Domestic Homicide Review
(DHR)

Commissioned by

South and Vale Community Safety Partnership

-Executive Summary-

Victim: Ann

Died: August 2022

Independent Chair & Report Author: Eileen Mills

Report completed 4th February 2025

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1. The Review Process

1.1. The subjects of this DHR have given pseudonyms of Ann and Marius to protect their identities and those of their family members.

1.2. The South and Vale Community Safety Partnership commissioned this Domestic Homicide Review (DHR) to examine agency contact with Ann, Marius and their family, and to identify learning to improve responses to domestic abuse and safeguarding

1.3. The South and Vale Community Safety Partnership (CSP), which commissioned this review, and those who participated would like to express deepest and heartfelt condolences to Ann's family for their loss.

1.4. Ann was brutally murdered by her husband, Marius. Ann had one child from a previous relationship. Ann is survived by her child, mother, and siblings, all of whom lived in the same area as her. Her husband is of Eastern European heritage and had no close family living nearby.

1.5. Marius was subsequently convicted of her murder in 2023. He will serve a minimum of twenty-one years.

2. Contributors to the Review

2.1. The review has been informed by contributions from multiple agencies and, critically, the voice of Ann's family, whose insights have been central to understanding her life, relationships and circumstances.

2.2. The first meeting of the DHR panel took place in November 2022, following the decision of the CSP in September 2022 to commission the DHR. It was identified that 15 of the 15 agencies contacted confirmed contact with Ann, Marius, and her child.

2.3. An Independent Chair and Author was appointed for the DHR. Who had no connection to the South and Vale Community Partnership and has never worked for any of the organisations that took part in this review. They have a professional background in safeguarding within Health Services.

2.4. After the initial scoping of information to screen the case against the eligibility criteria for a DHR, eight agencies then provided detailed Individual Management Reports (IMR)

- Family Solutions Plus (Children's Social Care)

- Primary Care services
- Oxfordshire Domestic Abuse Service
- Oxford Health NHS Foundation Trust
- Mountain Healthcare
- Oxford University Hospitals NHS Foundation Trust
- Turning Point
- Thames Valley Police (TVP)

2.5. A further four provided additional information. The school that Ann's son attended interviewed the author and provided an agency summary document. Adult Social Care also provided an agency summary and met with the author separately. SAFE! a service for support for young people affected by crime, which was offered to Ann's child, provided by an agency summary. The housing provider for the accommodation where Ann, her husband, and her child lived was interviewed by the author.

2.6. **Review Panel Members**

Temporary Head of Service, South Family Solutions Plus
Designated Nurses Safeguarding (Oxfordshire), Berkshire, Oxfordshire, Buckinghamshire, Integrated Care Board representing Primary Care services
Iffley Academy
Health Improvement Practitioner, Public Health, Domestic Abuse, Oxfordshire County Council
Licensing and Community Safety Manager, South Oxfordshire and Vale of White Horse District Councils
Adult Social Care, Oxfordshire County Council
Operations Manager, Oxfordshire Domestic Abuse Service, A2Dominion
Patient Safety Lead, Oxford Health NHS Foundation Trust
Deputy Chief Medical Officer, Oxford Health NHS Foundation Trust
Community Safety Area Manager, Peabody Housing Ltd
Head of Governance and Quality, Mountain Healthcare
Senior Specialist Nurse Safeguarding Adults, Oxford University Hospitals NHS Foundation Trust
Director, SAFE!

Oxfordshire Senior Operations Manager, Turning Point
Detective Chief Inspector of Thames Valley Police (TVP)

2.7. The panel were in roles that could provide independent and expert input to the review. The panel met on six occasions to develop the terms of reference, review and discuss Individual Management Reports and consider the findings and recommendations.

3. Terms of Reference for the Review

3.1. Statutory Guidance Section 2(7) states the purpose of the 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
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

3.2. Specific Terms of Reference for the Review

- Was the victim known to local domestic abuse services? Were there any previous concerns or warning signs? Could more be done to raise awareness of the services available to victims of domestic abuse?
- Was the relationship between alcohol/substances, mental health and domestic abuse fully considered?
- Were family, friends, and colleagues participating in the DHR aware of any abuse that may have been taking place?
- Were there any barriers experienced by the victim or family, friends, and colleagues in reporting the abuse?
- Was abuse present in any previous relationships? Did this affect the victim's decision on whether to access support?

- Were there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim that were missed?
- Are there any training or awareness-raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?
- Consider any equality and diversity issues that appear pertinent to the victim, perpetrator, and dependent children

4. Family Perspective

4.1. Ann's family described her as a much-loved mother, daughter and sister, and a central figure in their lives. They have expressed the profound impact of her loss.

4.2. They have also raised concerns about whether earlier opportunities to recognise and respond to risk were missed. They questioned how Marius, given his previous serious offending, was able to live and work in the UK and whether earlier intervention may have altered the trajectory of events.

4.3. This review acknowledges these perspectives and recognises their importance in informing learning and future practice.

5. Summary of Key Information

5.1. The period the review considered and analysed was from September 2018, when the family first had contact with several agencies, to the date of Ann's death.

5.2. In 2018, the family came to the attention of multiagency professionals for the first time following identification that Marius had met the criteria for sex offender registration in the UK. The sexual offences were committed in his home country. The information became known after the completion of "Foreign National Checks," during which police arrested Marius for driving-related offences. It is standard practice that when any foreign national is arrested, a request is made to their country of origin for information on any criminal history. In addition to the requirements for supervision and oversight of Marius, partnership working took place to consider the risk posed to Ann's child on identifying this information.

5.3. Ann and Marius had been together for about 10 years at the time of her death. During that time, there were two episodes of domestic abuse reported in 2020. These incidents took place in the context of the trauma the couple experienced

following a dog attack on Ann. There is also information to suggest that, at the same time, Marius was having an affair.

5.4. During this period, both Ann and Marius were in very high emotional states, leading to both deliberately self-harming and threatening to take their own lives on separate occasions, bringing them into contact with services for their mental health and safeguarding children, as well as the police. For Marius, these events were exacerbated by his alcohol use.

5.5. Ann was a private individual and shared limited information about her relationship with Marius with her family. In her interactions with professionals, she consistently presented the relationship as stable and positive. She appeared to retain independence and agency, while also describing herself as emotionally reliant on Marius for support. Ann and Marius presented to agencies as a united couple, wanting to help and support each other and willing to work with services.

5.6. Following the closure to children's services in 2021 there was little professional contact with the family and none that gave rise to any escalating concerns, until the weekend of Ann's death.

6. Key issues arising from the review and lessons learnt

6.1. This review identifies the systemic learning, particularly in relation to the identification, understanding and management of risk in complex domestic abuse cases.

6.2. There are two distinct episodes identified by the review that may have provided an opportunity for agencies to respond differently. The first was in 2018 when Marius's offences in another country became known, and the subsequent multiagency response to this. The second is the set of events leading up to and including the period of child protection intervention in 2020. Analysis of the events at these times identified the following issues

6.3 Partner agencies need a greater understanding of the process for foreign-national checks and its limitations.

The amount of information made available through foreign national checks is limited, and, in this case, it allowed Marius to create a narrative around the crimes that portrayed him as a victim, for example, taking the blame for others. There was a readiness to accept the narrative provided by professionals in the absence of detail. Therefore, the review found that professionals required greater knowledge of the process and its limitations.

6.4 **Despite the limited information, serious violence against a woman was known to have taken place within a non-domestic setting. However, this behaviour was not explored with Marius when he was now in an intimate relationship in a domestic setting in any depth during the child safeguarding assessment**.

There is no indication that any professional considered the impact of the information on the relationship between Ann and Marius. With the limited information available from the Foreign National check, it was still known that a serious sexual offence had taken place – the assessment by his offender manager and the children's social care assessment would have been an opportunity to explore Marius's view of women and link this to the possible risk of domestic abuse. This would have created an opportunity to work more closely with them as a couple and to understand better their relationship and its impact on Ann's child. There is no evidence that Marius's previous adverse childhood experiences were explored as to how they may impact his relationships or parenting.

In summary, there was limited professional curiosity, with an over-reliance on self-reporting and insufficient triangulation of information. This reduced professionals' ability to understand the level of risk within the family fully.

6.5 **There is a need for professionals to actively consider making a disclosure when a Registered Sex Offender (RSO) gains employment.**

During the review, it became known that Marius was working in the care sector; this employment was gained prior to his becoming a Registered Sex Offender. There was no consideration by his offender manager or those involved in the children's social care assessment of the need to inform his employer. At the time, employment checks were conducted every three years, and Marius left his position when it was due for review.

6.6 **A "Dual Support" procedure was not in place in the Victim First Emotional Support Services to consider how support is provided to multiple family members involved in the same crime.**

During the period under review, both Ann and Marius engaged with Thames Valley Partnership, which is commissioned to support victims of crime. The agency provides two services: the Victims First Emotional Support Service (VFESS) and the Victims First Specialist Service (VFSS). The couple were known to the agency because they were victims of a serious attack by a neighbour's dog. The same worker worked with both Marius and Ann for a short period, which was outside of agency policy.

6.7 **The DASH (tool for the assessment of risk for domestic abuse) was not used by the VFESS as part of expected practice.**

Although the service was originally engaged with support for Ann and Marius as victims of a dog attack, this coincided with incidents of domestic abuse that occurred in 2020. These events were discussed and explored with Ann, but the DASH tool was not used in line with agency expectations.

6.8 **Ann did not see herself as a victim of domestic abuse, and this was not explored or addressed to understand why such serious incidents had taken place between her and Marius.**

Throughout multiagency work and child protection planning, Ann was steadfast that she was not a victim of domestic abuse and her relationship with Marius was not defined by coercion or control. The planning and interventions offered focused on Marius attending a perpetrator programme, which did not exist, and Ann accessing a programme for victims, which was consent-driven. She did not see herself as that and therefore did not engage with the offer. There was insufficient challenge to narratives that minimised or contextualised abusive behaviour.

Ann repeatedly stated that the events that led to children's services becoming involved were triggered by stress, disappointment, and rejection. There was no response to this expressed need, no work undertaken to resolve conflicts and promote healthier relationships, nor any exploration of the dynamics of the relationship.

There was insufficient focus on Ann’s lived experience, including the impact of trauma, emotional dependency and relationship dynamics. A limited understanding of these factors affected professionals’ ability to assess risk and engage effectively and accurately.

This case highlights the challenges individuals face when they minimise or fail to recognise abuse, requiring a more persistent, skilled and adaptable professional response.

Ultimately, despite a period of child protection planning, there was no understanding of Ann and Marius’s relationship and ultimately how to make life safer for their child and themselves.

6.9 **There was no exploration of cultural and belief systems that may influence the behaviour of both Marius and Ann.**

The review found no exploration of cultural beliefs or how these may influence their relationships at any point during assessments.

The statutory process of child protection planning was superficial at best and did not fully explore the history and beliefs of Ann and Marius that lay behind their behaviours. This led to a plan that was neither reflective of their needs nor challenging to behaviours.

6.10 **The statutory Child Protection response was limited in depth and, at times, lacked the level of analysis, challenge, and clarity required to safeguard the child effectively and to understand the risk within the family fully.**

Of the two assessments undertaken, neither consistently demonstrated.

- robust multi-agency analysis of cumulative risk;
- The dynamics of Ann and Marius's relationship and the potential for escalation were not explored in sufficient depth;
- Interventions were not appropriately aligned to need, including reliance on services that were unavailable or not accessed;
- Planning lacked clear, outcome-focused actions and measurable impact;
- The child's lived experience was not consistently central to assessment and planning.

6.11 **Taken together, this resulted in a Child Protection response that did not fully reflect the complexity of the family's circumstances and limited the effectiveness of safeguarding interventions.**

6.12 **The way the General Practice reviewed the Child Protection Case Conference minutes meant they missed key information for inclusion in the patient records.**

There is no entry in any of the GP notes that indicates that Ann was experiencing domestic abuse, despite an alert being placed on her child's medical notes for safeguarding, as they were subject to a Child Protection Plan. The minutes sent to the GP indicated domestic abuse, mental illness, and alcohol misuse within the home. The practice has acknowledged, and it has now reviewed its processes.

This General Practice does not have an agreed approach for screening domestic abuse.

Information about domestic abuse was shared with the GP Practice; however, it was never discussed in the context of attendance for general medical conditions, and no opportunity to prompt Ann to share any information or seek support from them.

7 Conclusion

7.1 The murder of Ann was a tragic and devastating event. This review recognises her life, her central role within her family, and the profound impact of her loss.

7.2 This review has not identified that any single agency or practitioner could have predicted or prevented the homicide. However, it has identified several practice shortcomings, missed opportunities, and systemic learning themes, particularly regarding the quality and effectiveness of multi-agency safeguarding and child protection interventions.

7.3 Although risk factors were known, they were frequently considered in isolation rather than integrated into a cumulative, dynamic risk assessment, limiting agencies' ability to understand and respond to escalating complexity fully.

7.4 In particular, the statutory Child Protection response did not consistently demonstrate the level of analysis, challenge or coordination required. A more robust, integrated and outcome-focused approach may have strengthened safeguarding and improved understanding of risk.

7.5 The family have expressed strong views regarding the circumstances of this case, including concerns that earlier opportunities may have existed to recognise the risk and respond better. This review acknowledges those views and recognises that, while the homicide may not have been predictable in its immediacy, a stronger and more coordinated response may have altered the trajectory of multi-agency involvement.

7.6 Since these events, partner agencies have taken steps to strengthen practice, including:

- The development of enhanced multi-agency safeguarding models;
- Increased integration of **domestic abuse expertise within Child Protection processes;
- Greater emphasis on cumulative risk assessment and professional challenge

7.7 Agencies must demonstrate how this learning is embedded in practice to ensure meaningful and sustained change, in recognition of Ann’s life and in response to her family's experiences.

8 Recommendations

8.1 TVP provide a briefing document/ learning summary about assessing Foreign National convictions to support partner agencies' knowledge and understanding of foreign national convictions.

8.2 MOSOVO officers and Children's Social Care services that are assessing individuals, where serious harm against a female in a non-domestic setting has taken place, ensure that the behaviour is explored in the context of an intimate partner relationship and domestic setting.

8.3 TVP should ensure that their processes, guidance and training for MOSOVO staff in managing and accessing Foreign Nationals convicted abroad continue to be effective and that they consider and make appropriate disclosures to manage the risks posed by offenders.

8.4 The care home which employed Marius, following a review of their process for requesting DBS checks, assures the Commissioner for Oxfordshire County Council that the checks are being utilised appropriately.

8.5 Commissioned services provided by TV Partnership should review how support is provided to multiple family members involved in the same crime.

8.6 The VFESS will review how to assess and support clients who disclose domestic abuse during their involvement with the service.

8.7 Oxford University Hospitals NHS Foundation Trust to consider how they explore the impact and share any concerns for any dependent children of adults who present following an attempted suicide.

8.8 Children's Social Care are to assure the Community Safety Partnership that the new approaches to supporting children and families are addressing the concerns identified in this review.

8.9 The General Practice to review how information from child protection conferences is used to safeguard patients and provide assurance to the ICB that this will be done.

8.10 All agencies review how they develop an understanding of a person's particular cultural characteristics and belief systems during their work.