Safer Ealing Partnership

Domestic Homicide Review

Executive Summary Report

Death of Martyna

Aged 21 years

Died May 2022

Independent Panel Chair and Author Theresa Breen MA
Date report completed March 2024

Contents

Section 1- The Review Process

1.1 This summary outlines the process undertaken by the Ealing Community Safety Partnership area domestic homicide review panel, in reviewing the homicide of **Martyna**[1] who was a resident in their area.

1.2 The following pseudonyms[2] have been in used in this review for the victim and perpetrator, and other parties as appropriate, to protect their identities and those of their family members. The victim's sister chose the pseudonym's used for family members in this report from a list of popular names relevant to the subjects' country of origin. The author chose all other pseudonyms.

Table 1 are people referred to throughout police statements.

Pseudonyms:	**Relationship to Martyna**	**Police interview / MG11 statements reviewed in the DHR[3]**
Martyna	N/A	N/A
John	Ex-boyfriend-perpetrator	N/A
Alicja	Sister	Police MG11 taken. Spoken to by the report author.
Gabriela	Mother	No police MG11 taken. Not spoken to by the report author.
Millie	Ex Flatmate Bristol	Police MG11 taken. Not spoken to by the report author.
Becky	University friend	Police MG11 taken. Not spoken to by the report author.
Tom	University friend	Police MG11 taken. Not spoken to by the report author.
Julia	Work colleague and friend	Police MG11 taken. Not spoken to by the report author.
Martin	Male friend	Police video interview taken. Not spoken to by the report author.

[1] A pseudonym chosen by the victim's sister on behalf of the DHR panel
[2] List of culturally appropriate Pseudonyms chosen by the author on behalf of the DHR panel
[3] Denotes the Police statements (MG11) and/or taped interviews (which were later transcribed) that were taken during the police investigation and also served to the Coroner for Inquest. They were disclosed by the police panel member to the DHR Chair to serve a statutory purpose.

Rachel	John's mother	No police MG11 taken - telephone interview with the author.

Table 2 are people directly interviewed by report author.

Pseudonyms:	**Relationship to Martyna**	**Interview with report author[4]**
Jane	Work colleague and friend	Police MG11 taken - telephone interview with the report author.
Sean	John's friend	Police MG11 taken - teams interview with the report author.
Jed	John's friend	No police MG11 taken - telephone interview with the author.
Mark	John's friend and previous manager	No police MG11 taken - telephone interview with the author.

1.3 Martyna was a Polish national, who had lived in the UK for over 3 years, having moved to Bristol to work and later to London to attend University. She worked in a restaurant to support her living expenses in London. Martyna had met John online, commenced a relationship with him whilst she lived in Bristol, and initially maintained a relationship after moving to London. Martyna decided to end the relationship after finding her university work actual work and the relationship all difficult to juggle. John did not want the relationship to end. There were no domestic abuse incidents reported during this time to any agency.

1.4 Over a period of months, it appears that John refused to accept the end of the relationship and had threatened suicide several times. Martyna had reported her concerns about John to police, but John did not present 'at risk' when seen by officers.

1.5 On night of her death, Martyna was at work in the restaurant. The day before, John had travelled to London and had waited (stalked) outside of her work premises for several hours. On the day of the murder, he

[4] The interviewees were contacted and spoken to by the author, either by phone or Teams. Also seen by police. See detail at section 5.1.

purchased a knife and waited outside the restaurant until he saw Martyna leaving with a male friend. Following them into an alleyway, he attacked Martyna and stabbed her savagely causing her fatal injuries.

1.6 The subsequent police investigation concluded that John had murdered Martyna. John was arrested and charged with her murder. John made a no comment interview to police during interview. He then pleaded not guilty to her murder.

1.7 Following Martyna's murder, a formal notification was sent by the Metropolitan Police to the Ealing Community Safety Partnership, with an explanation that the case was being examined as a homicide. At a meeting of the DHR decision panel, it was confirmed that the case met the DHR criteria and partners were contacted and asked to secure their records.

1.8 The panel met 4 times by video conference with further work being conducted by telephone, video conferencing and the exchange of documents. At the start of the review process, the panel each confirmed their independence.

1.9 The review was concluded on 27.03.2024 following final consultation with the panel.

Section 2. Contributors to the review.

2.1 There was a dearth of agency information in this case.

Agency	**Contribution**
MPS	Summary report/ Police statements
Gwent Police	IMR
University of West London	IMR
University Hospital Bristol NHS Foundation Trust	Chronology
Avon and Somerset Police	Chronology
Local GP service (John)	Chronology

A number of other recognised / traditional agencies[5] provided a nil return.

[5] Includes Housing, Adult Social Care, Probation, VSS, Mental Health services, Druga and Alcohol services.

2.2 Each IMR author had no previous knowledge of the subjects of the review nor had any involvement in the provision of services to them. They were selected as people independent from any clinical or line management supervision for any of the practitioners who provided care for them and could provide an analysis of events that occurred; the decisions made; and the actions taken or not taken.

Section 3. The Review Panel Members.

3.1 These were independent people with no conflicts.

Name	**Role/Agency**
Theresa Breen	Independent Chair and Report Author
Tracy Mcauliffe	Associate Pro-Vice Chancellor University of West London
Viran Wiltshire	Detective Sergeant, Specialist Crime Review Group, MPS
Fozia Ashraf	Advance Charity
Howard Stanley	Aneurin Bevin UHB – Corporate Services
Aimee Ramiah	Head of Safeguarding, Advance Charity
Kate Aston	Designated Nurse, Adult Safeguarding- NHS NWL[6]
Joyce Parker	Community Safety Team Leader, Ealing CSP
Brenda Otto (BO)	Head of Advocacy Services, Southall Black Sisters
Stephanie Gordon (SG)	DoLS Team Manager, Ealing
Rhys Potter (RP)	Detective Inspector, Gwent Police

Section 4. Author and Chair of the Overview Report

4.1 Theresa Breen was selected as the independent Chair of the Review Panel and Author of the report. She retired from British Policing (MPS) in November 2018, after 30 years. As a former senior police officer, she worked across a range of policing disciplines, including Serious Organised Crime, Counter Terrorism and Safeguarding in management positions. She gained experience of reviews working extensively in partnership with other agencies and had experience of working with many diverse communities.

[6] Northwest London (NWL)

She was a trained Senior Investigating Officer (SIO). She did not work specifically in the borough of Ealing.

4.2 She worked across a number of Public Protection and Safeguarding portfolios in London and Surrey, managing and overseeing MAPPA[7] and MARAC[8]processes. As the police Public Protection lead in Westminster, she managed and oversaw Domestic Abuse services, to diverse communities. As a Borough Commander in a West London Borough, she was the core police member of the Safer and Stronger Strategy Group. Operating as 'Gold London[9],' Theresa had overall strategic command of multiple incidents including those involving domestic abuse and homicide.

4.3 Working in partnership, Theresa additionally led the national police implementation of the cross-agency Operational Improvement Review (OIR) recommendations following the terrorist activities across the UK in 2017/18. Theresa is independent has not worked for any agency in Ealing, Gwent or Bristol and has no connection with any of the agencies involved in this review. She has completed the relevant Home Officer DHR Chair training.

4.4 Theresa has been the Chair and Author for 10 DHR's and is a current Chair and Author for the new OWHR[10] pilot process. She is a trainer for Sancus Solutions, delivering safeguarding and equality training, and delivered the OWHR training to over 100 delegates, including safeguarding and, equality and diversity input.

Section 5. Terms of Reference

5.1 At the first panel meeting, the panel considered the TOR referenced in the Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 (section 2 paragraph 7) and adhered to the

[7] MAPPA stands for Multi-Agency Public Protection Arrangements, and it is the process through which various agencies such as the police, the Prison Service and Probation work together to protect the public by managing the risks posed by violent and sexual offenders living in the community.

[8] MARAC is a multi-agency meeting which facilitates the risk assessment process for individuals and their families who are at risk of domestic violence and abuse. Organisations are invited to share information with a view to identifying those at "very high" risk of domestic violence and abuse. Where very high risk has been identified, a multi-agency action plan is developed to support all those at risk.

[9] The generic command structure, nationally recognised, accepted and used by the police, other emergency services and partner agencies, is based on the gold, silver, bronze (GSB) hierarchy of command and can be applied to the resolution of both spontaneous incidents and planned operations.

[10] OWHR is Offensive Weapons Homicide Review is a HO pilot to deal with the under researched and reviewed area of homicides involving offensive weapons in 4 pilot sites across the UK.

guidance with some case specific terms[11]. The aim of the DHR is to identify the most important issues to enable lessons to be learned from homicides with a view to preventing homicide and ensuring that individuals and families are better supported. 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.

5.2 Timeframe under Review

The scope for this review was 01.01.2020 to 17.05.2022 and the reason for this period is that it initially appeared that Martyna appeared to have entered the UK during this time to study. It later transpired that she had moved to the UK in May 2019, but as agencies had already examined all possible contacts with her, it was unnecessary to vary the timeframe, and this was explained to the panel.

5.3 Case specific Terms

Subjects of the DHR

Victim: Martyna, aged 21 years

Perpetrator: John, aged 30 years

Specific terms: Key Lines of Inquiry:

The Review Panel and Chair considered the 'generic issues' as set out in statutory guidance and were asked to examine the following case specific issues.

4.5.3 The following **Case Specific Terms** were examined:

- **Were medical concerns appropriately considered when a hospital attendance occurred?**
- **Where suicidal concerns were raised, were any mental health referrals made?**
- **Is there sufficient Mental Health publicity and notifications for public awareness?**

[11] Referenced at section 5.3

- **Was Martyna aware of the patterns of coercive behaviour.**

4.5.4 The Review Panel and Chair discussed and agreed additional enquiries that the Chair would pursue with friends and family members if able:

- Whether any family, friends or colleagues were aware of any abusive behaviour from the perpetrator to the victim, prior to the homicide, and whether this had been shared, by them, with professionals.
- Whether there were any previous victims of John.

Section 6 Summary Chronology

6.1 During the review period, Martyna and John came to the attention of agencies for routine engagement and non-urgent matters. Neither were known to Adult Social Care or Mental Health services. The summary of agency engagement is as follows:

6.1.1 Police: There was limited police engagement and specifically related to 'concerns for safety'. John had come to the attention of police in the UK as a missing person on several occasions, reported by a friend and by Martyna on separate occasions. There was no engagement with Martyna as a potential victim of DA.

6.1.2 Medical (includes GP services and Integrated Care Partnership information): There are a number of routine medical appointments recorded for Martyna and John. The GP and hospital records are also unremarkable. This is because John denied any suicidal ideation when questioned about work related stress. However, there is one hospital attendance by John when he took an overdose which was not followed up, and no intervention occurred. . More professional curiosity could have been displayed. No information was held by these agencies which assisted this review or indicated any abusive behaviour or domestic abuse concerns.

6.1.4 University of West London (UWL): Information suggests that Martyna was struggling with her mental health although this was not proactively explored with at the time, due to confidentiality. UWL offered appropriate options for housing support and although the student welfare team offered support, Martyna did not take it.

6.2 Information from witnesses.

6.2.1 In this review, there are no agency records/disclosures linked to family, friends or colleagues prior to the murder where concerns about abusive behaviour were shared with agencies. This could be that wider public awareness of the risks are limited. The lack of agency information suggests that the murder of Martyna by John could not have reasonably been predicted or prevented by agencies. It is also impossible that any single family member or friend, could have predicted the likely escalation in John's behaviour.

6.2.2 John did not make any direct threats to harm Martyna, but the review and police investigation identified her vulnerability to ongoing

harassment from John when exploring the timeline after her death. Martyna describes her acute frustration about the repeated calls and texts over many months, which on reflection could have been addressed as harassment if she (or any of her friends or family) had reported his behaviours to any agency.

6.2.3 There was one identified time that Martyna suggested that she was unsafe. In the text exchanges between Martyna and Jane, she makes a reference to feeling unsafe, '*I am actually fucking scared *inaudible* cos I work, we have bouncers, I work only weekends, so every single weekend we have bouncers, so I'm safe at work, at uni the security is very strict so obviously I'm safe at uni, I feel kinda awkward telling all of my roommates about this, I don't know what to do'*. Martyna did not report these concerns to anyone in an official capacity, which suggests that she did not recognise herself as a victim. Also, in her discussions with Martyna, Jane understood that Martyna had not received a direct threat and in her interview with the author, said she was satisfied that Martyna was managing this concern.

6.2.4 Neither Martyna or Jane reported these fears to any agency, but Martyna did however describe that she intended to go and stay with a friend. It is unclear whether she recognised warning signs. She potentially did not know that she was at risk. Indeed, because their relationship did not involve consistent periods of physically abusive behaviour, Martyna's ability to identify individual incidents may have been limited. Martyna was a young woman, in her second serious relationship. She had previously lived with Jakub. Whilst she had her parents, and her sister's relationship, this means she may have had very little personally to compare her relationship with John to. Life experience and that of your friends and contemporaries are shared through discussion and Martyna's family and friends all agreed that she was a private individual, not prone to discussing personal matters.

Section 7- Conclusions

7.1 Five specific questions were examined as part of this review.

- **Whether there were any previous victims of John**
- **Were medical concerns appropriately considered when a hospital attendance occurred?**
- **Where suicidal concerns were raised, were any mental health referrals made?**

- **Is there sufficient Mental Health publicity and notifications for public awareness?**
- **Was Martyna aware of the patterns of coercive behaviour?**
- **Whether any family, friends or colleagues were aware of any abusive behaviour from the perpetrator to the victim, prior to the homicide, and whether this had been shared, by them, with professionals.**

There were no previous victims of John's. Whilst, through the process of this review, there are now observations about his mental health, they did not raise significant risk concerns prior to the murder. A number of family, friends or colleagues were aware of John's deteriorating behaviour, and some were aware of his any abusive behaviour towards Martyna but did not recognise it as DA and did not share it with professionals at the time. The information known now, following police interviews and statements from family and friends does not change the risk and vulnerabilities.

The behaviours which Martyna experienced were not explicitly obvious to friends or family members, and not evident to any agency involved in this review. As DA behaviours become more widely understood through a developing public narrative, there is the potential that family and friends will be more able to recognise the subtlety of controlling and coercive behaviours. Where agencies have involvement, (with victims or perpetrators), practitioners do identify and apply the 8 stages model to those risks.

Section 8 - Lessons Learned by agencies in this review.

8.1.1 The narrative around Martyna's murder does present learning for all agencies and services in terms of reinforcing current knowledge of how domestic abuse occurs and the usefulness of using the 8 stages of domestic homicide timeline to inform their assessments and advice.

8.1.2 Many practitioners working across services, engage with men and women who move in and out of relationships and thus have the ability to pick up on concerning behaviours and take appropriate action

8.1.3 Whilst there was extremely limited agency interaction, learning from the review highlights the importance of enquiry and the need for practitioners to be alert to the sometimes-subtle signs that individuals pose an increasing risk of harm to partners/ex-partners, or that they are

indeed already causing harm. In particular, the review highlights the importance of picking up on behavioural cues and emotional warning signs. These could take the form of emotional instability, evidence of a refusal to accept the end of the relationship, evidence of self-worth being too connected with the maintenance of the relationship, seemingly isolated instances of violence (albeit there were none in this case), and stalking type behaviours. In Martyna's case, it is particularly relevant for the police who had reported concerns of threats to take a life by suicide linked to a relationship ending. The police records do not show that his threats were assessed as emotional abuse towards Martyna.

8.1.4 Framing the observation of any concerns within the 8-stages timeline can support the practitioner (and /or family and friends) in understanding what they have observed and what other enquiry they might need to make. The narrative also supports our understanding of domestic abuse and domestic homicide as events that can be perpetrated by individuals from all walks of life and that victims can also come from all walks of life. Stereotyping should not blind practitioners to risk where there is evidence that it exists.

8.1.5 The issue of 'professional curiosity', respectful challenge and a greater understanding of the nature of coercive and controlling risk factors should be revisited and strengthened within existing domestic abuse training and approach to domestic abuse risk assessments. For example, frontline staff need to have a greater understanding of how coercion and control influence the way victims of domestic abuse engage with services. Similarly, practitioners working in multiagency

Section 9 - Recommendations

9.1 In retrospect, despite a lack of agency involvement, there were clear themes in Martyna's case which practitioners have now identified as learning concerning the assessment of risk, additional risks of stalking behaviour and risks at points of separation.

Recommendation 1:

In response to research and academic developments concerning domestic homicides (specifically connected to controlling behaviour and suicidal threats), the community safety partnership (in Ealing and Gwent) should review, reinforce, and develop the learning offer to ensure this is addressed in single and multi-agency training, and continues to do so through its workforce (including practical support like 'Ask for Angela' or 'Ask for Ani' campaigns).

Recommendation 2:

In response to research and academic developments concerning domestic homicides (specifically connected to controlling behaviour and suicidal threats), the MPS and Gwent police to ensure that there is a re-focus on DA training to ensure that coercive and controlling behaviours are understood by all officers and staff.

Recommendation 3:

To ensure that all agencies are conversant with the purpose and role of DHR's, that Home Office (HO) provides guidance and training in respect of DHR's, their purpose and necessity for multi-agency learning, to HMP Prison Service.

Recommendation 4: (National and to be included in HO action Plan)

HO to explore awareness raising and deliver a public / employer / education (including secondary or university education) focussed campaign on the risks that may be present during the period leading up to and including separation in a relationship.