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WILTSHIRE COMMUNITY SAFETY PARTNERSHIP DOMESTIC HOMICIDE REVIEW

Executive Summary of the report into the murders of Krystyna and Elżbieta[1] in June 2020

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[1] Pseudonyms

Contents

1. Review Process 3

2. Summary of the Chronology 4

3. Conclusions and Lessons to be Learnt 5

4. Recommendations 9

Appendix A: Review Panel Members 12

Appendix B: Independence of the Chair 13

Appendix C: Terms of Reference 14

Appendix D: Agency Involvement 16

1. Review Process

1.1 Background

1.1.1 This summary outlines the process undertaken by Wiltshire Community Safety Partnership in reviewing the circumstances leading to the homicides of a mother and daughter who were resident in their area. It considers the nature of the agencies' responses over the five years before their deaths.

1.1.2 In order to protect the anonymity of the victims and their family, the following pseudonyms have been used:

Designation	Relationship to victim	Age at the time of the homicides
Krystyna	Victim	40
Elżbieta	Victim and daughter of Krystyna	18
Piotr	Perpetrator; husband of the Krystyna and father of the three children	39
Child A	Child of Krystyna and Piotr	6
Child B	Child of Krystyna and Piotr	5

1.1.3 Criminal proceedings were completed in December 2020. The perpetrator was convicted of the murders of Krystyna and Elżbieta and sentenced to life in prison with a minimum tariff of 34 years before he could be considered for release.

1.2 Summary of the Review Process

1.2.1 The decision to undertake a domestic homicide review was made by the Chair of Wiltshire Community Safety Partnership, after consultation with partner agencies. The Home Office was notified of the decision on 24th June 2020. An independent chair and review panel were appointed, and the review was managed in accordance with the relevant statutory guidance.

1.2.2 The review panel members are listed in Appendix A. Wider matters of diversity and vulnerability were considered when agreeing on panel membership. Turning Point provided expertise on issues of alcohol. Splitz, a local specialist domestic abuse service, provided expertise around domestic abuse and Vesta, a specialist family support service, provided expertise on domestic abuse within the context of Polish families. Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case

1.2.3 The independence of the Chair and author of the report is featured in Appendix B.

1.2.4 The process began with an initial meeting of the review panel in September 2020. Terms of reference were drawn up and incorporated key lines of enquiry as featured in Appendix C.

Agencies participating in this review are featured in Appendix D, as well as those who had no contact.

1.2.5 The review panel met on four occasions and the Independent Chair sought engagement with family and friends, using translated materials where indicated, but family and friends did not seek to engage with the review.

1.2.6 The Overview Report was endorsed by Wiltshire Community Safety Partnership in December 2021 before being submitted to the Home Office for approval.

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

2. Summary of the Chronology

2.1 Both Krystyna and Piotr were born in Poland and Krystyna trained and worked as a physiotherapist. The couple were married in 2001 and had their first child, Elżbieta, in the following year.

2.2 In 2008, the family moved to the UK, having been recruited by a national grocery chain. Elżbieta was aged six at this time and after a period of five years, the couple went on to have two more children after which Krystyna began working for a care agency.

2.3 The younger children went on to achieve well in school and were supported by a Polish link worker. The school observed a close bond between Krystyna and her children but knew very little about the father who was not seen at school. Other than school and GP, the family received very little in the way of services. The family rented their Salisbury home from the local authority and maintained their tenancy, mostly without problems.

2.4 By June 2018, Piotr had become increasingly suspicious of the relationship between his wife and eldest daughter. He told work colleagues that he felt that that he was being harassed and abused at home by his wife and daughter and that they were laughing at him and stealing his money. He told his family that he was considering suicide, but this was not known by any agencies.

2.5 Neither was it known to agencies that, in April 2020, Piotr accused Krystyna of having an affair; strangled her until she was blue and threw her to the floor where she banged her head. When Elżbieta intervened to try to protect her mother, he threw her to the floor also. Piotr moved out of the family home, on Krystyna's insistence and rented a room locally and his heavy drinking increased. He became worried that he may be deported as a result of the separation. Although Krystyna and Elżbieta were both very frightened of Piotr, they do not appear to have approached any service for support.

2.6 Over the following weeks, Piotr's family and work colleagues heard him talk about his intensifying jealousy, anger and aggression towards both Krystyna and Elżbieta and, six weeks after their separation, he killed them at the family home on the day of a national Polish holiday[2].

3. Conclusions and Lessons to be Learnt.

3.1 Understanding domestic abuse

3.1.1 Evidence was provided to criminal proceedings that, unbeknown to agencies, Piotr had been abusive towards Krystyna since the early days of their marriage. She had told various friends and family about physical violence, threats to kill, jealousy, possessiveness, controlling behaviour and economic abuse. The circumstances highlighted the fact that victims of domestic abuse are more likely to disclose their experiences of abuse to friends and family than to professionals and Domestic Abuse Partnerships benefit from targeting public information and awareness raising to friends and family who will themselves face barriers to disclosure. Furthermore, the barriers faced by victims and their friends and family alike, are exacerbated within migrant communities.

3.1.2 Women experiencing coercive control who also experience economic abuse are at increased risk of being killed.[3] However, one third of victim-survivors do not tell anyone about financial abuse: those that do are most likely to tell a friend or family member. [4] Both professional and public awareness therefore needs to be raised about domestic abuse in general and economic abuse as a significant indicator of serious harm.

3.1.3 The review heard very little about how the Piotr's problematic alcohol use featured in the family's life and his alcohol usage fell under the radar of services in this country. However, problematic alcohol use has featured regularly in domestic homicide reviews.

3.2 Separation and routine enquiry

3.2.1 The homicides occurred only six weeks after Krystyna had separated from her husband. Separation is widely known to be key indicator and trigger of heightened risk of domestic abuse and domestic homicide. Practitioners should be alert to the possibility of domestic

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[2] To be redacted in published version

[3] Websdale, 1999

[4] Surviving Economic Abuse, 2020

abuse when they become aware that a person is separating from their partner, and where trained and able, undertake enquiry on domestic abuse routinely around separation when in a safe environment to do so.

3.3 Routine enquiry in secondary health care

3.3.1 There were some health conditions presented to the health agencies which could have given rise to routine enquiry on domestic abuse in line with national expectations.[5] Recommendations have been made at the primary care level to ensure that selective, routine enquiry is embedded into local practice.

3.3.2 Whilst routine enquiry on domestic abuse was well embedded in the Emergency and Maternity Departments of the hospital, the victim was also treated by secondary health care services. Victims will often not disclose domestic abuse immediately and so asking domestic abuse through a person's journey through services could be seen as good practice in a range of health settings. Nonetheless, the panel were not aware of evidence to indicate the value of this type of selective questioning across secondary health care settings and recommends that this evidence be sought.

3.4 Domestic abuse and the Polish community

3.4.1 The review considered how the various aspects of Polish and migrant identity, culture and economic position may have intersected with Krystyna and Elżbieta's experiences of abuse, help-seeking and access to safety and protection. It concluded that the needs of Polish women experiencing domestic abuse are less well understood than for many other migrant groups and they will face a broad range of barriers to help-seeking including isolation and lack of support; racism and discrimination, lack of awareness of laws and services available; language barriers; economic disadvantage and dependency.

3.4.2 Although domestic abuse is prevalent in every culture, the impact on this family of being brought up in Poland or living in the Polish diaspora was not known. Previous domestic homicide reviews have commented upon the high value placed upon family privacy, self-sufficiency and individual independence, leading to a view of domestic abuse as a family matter to be resolved by informal means without recourse to statutory agencies.[6]

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[5] National Institute for Health and Care Excellence (NICE) (2016a) *Quality Standard* [QS116]. Available online at: https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-3-Referral-to-specialist-support-services-for-people-experiencing-domestic-violence-or-abuse

[6] See: https://www.brent.gov.uk/media/16410477/brent-dhr-anna-overview-report.pdf
http://www.sandwell.gov.uk/download/downloads/id/22842/domestic_homicide_review_-_published_25_june_2015.pdf

3.4.3 The review heard how agencies such as Children's Services and the primary school had designated Polish workers which helped to link with the Polish community. It recommended that the Wiltshire Domestic Abuse Board extend its existing plans to raise public awareness of domestic abuse within the Polish community. More specifically it called upon the Board to sure up their responses to communities, such as the Polish communities, who are relatively small in number in the local area yet will face structural inequality.

3.4.4 The review recognised that there was a proportionally high number of domestic homicides involving Polish communities and asks the Home Office to consider undertaking a composite review of domestic homicide reviews in order to share learning and best practice concerning this marginalised group.

3.5 Schools and colleges

3.5.1 Prevention programmes were on the curriculum of all schools and colleges attended by the children and none of the children disclosed their experiences of domestic abuse to staff or school friends. Each of the educational settings had systems in place to respond to domestic abuse. The sixth-form college provided information and tutorials on domestic abuse and healthy relationships during Elżbieta's time there. The primary school included emotional literacy support and bi-lingual assistants who were recognised to be in a privileged and trusted position and had a greater likelihood of hearing disclosures from a member of one's own community. Dedicated training on domestic abuse will therefore be provided for support assistants in the school on top of their existing safeguarding training and the local authority has committed to extend this dedicated domestic abuse to its own support assistants and promote the value of dedicated training for these roles in particular across schools and colleges in the area.

3.5.2 Wiltshire has the Operation Encompass programme across the county: providing timely information to schools about reports to the police concerning domestic abuse; training school staff to respond to domestic abuse safely and encouraging support to be provided to the family.

3.6 Covid-19 and domestic abuse

3.6.1 The homicides took place during the lockdown and restrictions on movement and social interaction imposed during the Covid-19 pandemic. Research has shown this to have been a time of increased isolation, heightened domestic abuse and heightened demand for specialist domestic abuse services: the National Domestic Abuse Helpline has seen a 65 per

cent increase in calls and the Polish domestic abuse helpline run by Opoka has seen an increase of 150 to 1,200 calls per month.

3.6.2 Whilst both Krystyna and her husband continued to work during the pandemic, as they were 'key workers', they will undoubtedly have suffered from the isolation imposed upon family life by the restrictions in other ways. The review heard how, during the pandemic, Wiltshire has been undertaking targeted campaigns to enable access to domestic abuse services for domestic abuse victims.

3.7 The role of employers

3.7.1 The domestic abuse undoubtedly affected Krystyna's work in the weeks leading to the murders as her daughter would accompany her on her home visits for fear of being located by the perpetrator. Krystyna spoke with her manager and friend about the domestic abuse and was supported by her as a result. Employers therefore have an important role combatting domestic abuse and the review was alerted to recent developments from Business in the Community and the Employer's Initiative on Domestic Abuse which provide a range of guidance and support on domestic abuse.[7]

3.8 The 999 Response

3.8.1 The Ambulance Service was delayed by 26 minutes in reaching the evolving fatal incident. This was due to a combination of a wrong address initially being given by the police, but later corrected; an incorrect categorisation of the incident by the control room; an incorrect application of the procedure to address significant changes in an evolving incident and unexpected road closures. Training is to be provided for relevant Ambulance staff on these matters.

3.8.2 Although the judge concluded that the catastrophic nature of the attacks meant that neither victim was capable of resuscitation, given that address changes are common during incidents, South-West Ambulance Service has made a recommendation to explore whether colour coding can be applied to the computerised log when an address has been changed during the response to an incident.

[7] More information on the Employer's Initiative on Domestic Abuse can be found at:

4. Recommendations

Recommendations 2, 3, 4, 5 and 7 are not specific to Wiltshire but it was felt that these were helpful observations identified during the review that would inform wider learning.

4.1 **Multi-Agency recommendations**

Recommendation 1: Economic Abuse

Wiltshire Safer Communities Partnership should promote public and professional awareness of economic abuse as a method of coercive control. They should seek assurance from its agencies that they have enacted the new statutory definition of economic abuse within their policies and practice.

Recommendation 2: Routine Enquiry on Separation

Wiltshire Community Safety Partnership to consider introducing and arranging for the evaluation of a pilot programme with social housing providers on undertaking safe, routine enquiry into domestic abuse in circumstances where agencies become aware that an individual has separated or undergoing relationship breakdown.

The programme should require policy, guidance and training for practitioners to enable safe enquiry and safety planning to be effectively taken with the victim and, where necessary, steps taken to protect the individual or family.

The programme should link into existing work being undertaken locally to address the learning from the Child Safeguarding Review Panel on the invisibility of abusive men/fathers to safeguarding agencies.

The results of the evaluation should be considered for their broader impact on health, social care and criminal justice agencies response to separation in the context of domestic abuse

Recommendation 3: Routine enquiry in secondary health care

The Department of Health and Social Care to consider commissioning research into the effectiveness of selective, routine enquiry into domestic abuse, where health indicators are present, in a range of secondary care services.

Wiltshire Community Safety Partnership to promote routine enquiry and seek assurance from front line health services and beyond, that routine enquiry into domestic abuse, where health indicators are present, is being undertaken and embedded into local procedures.

Recommendation 4: Building awareness of services amongst Polish communities

Wiltshire Community Safety Partnership, working with specialist service providers who have experience of supporting Polish women experiencing domestic abuse, to identify the most effective way to increase awareness of domestic abuse and the services available amongst Polish communities and develop an action plan around this.

This should involve making links with the local Polish community in order to build trust and confidence in the development of resources to meet the community's needs.

Recommendation 5: Meeting the needs of Polish women and children experiencing domestic abuse.

Wiltshire Community Safety Partnership to seek assurance from its agencies in the form of equality audits that services are meeting the needs of Polish women and children experiencing abuse.

The Partnership should consider whether this recommendation should also be extended to other minoritised communities.

Recommendation 6: Increasing the evidence base around domestic abuse and domestic homicide in the Polish community

In view of the proportionally high number of domestic homicides involving Polish communities, the Home Office to consider undertaking a composite review of their corresponding domestic homicide reviews in order to share learning and best practice concerning this marginalised group.

The Partnership should consider whether this recommendation should also be extended to other minoritised communities.

Recommendation 7: Enabling disclosure from marginalised children in schools

Support roles within schools, particularly those with language skills, are in a privileged position to enable disclosure of domestic abuse from marginalised children that they work with. Dedicated domestic abuse training, rather than being delivered within broader safeguarding training with competing demands, enables the development of understanding and skills to enable and address disclosures of domestic abuse more effectively. Wiltshire Council Education and Skills Directorate should provide dedicated domestic abuse training for support assistants within its workforce and promote the

delivery of dedicated domestic abuse training for all support assistants in schools and colleges within its area.

Recommendation 8: Employers' role in combatting domestic abuse

In order to strengthen the role of employers in supporting their employees and addressing domestic abuse, Wiltshire Community Safety Partnership should promote the Toolkit for Employers and promote membership of the Employers' Initiative on Domestic Abuse amongst its partner agencies.

4.2 Individual agency recommendations

4.2.1 Salisbury Medical Practice

Patients presenting with indicators of possible domestic violence or abuse to be offered a private discussion by an appropriately trained member of the SMP team.

Ensure an interpreting service is available to clinicians when English is not the patient's first language.

An easy-to-use interpreting Language Line service/App is available for all clinicians to utilise during their consultations, when English is not the patient's first language.
Ensure the documentation of safeguarding at a consultation is completed following a patient presentation with a possible indicator of DV and abuse.

To arrange for the applications (Apps) on the SMART devices used within telephone and face-to-face templates for all GP appointments include prompts for domestic abuse. These new applications (Apps) will be rolled out to the primary care networks in the area.

4.2.2 Clinical Commissioning Group (now Integrated Care Board ICB)

To consider whether the individual recommendations for the GP Practice need to be applied more broadly, and if so, gain assurance from primary care in order to improve responses to domestic abuse across the system.

4.2.3 (Redacted) Primary School

To provide dedicated domestic abuse training for the Emotional Literacy Support Assistants (ELSA) within the school.

4.2.4 South-West Ambulance Service

To pursue changes to the computer system to highlight where changes of address occur mid incident.

Appendix A: Review Panel Members

Name	Job Title	Agency
	Independent Chair	Standing Together
	Designated Professional for Safeguarding Adults	Bath and North-East Somerset, Swindon & Wiltshire Clinical Commissioning Group
	Practice Review Manager, Public Protection Department	Wiltshire Police
	Phoenix Project Manager	Splitz Support Service
	Domestic Abuse Reduction Co-ordinator	Public Health, Wiltshire Council
	Managing Director	Vesta Specialist Family Support CIC
	Safeguarding Adults & MCA Lead Nurse	Salisbury NHS Foundation Trust
	Safeguarding Lead	Salisbury Medical Practice
	Head of Revenues and Benefits – Central	Revenue & Benefits, Wiltshire Council
	Named Nurse Safeguarding Children	Virgin Care Ltd.
	Safeguarding Lead	Wiltshire College
	Head of Student Development and Wellbeing & DSL	(redacted) Academy
	Head of Service – Support and Safeguarding	Children's Services, Wiltshire Council
	Head of Housing Operations and People Services	Wiltshire Council Housing
	Safeguarding Manager	Turning Point
	Paramedic/ Named Safeguarding Professional	South-West Ambulance Service
	Headmaster	(redacted) Primary School
	Minute taker	Public Health, Wiltshire Council

Appendix B: Independence of the Chair

The Independent Chair and Author is Paula Harding, an Associate Chair with the charity, Standing Together Against Domestic Abuse. She has over twenty-five years' experience of working in domestic abuse with both senior local authority management and specialist domestic abuse sector experience. For more than ten of those years, she was a local authority strategic and commissioning lead for domestic abuse and violence against women and has been an independent chair and author of domestic homicide and safeguarding adult reviews since 2016. She completed an M.A. (Birmingham) in Equalities and Social Policy in 1997, focusing on domestic abuse and social welfare, and is a regular contributor to conferences, national consultations, and academic research. She completed the OCR certificated training funded by the Home Office for *Independent Chairs of Domestic Homicide Reviews* in 2013. She has also completed the on-line training provided by the Home Office,[8] as well as undertaking training on the Significant Incident Learning Process and Learning Disability Mortality Reviews.

Standing Together is a UK charity bringing communities together to end domestic abuse. It promotes the adoption of the Coordinated Community Response (CCR).[9] The model is based upon 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. Standing Together has been involved in the domestic homicide review process from its inception, chairing over ninety reviews across England and Wales from 2013 until the present day.

The Chair has no connection with Wiltshire Community Safety Partnership or any of the agencies involved in this case aside from one previous domestic homicide review undertaken in the area.

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[8] Available at https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning

[9] For more information, go to: https://www.standingtogether.org.uk/ccr-network.

Appendix C: Terms of Reference

In addition to the generic issues set out in statutory guidance (Home Office, 2016), the panel agreed that the review should focus on the period from 2013, when agencies first had contact with the family, until the victims' deaths in June 2020. The key lines of enquiry were agreed in respect across four domains: service responses; public awareness; schools and removal of barriers to help-seeking for Polish communities.

For any agencies identified to have had contact with family members:

- Analysing key episodes in agencies' responses including the nature of assessments, decision making and responses to presentations which may have been indicators of domestic abuse and whether they met the expected standards of practice and procedures.
- How were barriers to engagement from any member of the family overcome? How responsive were agencies to identified protected characteristics and vulnerabilities of family members?
- How did agencies contribute to holding the perpetrator accountable for his domestic abuse and manage the risk that he presented?
- If domestic abuse was not known, how did agencies identify the existence of domestic abuse from other issues presented to them by family members and how did they respond? For example, were there policies and procedures for identifying indicators of domestic abuse and for direct, routine or clinical questioning on domestic abuse and how were they followed in this case?
- How robust was multi-agency working in terms of communication, co-operation, and co-ordination and shared decision making. How robust was agency working with specialist domestic abuse organisations?
- How well equipped were practitioners in responding to domestic abuse? How were staff supported to respond to issues of domestic abuse through policies, procedures, training, supervision, management and sufficient resources available at the time.

What can be established from informal networks (family, friends, community, work colleagues) regarding the nature of the perpetrator's domestic abuse and coercive control in the family:

- What knowledge did informal networks have of domestic abuse and coercive control?

- How did the perpetrator’s problematic alcohol use feature in the family’s life?
- How did economic abuse manifest itself in the family’s life?
- What barriers did informal networks feel to acting upon disclosures?

Specific questions for schools and colleges:

- What opportunities were taken for developing awareness with young people about domestic abuse?
- What sources of support were made available for young people living with domestic abuse and how were they made known to the children of the family?

***For all agencies**:*

- How has your agency worked individually or collectively to overcome barriers to help seeking for Polish families experiencing domestic abuse?

Equality and Diversity

The review will consider all protected characteristics, as defined by the Equality Act 2010, of the family, particularly how sex, age and race may have been relevant in this case. The review will also consider vulnerabilities including the perpetrator’s problematic alcohol use and language barriers. The review will apply an ecological and intersectional framework to review the family’s life experiences. This means to think of each characteristic of an individual as inextricably linked with all the other characteristics in order to fully understand one's journey and one’s experience with local services/agencies and within their community.

Appendix D: Agency Involvement

Individual agency reports and chronologies were provided by the following organisations:

- Bath and Northeast Somerset, Swindon and Wiltshire Clinical Commissioning Group
- Salisbury Hospital NHS Trust
- Primary School
- Secondary School
- Wiltshire Council
- Wiltshire College
- Wiltshire Police

Agencies without contact

The following agencies were contacted but confirmed that the victim or perpetrator were either not known to them, or that their involvement was not relevant to this review:

- Avon and Wiltshire Mental Health Partnership NHS Trust
- Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company
- Motiv8 (Substance misuse service)
- National Probation Service
- Royal United Hospitals Bath
- Splitz (domestic abuse service)
- Turning Point (Substance misuse service)
- Wiltshire Council Adult Social Care
- Wiltshire Anti-Social Behaviour Risk Assessment Conference
- Wiltshire Council Children's Services
- Wiltshire Children's Community Services - Virgin Care
- Wiltshire Health and Care (Minor Injuries Unit)
- Wiltshire Multi-Agency Safeguarding Hub
- Wiltshire Multi-Agency Risk Assessment Conference