SAFER BRISTOL
DOMESTIC HOMICIDE REVIEW
OVERVIEW REPORT
Into the homicide of Rasa
In June 2016

Independent Chair and Author of Report: Laura Croom
Associate Standing Together Against Domestic Violence
Completion sent to Bristol Safer Partnership: 26th February 2018
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1. Preface

The Independent Chair and the Domestic Homicide Review (DHR) Panel members offer their deepest sympathy to all who have been affected by the death of Rasa. We particularly thank Rasa’s son and daughter-in-law for their time and support for this review. We also thank Rasa’s managers for their open and honest engagement.

1.1 Introduction

1.1.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.1.2 This report of a Domestic Homicide Review (The Review) examines agency responses and support given to Rasa, a resident of Bristol, prior to the point of her murder at her home in June 2016. On that day in June, at around 13:30, Rasa activated the emergency cord in her sheltered complex first floor flat twice in the space of 10 minutes, saying ‘Help me’, when the calls were answered. The Housing Support Advisor attended and, finding the front door unlocked, she entered and found Rasa lying just inside the door. She was naked and covered in blood and her throat had been cut. The Housing Support Advisor spoke to the emergency contact operator who was still on the line and asked for an ambulance. Ambulance operators advised the Housing Support Advisor what to do until the paramedics arrived 10 minutes later. Rasa was transported to hospital where she was treated but soon died. The police found Nojus, Rasa’s partner, under the stairwell in the building. He had bloodstains on his jumper. He was arrested and convicted of murder in December 2016 and sentenced to life with a minimum tariff of 17 years.

1.1.3 The Review will consider agencies’ contact and involvement with Rasa and Nojus from 29 December 2014 (when Rasa’s tenancy in the sheltered accommodation began) to the day of her death.

1.1.4 In addition to agency involvement, the Review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

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

1.1.6 This Review process does not take the place of the criminal or coroner’s courts nor does it take the form of a disciplinary process.
1.1.7 The Review Panel expresses its sympathy to the family and colleagues of Rasa for their loss and thanks them for their contributions and support for this process.

1.2 Timescales

1.2.1 Safer Bristol, in accordance with the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews commissioned this Domestic Homicide Review (Review). The decision to launch a DHR was taken in July 2016, soon after the murder. The Home Office were notified of the decision in writing on 15th September 2016.

1.2.2 Standing Together Against Domestic Violence (STADV) was commissioned to provide an independent chair for this DHR on 22 December 2016. The completed report was handed to the Bristol Safer Partnership on 31 January 2018.

1.2.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. Safer Bristol decided to delay the launch of the DHR until after the trial was completed. Agencies were alerted on 6 January 2017 that the first meeting was delayed due to difficulties of identifying relevant agencies and ensuring a time when all could meet.

1.3 Confidentiality

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

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

1.3.3 To protect the identity of the victim, the perpetrator and family members, the following anonymised terms have been used throughout the Review. These have been agreed by the victim’s family.

1.3.4 The victim: Rasa

1.3.5 The perpetrator: Nojus

1.3.6 The son and daughter-in-law of the victim: Mattis and Leva.
1.4 Equality and Diversity

1.4.1 The Chair of the Review and the Review Panel bore in mind all the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the Review process.

1.4.2 Rasa was a 61-year-old widowed heterosexual Lithuanian woman. She came to this country in 2011. Rasa worked as a cleaner for a cleaning company (Warehouse Cleaners). Warehouse Cleaners are contracted to clean a warehouse in Bristol. Rasa worked at a site which was very physical work. She walked several miles to and from work.

1.4.3 Nojus was a 61-year-old divorced heterosexual Lithuanian man who came to this country in also in 2011. He was a mechanic but was employed only for short periods while in the UK.

1.4.4 Rasa and Nojus both spoke some English and were not married. Both had previously been married to other people.

1.4.5 The protected characteristics that did not pertain in this case were disability (neither was disabled), gender reassignment (neither were transitioning during the time period covered), sexual orientation and pregnancy.

1.4.6 The protected characteristics that might have impacted on this case appeared to be sex, age, ethnicity/national origin, language and religion. In addition, they drank heavily together which would have increased their vulnerabilities.

1.4.7 In the chair’s interview with the victim’s son and his wife, she asked whether Rasa was active in a local church or other religious community. Rasa lived with them for a time and they said that they did not know of any such activity.

1.4.8 To address national attitudes that may have influenced Rasa’s thinking, the chair asked Rasa’s son and daughter-in-law. There is no specialist Lithuanian organisation in Bristol and little academic research on the subject available in English, so the chair gathered Lithuanian and East European understandings of gender roles with the specialist East European worker at Bristol’s Next Link domestic abuse charity. The CCG panel member asked a staff member who was Lithuanian to help and she researched gender roles and understandings of domestic abuse in Lithuania for the panel. Standing Together also provided research on these topics. These were discussed by the panel in the course of reviewing the draft of this report.

1.4.9 Sex is relevant in that the victim was female and the perpetrator was male. Recent analysis of domestic homicide reviews revealed gendered victimisation across both intimate
partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators.¹

1.4.10 The information we gained about cultural attitudes also highlighted gender roles. To address the vulnerabilities around alcohol use, we had the commissioner for substance misuse services in Bristol as well as the substance misuse project officer for Bristol City Council.

1.5 Terms of Reference

1.5.1 The full Terms of Reference are included at Appendix 1. This Review aims to identify the learning from this case, and for action to be taken in response to that learning with a view to prevent homicide and ensure that individuals and families are better supported.

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

1.5.3 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from 29 December 2014 (the start date for Rasa’s tenancy) to the date of the homicide. Agencies were asked to summarise any relevant contact they had had with Rasa or Nojus outside of these dates.

1.6 Methodology

1.6.1 Throughout the report the term ‘domestic abuse’ is used interchangeably with ‘domestic violence’, and the report uses the cross government definition of domestic violence and abuse as issued in March 2013 and included here to assist the reader to understand that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The new definition states that domestic violence and abuse is:

1.6.2 “Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or

¹ “In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over”. Home Office, “Key Findings From Analysis of Domestic Homicide Reviews” (December 2016), p.3.

“Analysis of the whole STADV DHR sample (n=32) reveals gendered victimisation across both types of homicide with women representing 85 per cent (n=27) of victims and men ninety-seven per cent of perpetrators (n=31)”. Sharp-Jeffs, N and Kelly, L. “Domestic Homicide Review (DHR) Case Analysis Report for Standing Together” (June 2016), p.69.
family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.

1.6.3 Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

1.6.4 Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

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

1.6.6 This Review has followed the 2016 Home Office statutory guidance for domestic homicide reviews issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. On notification of the homicide, agencies were asked expeditiously to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with the victim or the perpetrator.

1.6.7 A total of sixteen agencies and a company were contacted to check for involvement with the parties concerned with this Review. Nine agencies returned a nil-contact, two agencies submitted IMRs and chronologies, three agencies submitted chronologies only due to the brevity of their involvement and two provided brief reports as their only contact was with Rasa on the day of her death. The chronologies were combined and a narrative chronology written by the Overview Report Writer.

1.6.8 Quality of IMRs. The IMRs received were thorough and though the agencies had limited contact, the IMRs provided enabled the panel to analyse the overall situation and to produce the learning for this review. Through the panel discussion, areas for improvement were identified and possible recommendations discussed. One IMR made a recommendation.

1.6.9 Documents Reviewed: In addition to the two IMRs, documents reviewed during the Review process have included research around Eastern European attitudes to domestic abuse (referenced in the text) and alcohol and abuse, statistics on domestic abuse and older people, statements to the police and early police reports, STADV Case Analysis and research on domestic abuse in general.

1.6.10 Interviews Undertaken: The Chair of the Review has undertaken three interviews in the course of this Review. This has included two face-to-face interviews: one with the son and daughter-in-law of the victim and the other with Rasa’s managers at Warehouse Cleaners. The telephone interview was with a specialist Eastern European domestic abuse worker in Bristol. The chair is very grateful for the time and assistance given by the family
and colleagues who have contributed to this Review and for the consent given by neighbours for us to review their police statements.

1.7 **Contributors to the Review**

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

(a) Next Link Domestic Abuse Support Service, commissioned service with specialist Eastern European worker

(b) OPOKA – an Eastern European domestic violence support centre

(c) National Probation Service

(d) Bristol City Council (BCC), Safeguarding Adults and Deprivation of Liberty Safeguard

(e) BCC, Adult Care

(f) BCC, Public Health

(g) Victim Support

(h) The Walk In Centre, Bristol

(i) Recovery Orientated Alcohol and Drug Service (ROADS)/ Bristol Drugs Project

(j) Bristol Clinical Commissioning Group assisted in the effort to find Nojus’s GP. There is no record that Nojus had registered with a GP in Bristol. Rasa’s GP provided the little information they had.

1.7.2 The following agencies and their contributions to this Review are:

<table>
<thead>
<tr>
<th>Agency</th>
<th>Contribution - Chronology/IMR/Letter/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bristol City Council, Emergency Control Centre, Call Handling and Alarm Receiving Centre</td>
<td>IMR and chronology</td>
</tr>
<tr>
<td>Housing Services, Bristol City Council</td>
<td>IMR and chronology</td>
</tr>
<tr>
<td>Avon and Somerset Constabulary</td>
<td>Report on police contact – only direct contact was when called to the scene of the murder</td>
</tr>
<tr>
<td></td>
<td>Witness statements</td>
</tr>
<tr>
<td>South Western Ambulance Service NHS Foundation Trust</td>
<td>Notes from contact with Nojus on 3 June 2015 when Nojus collapsed but refused to attend the Emergency Department</td>
</tr>
<tr>
<td>Cleaning Facilities Management Company Human Relations Department (employer)</td>
<td>Chronology of Rasa’s attendance at work</td>
</tr>
<tr>
<td>GP practice for Rasa</td>
<td>Chronology of contact with Rasa</td>
</tr>
<tr>
<td>North Bristol NHS Trust</td>
<td>Chronology of contact with Rasa</td>
</tr>
</tbody>
</table>

### 1.8 The Review Panel Members

1.8.1 The following were Panel Members for this DHR:

| Lynne Bosanko | Commissioner of this DHR and Crime Reduction Project Officer, Bristol City Council (BCC) |
| Adam Smith | Detective Sergeant in Bristol Investigations Department, Avon and Somerset Constabulary |
| Carol Doxsey | Detective Constable, Avon and Somerset Constabulary |
| Jo Murphy and Kate Harris | Senior Practitioner, Safeguarding Adults Team, BCC |
| Jody Clark | Substance Misuse Project Officer, BCC |
| Katherine Williams | Substance Misuse Team Manager and Lead Commissioner, BCC |
| Paulette Nuttall | Safeguarding Lead Nurse, Bristol, North Somerset and South Gloucestershire (BNSSG) Locality, NHS Bristol Clinical Commissioning Group (CCG) and on behalf of NHS England |
| Donna Sealey | Health Improvement Manager, Public Health, BCC |
| Peter Anderson | Manager, Emergency Control Centre (ECC), BCC |
Nicky Debbage  
then Martin Owen and Suzanne Ponsford  
Service Manager, Housing Delivery, BCC

Linda Mellows  
Safeguarding Officer, Next Link (domestic abuse charity)

Tracey Judge  
Safeguarding Services Manager, BCC

Mark Thompson  
Frances Keel  
Contract Account Manager, Victim Support – allowed to step down after first meeting  
Victim Services Manager, Victim Support

1.8.2 Independence and expertise: Agency representatives were appropriate as they had not had contact with the victim or perpetrator, were not direct line managers of those involved, and were at an appropriate level of seniority and expertise within their organisations.

1.8.3 The Review Panel met a total of four times, with the first meeting of the Review Panel on the 6 March 2017. There were subsequent meetings on 15 May 2017 and 11 September 2017 and 22 November 2017.

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

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

1.9.1 Initially, the Safer Bristol Partnership notified Rasa’s son in writing of their decision to undertake a review in a letter sent on 17 January 2017.

1.9.2 Particularly, as there was little agency involvement in this case, the panel decided that it was important to involve the family, friends, and work colleagues to try to build a picture of what Rasa’s experience was like.

1.9.3 The Chair of the Review and the Review Panel acknowledged the important role of Rasa’s son and daughter-in-law as Rasa and Nojus lived with them for a while. The chair interviewed the couple at their home before the second panel meeting. Both had lived in the UK for more than 10 years and an interpreter was not required. Their advice was sought on
the terms of reference, in particular on additional agencies that might be involved and the timeframe of the review. They were given information about the support that AAFDA\(^2\) could provide. The family was sent the notes from the interview for corrections and made corrections.

1.9.4 The draft report was reviewed by the panel and the subsequently revised report was shared with Rasa’s family in January 2018. The Chair met with Rasa’s son and daughter-in-law to talk about the review. The family was pleased with the report and felt that making people aware of the services was important. They thought the focus on identifying these problems in the older population was important and that more education was needed about what constitutes abuse. They thought that the recommendations were good and thanked the Panel for looking so closely at the situation and reacting so well to it.

1.9.5 The chair also interviewed managers at Warehouse Cleaners warehouse who were responsible for Rasa in her work. The managers identified that Rasa had a friend at work, a younger Polish woman with whom she could converse more freely than she could with her English colleagues. This work friend had since left Warehouse Cleaners but her mobile number was provided. The chair sought contact, but messages left went unanswered.

1.9.6 All interviewees were provided with the Home Office leaflet explaining the Domestic Homicide Review process and Rasa’s son and his wife were given a leaflet for AAFDA for further support.

1.9.7 Avon and Somerset Constabulary provided witness statements from Rasa’s manager and from her colleague at Warehouse Cleaners.

1.10 Involvement of Perpetrator and/or his Family

1.10.1 At the beginning of the review, the chair sought advice from Avon and Somerset Constabulary who had contact with Nojus. At that time, Nojus had denied the charge and been found guilty. He had shown no remorse and was talking about appealing his conviction. This suggested that he was likely to view an interview with the chair as an opportunity to build his appeal case. A number of months later, the chair sought contact with his probation officer for an update on his disposition and further information.

1.10.2 Nojus’s probation officer provided information about Nojus and his background. She reported that Nojus continues to minimise his crime and to maintain that Rasa’s death was

\(^2\) Advocacy After Fatal Domestic Abuse specializes in guiding families through inquiries including Domestic Homicide Reviews and Mental Health Reviews, and assists with and represents families on inquests, Independent Office of Police Conduct (IOPC) inquiries and other reviews.
an accident. In light of this, the chair decided that an interview with Nojus was unlikely to benefit this review. The Review Panel agreed.

1.10.3 Nojus had no family or friends in this country that could be traced by the police. His probation officer identified that a daughter in Lithuania rings him but no one has visited him in prison.

1.10.4 The police supplied information gained from neighbours. As these statements confirmed information from Rasa’s son and her employers, no further information from them was sought.

1.11 Parallel Reviews

1.11.1 Coroner’s court. The coroner’s court was contacted and reported that they had closed this case with the conclusion that Rasa was unlawfully killed and that ‘A full inquest did not take place as all the evidence was heard at the criminal trial.’

1.11.2 Criminal trial: The criminal trial concluded in December 2016 and Nojus was found guilty of murder. He was sentenced to life with a minimum of 17 years in prison. The criminal case was completed before the DHR was launched and Standing Together commissioned.

1.12 Independence

1.12.1 The Chair and Author of the Review is Laura Croom, an Associate DHR Chair with Standing Together Against Domestic Violence (STADV). She is an independent consultant who has worked in the domestic abuse sector for 14 years and received Home Office DHR Chair’s training in 2013. She is an experienced DHR Chair and is independent of all agencies involved and had no prior contact with any family members.

1.12.2 STADV is a UK charity bringing communities together to end domestic abuse. STADV aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors’ safety, hold perpetrators to account and ultimately prevent domestic homicides. STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 50 reviews.

1.12.3 All panel members and IMR authors were independent of any direct contact with the subjects of this DHR and they were not the immediate line managers of anyone who had direct contact.

1.13 Dissemination

1.13.1 The following recipients have received/will receive copies of this report:
2. Background Information (The Facts)

<table>
<thead>
<tr>
<th>Referred to in report as</th>
<th>Relationship to V</th>
<th>Age at time of V death</th>
<th>Ethnic Origin</th>
<th>Faith</th>
<th>Immigration Status</th>
<th>Disability Y/N</th>
</tr>
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<tbody>
<tr>
<td>Rasa</td>
<td>Victim</td>
<td>61</td>
<td>Lithuanian</td>
<td>None known</td>
<td>EU member state</td>
<td>N</td>
</tr>
<tr>
<td>Nojus</td>
<td>Perpetrator</td>
<td>61</td>
<td>Lithuanian</td>
<td>None known</td>
<td>EU member state</td>
<td>N</td>
</tr>
<tr>
<td>Mattis</td>
<td>Son of the victim</td>
<td>30s</td>
<td>Lithuanian</td>
<td>None known</td>
<td>EU member state</td>
<td>N</td>
</tr>
<tr>
<td>Leva</td>
<td>Daughter-in-law of victim and wife of Mattis</td>
<td>30s</td>
<td>Ukrainian</td>
<td>None known</td>
<td>N/A</td>
<td>N</td>
</tr>
</tbody>
</table>

2.1 The Homicide

2.1.1 Homicide: Rasa lived in sheltered housing in Bristol in a first story flat. Nojus lived with her on and off. On the day of her murder, Nojus and Rasa had been drinking. At 13:34, Rasa pulled the emergency cord in her flat. An operator spoke to her through the intercom system and asked if she was okay. Rasa spoke very faintly, saying ‘Help me, help me’. The operator told her that help was on the way. Nine minutes later, Rasa pulled the cord again and said, ‘Help me’ again. The Housing Support Advisor (HSA) arrived 7 minutes after this call and
found the door unlocked. She found Rasa naked and covered in blood, lying in the hallway. She saw that Rasa’s throat had been cut. There was a blanket nearby covered in blood.

2.1.2 The operator was still on the line and the HSA asked her to call an ambulance. The HSA received advice on what to do from the ambulance operators. Rasa was still conscious and kept saying, ‘Help me, help me’. The HSA asked Rasa if she had hurt herself or if someone else had, as she wanted to know if there was anyone else in the flat but Rasa did not answer that question.

2.1.3 The ambulance arrived at 14:02 and the paramedics identified the cut to Rasa’s throat as the source of the significant blood loss. There were no other injuries. The two paramedics carried her in a carry chair down on the lift to get her to the ambulance. They took her to Southmead Hospital where she was treated but died at 15:10.

2.1.4 Police arrived at the scene after the ambulance with Rasa had left for the hospital. They spoke to several residents in the complex who knew that Rasa and Nojus were in a relationship. Following the residents’ direction, the police found Nojus hiding under the stairwell. Officers noted blood on his jumper and arrested him on suspicion of murdering Rasa. Once in custody, the officers noted other bloodstains on him. Nojus made several statements when arrested, including, “I know I’m crazy, nothing’s changed. If you’re guilty, you’re guilty.” He also said, “Now I feel like a crazy guy. Just killed.”

2.1.5 When investigating the scene, a significant amount of blood was found in the hallway, bathroom, kitchen and lounge of the flat, suggesting that Rasa had been bleeding for some time before summoning help. A large kitchen knife with a 20 cm blade was found in Rasa’s kitchen with blood on the blade.

2.1.6 Post Mortem: The post mortem showed no defensive wounds or any injuries other than the single laceration to Rasa’s throat. It appeared that Nojus cut Rasa’s throat from behind. The cause of death was extensive bleeding due to the single laceration.

2.1.7 Criminal trial outcome: Nojus was charged with murder and was tried and found guilty in December 2016. He was sentenced to life with a minimum of 17 years. He will be deported back to Lithuania when he is released.

2.1.8 Judge sentencing summary: In summary, the Judge noted that Nojus and Rasa had known each other for many years and ‘there is no doubt that you held her in genuine affection. Unfortunately, you could not control the extent of your drinking . . . and when she was in your company she was drawn into heavy drinking as well. . . . You provided companionship for her, as she did for you, but the reality is that you were bad for her. It was as a result of your relationship with her that she drank more and more, became less reliable as a worker, and her debts accrued. Only you know what happened on the afternoon . . . but it is evident that in some dispute between you, you lost your temper and you behaved with inexplicable brutality . . . The extent of your reaction beggars belief. What is even more
reprehensible is that having inflicted this dreadful injury, which you did I am wholly convinced with an intent to kill her, you chose to leave her to die alone in her flat.

2.1.9. . . It is not an aggravating feature but it is an unpleasant feature of the case that you have tried to justify your action by blaming [Rasa] for what you did and by trying to disguise it in a truly hopeless way as an accident. . .

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

2.2.1 Background information on Rasa: Rasa was a white Lithuanian woman of 61 when she died. She had lived in a coastal town on the Baltic Sea. When she was young, she was a singer for a period in a popular restaurant. She worked as an accountant and auditor for the government. Her son recalled that his mother drank a bit as he was growing up, as he said everyone did, but she did not drink excessively.

2.2.2 Rasa’s husband (and Mattis’s father) had died of cancer in 2009. Rasa then met Nojus. They thought they might move abroad and her son suggested that they move near him. She moved to the UK in the spring of 2011 to be near her only son, Mattis, who had moved here in 2004 for a better life. As an EU national, Rasa freely entered the country and became self-employed as a cleaner here. She moved in with her son and daughter-in-law when she arrived and moved out of their house in the autumn of 2012. Her son says that she first lived in a room in a shared house and then moved to a larger room in another house. She then moved into sheltered housing in December 2014. She was able-bodied but had obtained sheltered housing due to her age. She sought this housing because she wanted to be settled and was on a limited budget.

2.2.3 Background Information on Nojus: Nojus was a white 61-year-old Lithuanian man. He had been married twice before and divorced.

2.2.4 Mattis understood that he had lived in the US for a period and that he had 1 or 2 children. He reported that he had served in the Russian military\(^3\), as had all men of his age in Lithuania. He met Rasa in Lithuania and followed her to the UK in 2011. He had a series of short-term casual labour jobs and lived off and on with Rasa. Rasa’s family think that he was homeless when not with her.

2.2.5 Nojus listed his services as panel beater, strip/fitter, welder and mechanic. Avon and Somerset Constabulary obtained evidence that he had various jobs as a panel beater in the UK but was often dismissed due to being unreliable.

\(^3\) From police information.
2.2.6 Synopsis of relationship with the perpetrator: Rasa and Nojus had been together, off and on, for 5 or 6 years before she died. When Rasa and Nojus lived with Rasa’s son, Mattis, and daughter-in-law for around 18 months, the younger couple saw the relationship daily. Mattis and Leva could see that Rasa and Nojus were close.

2.2.7 Members of the family and the household: Between her arrival in the UK in May 2011 and autumn 2012, Rasa lived with her son and his wife. When Nojus moved here, he too lived with Rasa’s son.

2.2.8 In autumn of 2012, Rasa moved out of her son’s house and rented a room privately.
3. Chronology

3.1. Chronology from 29 December 2014 to date of death (2016) (timescales under review)

3.1.1 Rasa and Nojus had very little contact with statutory agencies. Rasa had no contact with agencies, apart from the GP, before the timeframe of this review which therefore begins with Rasa’s moving into sheltered accommodation provided by Bristol City Council.

3.1.2 The table below identifies the agencies and organisations that had contact. The chronology gives the date and source of this information in parentheses.

<table>
<thead>
<tr>
<th>Organisation Name</th>
<th>Contact with V (Y/N)</th>
<th>Contact with P (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bristol City Council</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Bristol Emergency Control Centre</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>South Western Ambulance Service</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS Foundation Trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Warehouse Cleaners (generic name) - her employers. Had the contract for cleaning the warehouse in Bristol at the time</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**On day of Rasa’s death**

<table>
<thead>
<tr>
<th>Organisation Name</th>
<th>Contact with V (Y/N)</th>
<th>Contact with P (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avon and Somerset Constabulary</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>South Western Ambulance Service</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>NHS Foundation Trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Bristol NHS Trust, Southmead Hospital</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

3.1.3 **Terms of Reference start here: 29 December 2014** (Bristol City Council Housing): Rasa moved into the sheltered housing 1-bed flat, having bid on the property and meeting the criteria of being 60+.
3.1.4 **Between December 2014 and Rasa’s death** (Bristol City Council’s Emergency Control Centre or ECC): Rasa called the ECC 59 times, 26 of these were related to problems with the fire alarm. Twenty of these were accidental.\(^4\)

3.1.5 **8 January 2015** (Bristol City Council Housing, or BCC Housing): Rasa was assessed for a support plan at the start of her tenancy, as this was a sheltered housing scheme. This is a detailed assessment, during which Rasa disclosed no needs. She was fit and working. The minimal provision was a 24-hour emergency response cover through the intercom system and one weekly face-to-face welfare check. Rasa requested the weekly check not be carried out. Over the course of the following weeks, there were texts and discussions about setting up payments for rent and service charges. Rasa was advised to claim benefit to cover the service charges.

3.1.6 **12 March, 20 March, 11 May 2015** (BCC Housing): Letters and calls between Rasa and the Customer Call Centre in response to calculation of benefits and her growing rent arrears.

3.1.7 **3 June 2015** (ECC): Alarm was activated at Rasa’s flat. Rasa reported that her friend (Nojus) had collapsed. An ambulance was called and the Housing Support Advisor went to the flat.

3.1.8 (South Western Ambulance Service NHS Foundation Trust): Rasa reported that Nojus had collapsed to the floor and was shaking. His lips had gone blue. Nojus said he had felt tired that day. Nojus was advised to go in the ambulance to the hospital. Nojus refused to go to hospital and was advised about the risk of not following this advice. The ambulance service used Language Line to ensure he understood the advice he was being given. He was advised to visit his GP the next day.

3.1.9 (BCC Housing): Housing Support Advisor attended and noted that tenant’s friend had collapsed at her flat.

3.1.10 **13 July 2015** (BCC Housing): Rents Management Team contacted Rasa about her arrears and spoke with Rasa, using a translator. They discussed arrears and advised Rasa on housing benefit (HB) claim process and agreed to a payment plan.

3.1.11 **14 July 2015** (BCC Housing): Rasa came to Customer Service Point to say that she’d lost her job in April and was last paid housing benefit in May. She’d applied again that day and was starting another full time job on the following Monday. She asked that her claim be backdated and said she would provide new income details for a new benefit claim. She said she did not understand what happened with her previous claim and so had not applied

\(^4\) Includes calls labelled as false alarms, accidental and mistakes.
earlier. The new claim was dependent on the income proof and backdating was not agreed. The pending claim was cancelled in 6 October 2015 as no income proof had been provided.

3.1.12 8 September 2015 (BCC Housing): A Notice Seeking Possession served as rent arrears had continued to rise and Rasa had not made contact as agreed.

3.1.13 14 September 2015 (BCC Housing): Rang Rasa twice and texted to follow up the notice for possession and asked her to call back. There was no response from Rasa.

3.1.14 29 October 2015 (BCC Housing): Rang Rasa and then texted her as her direct debit had failed. Rasa did not respond.

3.1.15 2 November 2015 (BCC Housing): Sent letter warning about imminent court action.

3.1.16 3 November 2015 (BCC Housing): Rang tenant about court action and followed with text.

3.1.17 9 November 2015 (Bristol Emergency Control Centre): Smoke alarm activated and Housing Support Advisor attended as there was no response to the fire alarm

3.1.18 17 November 2015 (BCC Housing): Rasa rang CSP about Notice of Seeking Possession. Adviser used an interpreter to explain the court process and advised her to ask for an interpreter if she needed to attend court.

3.1.19 23 November 2015 (BCC Housing): Rasa called to arrange to pay off all arrears. Rang Rasa to let her know that the court action was stopped and left a message for her.

3.1.20 5 February 2016 (BCC Housing): Support plan re-assessment carried out. A short version was used as Rasa did not want to complete a full support plan. The short form simply provided doctor details, next of kin, basic key information, etc.

3.1.21 8 February 2016 (BCC Housing): Letter sent to Rasa with details of new direct debit amount and a statement of account. The new direct debit amount included the rent and an additional £40/week towards the arrears.

3.1.22 15 March 2016 (GP): Rasa attended about a facial rash.

3.1.23 March/April 2016 (Avon and Somerset Constabulary): Aware that Nojus went back to Lithuania for a period.

3.1.24 4 April 2016 (Warehouse Cleaners): Rasa started work as a Cleaning Company employee, working as a cleaner in the warehouse in Bristol. She worked nights – from 22:30 to 6:30 – as part of a team with both men and women. Rasa had worked there previously through an agency as a cleaner.

3.1.25 About this time: Mattis realised that his mother was back with Nojus and he stopped seeing her for a while.

3.1.26 12 April 2016 (Warehouse Cleaners): Rasa did not show up for work and did not contact the Absence Line to explain why.
3.1.27 The managers said that this behaviour did not fit with the hard-working woman that they saw when she came to work.

3.1.28 14 April 2016 (Warehouse Cleaners): Following the set procedures, a letter was sent to Rasa’s home address saying that she needed to return to work or her job would be terminated in 5 days.

3.1.29 28 April 2016 (Warehouse Cleaners): As Rasa had not been in touch, Warehouse Cleaners designated her a ‘leaver’ and her contract was terminated.

3.1.30 Early May 2016 (Warehouse Cleaners): Rasa returned to Warehouse Cleaners and said that she had been in Lithuania because her son had been in a lorry crash and had died. (This was not true.) She was very upset and asked for her job back. One of the managers spoke to Warehouse Cleaners HR on her behalf, explaining the situation and saying that she was a good worker. Warehouse Cleaners then reinstated her as an employee.

3.1.31 Around this time (Rasa’s colleague’s statement to the police): Rasa’s friend said Rasa came into work drunk. The friend said she had come in before smelling of alcohol, but her managers were unaware of this.

3.1.32 5 – 12 June 2016 (Police – evidence): Nojus went to London. Apparently this move was intended to be permanent but it did not work out for Nojus and he moved back to live with Rasa.

3.1.33 16 June 2016 (Warehouse Cleaners): Rasa missed work.

3.1.34 17 June 2016 (Warehouse Cleaners): The last day that Rasa attended work.

3.1.35 20 June 2016 (Warehouse Cleaners): Rasa rang to say that she was running late and would be at work at midnight. The trains did not run that late and she did not come to work that night.

3.1.36 On the day of her death: (ECC): 13:34 Rasa pulled the emergency cord. She was spoken to through the intercom system and said, ‘Help me’. She was assured that help was on the way.

3.1.37 At 13:43, Rasa rang again and again said, ‘Help me’.

3.1.38 (BCC Housing): At 13:50 the Housing Support Advisor arrived and found Rasa lying naked and covered in blood with a laceration to her throat. She asked for an ambulance through the ECC. She asked Rasa if she had done this to herself or if someone else had done it as she wanted to know if there was anyone else in the flat. Rasa did not answer this question and continued to ask for help.

3.1.39 (South Western Ambulance Service NHS Foundation Trust): 14:02 When the ambulance arrived, it was obvious to them that Rasa had life-threatening injuries so they did not gather any information from Rasa or others at the scene. They provided information to
the hospital so they were prepared for Rasa’s arrival, following standard clinical practice for major trauma cases.

3.1.40 (North Bristol NHS Trust, Southmead Hospital): 14:38 Arrived at hospital. Staff attended to Rasa’s life-threatening injuries. Rasa died at 15:10. The post mortem blood sample taken showed that Rasa’s blood alcohol level was more than twice the drink-driving limit, though her true blood alcohol level would likely have been somewhat higher as she had had a blood transfusion which would have diluted her own blood.

3.1.41 Toxicology results for Nojus estimated that his blood alcohol level around the time of the murder was three times the drink-driving limit.
4. Overview

4.1.1 Summary of Information from Family, Friends and Other Informal Networks:

4.1.2 From her family: Mattis described his mother as friendly, chatty and beautiful. Mattis said that his mother and father’s relationship had not been abusive. She came to live with him and his wife when she moved to the UK. Nojus came over several months later and he too moved in with them.

4.1.3 Mattis became frustrated that Nojus did not work and drank during the day. Mattis ejected Nojus from his home the first time when he came home from work and found Nojus already drunk. Mattis thought the relationship was damaging to his mother because when she was with Nojus, she drank to the point where it badly affected her life. When she was drinking with him, she would miss work and neglect to pay her bills.

4.1.4 Mattis threw Nojus out of his own home and then his mother’s subsequent residences a number of times. Rasa did not protect Nojus or protest Mattis’s actions when ejecting Nojus. She would then live for weeks, sometimes for months, without Nojus. During these breaks, Rasa would say that she was happy and that it would not happen again. During these periods, she did not drink. She was her usual chatty and friendly self during these periods.

4.1.5 However, even when they were not living together, Rasa still looked after Nojus, for instance, she would cook for him.

4.1.6 Eventually, Rasa and Nojus would get back together. It became a pattern. Mattis did not know who initiated the reunions and does not understand why his mother let Nojus back in. When Rasa was back with Nojus, she seemed to cut off contact with others. She would lie to Mattis and Leva. Rasa’s family in Lithuania started ringing Mattis to find out what was happening with Rasa.

4.1.7 At one point, Mattis asked Rasa’s cousins and uncle to intervene and talk to Rasa about her drinking. When they did, Rasa said that there was no problem.

4.1.8 Mattis and Leva were worried enough about Rasa’s drinking that Leva contacted the helpline supplied by her employers. She was advised that unless Rasa sought help herself, there was little that Leva could do to help her. They provided the name of a drug and alcohol service, but Leva did not pass it on as Rasa did not acknowledge that she had a problem so they knew she would not try to get help.

4.1.9 When Rasa was with Nojus, she did not manage her finances well. After Rasa moved out of Mattis’s and Leva’s house, a P45 for Rasa arrived and Mattis learned that Rasa had lost her job. He went to check on her and found her drinking with Nojus. He then found the paperwork for many unpaid bills including one that would have made her homeless if not
paid that day. Mattis evicted Nojus, sorted the bills and paid the debt so that his mother could keep her rented room.

4.1.9 Mattis managed Rasa’s finances for a time after this and could see that when Rasa was with Nojus, she would spend less on basics, such as rent. Nojus would use Rasa’s cards, whether with her permission or not was unclear, to buy alcohol and other things. Mattis tried actively to manage his mother’s finances for her but after about 3 months, Nojus returned to live with Rasa and the pattern began again.

4.1.10 When Mattis realised that Nojus was back and his mother was drinking again, he was at a loss as to what else he could do and decided to leave her alone for a while. He found the situation hard to watch. He had not seen his mother for about 3 months when she died.

4.1.11 Though worried about Rasa’s and Nojus’s drinking and its consequences, Mattis and Leva never saw or heard Nojus being violent, abusive or controlling of Rasa. Mattis noted that even when he was throwing Nojus out of the house, Nojus did not physically resist.

4.1.12 Leva asked Rasa several times if Nojus scared or harmed her and Rasa always said no. Mattis talked to his mother many times about her relationship with Nojus but still does not understand what she thought about that relationship. He could see that Rasa appeared to be happy when she was with Nojus. Though she accepted that her life was better without Nojus, she obviously missed him.

4.1.13 Mattis and Leva did not think that Rasa had ever asked for any help for her drinking or with her relationship with Nojus, particularly as she never indicated that she thought she had any problems.

4.1.14 After Nojus killed Rasa, one of Nojus’s previous wives got in touch with Mattis through Facebook. She said that she had met Rasa in Lithuania and could not believe that Nojus had killed Rasa as he had never been violent with her.

4.1.15 Employers: Rasa’s direct line manager at Warehouse Cleaners no longer works there and the mobile number they had for him is obsolete. The chair interviewed the two line managers above him who were still with the company (at the time of the interview) and who knew Rasa.

4.1.16 These managers said that Rasa had first come to work as a cleaner there on a 12-week contract with a cleaning agency. She did a very skilled job for them and they said that it was very unusual for them to hire an agency worker as a full-time staff worker, particularly for such skilled work. She swept and dealt with spillages.

4.1.17 The managers described Rasa as an excellent employee with a strong work ethic. She arrived promptly at work which required that she take a train to the site and then walks 2 miles from the train station to the warehouse. She seemed grateful for the job and worked hard. She appeared very happy when she was working.
4.1.18 The managers say that she was quiet and a private person. She was very well-liked and left a strong impression with her co-workers. The managers said that her English was not very good and that when she was interviewed for the job, Rasa had some difficulty understanding the questions and had come with a man to act as a translator for her. They did not know this man’s name. Rather than use the translator, the manager conducting the interview simplified the questions to the point that Rasa could understand and answer for herself.

4.1.19 The managers said that Rasa had not seemed like herself for the last few weeks she worked there, but her performance had not dropped so they did not talk to her about this. Also, they understood that her son had recently died.

4.1.20 Rasa’s friend at work gave a statement to the police in which she said that Rasa had told her that she had a problem with her boyfriend as he was drinking a lot and that she had to pay for everything herself. Rasa had told her that she told her boyfriend that the relationship was over and that he had gone back to Lithuania.

4.1.21 Neighbours in sheltered housing: Neighbours greeted Rasa, but described her as ‘keeping herself to herself’. They noted that she spoke very little English. They thought that Rasa drank sometimes as one neighbour reported that she had smelled of alcohol on occasion.

4.1.22 One neighbour reported lending small amounts of money to Rasa on three occasions and that she always gave it back, though sometimes not as quickly as she had promised.

4.2 Summary of Information about the Perpetrator:

4.1.1 In conversation with probation, Nojus disclosed after his conviction that he has siblings living in Lithuania who are aware of his conviction. Since he has been in jail, his probation officer has reported that he has a daughter who has phoned him to talk to him. Nojus has reported that he has three adult children and three grandchildren. Nojus lived in the US for a time and his ex-wife and youngest child continue to live there.

4.1.2 Nojus told probation that he had a ‘body shop’ in Lithuania and rented workshop space there for it. He said that he was imprisoned for 20 years due to ‘fighting the Russians’, though this information has not been corroborated. Interpol revealed no previous convictions.

4.1.3 From Mattis and Leva: Mattis and Leva report that Nojus hid his drinking from them when he first came to live with them which led Mattis and Leva to think that Nojus knew that he had a drinking problem. They said that when he first came to the UK, his drinking was not bad. Neighbours and Rasa’s son and daughter-in-law report that eventually Nojus drank so heavily that he was unable to hold down a job. It is not clear where he lived when he was not
with Rasa, but it appears that he sometimes went back to Lithuania and sometimes slept rough.

4.1.4 Mattis said that he did not have a relationship with Nojus. The last time that Mattis and Leva saw Nojus, he described himself as ‘a shit’ and said that he had not achieved anything in his life. Mattis said that this was a change as he had always presented himself as ‘the man, who was in charge’.

4.1.5 Neighbours: The police shared statements made to them by two neighbours, after gaining their consent to share with this panel. A neighbour of Rasa’s reported to the police that he had taken Nojus in for several weeks when Rasa had thrown him out around Christmas 2015. The neighbour reported that Nojus was infatuated with Rasa and that when Nojus was drinking, he would be loud and animated which made the neighbour uncomfortable. Nojus also told stories about his treatment of prisoners while in the Lithuanian army that upset one of the neighbours. Though Nojus’s stories of his military background have not been corroborated, it may be that Nojus had both suffered and inflicted brutality in the course of his life.

4.1.6 Other neighbours told police after the murder that they heard Rasa and Nojus arguing in Lithuanian from time to time. One neighbour described the relationship as ‘tempestuous’. He said that Nojus sometimes stayed with Rasa and sometimes she threw him out. Sometimes, Nojus had a key to Rasa’s flat and sometimes he did not. Occasionally, he slept under the stairs or behind the bins, particularly when he was drunk. Sometimes a neighbour would take him in for a period.

4.1.7 Though the neighbours said they heard Nojus and Rasa arguing from time to time, they had not seen them fighting or any injuries on Rasa.

4.1.8 Knowing that Nojus was drinking a great deal, one neighbour shared his own experiences with Nojus, where he tried to form a relationship with him that would allow him to help Nojus get help for his drinking. This did not develop into a relationship that allowed the neighbour to help him, however.

4.1.9 Nojus told neighbours that he was working but then they would see him walking nearby during work hours. Nojus said he had found a new job in the week or so before he killed Rasa. The neighbour offered to give him a lift to the jobsite when he started, but Nojus did not appear on that day and the neighbour did not see him again. That neighbour reported hearing arguments between Rasa and Nojus after that.

4.1.10 That Nojus drank excessively appears to have been well-known with one neighbour who reported having seen him ‘well and truly hammered with drink’.

4.3 Summary of Information known to the Agencies and Professionals Involved
4.3.1 Rasa and Nojus had little contact with agencies and services. No one, including Rasa’s son and daughter-in-law, had any indication that Nojus was abusing Rasa. She was directly asked on a number of occasions by her family if she was being hurt by Nojus and she said no.

4.3.2 The main concern identified by her family and her employers was her alcohol use. For her family, Rasa’s drinking was tied up with her relationship with Nojus. They were unclear if Rasa’s poor financial management was the result of financial abuse by Nojus or if, when drinking, she made poor decisions about her money. Efforts by the family to get professional help to Rasa lapsed when they were told that for Rasa to get help, she would have to acknowledge that she had a drinking problem, which she never did.

4.3.3 *Warehouse Cleaners, her employer.* The staff at Warehouse Cleaners had no indications that Rasa suffered abuse. She did not mention any abuse to her employers or other staff members and she had no visible injuries.

4.3.4 When Rasa returned to work after her absence in April – early May 2016, her managers did not undertake the usual back-to-work interview because of the reason she gave for her absence.

4.3.5 This was also the case when Rasa appeared at work once smelling of drink. The managers agreed to breathalyse Rasa if it happened on another occasion. But they were not aware of another occasion when she appeared to have been drinking.

4.3.6 *BCC Housing.* When Rasa moved into sheltered housing, she was assessed to see what support she would need and want. Rasa identified no particular needs and was assessed as needing minimum support. She declined the weekly face-to-face welfare checks. Housing report that it is common for residents to not need the support, but for them to want the flats in the scheme because they are relatively inexpensive, of good quality and secure. A colleague at Rasa’s work confirmed this in her statement to the police as Rasa had told her that she had found an inexpensive place to live.

4.3.7 The needs that Rasa might have requested help with were her alcohol use, managing her money and concerns about debt. All these are asked about in the course of the housing assessment and Rasa did not identify that she had any of these needs. Domestic abuse is not specifically asked about.

4.3.8 Rasa started her tenancy in arrears and this continued. Many attempts were made to contact her in a variety of ways: letter, text, phone and email. She responded best to letters. When she called the call centre, her questions were usually about the charges. A translator was used when required. Eventually, payments were set up that paid her rent and an agreed amount towards her arrears. When Housing took court action about the arrears, a significant amount had already been paid off. In discussion with her, the problem appeared to stem from Rasa not setting up payments for the right amounts.
4.3.9 It is part of the standard script that tenants are offered debt advice in such a situation, but it appears that Rasa did not take up this offer.

4.3.10 In the aftermath of Rasa’s death, one staff member said that she had once seen Nojus sleeping under the stairs in the building. That he was living with Rasa off and on was not known to staff, though other residents knew this. It is not unusual for other people to be living with tenants and the tenancy agreement does not require that others are declared. No complaints about breaches of her tenancy, noise or any anti-social behaviour were received during Rasa’s tenancy.

4.3.11 GP. Rasa had little contact with the GP surgery, having only attended on three occasions for specific complaints. Rasa’s GP surgery is an IRIS (Identification and Referral to Improve Safety\(^5\)) practice where doctors and staff have been trained to pick up indications of domestic abuse. No indicators were noted and Rasa did not disclose any abuse.

4.3.12 Nojus had not registered with a GP and there was no record that he had accessed any other primary care service.

4.3.13 Avon and Somerset Constabulary. Neither Rasa nor Nojus were known to the police before the day she was killed. The police also found no wider UK or Lithuanian police records for Nojus.

4.3.14 The police discovered that in the days leading up to the murder, Rasa’s bank card was used in ways that were not normal for her but instead followed Nojus’s spending patterns. Nojus’s bank account had been empty for a week at the time of the murder and CCTV shows Nojus using Rasa’s bankcard to try and withdraw money from her account on the day of the murder. This was refused, as there was no more money left in her account.

4.3.15 Emergency Control Centre. There were 59 calls logged during the time period reviewed, 26 of which were related to two different issues with the fire alarms. The ECC reported that this number of activations is not unusual. Following the call in June 2015 for Nojus when he collapsed, the response followed the correct procedure and there was nothing unusual about the call that should have elicited a different response.

4.3.16 On the day that Rasa died, the call-handler understood from Rasa that she needed help, but the nature of the help needed was unclear until the Housing Support Advisor attended, as requested, and was able to see what was needed.

4.3.17 South Western Ambulance Service NHS Foundation Trust: The ambulance service attended in response to a call following Nojus’s collapse at Rasa’s flat in June 2015. The

\(^5\) IRIS is a general practice-based domestic violence and abuse training support and referral programme that has been evaluated in a randomized controlled trial. www.irisdomicileviolence.org.uk/iris'.
service gathered information about Nojus’s health and focused their efforts on convincing Nojus to go to hospital in the ambulance.

4.3.18 When the ambulance service was called to Rasa on the day of her death, her life-threatening injuries were apparent and no wider information on her situation was sought or collected.

5. Analysis

5.1 Domestic Abuse/Violence and Rasa:

5.1.1 Indicators of domestic abuse: The chair undertook a retrospective SafeLives DASH risk assessment of Rasa on what is now known. The assessment rendered a risk rating of 4 which is standard risk. The risks clearly identified were isolation, separation from the abuser, financial issues and problems with alcohol.

5.1.2 Rasa’s son stated that he did not understand why his mother and Nojus kept coming back together. It may be that this was helped by Rasa’s view of her role as a woman which is explored below under Equality and Diversity. It may be that Nojus was controlling her.

5.1.3 There are a number of behaviours observed in this relationship that are the same as those in controlling relationships.

(a) The pattern of separating and reuniting is common\(^6\). Perpetrators are often apologetic after an incident that has led to separation and manipulate the victim into returning through her sense of responsibility for the abuser. Nojus also did not appear to go far when she threw him out – was this because he did not have anywhere else to go? Or did he stay near to keep an eye on her, intimidate her or play on her sense of responsibility?

(b) Rasa’s neglect of herself when with Nojus. Rasa did not look after her own interests when she was with Nojus, missing work and not spending money in a way that would keep her safe, healthy and secure. That Nojus was bad for Rasa did not seem to concern him.

(c) Some women use alcohol as a coping strategy when in an abusive and controlling relationship.

(d) Missing work is also common when a woman is a victim of abuse. This can be the victim’s response to injuries or to the abuser exercising control in other ways.

(e) Isolation. Rasa appears to have had few people she was close to in this country and the relationship between Rasa and Nojus eventually led to Rasa’s son deciding to stay away. Being isolated from support is a risk factor for serious injury or death in situations of domestic abuse.

(f) Demonstration of devotion. In the few weeks before her death, Rasa and Nojus had been in London and Rasa had been trying to phone him and he did not answer. This is a common safety strategy employed by domestic abuse victims to demonstrate love, loyalty and devotion to appease the abuser.7

(g) Use of Rasa’s money. Nojus used Rasa’s credit card to buy alcohol8. This might indicate financial abuse, though we do not know if Nojus’s use of Rasa’s bankcard was with her consent.

5.1.4 These behaviours suggest a controlling relationship. However, Rasa’s son did not see any controlling behaviour when they were living together.

5.1.6 Rasa did not tell her friend at work about any abuse, though she did mention that there were financial strains. She denied there was a problem when asked directly by her son, daughter-in-law, and family in Lithuania. The information we are missing is whether Rasa felt she could make different decisions without repercussions; that is whether she had agency and could freely make choices about her life. We return to cultural understandings that might have been barriers to Rasa identifying abuse below in the Equalities and Diversity section.

5.1.7 The most obvious concerns, that Rasa had stopped going to work and was not spending her money on necessities, are also behaviours of someone with a severe drinking problem.

5.1.8 Of the behaviours above, the only two observed by agencies or organisations were Rasa’s absence from work and the occasion that she came to work smelling of drink. The first she explained with a convincing lie and the second was viewed by her managers as a bad day for a hard-working employee. So there were no statutory agencies in a position to draw any conclusions from these behaviours and her managers gave her the benefit of the doubt as a response to her evident work ethic.

5.2 Analysis of Agency Involvement:

8 Information from police investigation.
5.2.1 *The Terms of Reference:* The terms of reference asked that the panel:

(h) Analyse agency responses to any identification of domestic abuse issues.

(i) Analyse the co-operation between different agencies involved with Rasa and Nojus.

(j) Analyse organisations’ access to specialist domestic abuse agencies.

5.2.2 Rasa and Nojus had very little contact with agencies and there were no disclosures and nothing observed by agencies or organisations to lead them to ask questions about Rasa’s domestic situation.

5.2.3 However, in the course of our discussion of the case, the panel drew on the little contact they had with Rasa to address the following points.

(k) Analyse the opportunity for agencies to identify and assess domestic abuse risk.

(l) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.

(m) Analyse the communication, procedures and discussions, which took place within and between agencies.

(n) Analyse how the protected characteristics and particular vulnerabilities of Rasa and Nojus may have impacted on their ability to engage with services and support.

5.2.4 We also looked at how the protected characteristics might have impacted on their access to services and support.

5.2.5 A number of issues arose in discussing this case. Alcohol misuse, domestic abuse, and debt perhaps caused by financial abuse were discussed by the panel.

5.2.6 **Opportunities to identify and assess abuse**

5.2.7 *Rasa’s family.* Rasa’s family identified that she had a problem, though whether her relationship with Nojus was abusive, they could not say. Rasa did not share any concerns with her family, despite their directly asking and her son stepping in on several occasions to stop Rasa and Nojus drinking together and to manage Rasa’s debt. The family could see that her drinking was escalating and sought help for it.

5.2.8 *BCC Housing.* The sheltered housing scheme is targeted at older residents. When residents take up their tenancy, a thorough assessment of needs is undertaken. In the course of this, questions are asked about alcohol use and whether tenants need help to manage their use. They are asked about their ability to manage money and whether they are worried about debt and need help with this. They are asked about their language needs and
support with form-filling and letter-writing. They are asked about falls and stumbling. They are asked about undertaking activities on their own and about contact with family.

5.2.9 Rasa was given an opportunity to disclose her problems with money and with alcohol in the course of her assessment when she moved into the sheltered housing scheme. At her re-assessment the following year, Rasa did not complete the full form. Rasa did not flag any needs and declined support. There were no further opportunities to ask these questions.

5.2.10 The Panel realised the potential for using this assessment to identify domestic abuse. So many of the questions asked could be used to identify domestic abuse: the questions about regular contact with the family could identify isolation imposed by an abuser, concerns about paying bills and incurring debt could flag financial abuse and positive responses to questions about falls and stumbles might identify abuse being masked as clumsiness. The questions about alcohol use could be broadened to include substance misuse. Questions about the tenant doing things on their own could assist workers, with training, to identify a controlling partner. The sheltered housing scheme already have pendant alarms that could be provided for those at risk of domestic abuse without the abuser necessarily knowing that its provision was a response to reports of abuse.

**Recommendation 6 addresses this.**

5.2.11 If Rasa had disclosed abuse to a statutory agency, told her family, or sought help herself for abuse, she could have found or been referred to Next Link. Bristol's process for agencies is a referral and the Bristol City Council website directs people to the Bristol Against Violence and Abuse (BAVA) page. This page identifies agencies and provides links for services for victims of violence against women and girls (VAWG). The domestic abuse page lists Next Link and other related services.

5.2.12 **Next Link.** If Rasa had been referred to or called Next Link, an interpreter would have been used if needed. The process for such conversations is that confidentiality is explained and a SafeLives DASH risk assessment is completed. Rasa would have been asked whether other agencies were already involved and for consent to share information would have been sought.

5.2.13 Assuming Rasa had a standard risk rating based on what is now known, she would have been given initial advice, including immediate safety planning. Options for support would have been given, including safeguarding referrals and safe housing, if needed. If she had wanted on-going support, she would have been allocated a support worker from the community outreach team. Next Link employs a specialist worker for those from Eastern Europe. She is part of the crisis support team and works with clients for 4 to 6 weeks.

5.2.14 If Rasa had disclosed more information than we now have and scored 14 or more on the SafeLives DASH, then she would have been referred to the Multi-Agency Risk Assessment Conference (MARAC). She also might have been referred to the MARAC if the effect of Rasa's and Nojus's mutual drinking, Rasa's presentation, or particular disclosures had allowed the assessor to raise the risk level, based on professional judgement.
5.2.15 If Rasa had been referred to the MARAC, her situation would have been discussed by this multi-agency panel and an action plan made to increase her safety. She would have been provided with an Independent Domestic Violence Adviser (IDVA) as a caseworker to support her and ensure a coordinated community response to her risk and safety planning.

5.2.16 As Rasa did not disclose abuse, even when asked directly by her family, she was not referred to nor did she access Next Link or other specialist domestic abuse provision. Consequently, this case does not provide information about the effectiveness of the systems described above.

5.2.17 OPOKA. The other service that Rasa may have been directed to is OPOKA, a Bristol service for Polish women. Rasa’s employers noted that she spoke easily to her Polish colleague and therefore may have found it easier to contact a Polish organisation. OPOKA report that they have worked with a few people who were Lithuanian in their five years and had volunteers at the time that spoke Lithuanian. OPOKA offers IDVA and ISVA (Independent Sexual Violence Advisor) support as well as counselling, therapeutic group-work, peer support and advocacy and legal help.

5.2.18 Policies, procedures and training on domestic abuse and communication

5.2.19 Emergency Control Centre: The number of activations for Rasa’s flat seemed high, but many related to a fault in the smoke detector. There were an additional number of mistaken activations. It is common for tenants in sheltered housing to press the button for reassurance or to check that activation does actually link to a person.

5.2.20 Currently, the ECC does not have systems in place to identify any pattern of activations that might trigger an enhanced response.

5.2.21 Thinking that a victim of domestic abuse might use this alarm system to manage abuse – that is, by calling to get help and then perhaps say it was a mistake if the situation had calmed when contact was made.9 The panel agreed that there was an opportunity to develop service reports so that those providing support were alerted to patterns of activation that might flag the need for additional services. Recommendations 1 and 2 follow from this.

5.2.22 Warehouse Cleaners: Rasa’s explanation for her long absence from work in April 2016 made it difficult for her managers to understand what was really happening to her; in sympathy for her personal loss, they reinstated her in her job, but out of respect for her privacy and the grief they thought she was suffering, did not undertake the usual ‘back to work’ interview or ask many questions about her absence.

5.2.23 Both managers said that they discussed the situation at the time and agreed that the story Rasa gave ‘did not quite add up’.

5.2.24 The managers said that when Rasa arrived at work smelling of drink once, her immediate line manager identified the problem and spoke to them. As Rasa was a hard worker, they agreed that if it happened again, she would be breathalysed and sent home if she tested positive. No further incident was reported.

5.2.25 The managers said that in the aftermath of Rasa’s death, they were less likely to make assumptions about what was happening in the lives of their staff. They say that they now ask questions and that this has been to the benefit of staff since. They said that if Rasa had disclosed abuse, there was a company policy that would have enabled them to act to help her. They also observed that they were not sure that their international staff knew what the HR department was for and therefore may not be using the services available as a result.

5.2.26 A conversation with the HR department identified that Warehouse Cleaners had no policy on domestic abuse as they felt that it rarely arose. Research has shown that one in ten people who have experienced domestic abuse have been forced to take time off work because of the effects.\(^{10}\) Twenty per cent of those have been absent for more than a month.\(^{11}\) It is therefore likely that domestic abuse is impacting employee performance and that not only this employer, but most employers are not seeing these absences as relating to abuse. The panel acknowledges the improvements made by the individual managers to their own management practices. Recommendation 3 follows aimed at all businesses in the Bristol area to improve their practices around identifying and responding to domestic abuse.

5.2.27 Opportunities to address Rasa’s alcohol use that left her vulnerable

5.2.28 Rasa’s drinking had reached the point where it interfered with her ability to stay in work and would have made her more vulnerable to abuse by Nojus. Nojus’s drinking stopped him from holding a job.

5.2.29 Neither Rasa nor Nojus sought help for their drinking. In Bristol, the substance misuse treatment services, ROADS, deliver treatment interventions across the city. Most referrals to ROADS come from GPs and through self-referrals. Those who are referred or get in touch with ROADS themselves are assessed within two weeks when their needs, support and treatment options are discussed. Contact is available through a dedicated advice and information line with opening hours that extend beyond normal work hours and on Saturdays.


\(^{11}\) Roe et al, 2009, p. 66.
5.2.30 Rasa’s family were worried about her drinking and were not given information to support them when they rang Leva’s work helpline. Bristol offers services for family members: Developing Health and Independence and Adfam, among others. Such services might have helped Leva and Mattis to address Rasa’s drinking with her more effectively. They might have helped Rasa access the tier of services that encourages engagement. Leva was not signposted to these organisations. **Recommendation 7 follows.**

5.3 Equality and Diversity

5.3.1 In the Terms of Reference, the Review Panel identified the following protected characteristics of Rasa and Nojus as requiring specific consideration for this case: **age, sex, ethnicity, language and religion.** We reviewed how these might have impacted on their ability to engage with support and services and also how these might have impacted on the agencies’ responses to them.

5.3.2 We have very little information about Nojus and therefore have been unable to review his experiences against these criteria.

5.3.3 **Religion.** Rasa’s son did not think that his mother attended mass or church in this country and reported that she did not hold strong religious views.

5.3.4 **Sex and national origin/ethnicity:** Rasa’s daughter-in-law described a cultural understanding that she thought Rasa held about her role in relation to her male partner. Leva described the understanding of Ukrainian (Leva is Ukrainian) and Lithuanian women of Rasa’s age: that when they are involved with a man, they have to live with him and look after him all his life, no matter what he does. She said that many older men drink a lot and older women would assume they have to take care of their men when they are drunk. She said that Rasa felt responsibility for Nojus and wanted to save him and thought that if she did not look after him, he would die or hurt himself. She also said that older women in their countries often thought that they could not survive without a man and would do everything for their men.

5.3.5 The chair gathered the experience of Next Link’s Eastern European worker who said that there were broad similarities in the cultural understanding of abuse across Eastern Europe. She reported that patriarchal attitudes are more common in the older generations; for instance, men would expect the woman to do all the housework. Abuse would be tolerated and probably not even labelled as such. Such traditional views would also include a presumption that providing sex was a marital obligation. Women would be expected to cope with anything and everything. The worker reported that in her experience, older Eastern European women are also more likely to think that physical violence was bad but not recognise emotional abuse or coercive control as abuse. She reported that women often still feel a sense of shame around domestic abuse.
5.3.6 Regarding drink, the worker reported that it is understood that Eastern European men like to drink; a man who drinks heavily and regularly is unlikely to be labelled as an alcoholic. ‘A good wife just copes with it.’

5.3.7 A Lithuanian CCG staff member undertook research for the use of this review on domestic abuse in Lithuania, for which the chair and panel are very grateful. She did not find any statistics on the prevalence of domestic abuse but found information that supports the anecdotal information from Leva and from the Next Link workers’ experience as well as some research on attitudes.

5.3.8 The worker identified that in Lithuania, as part of the Soviet Union for many years, family life was idealised, leading to a denial of sexual abuse and domestic abuse. Men were encouraged to be superior and controlling. This meant that there was no place to report abuse and if women did, they would be shamed because domestic abuse did not exist officially. Lithuania gained independence in 1989, but it was only in 2011 that a law was brought in that protected women from domestic violence. Due to this historic cultural understanding, those who grew up as part of the Soviet Union can find it difficult to recognise abuse and seek help.

5.3.9 MOTA, a women’s rights association in Lithuania, reports that unofficially one-third of women in Lithuania have experienced violence in their lifetime. They also catalogue common attitudes and beliefs: that a woman cannot live without a man, that often domestic abuse is an open secret and is seldom reported, that women are thought to ‘have asked for it’ and therefore are shamed when they report, that it is acceptable for men to be controlling, and that it only happens in poor families and in villages.12

5.3.10 Research done in Vilnius University Social Care Department in 2015 asked women a series of questions. Their answers tell something about attitudes. When asked about the situations in which abuse happens, 38.5% of women reported that abuse happens when the perpetrator has something to drink, 27% said when the perpetrator was angry, 22% said it happened when the perpetrator couldn’t get any alcohol, 16.7% due to mental illness, and 13.5% identified other situations. So there is an understanding that alcohol use is closely linked to abuse.

5.3.11 The link between alcohol and domestic abuse is complex but much of the evidence supports the idea that alcohol does not cause domestic abuse, but intensifies the harm13.

5.3.12 This information and the attitudes described are not that dissimilar to attitudes found in the UK and in other countries. These attitudes would have affected both Rasa and

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Nojus’s views of their gender roles and of alcohol as the cause rather than the excuse for abuse.

5.3.13 **Particular support needs of those from Eastern Europe:** The 2011 Census showed that 2.5% of the Bristol population were born in Eastern Europe and 44% of that group are from Poland. The Lithuanian population is 4.6% of that cohort and 0.001% of the entire Bristol population. Of the Eastern European population in Bristol, just under 10% of them are over 50, that is, just over 1000 people.

5.3.14 In a study of the work of Eastern European Advocacy Service in London, the issues for Eastern European women were described as complex. The issues they identify may have also impacted Rasa: language barriers, high levels of isolation, acceptance of domestic violence within their communities, high level of dependence on the perpetrator, financial abuse and a reluctance to approach the police or other services. The women’s different cultural understanding shaped their responses to their situations. Abuse often started ‘soon after the women arrived in the UK giving them little or no time to adapt to life in the UK’. This study found that the clients of the service often continued to live with their abusers because they felt their options were limited and were reluctant to leave. They also found that the women required considerable emotional support to leave and it was common for the women to blame the men’s violence on alcohol. It required more time to help the women understand that the violence was not acceptable.

5.3.15 **Age.** Avon and Somerset Constabulary’s statistics show that in Bristol, the number of domestic abuse in which the victim was 60 or over has been increasing since 2011 (with a dip in 2015). This is also the case across the force area. Given the barriers to reporting for this age group, this increase may be the result of increased awareness amongst victims that this abuse was a crime

5.3.16 Not only the number, but the percentage of domestic abuse crimes in Bristol in which the victim is 60 or over has also been increasing (with the same dip in 2015). In 2011, domestic abuse crimes against someone 60 or older was 2.76%, increasing to 4.31% in 2016. However, 13.1% of Bristol’s population is 65 or over.

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5.3.17 In Bristol’s DHRs to date, Rasa was the only victim over 60. However, in STADV’s review\(^{17}\) of 23 domestic homicides, a quarter of those murdered by their current partner were aged 58 or above.

5.3.18 In an overview of information about older women and domestic violence, compiled for Women’s Aid in 2007 (2007:7)\(^{18}\) research noted\(^{19}\) that one reason that older women did not report abuse was that they thought it was ‘normal’ and acceptable. Research from the US and Canada identifies 3 key factors affecting an older woman’s efforts to escape domestic abuse, one of them being the extent to which the woman holds traditional views about gender roles.\(^{20}\)

5.3.19 Wider information on abuse amongst those over 60 is scarce. Traditional attitudes and understandings about gender roles may stop older women from identifying their situation as abusive. Many do not realise that there is support for those suffering abuse. This is likely to be even more common for those who have immigrated to this country. So efforts need to be made to get information to older women and especially those from immigrant communities. The Crime Survey for England and Wales will include collection of data on women between 59 and 74 from April 2017.\(^{22}\)

5.3.20 In line with Mattis’ observation about his mother’s drinking, about a third of older people with drinking problems (mainly women) develop them for the first time in later life.\(^{23}\) Contributing reasons are thought to be sudden disruption in lifestyle caused by retirement and bereavement, isolation and loneliness.\(^{24}\) Symptoms of alcohol misuse by older people can be obscured by other symptoms of old age and agencies and support staff can therefore miss it.

5.3.21 Recommendations 4, 5 and 8 relate to gathering information and addressing domestic abuse and addressing alcohol abuse in the older population.

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\(^{23}\) [http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/alcoholandolderpeople.aspx](http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/alcoholandolderpeople.aspx) [Accessed November 2017]

\(^{24}\) Institute of Alcohol Studies information about the drinking habits of older people at [www.ias.org.uk](http://www.ias.org.uk).
5.3.22 *Language.* In reviewing the responses of agencies that came into contact with Rasa and Nojus, BCC Housing used a translator to reach across the language divide. Her employers simplified their sentences to the point where Rasa could understand what was being said. However, they did note that the support that they would have been able to provide to Rasa might not have been clear to her. Though an information line telephone number is displayed in the women’s toilets at Rasa’s place of work, the employers thought they might need to be more proactive at explaining what help they can offer to employees in a clear way to their international staff. **Recommendation 3 includes this concern.**

5.3.23 With the possibility that these traditional gender roles and attitudes to domestic violence informed Rasa’s understanding of her relationship with Nojus and her role in that relationship, it is likely that Rasa would not have identified her relationship as abusive. She might have identified it instead as the burden of being a woman and part of her responsibility as a woman. That she cooked for Nojus even when they were not living together suggests that she felt that she had a responsibility to look after him even, or especially, when he was drinking or in trouble. She might also have normalised their excess drinking. By joining in with Nojus’s drinking, Rasa made herself more isolated and more vulnerable.

6. **Conclusions and Lessons to be Learnt**

**Conclusions (key issues during this Review):**

6.1.1 Though the panel examined the information provided closely, there is no clear evidence of domestic abuse between Nojus and Rasa. Rasa’s family observed no controlling behaviour or physical abuse when Rasa and Nojus were living with them. Rasa’s son and daughter-in-law had also asked Rasa the question directly many times and Rasa had consistently said that she was not being abused. Neighbours heard them arguing, but did not think Rasa was being hurt.
6.1.2 There remains the possibility that Rasa was being controlled by Nojus but because of her cultural understanding of gender roles and expectations of male behaviour, she did not identify it as such. This is more common in the older generation of women and may be more entrenched in immigrants from areas where the gender roles are more traditional, such as in Lithuania. It is possible that the privacy gained when Rasa moved out or her son’s house also isolated Rasa and provided the opportunity for Nojus to exercise more control over her.

6.1.3 The Review Panel was also concerned with the vulnerabilities of Nojus and Rasa as a result of their drinking.

6.1.4 As there was little contact with agencies and no contact around Nojus’s treatment of Rasa, the panel looked at awareness raising and how agencies might use existing systems to identify those needing help. This includes educating employers around signs of abuse and getting more effective help to family members around relatives' harmful drinking and abuse.

6.1.5 There are gains to be made in focussing information to older women and women from immigrant communities about coercive behaviour.

6.1.6 As part of this review, the chair looked at Bristol City Council’s Domestic Abuse Policy and at its Bristol Against Violence and Abuse Strategy 2015-2020 and action plan. The chair understands that the action plan is being refreshed. **Recommendation 9 addresses the need to prioritise this work.**

**Lessons to be Learnt:**

6.2.1 Though it is not clear that Rasa was suffering from abuse, there were a number of markers that suggest that she may have been. Her alcohol use was clearly making her more vulnerable. In these circumstances, the Review Panel was keen that the opportunity to improve services was not missed.

6.2.2 The lessons to be learnt were found to be:

6.2.3 **Lesson 1:** That Bristol employers can play an important role in identifying abuse and alcohol problems in their staff and signposting staff to appropriate help.

6.2.4 In response to a previous DHR in Bristol, there was a recommendation to encourage companies and organisations to implement HR workplace policies on domestic abuse (DHR Gill 2013). This resulted in the Bristol Zero Tolerance event that was launched in Bristol on International Women’s Day in March 2015. This encourages businesses to sign a pledge that their organisation agrees to be proactive in its commitment to working in partnership to tackle gender-based violence, abuse, harassment and exploitation. To date 70 organisations have signed up and another 60 are in conversation with the initiative.
6.2.5 Free training was also developed by Women’s Aid working with Bristol City Council, Public Health and Bristol Zero Tolerance. These initial training sessions for businesses were launched in September 2017 and aim to raise awareness of domestic abuse and workplace issues so that businesses can offer a safer and more supportive response to those experiencing gender-based violence. Seven organisations have undertaken training and 3 more have booked the training.

6.2.6 Developing outcome measures would help to evaluate the impact of the work underway.

6.2.7 Lesson 2: That Bristol employers can ensure that their international staff understand the help that can be offered to them through the HR policies of the organisation and through local services.

6.2.8 Lesson 3: That older women and women with more traditional understandings of women’s roles are less likely to identify coercive and controlling behaviour as abusive. There are opportunities for Bristol City Council and for those providing services to older people to help victims identify this abuse and to get them the support they need:

(o) That information should be created and targeted at older women and women with more traditional understandings of women’s roles to help them identify controlling behaviour by men as abuse. It is important that this information should be in the languages of the local immigrant communities and available in likely places.

(p) That there is the opportunity for the Emergency Control Centre to identify patterns of help-seeking and provide this information to service providers so they can offer appropriate help.

6.2.9 Lesson 4: That families struggling to help relatives with problematic alcohol use need effective support too and should be signposted to appropriate services. Such services are available in Bristol through Recovery Oriented Alcohol and Drug Service (ROADS), but need promoting.

6.2.10 Lesson 5: Residents of Bristol need guidance on reporting concerns about abusive relationships of their family and friends.

6.2.11 Lesson 6: Though housing staff have been trained on domestic abuse in the past, the training needs to be refreshed. Existing processes and questionnaires can be developed to include an understanding of coercive control and the ways that abuse may present in older residents’ lives and conversations.

25 In SafeLives Spotlight on Older People and Domestic Abuse, older people interviewed suggested information in bus stops and other transport links, in shopping areas, and at GP surgeries (page 17 – 18)
7. Recommendations:

7.1 IMR Recommendations (Single Agency):

7.1.1 Recommendation 1: BCC Emergency Control Centre to define vulnerability reporting criteria, including indicators of domestic abuse, for the new alarm monitoring system for Estate Management Services by July 2018.

7.1.2 Recommendation 2: Ensure that the Team Leaders within the BCC Emergency Control Centre receive domestic abuse awareness training which is refreshed annually.

7.2 Overview Report Recommendations:

7.2.1 The recommendations below should be acted on through the development of an action plan, with progress reported on to the Safer Bristol Partnership within six months of the review being approved by the partnership.

7.2.2 Recommendation 3: Bristol Domestic and Sexual Abuse Strategy Group (BDSASG) to work with local employers to provide and promote information about domestic abuse to their employees and provide this information in the languages of the workforce. Employers should be trained to identify employee behaviour that might indicate abuse and how to support victims. Bristol City Council should develop outcome measures to assess progress as a result of this work.

7.2.3 Recommendation 4: Bristol City Council to provide and promote information targeted to older people about coercive control and the help available to victims. Ensure this information is provided in the languages of the immigrant communities. BCC to share this information with the Bristol Older People’s Forum, with care-givers, with Bristol Housing Partnership and related groups. Information to be sent to the Safeguarding Adults Board to cascade to relevant organisations.

7.2.4 Recommendation 5: Bristol City Council to ensure the ROADS substance misuse treatment services are promoted through the city’s business and commercial sector through Public Health’s annual targeted health promotion campaigns.

7.2.5 Recommendation 6: BCC Housing work with Next Link to develop their assessment for sheltered housing to include substance misuse and to develop training for staff to use the form to identify and address domestic abuse, including referral routes. Training to be extended to other providers of sheltered housing.

7.2.6 Recommendation 7: BDSASG to develop information campaign guiding neighbours and families in how to respond to concerns about domestic abuse. BCC Housing put up domestic abuse posters in common areas of properties so that tenants are alerted to this information and guided as to how to respond.
7.2.7 **Recommendation 8: BDSASG, Next Link and local drug and alcohol services** develop training for housing providers that enables them to identify and respond to domestic abuse, in particular coercive control, and substance misuse in tenants over 50.

7.2.8 In order to continue to develop BCC’s response to domestic abuse and implement the changes suggested, the following recommendation.

7.2.9 **Recommendation 9: BDSASG** prioritises populating the current strategic Action Plan and develops outcome measures to show the improvements intended by the actions.
Appendix 1:

**Domestic Homicide Review Terms of Reference**

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

**Purpose**

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

2. To review the involvement of each individual agency, statutory and non-statutory, with Rasa and Nojus during the relevant period of time 29 December 2014 to the time of Rasa’s death. To summarise agency involvement prior to 29 December 2014.

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

4. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.
5. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.

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

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

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

Definitions: Domestic Violence and Coercive Control

9. The Review Panel understand and agree to the use of the cross government definition of domestic violence and abuse (amended March 2013) as a framework for understanding the domestic violence experienced by the Victim in this DHR.

The cross government definition states that domestic violence and abuse is:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial, and emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."
This definition, which is not a legal definition, includes so-called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

**Ethnicity, Equality and Diversity**

10. The Review Panel will consider all protected characteristics as defined by the Equality Act 2010 of both Rasa and Nojus (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any additional vulnerabilities (e.g. being a member or former member of the armed forces, carer status and looked after child).

11. The Review Panel identified the following characteristics of Rasa and Nojus as requiring specific consideration for this case: age, gender, and ethnicity, language and religion.

12. The Review Panel agrees it is important to have an intersectional framework to review Rasa and Nojus’s life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one’s experience with local services/agencies and within their community.

13. The Review Panel will seek additional information from East European support groups to ensure they are providing appropriate consideration to the identified characteristics.

**Membership**

14. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Panel members are independent of any line management of staff involved in the case and are sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.

15. The following agencies are to be represented on the Panel:

   a) Bristol Clinical Commissioning Group
   b) Bristol City Council, Adult Safeguarding
   c) Safer Bristol (including Crime Reduction and Emergency Control Centre) – Bristol City Council
   d) Bristol City Council Housing Delivery
   e) Bristol City Council Public Health
   f) Next Link, the local domestic violence specialist service provider
   g) NHS England
16. Expertise: The Review Panel recognised that the particular issues in this case are substance misuse and, perhaps, nationality and immigration and therefore there is a substance misuse expert on the Panel. Further expertise was sought for nationality. Immigration was relevant in that Rasa and Nojus had recently moved to the UK, but their status as immigrants was not an issue.

17. Parallel Reviews: There are no other parallel reviews known to the Panel.

18. Role of Standing Together Against Domestic Violence and the Panel:
   STADV have been commissioned by Safer Bristol Partnership to independently chair this DHR. STADV have in turn appointed their Associate Laura Croom to chair the DHR. STADV DHR team consists of an Administrator and Manager. STADV DHR team Administrator will provide administrative support to the DHR and the STADV DHR Team Manager will have oversight of the DHR. STADV Manager may at times attend a panel meeting as an observer. STADV DHR team will quality assure the Overview Report before it is sent to the Home Office. STADV DHR team will liaise with the CSP around publication. The contact details for all on the STADV team will be provided to the panel.

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

20. Chronologies and/or IMRs will be completed by the following organisations known to have had contact with Rasa and Nojus during the relevant time period, and produce an Individual Management Review (IMR):
   a) Avon and Somerset Constabulary
   b) Bristol City Council Emergency Control Centre
   c) Bristol City Council, Housing Delivery
d) GP – CCG to prepare

e) South Western Ambulance Service NHS Foundation Trust

f) North Bristol NHS Trust

g) Warehouse Cleaners

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

22. Each IMR will:

a) set out the facts of their involvement with Rasa and/or Nojus

b) critically analyse the service they provided in line with the specific terms of reference

c) identify any recommendations for practice or policy in relation to their agency

d) consider issues of agency activity in other areas and review the impact in this specific case

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

Analysis of findings

24. In order to critically analyse the incident and the agencies’ responses to Rasa and/or Nojus, this review should specifically consider the following points:

a) Analyse the communication, procedures and discussions, which took place within and between agencies.

b) Analyse the co-operation between different agencies involved with Rasa and/or Nojus and wider family].

c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.

d) Analyse agency responses to any identification of domestic abuse issues.

e) Analyse organisations’ access to specialist domestic abuse agencies.

f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
g) Analyse how the protected characteristics and particular vulnerabilities of Rasa and Nojus may have impacted on their ability to engage with services and support

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

Development of an action plan
25. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the Safer Bristol Partnership on their action plans within six months of the Review being completed.

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

Liaison with the victim’s family and perpetrator
27. The review will sensitively attempt to involve the family of Rasa in the review. The chair will lead on family engagement with the support of the Avon and Somerset Constabulary Service.

28. The Review Panel understands that there are no children in this family

29. Invite Nojus to participate in the review.

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

Media handling
31. Any enquiries from the media and family should be forwarded to the Safer Bristol Partnership who will liaise with the chair. Panel members are asked not to comment if requested. The Safer Bristol Partnership will make no comment apart from stating that a review is underway and will report in due course.
32. The Safer Bristol Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

**Confidentiality**

33. 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.

34. 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.

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

**Disclosure**

36. Disclosure of facts or sensitive information will be managed safely and appropriately so that problems do not arise. The review process will seek to complete its work in a timely fashion in order to safeguard others.

37. The sharing of information by agencies in relation to their contact with the victim and/or the perpetrator is guided by the following:

a) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).

b) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:

i) It is needed to prevent serious crime
ii) there is a public interest (e.g. prevention of crime, protection of vulnerable persons).
### Appendix 2 (Rasa)

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Scope of recommendation i.e. local/regional/national</th>
<th>Action to take</th>
<th>Lead agency</th>
<th>Key milestones achieved in enacting recommendation</th>
<th>Target date</th>
<th>Date of completion and outcome</th>
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| **Recommendation 1**: BCC Emergency Control Centre to define vulnerability reporting criteria, including indicators of domestic abuse, for the new alarm monitoring system for Estate Management Services by July 2018. | Local: Single Agency | Operations Centre to agree and implement vulnerability indicators with Housing Delivery by July 2018 | Bristol City Council – Operations Centre | • Operations Centre to agree schedule of reporting criteria with Housing Delivery  
• Operations Centre staff to receive training  
• Operations Centre to implement new monitoring system | April 2018  
June 2018  
July 2018 | |
| **Recommendation 2**: Ensure that the Team Leaders within the BCC Emergency Control Centre receive domestic abuse awareness training which is refreshed annually. | Local: Single Agency | Operations Centre management to incorporate DVA training in annual their service delivery plan and individual staff development plans | Bristol City Council – Operations Centre | • Add DVA training in the Service Delivery Plan 2018/19  
• Add to individual staff development plans in 18/19 | April 2018  
April/ May 2018 | |
| **Recommendation 3**: Bristol Domestic and Sexual Abuse Strategy Group (BDSASG) to work with local employers to provide and promote information about domestic abuse to their employees and provide this information in the languages of the workforce. Employers should be trained to identify employee behaviour that might indicate abuse and how to support victims. Bristol City | Local: Cross Agency | Public Health to develop bespoke Prevention information and marketing programme in collaboration with Bristol Womens Voice (Zero Tolerance Pledge and campaign) | Bristol City Council – Public Health with Bristol Womens Voice (Zero Tolerance Pledge) | • Information and campaign materials produced  
• Information materials disseminated to employers  
• Impact Measures (feedback questionnaires) undertaken with employers and employees – annually | July 2018  
Aug 2018  
March 2019 onwards | |
Council should develop outcome measures to assess progress as a result of this work.

**Recommendation 4:** Bristol City Council to provide and promote information targeted to older people about coercive control and the help available to victims. Ensure this information is provided in the languages of the immigrant communities. BCC to share this information with the Bristol Older People's Forum, with care-givers, with Bristol Housing Partnership and related groups. Information to be sent to the Safeguarding Adults Board to cascade to relevant organisations.

Local: Single Agency

| Information materials developed and disseminated to target groups through stakeholder forums | Bristol City Council – Crime Reduction Team | • Information materials designed and produced in community languages  
• Materials disseminated through stakeholder forums and made available through BAVA website | July 2018 | Aug-Oct 2018 |

**Recommendation 5:** Bristol City Council to ensure the ROADS substance misuse treatment services are promoted through the city’s business and commercial sector through Public Health’s annual targeted health promotion campaigns.

Local: Single Agency

| Public Health to promote ROADS services through annual targeted health promotion campaigns | Bristol City Council – Substance Misuse Commissioning Team with Public Health | • Information on ROADS treatment services to be provided to Public Health by Substance misuse team  
• Public Health to promote widely | May 2018 | June 2018 onwards |

**Recommendation 6:** BCC Housing work with Next Link to develop their assessment for sheltered housing to include substance misuse and to develop training for staff to use the form to identify and address domestic abuse, including referral routes. Training to be extended to other providers of sheltered housing.

Local: Cross Agency

| Housing Delivery to consider within scope of the Services to Older People service redesign. | Bristol City Council – Housing Delivery with Next Link | • Implement STOP service redesign | April 2019 |

**Recommendation 7:** BDSASG to

Local: Cross Agency

| No Excuse campaign | Bristol City | • Incorporate No Excuse | April 2018 |
develop information campaign guiding neighbours and families in how to respond to concerns about domestic abuse. BCC Housing put up domestic abuse posters in common areas of properties so that tenants are alerted to this information and guided as to how to respond

<table>
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<tr>
<th>Recommendation 8: BDSASG, Next Link and local drug and alcohol services develop training for housing providers that enables them to identify and respond to domestic abuse, in particular coercive control, and substance misuse in tenants over 50.</th>
<th>Local: Cross Agency</th>
<th>Next Link and BDP to develop a bespoke training package(s) for social housing providers</th>
<th>Bristol City Council Housing Delivery with Next Link and ROADS treatment providers</th>
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<tr>
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<td>Training packages designed and promoted through BAVA website</td>
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<td>Training delivered at least annually</td>
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<td>Oct 2018 Mar 2019</td>
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<th>Recommendation 9: BDSASG prioritises populating the current strategic Action Plan and develops outcome measures to show the improvements intended by the actions.</th>
<th>Local: Cross Agency</th>
<th>BDSASG to agree revised VAWG strategy 2018- and comprehensive accompanying action plan (In context of One City Plan)</th>
<th>Bristol Domestic and Sexual Abuse Strategy Group</th>
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<td>VAWG Strategy 2018 signed off</td>
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<td>VAWG Strategy Action Plan populated and signed off</td>
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<td>July 2018 Aug 2018</td>
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Dear Mr Pattison,

Thank you for submitting the Domestic Homicide Review (DHR) report for Bristol (‘Rasa’) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 25 July. The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded that this is a good, respectful report that is well-referenced and identifies useful learning. The Panel particularly commended the wide-ranging scope of the review and the detailed exploration of equality and diversity issues.

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

- Whilst the Panel understood the basis for applying a DASH risk assessment retrospectively, they were concerned that it was too speculative and therefore questioned the value it added to the analysis. The Panel felt that the risks could have been considered in the broader narrative;

- You will wish to note that, in relation to the national recommendation at 7.1 in the report, which advocates the collection of data on older women in the Crime Survey for England and Wales, the upper age limit was raised from 59 to 74 in April 2017. More information on this can be found on the Office for National Statistics website:

https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/methodologies/improvingcrimestatisticsforenglandandwalesprogressupdate
• In relation to the housing recommendation for training, you may wish to explore whether the Domestic Abuse Housing Alliance (https://www.dahalliance.org.uk/) can provide support in terms of best practice and assessment of training needs;

• The Panel suggested a representative from the victim and perpetrator’s ethnic community on the review panel may have been beneficial in relation to any cultural issues that emerged;

• It is unclear in the report whether the family were offered a specialist and expert advocate for the review;

• You will wish to update the action plan before publication;

• The precise date of death in the Judge’s summing up remarks (2.1.8) could be further anonymised.

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 the PCC for information.

Yours sincerely

Charlotte Hickman
Chair of the Home Office DHR Quality Assurance Panel