STANDING together
against domestic violence

DOMESTIC HOMICIDE REVIEW

Southampton

"TL"

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1. EXECUTIVE SUMMARY

1.1 Brief facts leading to this Domestic Homicide Review (DHR)

1.1.1 In the summer of 2015 TL[1], a white male was killed by CF, also a white male. The case was concluded at a Crown Court the following year when CF was convicted of murder and sentenced to life imprisonment with a minimum term in prison of 22 years.

1.1.2 TL was an acquaintance of CF and had an informal flat sharing agreement with him which was the main basis of the relationship. The murder took place in this flat. The cause of death was multiple blunt force trauma.

1.1.3 Both TL and CF came to this country from Poland over 10 years ago.

1.2 The Review Process

1.2.1 Following an unsuccessful appeal to the Home Office based on extremely limited contact with the statutory sector and existing development plans around the Southampton approach to domestic violence and abuse, this “proportionate” DHR was commenced. (The fact that this review was deemed necessary is the subject of discussion within the report and a recommendation.)

1.2.2 In the absence of any meaningful contact with the statutory sector the Southampton Safe City Partnership (SCP) sought to explore any potential issues or learning for the partnership in relation to wider concerns or learning which may be affecting the Polish community.

1.2.3 An independent chair was appointed. This was Anthony Wills an associate of Standing Together Against Domestic Violence and a police officer for 30 years. He has also been a DHR reader for the Home Office, DHR reviewer and as a consultant delivering improved responses to domestic violence. He has no connection with Southampton apart from as a previous reviewer into cases in the City and an adviser to the domestic abuse partnership many years ago.

1.3 The Panel

1.3.1 This was established to respond to the likely outcomes of the review process and included representation with links to the Polish community. The members came from the following organisations:

- Hampshire Constabulary

[1] This report has been anonymised in order to avoid the identification of individuals involved. Family and friends chose not to participate in the process and random initials were therefore used to define those involved.

- Southampton City Council – Adult Social Care, Housing, Equality lead
- Southampton Safe City Partnership
- Strategic Lead for Domestic Abuse
- Southampton City Clinical Commissioning Group
- Integrated Commissioning Unit
- EU Welcome (an organisation supporting those who have migrated into Southampton from Eastern Europe).

1.4 Contact with family and friends

1.4.1 Much effort was expended to try to speak to the family of TL, his friends and acquaintances but this was to no avail. Letters asking them to participate were translated into Polish but this did not lead to contact. TL's family did not come to the UK for the trial. A letter was also sent to CF asking him to participate in this review but he has so far failed to respond to such a request.

1.5 Equalities

1.5.1 None of the protected characteristics apply in this case. The fact that both the victim and perpetrator were Polish males led to further consideration of issues facing this community.

1.6 The facts

1.6.1 On the night of the murder TL and CF had been at a party with friends. Some drinking and possible drug use had taken place. After leaving the party they made their way home to their shared accommodation where CF killed TL. No explanation has been given for this fatal assault.

1.6.2 There is extremely limited information about their relationship, the events leading up to the deadly assault and their lives in the UK. Both had been living in the UK for more than 10 years.

1.6.3 CF had a police caution from 2008 and TL was given a drink dispersal order in 2014. TL had no apparent contact with any NHS organisation whilst CF had a GP, but this contact was minimal. No other agency was able to discover any reference to either man in their records.

1.6.4 With such sparse information it was difficult to draw any conclusions based on their relationship. The review process did allow for other considerations and these are described briefly below. Where relevant recommendations have been made to address any findings.

1.7 Previous convictions in another country

1.7.1 Both men had significant convictions in Poland and these were unknown to the UK authorities. CF is actually wanted for a serious offence in Poland committed whilst apparently living in the UK and visiting Poland.

1.8 CF's contact with his GP

1.8.1 CF had visited his family doctor for injuries on two occasions. One visit was for an assault. The background to the assault was not investigated.

1.9 Issues for the "Polish" community

1.9.1 Contact was made with EU Welcome, an organisation that supports immigrants from Eastern Europe to Southampton, and a very successful focus group was held. Additionally this led to a conversation with a representative from the Roman Catholic Church. These meetings led to a more informed understanding of how those residents originally from Poland found the experience of living in Southampton and any concerns or suggestions about how things might change.

1.9.2 The whole issue of a "Polish" community is largely invalid as was demonstrated by the focus group. There was a large variety of views about each subject raised and the potential problems facing them were similar to any other resident of the City. Subjects touched upon were housing, relationships with the police and other agencies, language difficulties and drug and alcohol use.

1.9.3 Nothing of a specific nature was identifiable within the community that was significantly different from the general populace to bear comment. The possible exception to this is the issue of communication with agencies, hampered by a potential language barrier and cultural differences. This was not represented as a great concern but the high proportion of residents of Southampton that emanate from Poland makes it sensible to address these issues.

1.10 Conclusions and recommendations

1.10.1 This was neither a predictable nor preventable death. There are no lessons to be learnt from the specific circumstances of the relationship between TL and CF. A more proactive approach to the potential risk to individuals should be a beneficial aspect of this process but this was not a notable finding in relation to CF or TL

1.10.2 **Recommendations**

The breadth of the review has allowed consideration to be given to wider issues that may improve the communication and relationships within Southampton. The recommendations below also include recommendations beyond the Southampton SCP remit.

Recommendation 1

On the basis of the proportion of Polish residents in Southampton that the Safe City Partnership considers the development of an enhanced approach to this community. This should address issues of relationships with the police and more general communication (including language issues) with other agencies as highlighted within this report.

Recommendation 2

That Health and other agencies be given the tools to develop an approach to professional inquisitiveness that seeks to establish the potential risk to individuals and delivers an improvement to risk awareness, management of risk and subsequent communication processes.

Recommendation 3 (National)

That the Home Office consider the issue where those with serious previous convictions are entering the country and whether a process should be instituted to gather and risk assess such information.

Recommendation 4 (National)

That the Home Office consider allowing more flexibility in the guidance for DHRs to allow local Community Safety Partnerships to make a case for not completing such a review where the circumstance of a homicide do not fall within the spirit of the guidance, as for example in this case where the victim and suspect had not been in an intimate personal relationship, nor were they related in any way.

2. INTRODUCTION

2.1 Details of the incident

2.1.1 During May 2015 police were called to a ground floor flat in Southampton. TL was found there severely injured and immediately transported to Southampton General Hospital where he could not be saved. The cause of death was multiple blunt force traumas. The investigation showed a very considerable degree of violence over a sustained period.

2.1.2 TL was sub-letting space at this flat from CF the tenant. CF was arrested for this assault and subsequently charged with TL's murder. He was found guilty at a Crown Court and in 2016 sentenced to life imprisonment with a minimum term in prison of 22 years.

2.1.3 Both TL and CF were Polish males having arrived to live in the United Kingdom over 10 years ago. They were not in an intimate relationship.

2.1.4 The Panel would like to offer their sympathies to the family, friends, colleagues and acquaintances of TL for their loss and to thank those who have contributed to this DHR process.

2.2 The review

2.2.1 The Southampton Safe City Partnership (SCP) immediately reviewed the circumstances of this case which are described more fully below. Whilst in strict terms it fulfilled the requirements of the guidance on conducting domestic homicide reviews (DHRs) (i.e. people living in the same household) they felt that the opportunity for learning from the specific circumstances of this case in relation to the issue of domestic abuse were very limited. Additionally Southampton CSP had conducted other, non-statutory reviews where domestic abuse was a factor in the death of individuals and are conducting an extensive improvement programme around this issue.

2.2.2 The Home Office were asked to waive the requirement for a DHR in this case but this was refused and a "proportionate" review was demanded.

2.2.3 The scoping exercise prior to this review made it clear that this case was a considerable departure from a domestic abuse context. It is the view of this reviewer and the panel that the Home Office's decision was made without sufficient weight being given to the circumstances of the case or give sufficient recognition to recent reviews and the current ongoing work against domestic

abuse in Southampton. This decision has led to an expenditure of resource which could have been better utilised in relation to the innovative changes which are being instituted within the City.

2.2.4 Southampton SCP are to be commended for agreeing to expand the terms of reference of this DHR (to include issues which may affect the Polish community more generally) and their commitment to their changing response to domestic abuse and trying to seek opportunities in this review to add value to the process.

2.2.5 Following a lengthy panel discussion the panel agreed that they should recommend that the Home Office should consider their approach to the decision-making process around DHRs. They should give increased flexibility to those CSPs where a commitment to domestic abuse can be demonstrated and the circumstances of the case do not relate to the clear dynamics of domestic abuse.

2.2.6 The DHR process was established under Section 9(3) of the Domestic Violence, Crime and Victims Act 2004 and was conducted in accordance with the Home Office revised guidance 2013.

2.2.7 In this case the first official meeting of the panel was held on the 4th September to scope any relevant contact of the individuals with agencies. This followed an initial discussion on the potential need for a DHR at the Southampton SCP meeting on 24th July 2015. It was clear that there was, at most, extremely limited contact with either party in this case. However, it was decided to expand the scope of the review to consider the possibility of learning within the "Polish community" which may be related to this case.

2.2.8 The purpose of these reviews is to:

- Establish what lessons are to be learned from the 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 those lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

- This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process within individual agencies.

2.3 Terms of Reference

2.3.1 The full terms of reference are shown at Appendix 1. In brief, the purpose of this review is to establish whether there was any relevant contact with agencies by either TL or CF and any lessons to be learnt from that contact, or other opportunities to change the outcome of this case. It is also intended to consider any issues within the "Polish community" that have some bearing on the circumstances of TL and CF's lives to learn lessons for the future.

2.3.2 The definition of domestic abuse does not apply in this case as those involved are not intimate partners or family members.

2.4 Parallel and related processes

2.4.1 There are no other reviews being conducted into this case. This review has no bearing on any trial or coroner's court process.

2.5 Panel membership

2.5.1 The panel consisted of representatives from the following agencies:

- Hampshire Constabulary
- Southampton City Council – Adult Social Care, , Housing, Equality lead
- Southampton Safe City Partnership
- Strategic Lead for Domestic Abuse
- Southampton City Clinical Commissioning Group
- Integrated Commissioning Unit
- EU Welcome (an organisation supporting those who have migrated into Southampton from Eastern Europe).

2.6 Independent chair

2.6.1 The independent chair of this DHR is Anthony Wills. Anthony is an associate of Standing Together Against Domestic Violence, an organisation dedicated to developing and delivering a coordinated response to domestic violence through multi-agency partnerships. He has served as a police officer for 30 years, concluding his career as a Chief Superintendent where he supported the development of the coordinated response to domestic violence. Since leaving the police in 2003 his main roles have been chief executive of Standing Together, DHR reader for the Home Office, DHR reviewer and as a consultant delivering improved responses to domestic violence. He has now been involved in over 20 DHRs. He has no connection with Southampton apart from as a previous reviewer

into cases in the City and an adviser to the domestic abuse partnership many years ago.

2.7 Methodology

2.7.1 This review has sought to establish whether TL or CF had any contact with agencies, either statutory or voluntary. Apart from a caution for common assault in 2008 CF was not known to the police or other agencies (except his GP – see below). TL had been subject to a drink-related dispersal order in 2014 but was not known to any other agencies.

2.8 Contact with family and friends

2.8.1 TL's parents are separated and live in Poland. No other family members have been identified. Whilst they were kept informed of this case by the police they did not to travel to the UK for the trial and they added nothing of evidential value to the prosecution. They speak no English so they were written to by the reviewer asking them to participate in the review. This letter was translated into Polish but no response was received.

2.8.2 TL and CF had mutual friends and three were particularly relevant in their lives. These have also been contacted, again in the form of a letter translated into Polish as there was some concern about their command of English. To date they have not been willing to participate in this review.

2.8.3 CF has been contacted in prison and asked to participate in this review, again with a letter in Polish (with a copy of the letter to the Prison Governor in English). He has not responded to this letter. It has not been possible to establish whether CF has family or where they may be located.

2.9 Equalities

2.9.1 The protected characteristics within the Equality Act 2010: race, sex, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, religion or belief and sexual orientation were not considered by the panel to be relevant to this review. There is no evidence of any of these factors applying to either individual within this case.

2.9.2 Both TL and CF were Polish and whilst this has no bearing on the homicide the wider context of the "Polish community" was considered within the review process.

3. The Facts

3.1 TL's death

3.1.1 During May 2015 TL and CF attended a party at a flat in Southampton where friends lived. They and others left the flat in the early hours of the next morning.

3.1.2 After the party police were called to a nearby flat which was rented by CF. TL was found there severely injured and immediately transported to Southampton General Hospital where he could not be saved. The cause of death was multiple blunt force trauma. The investigation showed a very considerable degree of violence over a sustained period.

3.1.3 TL was sub-letting space at this flat from CF the tenant and had been doing so for some months. CF was arrested for the assault on TL and subsequently charged with his murder. He has now been found guilty of the murder of TL and sentenced to life imprisonment with a minimum term in prison of 22 years.

3.1.4 Both TL and CF were Polish having arrived separately to live in the United Kingdom over 10 years ago.

3.2 Prosecution of CF

3.2.1 As described above CF was prosecuted for the offence of murder and found guilty after a very thorough investigation which entailed considerable forensic evidence gathering.

3.3 Relationship between TL and CF

3.3.1 There is no evidence of a clear friendship between TL and CF although they mixed in the same circles. Their relationship was largely based on the economic realities of sub-letting a flat informally. Whilst probably known to each other for some time it is believed that it was never a close relationship.

3.3.2 There is also no evidence of a period of animosity or a dispute between the two leading up to the death. On the night of the death there is a suggestion that the two may have had a disagreement prior to leaving the party but this cannot be described or defined.

3.3.3 On the way home from the party there is also CCTV evidence of a possible argument followed by a possible rapprochement in the street. The assault which led to the death took place when both arrived home.

3.4 Agency contact

3.4.1 Apart from the conviction for common assault[2] in 2008 and the GP, it has not been possible to identify any significant contact that either CF or TL had with any agencies.

3.4.2 The limited information available in relation to both the victim and perpetrator comes in the main from the police investigation.

3.5 GP practices

3.5.1 There is no trace of TL registering with the NHS at any location in the UK. CF was registered at a GP practice in Southampton from 2014. Within his notes there is information relating to an injury caused by an assault. He was treated at a minor injuries unit and details passed to his GP. This was in January 2015. In April 2015 he injured his ankle and was seen both in casualty at Southampton General Hospital and at the GP surgery. The background and history of these injuries was not investigated.

3.6 Other relevant issues

Criminal Convictions in Poland

3.6.1 Both TL and CF had convictions for very significant offences in Poland. The nature of the recording of convictions in Poland differs from that in the UK so details remain vague despite further efforts being made to fully establish the circumstances relating to these matters. They are considered relevant within this review.

3.6.2 CF, at his own admission had been convicted in Poland of offences of robbery and possession of a firearm for which he received an 8.5 year sentence of imprisonment. He is also currently wanted in Poland for aggravated battery which appears to have taken place in December 2014. No further details are known of these cases at this stage but this information also seems to indicate that a return to Poland took place recently when a crime was committed.

3.6.3 TL's convictions in Poland consist of assault on police, grievous bodily harm and burglary. No further details are known of these cases.

Housing issues

3.6.4 TL appears to have been informally subletting space in CF's one-bedroom flat and had been doing so for some months. Despite the obviously limited space available

[2] In June 2008 CF was seen by police to assault another male outside licensed premises. He was arrested, later admitted the offence and was subsequently cautioned.

this was considered helpful to both parties for economic reasons. Once again it is impossible to be absolutely certain but this appears to be the basis of the relationship between the two individuals. They were certainly acquaintances before this accommodation solution was reached. There is no real evidence of a strong friendship between the two.

3.6.5 The reviewer was made aware that the practice of informal sub-letting is evident in Southampton and particularly for those rented by people from Eastern Europe. This is regarded as a 'least worst' scenario bearing in mind the shortage of suitable/affordable rental accommodation in this area.

Alcohol and substance misuse

3.6.6 The investigation of this case shows that a small party was held on the night of the death which both TL and CF attended. It is apparent that those attended drank heavily. There is also reference to the use of drugs, possibly amphetamines or cocaine and cannabis. CF was also found to have traces of steroids within his system.

3.6.7 TL's employer did feel that his performance at work was deteriorating and this may have been due to his intake of drink or drugs.

The "Polish community"

3.6.8 This review has expanded its terms of reference, to establish whether there can be any beneficial learning from this case which relates to what has been described as a "Polish community". The quotation marks have been used deliberately as this very expression has led to much debate and possible criticism. Definitions of community can be: a group of people living in the same place or having a particular characteristic in common, or the condition of sharing or having certain attitudes and interests in common. By these definitions it is possible to consider how this case relates to a Polish community but only with caution.

3.6.9 It must be stated that this case in itself does not point to issues within the "Polish community". It appears that the circumstances are not directly related to Polish culture or the issues for that community within Southampton.

3.6.10 It is a fact that those residents of Southampton who have migrated from Poland number in the region of 30,000. Out of a total population of over 240,000 in Southampton this is a significant proportion of the whole community.

3.6.11 To further consider this issue generally a focus group of Polish nationals (or ex-nationals who now have British citizenship) was held with the support of EU welcome[3]

3.6.12 This group consisted of individuals of both genders, a variety of ages and occupations and life experiences. They were varied in their opinions about issues confronting migrants from Poland and were vociferous in the ensuing debate. They all felt that there were many similar characteristics amongst those who came from Poland and were now living in Southampton but that there were just as many dissimilarities.

3.6.13 For this reason, there was a lack of enthusiasm for describing a "Polish community" but there was considerable support for the opportunity to consider any issues that could be relevant in this case. The reviewer is very grateful for the support of EU Welcome and those who participated in the focus group for their openness, honesty and helpful commentary.

3.6.14 It must be stressed that this conversation was very general in its nature. The details of the death under review were not discussed although there was a very limited awareness of the circumstances amongst some of the participants.

3.6.15 With all the above in mind it was possible to draw some over-arching conclusions which the SCP may consider relevant in its consideration of any future steps. These are simple summaries of a much longer discussion and are not necessarily the view of all of those involved. It is also true that the points made below may well equate to other communities, and not necessarily those based solely on nationality.

3.6.16 Of necessity the following also tends to focus on the negative but all the group were hugely attached to the UK and Southampton in particular. Many had taken British citizenship or were planning to do so. They mostly regard this country as their home and have deep affection for the wider community, its culture and generous nature. Of course there are also migrants from Poland who intend to return home in due course but that does not affect the points raised below.

[3] www.euwelcome.org.uk E U Welcome exists to provide help and support to migrants in the Southampton area from EU and other European countries.

Summary of points raised

3.6.17 Reporting of disputes and crimes to the police or other agencies is an unusual step. It was suggested that “Poles do not ask for help” and would prefer where possible to resolve matters amongst themselves.

3.6.18 The factors of culture and language do tend to lead to an element of isolation from the wider community.

3.6.19 The culture of socialising tends not to rely on gathering in public houses. It is more common to gather in an individual’s home whether this be with friends or family.

3.6.20 It was accepted that alcohol can play a large part in the lives of those from Eastern Europe. To an extent this can be exacerbated by their working conditions. Many work very long hours and simply sleep and return to work the next day. This can lead to excessive intake of alcohol on the few days off that they have. Whilst it is also recognised that misuse of drugs were part of the landscape this was not considered significantly different to the rest of the Southampton populace.

3.6.21 There were very mixed views about policing. The point was made strongly that the approach to policing in Poland is more authoritarian and direct, with little room for discretion. They felt that crime and disorder was more “overt” in the UK because in Poland public nuisance was met with a very stern response.

3.6.22 With this said it was generally felt that all had very limited enthusiasm for being involved in the criminal justice system (especially as a witness) as it led to “hassle” and possibly heightened risk from those under investigation.

3.6.23 There was a natural fear of being involved with the police but they thought that officers were courteous and pleasant but, unfortunately, not very effective in their role, i.e. not able to sufficiently prevent crime, arrest perpetrators or reduce anti-social behaviour. This seemed to be a premise based on their view of policing in Poland but may well result in an aversion to reporting incidents to the authorities

Potential solutions

3.6.24 The group were asked to consider what could be changed or developed to help deal with the issues some of those from Poland (and other minority communities) face. They were aware that budget restrictions will play a part in any initiatives but the following suggestions were provided without considering available resources.

3.6.25 Language is a key issue and whilst some Poles do not have a desire to learn English anything that can be done in the form of teaching English, offering translation or providing explanatory leaflets in their home language would be helpful. It was mentioned that inducements to learn English would increase the likelihood of an increase in the take up of language courses.

3.6.26 Training of those involved in dealing with or supporting the Polish community could help remove barriers to understanding and progress. A grasp of their culture and influencing factors would allow for more effective communication and responses.

3.6.27 Exchange programmes, co-working and role observation (e.g. ride-alongs) were all suggested as a means of increasing mutual understanding. (There is an existing exchange system operating between the respective police forces.)

3.6.28 Communication remains the key to all of the above. Much of the information obtained within the Polish community comes through word of mouth. There is a significant need to develop a more innovative approach to the dissemination of news, opportunities and a cross fertilisation of ideas and local developments. Social media, Polish newspapers, radio stations and other local media were all suggested as potential avenues of communication. It was also mooted that an increase in the availability of Polish interpreters and those speaking Polish, particularly in the Police would be very beneficial.

3.6.29 Alcohol or drug use are present within elements of the Polish community, as they are in most communities. Support, where necessary, targeted and designed for those from Poland could lead to increased help-seeking.

3.6.30 Whilst vague there was also a view that increased partnership, networking and interpreting facilities would aid the process of mutual understanding and support.

The Polish Catholic Church

3.6.31 The group referred to above strongly recommended that a representative from the Roman Catholic Church in Southampton was also involved in this review. This meeting took place on the 4th April and strongly reinforced the thoughts of the earlier group.

3.6.32 The representative was very clear that Polish people “do not clearly know the rules” in the sense of both the law and some cultural traditions. This is exacerbated by language difficulties and the tendency to live in small, Polish enclaves within the City.

3.6.33 In relation to the use of drink and drugs he did feel that a problem existed with some individuals but the problems referred to above made it difficult to seek help.

3.6.34 On arrival in the country new immigrants are happy to simply secure a bed. They largely fail to understand the legislation and practice governing renting and there is a suspicion that landlords may take advantage of this.

3.6.35 Finally he believes that many Polish immigrants have a sense of insecurity about their presence in the UK. They do occasionally experience racism and worry that at some time they may be returned to their country of origin.

3.6.36 The potential solutions referred to above were discussed and supported. This representative felt that the first step should be a meeting of interested parties to explore the issues, build trust and agree actions to raise awareness and develop communication systems to the wider Polish populace.

Local policing

3.6.37 An opportunity to discuss the issues arising from this case with the local neighbourhood policing inspector was taken. It is her view, based on experience of working in the area that the key point made was that this death did not relate to "Polish issues" but that it was a set of circumstances that could have arisen with any community and it would be wrong to extrapolate a wider Polish problem from the facts surrounding this case. It was not a case which in itself provided a driver for change.

3.6.38 This officer felt that the community was not a homogenous one and that whilst there was a degree of connectedness the Polish inhabitants of the area where the party and the murder took place were not particularly "tight".

3.6.39 She said that community tension did not increase in the area where the death occurred after the event and that such tension was described as low.

3.6.40 There was an acknowledgement that there was a degree of caution amongst the Polish inhabitants in their dealings with the police and they were not keen to report matters to the police or engage with them more widely.

3.6.41 There does appear to be a culture of heavy drinking in groups in a home environment.

3.6.42 Potentially of greater concern was the issue of housing and poverty and the possible development of an underclass. There is apparently a considerable amount of sub-letting due to limited suitable housing stock. She believed this may be driven by very low wages and/or unemployment but that this was true of many individuals and families within the general community and was not specifically a problem within this community.

4. Analysis

4.1 Relationship between victim and perpetrator

4.1.1 The victim and perpetrator in this case, TL and CF were more acquaintances than friends. All the evidence from the investigation, the review and comments by friends that were made to the police indicate that they were probably living together for economic reasons rather than any form of emotional bond.

4.1.2 There is some evidence of some form of dispute on the night of the death but nothing of any long standing nature.

4.2 Domestic abuse?

4.2.1 This was not domestic abuse as the two were not in an intimate relationship or of the same family. The reason for this DHR is that they were living in the same household and the guidance for DHRs requires that this review be completed.

4.3 Access to support services

4.3.1 There appears to be no reason for either TL or CF to seek help for the factors directly involved in this case. Whilst there is a history of violence with both individuals in Poland this is not the case in the UK, with the exception of CF's caution for assault in 2008.

4.3.2 Other factors for which they may have sought help were possibly for drug or alcohol misuse, financial concerns or housing issues. There is no evidence of any of these issues being a concern for either man.

4.3.3 TL had not registered with a GP so this avenue of support was not available to him. CF did seek help from the NHS for injuries (at least one of which was an assault). It is possible to view these as missed opportunities to explore his social history or causes of the injuries and consider whether other support could have been provided or suggested.

4.4 What might have helped?

4.4.1 Nothing in this review clearly indicates that specific actions in relation to TL or CF would have helped them. The circumstances do not lead to a clear indication that either needed, or should have sought help.

4.5 Broader issues for TL and CF beyond the direct circumstances of this death.

4.5.1 The processes adopted in this review have indicated some areas where consideration could be given to future action.

Convictions in other countries[4]

4.5.2 The fact that two men are living in this country with previous convictions of a serious nature (and one wanted for another serious offence) which are totally unknown to the police may give cause for concern. This concern is exacerbated when it appears that CF may have committed a serious crime whilst on a return trip to his native land. With one minor exception both TL and CF were not suspected or convicted of any offences in the UK prior to the murder relevant to this review so this may not be an issue

4.5.3 It is axiomatic that good policing depends on good intelligence and the criminal antecedents of individuals may be a pointer to future behaviour and that lack of knowledge of significant offending behaviour can be a disadvantage to those seeking to investigate or prevent crime.

4.5.4 Individuals must be allowed to live life without fear of unwarranted attention on the basis of past misdeeds and in this case there appears to have been no harm caused by the lack of knowledge about their previous convictions. This may not be true of all those coming into the country from abroad.

Alcohol and drug use

4.5.5 There is evidence on the night of the murder of drinking and drug use by both TL and CF. Apart from TL's employer feeling that his standard of work was declining which may have been due to substance misuse there is insufficient evidence to make a case for suggesting their use of these substances was problematic.

Housing

4.5.6 TL and CF seem to have found their living arrangements mutually agreeable and there is no indication that what would seem to be restricted living space for both was difficult for them over the long term.

4.6 Issues for the "Polish community"

4.6.1 This review cannot extrapolate from the events leading up to this death factors which allow for any description of these circumstances as problems for the Polish community. Put simply this was an assault by one male against another which could have taken place in any community at any time.

[4] As this report was being prepared an article appeared in the media stating that the Immigration Minister had introduced a process whereby foreign visa applicants must provide details of previous convictions but that EU citizens would be exempt. http://www.telegraph.co.uk/news/uknews/immigration/11751773/Foreigners-must-disclose-criminal-records-to-come-to-UK-but-European-Union-is-exempt.html

4.6.2 As the review sought to further explore the possibility that learning may be available on a broader and more general basis for those of Polish extraction within Southampton some issues bear further consideration.

4.6.3 These are referred to more extensively above but focus on:

- Policing – relationships and reporting
- Communication – language, understanding of culture,
- Alcohol and drug use – developing a more targeted approach to intervention services.

4.7 Housing issues in Southampton

4.7.1 The possibility of sub-letting on a large scale (and high levels of sofa-surfing as it has been described) may indicate an existing problem. It may also lead to other unwanted social consequences that bear further consideration. However the shortage of accommodation is likely to make this a continuing problem and not one easily remedied.

4.8 Equalities

4.8.1 It has not been possible to identify any issues of equality in relation to this case. None of the protected characteristics apply in this case.

4.9 Good practice

4.9.1 The success of the focus group is a direct result of the good relations EU Welcome have formed with their target communities. They were also highly praised by those who attended the group.

5. Conclusions and Recommendations

5.1 Preventability

5.1.1 This was neither a preventable nor a predictable death. Any evidence that could lead to such a conclusion is simply not available.

5.1.2 Whilst there may be some action that could potentially help residents of Southampton in the future which is described below there are no lessons to be learnt from the specifics of this case. It does allow for further consideration of the approach taken by agencies to protect individuals in the future.

5.2 General opportunities for change

5.2.1 Whilst the death of TL could not be foreseen, the review process may allow for an improvement in the way the police and other agencies interact with Polish residents of Southampton. It may also lead to approaches to housing and substance misuse that could have wider applications.

5.2.2 The issue of people entering the country with serious previous convictions should be considered at a higher level. This case may be unusual but if it is believed that a more intrusive approach on entry into the UK would aid the prevention and reduction of crime it may be appropriate for HM Government to explore the possibilities in this area.

5.3 Recommendations

5.3.1 The following recommendations are based on the findings of this case and are mainly general, i.e. not related to the specific circumstances of this death. There is an expectation that the local recommendations (1 and 2) be overseen by the Southampton Safe City Partnership. The SCP should also be informed of the outcome of the national recommendations at 3 and 4.

Recommendation 1

On the basis of the proportion of Polish residents in Southampton that the Safe City Partnership considers the development of an enhanced approach to this community. This should address issues of relationships with the police and more general communication (including language issues) with other agencies as highlighted within this report.

Recommendation 2

That Health and other agencies be given the tools to develop an approach to professional inquisitiveness that seeks to establish the potential risk to individuals and delivers an improvement to risk awareness, management of risk and subsequent communication processes.

Recommendation 3 (National)

That the Home Office consider the issue where those with serious previous convictions are entering the country and whether a process should be instituted to gather and risk assess such information.

Recommendation 4 (National)

That the Home Office consider allowing more flexibility in the guidance for DHRs to allow local Community Safety Partnerships to make a case for not completing such a review where the circumstance of a homicide do not fall within the spirit of the guidance, as for example in this case where the victim and suspect had not been in an intimate personal relationship, nor were they related in any way.

Appendix 1: Domestic Homicide Review Terms of Reference for TL

This Domestic Homicide Review is to consider agency involvement with TL and CF following the death of TL in May 2015. The Domestic Homicide Review is conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Reason for the Review

The victim and suspect are both Polish nationals and recently had been sharing a first floor flat in Southampton. Both men attended a party. The victim and suspect both left the party at 05.00 and walked back to their shared accommodation. Later evidence suggests that both had been drinking. CCTV along the route and subsequently neighbours both show the two arguing. CF was overheard saying he had killed TL and was going to kill himself. An ambulance was called and the body of TL was found in the kitchen of CF's flat. Efforts to save him were unsuccessful and TL was pronounced dead at the scene. In the meantime the police arrested CF on suspicion of murder. The post mortem was conducted and cause of death was established as multiple blunt force traumas to the head, neck and chest. CF was charged with the murder of TL.

The 2013 Home Office Domestic Homicide Review (DHR) guidance sets out the criteria for when a Community Safety Partnership should commission a statutory DHR under section 9 of the Domestic Violence and Victims Act 2004. The act states:

A Domestic Homicide Review means a review of 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 is related or with whom he was or had been in an intimate relationship, or
b) A member of the same household himself, held with a view to identifying the lessons to be learnt from the death.

This case was referred to the Southampton Safe City Partnership (SCP) as the victim to this violent death was an adult who had been living in Southampton and who, it is

alleged, was murdered by a member of the same household, thereby potentially meeting the criteria for the SCP to commission a DHR.

The SCP Chair raised with the Home Office the limited relationship between these two parties but was informed this did meet the terms of the DHR statutory requirements, albeit with scope to take a 'proportionate approach'.

On 4th September 2015 the SCP agreed that a DHR should be conducted and an independent Chair appointed. It was further agreed that the review should be proportionate given the limited level of contacts and the nature of the offence, and that the potential learning from engagement with the Polish community should be welcomed.

Purpose

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

2. To review the involvement of each individual agency, statutory and non-statutory, with CF and TL during the relevant period of time – to be identified by the first panel meeting.

3. To summarise agency involvement prior to the agreed date and identify gaps in appropriate agency involvement where appropriate

4. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to the needs of new Southampton residents from diverse communities (specifically here Eastern European) to reduce the risk of violence and conflict between individual associates or those in intimate relationships (as defined by the Domestic Violence Crime and Victims Act 2004).

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

6. To improve inter-agency working and better safeguard adults experiencing domestic abuse and/or at risk of violence and abuse and not to seek to apportion blame to individuals or agencies.

7. To commission a suitably experienced and independent person to:
   a) chair the Domestic Homicide Review Panel;
   b) co-ordinate the review process;
   c) quality assure the approach and challenge agencies where necessary; and
   d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

8. To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries. To use a method of enquiry and review that is proportionate and effective.

9. To present the interim findings to the DHR sub-group of the DV Strategy Group and to present the final report to the Safe City Partnership.

Membership

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

11. The agencies to be involved will be determined by those known to the parties and determined by the panel. This is likely to include:
    a) Clinical Commissioning Groups
    b) General Practitioner for the victim and alleged perpetrator
    c) University Hospital Trust
    d) Private landlord
    e) Employers
    f) Family, friends and neighbours.
    g) Local Polish community group representatives e.g. EU Welcome Trust
    h) Local Mental Health Trust

i) Hampshire Constabulary

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

Methodology

13. The methodology for this review will be agreed in detail with the appointed independent Chair and Panel, but it is likely to include:
    - A review of summary information and chronologies provided by individual agencies where there was contact with the family
    - A review of relevant policies, procedures and processes that are in place
    - Meetings with a panel of representatives from the agencies involved to seek advice, guidance and approval of the review process and terms of reference
    - Interviews of key professionals, workers, colleagues of the family members, managers and service leads – individually and in groups where relevant
    - Liaison with the Senior Investigating Officer in the case and leads for the other parallel processes including civil care proceedings and the Coroner's Inquest where relevant and appropriate
    - Further panel meetings to discuss findings and finalise report and recommendations

To retain a proportionate response detailed Individual Management Reviews and chronologies will only be required as necessary. It is more likely that the lessons can be learnt from interviews and group discussions with a brief summary of findings forming the basis of the final report.

Analysis of findings

14. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following six points:
    a) Analyse the communication, procedures and discussions, which took place between agencies.
    b) Analyse the co-operation between different agencies involved with the victim, alleged perpetrator, and wider family.

c) Analyse the opportunity for agencies to identify and assess diverse community needs and issues that could increase risk of abuse or violence.
d) Analyse agency responses to any identification of risks within diverse communities – specifically Eastern European or newcomers to the City.
e) Analyse organisations access to specialist cultural or domestic abuse agencies.
f) Analyse the training available to the agencies regarding the needs of diverse communities in the context of reducing violence and abuse.

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

15. Sensitively involve the family of TL in the review, if it is appropriate to do so in the context of on-going criminal proceedings. Also to explore the possibility of contact with any of the alleged perpetrator's family who may be able to add value to this process. The chair will lead on family engagement with the support of the senior investigating officer and the family liaison officer.

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

17. Coordinate with any other review process concerned with the children of the victim and/or alleged perpetrator.

Development of an action plan

18. Establish a clear action plan for individual agency implementation as a consequence of any recommendations.

19. Establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report. This Plan will be developed with the Chair by the Service manager (Domestic Violence).

Media handling

20. Any enquiries from the media and family should be forwarded to the chair who will liaise with the SCP. Panel members are asked not to comment if requested. The chair will make no comment apart from stating that a review is underway and will report in due course.

21. The SCP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

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

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

24. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents can be password protected.

Disclosure

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

Appendix 2: Members of the Panel

Hampshire Constabulary: DCI Colin Mathews, Head of the Serious Case Review Team

Southampton City Council:

- Adult Social Care, Paul Juan, Service Manager
- Housing, Liz Slater, Housing Needs Manager
- Equality lead, Sara Crawford, Improvement Manager

Southampton Safe City Partnership - Dorota Goble, Partnerships Manager

Strategic Lead for Domestic Abuse, Southampton City Council - Linda Haitana, Service Manager Projects & Programmes

Southampton City Clinical Commissioning Group and Integrated Commissioning Unit – Katherine Elsmore, Head of Safeguarding

Integrated Commissioning Unit and Southampton City Clinical Commissioning Group - Carole Binns, Associate Director - System Redesign

EU Welcome - David Adcock, Project Manager EU Welcome

Appendix 3 – Action Plan

The Panel is responsible for ensuring that all recommendations must be SMART (specific, measureable, achievable, realistic, time bound) and for the completion and implementation of the Action Plan. The CSP will monitor the implementation and delivery of the Action Plan.

	Recommendation	Scope of recommendation i.e. local, regional or national	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
1	On the basis of the proportion of Polish residents in Southampton that the Safe City Partnership considers the development of an enhanced approach to this community. This should address issues of relationships with the police and more general communication (including language issues) with other agencies as highlighted within this report.	Local	Identify with relevant partners and community representatives specific actions to take to address the recommendation; Develop & deliver agreed action plan.	Police with support from SCC – DSA Lead	• Develop specific multi-agency & community action plan. • Agree action plan at strategic DSA Group. • Deliver plan, with actions monitored by DHR Group, DSA Strategic Group reporting up to SCP.	30.10.16 November 2016 End March 2017	

	Recommendation	Scope of recommendation i.e. local, regional or national	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
2	That Health and other agencies be given the tools to develop an approach to professional inquisitiveness that seeks to establish the potential risk to individuals and delivers an improvement to risk awareness, management of risk and subsequent communication processes.	Local	• Complete a brief audit of existing risk identification tools & processes, supported by LSCB & LSAB. • Establish a multi-agency 'tool kit' to improve 'professional inquisitiveness' regarding DVA and wider safeguarding, building on existing processes and initiatives with this purpose. • Deliver an agreed 'tool kit' raising awareness of risks and risk management. • Deliver the 'tool kit' and related	Health (CCG) – supported by SCC DSA Lead.	• 'Tool Kit' proposal agreed and develop Tool Kit. • Multi-agency roll out of communications on the 'tool kit' and inquisitive inquiry.	November 2016 Roll out from December 2016 to April 2017	

	Recommendation	Scope of recommendation i.e. local, regional or national	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
			communications. • Report on proposals and progress to DHR Group, DSA Strategic Group and to the SCP.				
3	That the Home Office consider the issue where those with serious previous convictions are entering the country and whether a process should be instituted to gather and risk assess such information.	National	• Letter from Chair SCP to Home Office regarding DHR Recommendation (3)	Police	Letter written, approved and sent.	Sept 2016	

	Recommendation	Scope of recommendation i.e. local, regional or national	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
4	That the Home Office consider allowing more flexibility in the guidance for DHRs to allow local Community Safety Partnerships to make a case for not completing such a review where the circumstance of a homicide do not fall within the spirit of the guidance, as for example in this case where the victim and suspect had not been in an intimate personal relationship, nor were they related in any way.	National	Letter to Home Office re DHR recommendation (4) from Chair of SCP. Action monitored by DHR Group.	Police	Letter written, approved and sent	Sept 2016	

Appendix 4: Letter received from Home Office

All recommendations advised in this letter have been addressed

Home Office

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848
www.gov.uk/homeoffice

Admin Support Officer
IDVA Service
Southampton City Council

31 March 2017

Dear

Thank you for submitting the Domestic Homicide Review (DHR) report for Southampton to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 24 January 2017.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this was a good review despite the limited agency contact with both the victim and the perpetrator. The Panel was particularly struck by the relevance of issues to the community that was the subject of the review and commended the chair for the good use of the expertise of the voluntary sector specialist panel member. The Panel was especially impressed with the focus group undertaken with the community involved which illustrates the creative effort of gaining learning by alternative means.

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

- Please review the footnote at the bottom of page 10 as it may contain the real initials of the perpetrator;
- The Panel felt it would be helpful if paragraph 4.1.1 could briefly clarify why the individuals concerned were not determined to be in an intimate relationship;
- The Panel noted the executive summary is a chapter within the overview report and recommended that it should be a standalone report that can be read in isolation, as outlined in the statutory guidance;

- You may wish to review the anonymisation in the report as there are a number of identifiable features, for example the date of death and the trial and the district where the homicide took place.

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

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to your PCC for information.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel