal London Hospital A&E following an assault in late April 2012.

43. In December 2012 he was taken by ambulance to Wexham Park Hospital, Slough as a result of excess alcohol consumption and was referred to Berkshire Healthcare Foundation Trust who later made two home visits before discharging him.

44. Employment history is difficult to trace – he claims to have worked in Greenford, Middlesex for a period of 3 years in airport catering. If this is true, it took place before he relocated to east London.

45. He claims to have worked at [redacted] for several years. It is known that this employment started no earlier than his move to Bracknell in May 2012. Employment records for Illya will not be released by [redacted] due to their interpretation of the Data Protection Act. Records provided directly by [redacted] show him starting on 30 April 2012. Of note, very soon after his being assaulted in east London.

46. Illya lived in unsecured accommodation in Bracknell, first in B[redacted], then in a caravan in the garden of 2 [redacted] Road and then in the same property as Andrius at 25 [redacted].

The relationship between Andrius and Illya

47. There is limited information about the relationship between Andrius and Illya. Much of it comes from the account of Illya in interview and accounts given at different times vary considerably. The Panel was unable to form a clear view about the precise nature of the relationship.

48. From Andrius' most recent arrival in the UK to the time of his death is a period of approximately 10 months. Victim and perpetrator rented the same properties for a period of 14 weeks up until the time of the homicide.

49. It is likely that Andrius became known to Illya shortly after he arrived in Bracknell through links within the east European community. That Andrius secured employment at [redacted] where Illya was already working is probably not a coincidence.

50. There is no record of Andrius having a bank account. It was Illya's account that was used to make and receive payments from Bracknell Forest Council and into which Andrius's wages were paid. Illya refers to Andrius looking for his (Illya's) banking details in advance of attempting to arrange a loan. It appears that Illya controlled the income of Andrius. Illya continues to be concerned about withdrawals from the account by the Council to repay loans made to both men.

51. Andrius and illya went to Latvia on 28 or 29 July 2013 and returned on 5 September 2013. It is not clear where they stayed or what they did but the trial reports indicate that they met with Andrius' brother and his partner E[redacted]. Trial reports also indicate that a relationship formed between E[redacted] and Andrius whilst there. Andrius was later seeking to bring his girlfriend from Latvia to the UK and was asking Illya to help arrange the necessary documentation. It is not clear to the Panel if this is E[redacted] or the mother of his child or they are one and the same.

52. There was reported friction in the relationship but there is no evidence of physical violence. Other tenants report 'low level arguing and grumbling' – all conducted in a language other than English. The arguing reached a new intensity on the night of the murder, with a witness saying that he heard the older male, Illya 'really shouting for a long time at the younger male, Andrius.

53. Andrius died on the evening of 20 September 2013. The cause of death was a single stab wound, 13cm deep, which had pierced his heart. Victim and perpetrator had been together for the evening and still were when police officers arrived. Illya was arrested at the scene, detained under Section 2 of the Mental Health Act, released into police custody and immediately charged with the murder on 3 October 2013.

54. At the trial, Illya was described as the dominant partner in the relationship and there is some evidence of a controlling and possibly abusive relationship. Andrius was vulnerable and the Panel concluded that Illya probably took advantage of this. There is no definite way of determining Mr Andrius' sexuality.

The Panel considered that both parties may have had entirely different understandings of the nature of the relationship.

Terms of reference for the review

55. These were to:

- Establish the facts that led to the homicide on 20 September 2013 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 September 2013.

- 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.

56. The Panel was clear in its understanding that Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable: these are matter for the police, coroners and criminal courts.

The scope of the Review

57. The Review will:

- Seek to establish whether the incident on 20 September could have been predicted or prevented.

- Consider the period since the deceased entered the UK prior to the event, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

- Request Independent Management Reviews by each of the agencies defined in Section 9 of the Act, and invite responses from any other relevant agencies or individuals identified through the process of the review.

- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of events.

- Provide a report for the CSP which summarises the chronology of events, including the actions of involved agencies, analysis and comments on actions

taken and makes any recommendations regarding safeguarding of families and children where domestic abuse if a feature.

- Aim to produce a report by the end of August 2014 subject to IMRs being completed and the potential for identifying matters, which may require further review.

58. The Review will seek to involve the family of both the victim and the perpetrator in the review process.

Establishing a Review Panel

59. A review team was appointed by the Chair of the Bracknell Forest Community Safety Partnership. The Membership followed the statutory guidance and an Independent Chair with relevant experience was appointed to oversee and take forward the Domestic Homicide Review.

60. Core Members of the Panel were representatives from Thames Valley Police; Bracknell Forest Council through the Community Safety Manager and the Head of Housing Needs; Berkshire Women's Aid; Victim Support Bracknell; and Bracknell Forest Community Mental Health.

61. The review was conducted between May and August 2014. During this period the Review team met on 7 May. 18 June, and on 5 August 2014.

62. The function of the Panel is to shape and consider an Overview Report. This aims to bring together and draw overall conclusions from the information and analysis contained in the Independent Management Reviews (IMR) and is informed by the professional expertise of the Panel members. The review of IMRs and ancillary information also raised questions and actions for further investigation during the life of the panel.

Individual Management Reports (IMRs)

63. The Chair of the Review Panel wrote to the senior manager in each of the relevant agencies to commission from them an IMR. The IMRs form part of the information considered in preparation of this Report.

64. IMRs were requested from

    (a) Bart's Healthcare Foundation Trust
    (b) East London NHS Foundation Trust
    (c) Thames Valley Police
    (d) Berkshire Healthcare Foundation Trust
    (e) Bracknell Forest Council Housing Needs Team

    being the agencies with whom either the victim or the perpetrator had had contact. Appropriate responses were received from all agencies

65. 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.

66. Andrius had almost no engagement with statutory or voluntary agencies. It has not been possible to trace any engagement with a General Practitioner or other medical services. He has previously had some contact with the criminal justice system, and additionally with the police. This is documented. More recently, he had contact with Bracknell Forest Housing Services.

67. The focus of IMRs has therefore primarily been on agency engagement with Illya.

68. Illya has had engagement with the NHS – he had a GP in London and also in Bracknell, he was seen at acute hospital trusts and also engaged with two mental health trusts. He also had contact with the Metropolitan Police and Thames Valley Police unrelated to the homicide and with Bracknell Forest Housing Services.

69. Of note, the IMRs provided were generally of high quality and conformed with Home Office guidance.

Further information sources

70. The Panel was provided with a copy of the assessment report on Illya produced by a Forensic Psychiatrist following an interview with him on 26 September 2013. At the time, he was detained under Section 2 of the Mental Health Act.

71. Information was also sought from the victim and perpetrator's private landlords in Bracknell and their employer, [redacted] Employment Services. Further enquiries were made at the company where both men most recently worked.

72. Witness statements pertaining to the prosecution of IS were supplied by the police to assist the Panel. These statements were provided by the landlord's agent who was a regular visitor to the property where the homicide took place and another tenant of the property.

73. A Domestic Homicide Review conducted in Bracknell Forest in 2012/13 had requested an IMR from the UK Border Agency in order to seek to ascertain the entry and exit of the victim in that case. Information supplied indicated that no tracking information was held of the movements of EU nationals. At the request of the Panel, a similar enquiry was made of the UKBA with regard to the victim, Andrius. The same response to this enquiry was received and it has therefore not been possible to be definite about Andrius' precise entry date to the UK in December 2012/January 2013 or previous visits.

74. A letter, appropriately translated was sent to the only known relative of the victim. This was either a brother (or half-brother) living at an address in Latvia. No response has been received. The only information that we have therefore is that supplied to the police as part of their investigations.

Information provided following requests for IMRs

(a) Bart's Healthcare Foundation Trust

75. Information was sought in respect of Illya. An IMR was not supplied but copies of admission and discharge notes were. Illya was treated at A&E at the Royal London Hospital.

76. A&E Forms indicate that Illya was treated on two occasions at the hospital, firstly on 20 March 2012 and secondly on 28 April 2012. On both occasions, the underlying issue was intoxication. On the second occasion Illya had additionally been assaulted and had sustained a head injury.

77. Each time, he was discharged following routine investigations, treatment and advice.

78. The first of these occasions was two days before he was admitted as a patient at the City and Hackney Centre for Mental Health (CHCfMH) (East London NHS Foundation Trust) on 22 March 2012 (see below). The second occasion (28 April 2012) was just under one month after his discharge from CHCfMH (29 March 2012).

79. There is no evidence in the notes provided of any investigation linking his later treatment at the Royal London and his recent admission to CHCfMH.

Conclusions

80. There is no indication that Illya presented a risk to others.

81. The Panel concluded that three hospital episodes in quick succession should have provided more of an alert to the needs of Illya.

(b) East London NHS Foundation Trust

82. Information was sought in respect of Illya. A Serious Incident Review Report was supplied.

83. Illya had presented at Homerton Hospital A&E (Homerton University Hospital NHS Trust) on 22 March 2012. He was properly assessed and admitted to the City and Hackney Centre for Mental Health (CHCfMH).

84. The diagnosis was 'alcohol dependence and an adjustment reaction'. He was treated and discharged (on 29 March 2012) with a recommendation that his GP be requested to facilitate bereavement counselling, with an interpreter, and further that an outpatient appointment be arranged with North Hackney CMHT (Community Mental Health Team).

85. A discharge notification form and a discharge summary were uploaded in Illya's case record but the GP surgery has no record of receiving either and there is no conclusive evidence that it was sent. Bereavement counselling was therefore not offered and no other follow-up action was taken by the GP.

86. Nor was the outpatient appointment offered. If it had been, this would have provided an opportunity to review the risk management and care planning for Illya and would have clarified whether or not the GP surgery had taken forward the recommendation for bereavement counselling.

Conclusions

87. There is no evidence that Illya, in any risk assessment conducted, presented a threat to others. The main focus of treatment, care and care planning was his own well-being.

88. Opportunities existed to provide Illya with on-going support but these were missed. Given the history of Illya's alcohol dependence it is debateable whether he would have cooperated and that such intervention would have prevented later hospital attendances, but excessive alcohol consumption and bereavement reaction are a recurring theme.

89. Those conducting the review at East London NHS Foundation Trust have made a number of recommendations regarding the transmission of information to GPs and protocols for the arrangement of outpatient services following discharge.

90. Whilst there are some issues that this Trust will address, the Panel concurs with the opinion of the assessors that there is no evidence that the Trust could have predicted or prevented the events of September 2013.

(c) Berkshire Healthcare Foundation Trust (BHFT)

91. Information was sought in respect of Illya. An Internal Management Review was supplied.

92. Illya was taken to Wexham Park, Slough A&E by ambulance on 7 December 2012. The ambulance had been called by a friend (not Andrius) who had become concerned by his behaviour following a period of heavy drinking.

93. He was referred to the BHFT Urgent Care Team (UC) for assessment. A Safeguarding Risk Assessment was conducted and a further Risk Assessment form was completed which indicated evidence of risk factors relating to alcohol use and current mental state, but no known risk of self-harm, harm to others or harm from others.

94. No interpreter was present and it is noted in the IMR that this would have been desirable, but on the basis of Illya's presentation, the conclusion of the IMR author was that a prompt assessment followed by a home visit with an interpreter present four days later was an appropriate plan of action.

95. Illya was visited at home on 11 December 2012. An interpreter was present and the author of the IMR reports that the notes of the assessment included a detailed consideration of Illya's needs and a further assessment of risk of self-harm, harm to others or harm from others.

96. Following this visit a decision was made to discharge Illya with a plan for him to self-refer to alcohol services in Bracknell (New Hope). A further home visit was conducted, on 14 December 2012, before Illya was finally discharged. A discharge letter was sent to the GP and to Illya on 17 December 2014.

Conclusions and recommendations

97. The IMR author concluded that judgements made about Illya were sound and the way in which he was dealt with were appropriate.

98. A number of points emerged from the IMR, however. Firstly, it would have been more helpful if an interpreter had been present at the initial assessment. Illya's command of English and the ability of others to understand him is frequently evidenced. Secondly, it would have been appropriate to check the previous psychiatric assessment in London (CHCfMH), 2012 before discharge. Thirdly there was no updated risk assessment conducted before discharge. The report author is confident, however, that risk issues were adequately evidenced in the assessors notes.

99. There was no follow-up to the recommendation that Illya self-refer to alcohol services in Bracknell. He did not. It is noted in the IMR that there has been a change of practice so that this is now routinely done in similar circumstances. Whilst this may have prompted engagement by Illya, there is a contrary view that in order for interaction with such services to be successful, it is *'the client's motivation to engage with the service, not the other way round'* that is most effective.

100. Whilst there are some issues that the Trust will address, the Panel concurs with the opinion of the report author that there is no evidence that BHFT could have predicted or prevented the events of September 2013.

(d) Thames Valley Police (TVP) (Illya)

101. Information was sought in respect of contact with both Illya and Andrius. An Individual Management Review was supplied.

102. The IMR stated that both the victim and the perpetrator had records of previous involvement with the criminal justice system on the Police National Computer (PNC). These incidents fell outside the time period of the Review but were considered by the Panel as essential background information regarding the perpetrator in particular.

103. There were two incidents where attendance was requested to properties in Bracknell involving Illya, prior to the homicide on 20 September 2013.

104. The first incident occurred in May 2012 – Illya was intoxicated, feeling low and suicidal. Illya reportedly had a knife. A friend called the Ambulance Service who then requested police support. An immediate response was given. Attending officers found two males drinking quietly in the garden, there was no sign of a knife or evidence of intention to self-harm. The officers spoke to both men, reassured themselves of the situation and then left.

105. The second incident was in early June 2013. Illya was complaining about access to the property where he was living because of others drinking – he was renting space in a caravan in a garden at the time. Police activated an urgent response. Whilst Illya did have a knife (was preparing food at the time) there is no suggestion of him threatening anyone with it.

106. Illya also stated that he was being bullied because he was 'gay'. All other males present denied this. The officers resolved the issue and left.

107. The Panel considered that it was very unlikely that the victim, Andrius, had been present at either of these events. This follows discussion with the landlord (same landlord, both properties) and a retraction of information previously supplied by Bracknell Forest Housing Services that linked him financially to the first of the properties.

Conclusions and recommendations

108. The author of the TVP IMR determined that attending officers had handled the first incident appropriately and there were no learning points.

109. In interview the officer attending stated, however, that current practice would be to create a CEDAR Report for Adult Protection. This procedure was confirmed by the TVP Mental Health lead. No check was made with the Community Mental Health Team to see if they knew Illya. A name check on the PNC for Illya indicated that he had a chronic drink problem; it would also have indicated

that he was considered to be a suicide risk. He would not, at this stage, have been known to the local CMHT.

110. TVP Force policy states that the second incident should have been treated as a homophobic incident and recorded on CEDAR as such. Currently, that would have triggered follow-up visit from a Lesbian/Gay Transgender Liaison Officer LAGLO (a post did not exist at the time of the incident).

111. The Panel queried the fact that a knife was mentioned in relation to both incidents. In the first, officers attending did not see a knife and the atmosphere was calm. In the second, the perpetrator was using a knife for food preparation and none present indicated that it was used in a threatening way. Both incidents occurred on private property.

112. In neither incident was there an indication that the perpetrator, Illya, posed any risk to others.

113. TVP have taken appropriate action regarding the implementation of their policies and there are no further recommendations from the Review Team.

114. Whilst there are some issues that TVP will address, the Panel concurs with the opinion of the report author that there is no evidence that TVP could have predicted or prevented the events of September 2013.

(e) Thames Valley Police (Mr AV)

115. In the same IMR, TVP recorded their interaction with the victim, Andrius.

116. This followed Andrius reporting a burglary and the theft of a mobile telephone from his room at 25 [redacted] on 15 July 2014.

Conclusions

117. The author of the IMR concluded that the incident had been properly dealt with and that there were no learning points from the incident.

118. There is no mention Illya being present or otherwise involved in this incident and the Panel concluded that it had no relevance to this DHR.

(f) Bracknell Forest Housing Services (IS and AV)

119. An IMR was requested from Bracknell Forest Housing Needs Team in respect of both Illya and Andrius.

120. Illya and Andrius attended Housing Services for housing advice in June 2013. They stated that they were living in poorly managed and overcrowded accommodation. Housing Services knew of the landlord and property.

121. Both men were advised to move to accommodation with a secure tenancy. Such accommodation was available with a landlord in whom Housing Services had confidence. Illya and Andrius were each supported with rent deposit and

rent in advance loans for tenancy in a privately rented, shared house in [redacted], Bracknell.

122. Illya and Andrius had separate tenancy agreements for separate rooms in the property and were provided with separate loan agreements.

123. Andrius confirmed that he did not have his own bank account and that his wages were paid into Mr IS's account. The monthly direct debit to repay the deposit and rent in advance loan were therefore set up to be paid for from Illya's account.

Conclusions and recommendations

124. Bracknell Forest Housing provided good support to men who were in poor, unsecured accommodation.

125. Interview notes with the two applicants are confusing and led the Panel initially to some erroneous conclusions about the length of the relationship between the two men and this is also reflected in the TVP IMR. Illya's poor language skills and the transitory nature of both men's histories contributed to these misunderstandings.

126. The financial arrangements between the victim and the perpetrator were accepted at face value. Such an arrangement is characteristic of a controlling relationship and the Panel recommend that agencies should seek more assurances in such circumstances.

Information from other sources

127. The Panel have sought to be clear about the relationship that existed between the victim and the perpetrator through conversations with and reviewing evidence presented by other parties outside the IMR process.

128. Private landlords have provided information about the tenancies of Andrius and Illya. Much of this information is unreliable.

129. Through corroborating the information with other sources, it is clear that the period in which they lived together in the same properties was short – from 3 June 2013 to the 20 September 2013, a period of 16 weeks, four weeks of which were spent in Latvia with family members of Andrius.

130. None of the landlords report anything that might be construed as a violent or abusive relationship between the two men. Information provided by other tenants indicates nothing more than some low level arguing from time to time between them.

131. Employer information indicates that there was nothing of concern in the relationship at work. The Head of Security at the company were they were employed reported that they 'kept their heads down' and gave no cause for concern.

132. No information has been provided by family members and the Panel has been unable to establish whether there were any friends from whom further information could be sought.

Conclusions of the Panel

133. Members of the Panel noted that the murder of Andrius occurred on 20 September 2013 and that this DHR report has not been completed within the timescale as set out in the Home Office DHR guidance, Section 5, paragraph 42. This was due to a delay in fully understanding the particular circumstances that led to this death being identified as a domestic homicide, identifying a suitable Panel Chair and the complexities of establishing the contacts that both the victim and perpetrator had had with service providers in Berkshire and London as they were both recent immigrants to the UK and records of their movements were difficult to ascertain. Attempts were also made, without success, to establish contact with the victim's family in Latvia.

134. The Panel is satisfied that this protracted timescale has not had any adverse impact on taking actions identified through the process.

135. Throughout this Review it has been striking how little has been known about the victim, Andrius. He had limited contact with statutory agencies in the short period that he lived in Bracknell Forest. He had no involvement with a GP that can be established. Despite extensive efforts, the Panel has been unable to trace his movements in and out of the UK and has no clear understanding of how he ended up living in Bracknell.

136. The Panel noted that there are no records maintained by UKBA that allow for entry into and out of the UK by other EU Nationals are maintained.

137. The Panel noted the difficulty experienced in obtaining employment records for the victim and the perpetrator. The employer cited the Data Protection Act as a reason for not releasing requested information. Advice was sought from the Home Office Domestic Violence Policy Team on this point. A number of helpful suggestions were received and these enabled the Panel to establish sufficient information for the purposes of this Review.

138. The nature of his relationship with Illya has been considered by the Panel. The perpetrator has described himself as a homosexual and has painted a picture of the relationship from his perspective. Through this Andrius appears to have been vulnerable and Illya claims to have supported him to find employment and evidently had an interest in the way in which his finances were managed.

139. It is impossible to ascertain the nature of the relationship from Andrius' perspective. There are a number of contradictions and information presented at the trial indicates that Andrius was seeking to end any relationship that did exist.

140. Illya had much more contact with statutory agencies. He was also vulnerable, with a history of alcoholism; homelessness and unsecure accommodation; unemployment and contract work; and a poor command of English. Mostly agency contacts focussed around the after effects of heavy drinking.

141. Appropriate risk assessments were included as part of all of these contacts. There has been no suggestion in any of the reviews conducted by these

agencies that Illya presented a risk to others. The focus of all of them has been his personal well-being.

142. The aim of this Review has been to look openly and critically at individual and organisational practice and the context within which people were working and to see whether the homicide indicates how changes should and could be made. The two key issues of predictability and preventability have been considered as underpinning themes.

143. The Panel noted that mostly comprehensive and high quality IMRs were supplied by the agencies that completed them.

144. Each of the IMRs has indicated good practice in their dealings with mostly the perpetrator but also the victim. They have also identified ways in which practice could be improved. Mostly these revolve around ways in which the issues presented by Illya's alcoholism could have been better addressed. In order for them to have had any impact, they would have needed a willing and cooperative client. The transitory nature of Illya's existence would make intervention challenging.

145. The Panel noted the fact that incidents of Illya receiving medical interventions were largely not linked to each other by health authorities: a comprehensive picture of his on-going needs was not identified.

146. The Panel also noted that this is the second Review of a domestic homicide in Bracknell Forest in recent years that relates to foreign nationals, including those form the EU. It is striking that there is an overlap and closeness of the geographical proximity of relevant addresses in both cases. They highlight an existence that most residents of Bracknell Forest would not recognise. Similar issues arise in both cases with regard to the tenancies of victims and perpetrators and the difficulty in establishing contact and engagement with the communities concerned. **These matters should be an issue for discussion at the Community Safety Partnership**.

147. A summary of recommendations contained in IMRs and considered by the Panel is set out in Annex B.

148. The Panel concludes that there is no evidence that the homicide could have been predicted by any of the agencies involved or could have been prevented by any action that they might have taken.

Annex A

Chronology of key events

Date	Event	Source of information
2008/9	Illya first enters the UK. Living in London	Self reported by Illya in several interviews. Different accounts are given at different times. It is impossible to be definitive as no records are available from UKBA
Dec 2011	Illya receives two separate police cautions in London: Drunk and disorderly	Thames Valley Police IMR
20 March 2012	Illya treated at Royal London A&E: intoxicated	Bart's NHS Trust records
22 March 2012	Illya admitted to CHCfMH: heavy drinking and suicidal thoughts	East London NHS Foundation Trust IMR
29 March 2012	Illya discharged from CHCfMH	East London NHS Foundation Trust IMR
2 April 2012	Illya receives police caution in London: handling stolen goods	Thames Valley Police IMR
28 April 2012	Illya treated at Royal London A&E: intoxicated and assaulted	Bart's NHS Trust records
30 April 2012	Illya commences work at [redacted] distribution centre in Bracknell. Living at 13 [redacted]	Employer records Confirmed by landlord (FN) Bracknell Forest Housing Benefit Records
21 May 2012	Incident at 13 [redacted], Bracknell (URN65). Police called to assist intoxicated male (Illya) with a knife threatening suicide	Thames Valley Police IMR
4 December 2012	Andrius commences work at Waitrose distribution centre in Bracknell Living at [redacted], Bracknell	Employer records Confirmed by landlord (A[redacted])
7 December 2012	Illya taken by ambulance to Wexham Park Hospital and assessed by BHFT Urgent Care	Berkshire Healthcare Foundation Trust IMR
11 December 2012	Illya assessed at home by BHFT Urgent Care nurse 13 [redacted], Bracknell	Berkshire Healthcare Foundation Trust IMR

14 December 2012	Illya seen at home by BHFT Urgent Care nurse 13 [redacted], Bracknell	Berkshire Healthcare Foundation Trust IMR
20 January 2013	Andrius moved to 13 B[redacted] Road	Confirmed by landlord (A[redacted])
April 2013	Illya moved to 2 [redacted] Road	Confirmed by landlord (F[redacted])
2 June 2013	Incident at 2 [redacted] Road, Bracknell (URN1599). Police called to assist male (Illya) to access his property	Thames Valley Police IMR
3 June 2013	Andrius moved to 25 [redacted], Bracknell	Confirmed by landlord (A[redacted])
Later in June 2013	Illya moved to 25 [redacted], Bracknell	Confirmed by landlord (A[redacted]) Bracknell Forest Housing Needs IMR
June 2013	Andrius and Illya seek housing advice	Bracknell Forest Housing Needs IMR
30 June 2013	Andrius and Illya sign documentation relating to rent deposit and rent in advance loan	Bracknell Forest Housing Needs IMR
26 July 2013	Andrius and Illya move to 86 [redacted], Bracknell	Confirmed by landlords agent (A[redacted])
28 or 29 July 2013	Andrius and Illya depart for Latvia	Confirmed by landlords agent (A[redacted])
5 September 2013	Andrius and illya return from Latvia	Confirmed by landlords agent (A[redacted])
20 September 2013	Police attend reported stabbing at 86 [redacted] (URNxx) at 11.30pm	Thames Valley Police IMR
21 September 2013	Andrius declared deceased at 00.09am Illya arrested at the scene.	Thames Valley Police IMR

Annex 2

Summary of actions and Panel observations arising from IMRs

(a) Bart's Healthcare Foundation Trust

1. Not an IMR

2. No issues noted

Observations:

3. No evidence that any attempt was made to consider implications arising from hospitalisation at CHCfMH.

4. Linking these events may have caused a different treatment plan.

(b) East London NHS Foundation Trust

5. Issue 1: Transfer of information to GPs on discharge

6. Issue 2: Arrangement of out-patients appointments on discharge

Observations:

7. Actions to address these two issues are identified in the Report. The Report Author concludes that neither of these issues were contributory factors to the events that followed in 2010.

8. Illya's well-being and behaviour was significantly affected by his alcoholism. If out-patients appointments had been arranged, these might have contributed towards addressing this. He was intoxicated on the night of the murder.

(c) Berkshire Healthcare Foundation Trust

9. Issue 1: Lack of availability of a translator at the point of assessment. This was identified as a resource issue

10. Issue 2: Discharge without follow-up of earlier admission at CHCfMH in London.

11. Issue 3: Follow-up with alcohol service to see if IS had in-fact self referred.

12. Issue 4: Lack of follow-up risk assessment before discharge.

Observations:

13. Alcohol misuse played a significant part in the initial attendance of Illya at Wexham Park and his referral to BHFT. A check on his previous involvement with mental health services would have identified this as a recurring problem and may have led to different decisions at the point of discharge.

14. Again, the lack of engagement with services that might have helped Illya to address problems with alcohol was an opportunity missed.

15. There is a counter argument that Illya needed to engage with such services voluntarily for them to be effective. This is the second time that Illya was discharged following hospital treatment. It could be argued that on this occasion chances of success could have been greater as he was in reasonably stable employment and accommodation whereas before he had been homeless and jobless.

16. Recommendations in the report address issues 2,3 and 4.

(d) Thames Valley Police (IS)

17. Issue 1: A CEDAR record was not created for Adult Protection at the time of the first interaction between TVP and Illya.

18. Issue 2: At the second interaction, Illya made allegations relating to homophobia. The event was not treated as a homophobic incident and therefore an appropriate CEDAR Record was not completed.

19. Issue 3: A minor is reported to have been present in the property at the time of the murder. This emerged in the examination of the witness statements. There is no information about the support for the young person involved post event.

Observations:

20. Neither of the omissions highlighted in paragraphs 17 and 18 above were contributory factors in the events of September 2013. With regard to the first issue, current practice is that such a report would be completed. With regard to the second issue, the lack of recording is noted as an oversight. Additional resources are currently deployed in support of members of the lesbian, gay and trans-gender communities in the form of liaison officers. At the present time a record on CEDAR of a homophobic incident would prompt a visit from the liaison officer to offer support.

21. There is a potential safeguarding incident regarding a young person. There is no detail in the IMR of how this has been addressed. Subsequent discussions have indicated that this matter was handled properly and appropriate support was offered to the young person.

(f) Bracknell Forest Housing (Illya and Andrius)

22. An IMR was provided but this lacks analysis. Some questions over the quality of record keeping arise.

23. In subsequent discussions, it was agreed that the issue of the nature of the financial arrangements between the victim and the perpetrator should have been further questioned.

Observations:

24. Lack of questioning about unusual financial relationship was not a contributory factor to the events in September 2013.