SAFER CORNWALL

Kernow Salwa

Safer Cornwall Partnership

Adult A

Date of Death: March 2020.

Author: Paul Northcott

Date the review report was completed: 03/02/2021.

Contents

Preface

I would like to begin this report by expressing my sincere sympathies, and that of the Review Panel, to the family of Adult A many of whom currently live in Poland. The death of Adult A was a tragic and unforeseen incident and I have no doubt that it has a huge impact on all that knew the family.

1.0 Introduction

1.1 This is the report of a Domestic Homicide Review (DHR) undertaken by the Safer Cornwall Partnership and examines the interaction that local agencies had with Adult A, prior to her death in March 2020. At the time of her death Adult A lived with her husband (Adult B) and had a son (Adult C) who lived nearby.

1.2 The key purpose for undertaking a DHR is to enable learning from those deaths where a person has died and where domestic abuse was or could have been a factor. In order for the learning to be shared as widely and thoroughly as possible, professionals need to be able to understand fully what happened and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.3 In this case Safer Cornwall wanted to review the death of Adult A in order to establish if there had been effective intervention by agencies and whether she had been a victim of abuse prior to the incident taking place.

1.4 This report will consider the contact and involvement that agencies had with Adult A between the dates of December 2013 and March 2020. The reason that the Panel chose these dates is that they provide a time frame during which agencies had contact with Adult A.

1.5 This Panel have used the DHR process to examine whether there were opportunities to provide Adult A with additional support. This was done by looking at critical intervention points in her past where action, advice and guidance could have been put into place that would have assisted in protecting her from harm and mitigated the risks of domestic abuse.

1.6 Every effort has been made to conduct this review process with an open mindset and to avoid hindsight bias. Those leading the review have made every attempt to manage the process with compassion and sensitivity.

2.0 Summary

2.1 Adult A was aged forty-seven at the time that she died. Adult A lived with her husband who was also aged forty-seven in a town within Cornwall. Adult A had one adult son who lived in close vicinity to his parents.

2.2 In March 2020, Adult B attended the front desk of his local police station. Adult B explained that there was a body at his home address.

2.3 Police officers were dispatched to the address and on their arrival they found that two ambulances were already in attendance. The body of Adult A was found lying at the bottom of the stairs at the address.

2.4 Later that same day, Adult B was arrested on suspicion of murder. Adult B was later interviewed by the police but he denied murdering his wife. Adult B was given bail and released from police custody whilst further enquiries were carried out.

2.5 The Police investigation identified that there had been a history of domestic abuse between the couple and that Adult A had been discussed at a Multi-Agency Risk Assessment Conference (MARAC) on the 8TH November 2017.

2.6 Following the Police investigation and a forensic post mortem which concluded that Adult A's injuries were inconclusive, no charges were brought against Adult B and the case was referred to HM Coroner for inquest.

2.7 The cause of death provided by the pathologist who dealt with this case was a head injury and acute alcohol intoxication.

3.0 Timescales

3.1 The decision to commission a review was taken by the Chair of the Safer Cornwall Partnership in April 2020. The Home Office had been informed of the decision to undertake a review on the 19/05/2020. The review was conducted in line with the Home Office Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016).

3.2 This review commenced on 25/05/2020. The Home Office Statutory Guidance advises that where practically possible the Domestic Homicide Review should be completed within six months of the decision made to proceed with the Review. For this reason an initial timetable was drawn up to ensure that agencies complied with this request.

3.3 The review was unable to be completed in the six-month time frame due to the complexity of trying to contact and engage with the family and the requirement for the investigation to be concluded.

3.4 The Independent chair was appointed on 1st May 2020 and the first panel meeting was held on the 21st July 2020. During this meeting, the draft terms of reference were discussed and the Panel agreed upon their content.

3.5 The family of Adult A were contacted and invited to actively contribute to the review. Contact was initiated through the police investigation team who explained the DHR process and this was later followed up using a letter. The content of the letters were reviewed by the Vesta - Specialist Family Support CIC representative on the panel and translated into Polish.

3.6 The Panel met formally on four occasions. In the interim period and in order to ensure that the review was comprehensive contact was made with panel members on a regular basis to clarify issues and matters of accuracy about their agency's involvement with the family. Documents including draft reports were circulated electronically to members and discussed on an individual basis as were the themes identified from the review process.

3.7 The review concluded on 3rd February 2021. The Safer Cornwall Partnership actively reviewed the progress of the review throughout the process.

4.0 Confidentiality

4.1 The findings of this review are confidential. The Information obtained as part of the review process has only been made available to participating professionals, and their line managers.

4.2 Before the report is published the Safer Cornwall Partnership will circulate the final version to all members of the review panel, the Chief Executives of their agencies, and the family members. The family will be notified of the publication date.

4.3 The content of the overview report has been anonymised to protect the identity of the Adult A, relevant family members and all others involved in this review. Due to the family making the choice that they did not want to engage with the review process the Panel agreed to use the following pseudonym/s;

Family composition and pseudonyms used.

- Adult A – Deceased female
- Adult B – Husband
- Adult C – Son

5.0 Methodology

5.1 Domestic Homicide Reviews were established on a statutory basis under section 9 of the Domestic Abuse, Crime and Victims Act (2004). The Act, which came into force on the 13th April 2011, states that a DHR should be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

a. A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship or;

b. A member of the same household as him/herself; held with a view to identifying the lessons to be learnt from the death'.

5.2 Whilst there was no conclusive evidence to suggest that Adult B had been involved in the death of his wife, the Safer Cornwall Partnership commissioned a DHR due to the fact that there had been incidents of domestic abuse involving the couple. The review was commissioned with a view to identifying whether the relationship between Adult A and Adult B had been abusive and whether this had indirectly contributed to her death.

The purpose of the review was therefore set to;

- Establish the facts that led to the death of Adult A and whether there was learning in the way in which local professionals and organisations carried out their responsibilities and duties, and worked together to safeguard Adult A;

- Identify clearly the learning, how this will be acted upon, and what is expected to change as a result;

- Apply the learning to service responses including changes to policies, procedures and practice of individual agencies, and inter-agency working, with the aim to better safeguard victims of domestic abuse in Cornwall;

- Identify what needs to change in order to reduce the risk of such tragedies happening in the future and improve single agency and inter-agency responses to all domestic abuse victims and their children through improved partnership working;

- Identify, on the basis of the evidence available to the review, whether the death of Adult A was foreseeable and avoidable, with the purpose of creating a joint strategic action plan to address the gaps and improve policy and procedures in Cornwall and across the Southwest Peninsula;

- Identify from both the circumstances of this case, and the review process adopted in relation to it, any learning which should inform policies and procedures in respect to national reviews and make this available to the Home Office.

5.3 In addition to the above, the following terms of reference were initially set by the DHR panel and there was a requirement that these needed to be addressed in the overview report;

1. To provide an overview report that articulates Adult A's life through her eyes, and those around her, including professionals.

2. Establish the sequence of agency contact with Adult A, and the members of their household (between the dates of December 2013 and March 2020); and constructively review the actions of those agencies or individuals involved.

3. Provide an assessment of whether the death of Adult A was an isolated incident or whether there were any warning signs that would indicate that there was any previous history of abusive behaviour towards the deceased and whether this was known to any agencies.

4. Seek to establish whether Adult A was exposed to domestic abuse prior to adulthood and the impact that this may have had on the individuals concerned.

5. Establish whether family or friends want to participate in the review and meet the Review Panel.

6. Provide an assessment of whether family, friends, neighbours, key workers (if appropriate) were aware of any abusive or concerning behaviour in relation to the Adult A (or other persons).

7. Review of any barriers experienced by Adult A/family/friends in reporting any abuse or concerns in Cornwall or elsewhere, including whether they knew how to report domestic abuse.

8. Assess whether there were opportunities for professionals to enquire or raise concerns about domestic abuse in the relationship.

9. To review current roles, responsibilities, policies and practices in relation to victims, individuals engaging in abusive behaviour and families of domestic abuse – to build up a picture of what should have happened.

10. To review national best practice in respect of protecting victims and their families from domestic abuse.

11. An evaluation of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in Cornwall.

12. Whether the work undertaken by the services in this case was consistent with their own professional standards, compliant with their own protocols, guidelines, policies and procedures.

13. Establish whether thresholds for intervention were appropriate and whether they were applied correctly in this case.

14. Consideration of any equality and diversity issues that appear pertinent to Adult A or family members e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

15. To clearly identify learning and draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse.

16. To clearly articulate how learning will be acted upon, and what is expected to change as a result.

17. To identify whether, as a result, there is a need for changes in organisational and/or partnership policy, procedures or practice in Cornwall in order to improve our work to better safeguard victims of domestic abuse and their families.

18. To identify good practice.

19. To review any other information that is found to be relevant.

The Review excludes consideration of how Adult A died.

5.4 The methods for conducting DHRs are prescribed by the Home Office guidelines[1]. These guidelines state;

> *'Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safe interventions'*.

The Panel chose the initial time period for the terms of reference to ensure that it covered the period that agencies had contact with Adult A and her family. This time period was later extended to include a report by Adult A to the Police in July 2009 concerning domestic abuse.

5.5 The Panel hoped that by reviewing this period of Adult A and Adult B's life that they would be able to ascertain if there were critical points at which agencies should or could have taken action to minimise risk and support the couple.

5.6 In order to ensure that the review was comprehensive the Safer Cornwall Partnership arranged for all agencies who were known to have had contact with Adult A and her family to check their records for all relevant information.

5.7 All of those agencies who were identified as having contact with the family were asked to secure relevant documents, and appropriate members were invited to become panel members. Additional inquiries were made with the Polish Embassy, OPOKA[2] and Poles in Need CIC[3] to ascertain whether Adult A had asked for additional help and support during the period covered by this review. These organisations had no record of contact.

5.8 The following agencies provided chronologies;

- Police
- Royal Cornwall Hospital Trust and Cornwall Foundation Trust
- Primary Care – GP
- First Light

[1] Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews; Home Office: Dec 2016
[2] Opoka is a Polish voluntary organisation set up in the UK to support Polish women and children who are experiencing the devastating and damaging consequences of Domestic Violence and Abuse.
[3] Poles in Need CIC – Is a Polish voluntary organisation which supports families and individuals who find themselves in difficult situations. This includes those who are suffering in their personal and family life due to social isolation, discrimination, poverty, mental health issues, safeguarding concerns and domestic violence.

5.9 Following a comprehensive review of the initial chronologies the Panel decided that there was no requirement for Individual Management Reviews (IMR). This decision was based on the fact that there was little contact with the family and limited information recorded by agencies. The Panel decided that information could be more effectively gathered through interviewing the appropriate professionals involved in this case (Police, GP staff, Health staff and those providing Domestic Abuse Support Services (First Light)) and by those involved identifying and discussing the themes which have been highlighted in this report at section 16. The DASH forms completed in this case were also reviewed as were policy documents.

5.10 The report author spoke to Adult A's previous employers but they had very little knowledge about her. They were unable to identify any friends and according to their records she had not disclosed any abuse.

5.11 All of the relevant agencies identified independent and experienced staff members to complete chronologies. These members of staff didn't know the individuals involved, or had direct involvement in the case. None of them had direct line management responsibility for any of the professionals who had been involved with the family.

5.12 Additional information was also reviewed by the Chair of the Panel and this included reading national DHRs involving Polish nationals, and reviewing policies and procedures.

6.0 Involvement of family, friends, neighbours and the wider community

6.1 Adult A's parents, her son, her brother and Adult B were invited to contribute to the review. All of these individuals were provided with a leaflet prepared by the Home Office about the DHR process. The family were also provided with the Advocacy After Fatal Domestic Abuse Leaflet and signposted to support services.

6.2 Contact with the family was initially instigated through the police liaison officers who had dealt with the family. Letters were also sent to these individuals following the police decision to refer the matter to HM Coroner. These letters had been translated into Polish. The content of these letters were checked by a representative from Vesta - Specialist Family Support CIC, to ensure that they were culturally sensitive. Attempts were also made to contact Adult A's niece by telephone. Adult B did make contact but after the Vesta - Specialist Family Support CIC representative explained the process to him he decided that he didn't want to be involved with the process. Despite the attempts that were made the other family members that were contacted did not reply.

6.3 Whilst Adult A's family members were encouraged to take part in the DHR process the Panel appreciated that they may not want to participate for a variety of personal reasons.

6.4 The Police investigation had shown (through witness statements and reviewing laptops and mobile devices) that Adult A had limited contact with her family and with those that she had worked with. As a consequence and to minimise unnecessary distress only

those family members that had contact were approached to take part in the review. The investigation identified that she had no friends or close work colleagues who could assist with the review process.

7.0 Contributors to the Review

7.1 The contributors to the DHR were;

- Safer Futures – Chronology/Information/Advice.
- Devon and Cornwall Police – Chronology, access to investigative records/Domestic Abuse Stalking and Harassment and Honour Based Violence (DASH) risk assessments/MARAC minutes.
- Cornwall Partnership NHS Foundation Trust (CFT) and Royal Cornwall Hospital Trust –Chronology/Information/advice.
- Adult Social Care – Information/advice.
- General Practitioner (GP) Services- Chronology.
- Cornwall housing – Information/advice.
- We Are With You [4](formally Addaction) – information.

7.2 Specialist domestic abuse advice and scrutiny was provided by the members from Safer Futures[5].

7.3 In terms of the wider issues faced by the Polish community additional advice was sought from the Devon and Cornwall Police Diverse Communities Team, the Social Inclusion Officer for the County concerned and from a Polish national living in the area who had experienced domestic abuse.

7.4 Specialist support in terms of advice relating to domestic abuse and the Polish Community was provided to the Panel by Vesta -Specialist Family Support CIC. Vesta - Specialist Family Support CIC support Polish families with domestic violence issues through therapeutic courses for victims, counselling and short one-to-one interventions with individuals engaging in abusive behaviour. They also focus on improving parenting skills and general well-being of the Polish families.

8.0 The Review Panel Members

8.1 The Panel for this review were made up of the following representatives;

- Paul Northcott-Independent Chair.
- Detective Sergeant Rob Gordon – Devon and Cornwall Police.
- Temp detective Chief Inspector Peter Found - Devon and Cornwall Police.
- Martin Bassett- Cornwall Council (Safeguarding Adults Board – SAR Manager).
- Vanessa Fudge - Cornwall Council (Domestic Abuse Co-ordinator).

[4] Drug and Alcohol Support Service
[5] Safer Futures is a charity supporting people in Cornwall who have been affected by domestic abuse and sexual violence.

- Mel Francis – Safer Futures (Service Manager).
- Zoe Cooper –CFT and RCHT (Consultant Nurse for Integrated Safeguarding Services).
- Alexandra Morgan-Thompson – Cornwall Housing (Quality and Information Manager)
- Laura Ball - Cornwall Council (Domestic Abuse and Sexual Violence Strategy Lead).
- John Groom – NHS Kernow Clinical Commissioning Group (CCG – Director of Planned Care).
- Ewa Wilcock - Vesta –(Specialist Family Support CIC.)

8.2 The Safer Cornwall Partnership ensured that there was scrutiny and accountability throughout the DHR process particularly in respect of independence and impartiality. The impartiality of the independent chair and panel members are essential in delivering a process and report that is legitimate and credible. None of the panel members knew the individuals involved, had direct involvement in the case, or had line management responsibility for any of those involved. This was confirmed by agencies at the initial panel meeting.

8.3 Responsibilities directly relating to the commissioning body, namely any changes to the terms of reference, and the agreement and implementation of an action plan to take forward the recommendations in this report, are held by the Safer Cornwall Partnership.

9.0 Author of the Overview Report.

9.1 The Safer Cornwall Partnership appointed Paul Northcott as Independent Chair and author of the overview report on 1st May 2020.

9.2 Paul is a safeguarding consultant specialising in undertaking reviews and currently delivers training in all aspects of safeguarding, including domestic abuse. Paul was a serving police officer in the Devon and Cornwall Police and had thirty-one years' experience. During that time he was the head of Public Protection, working with partner agencies, including those working to deliver policy and practice in relation to domestic abuse. He has also previously been the senior investigating officer for domestic homicides.

9.3 Paul had not worked in the Devon and Cornwall Police area since 2015 and retired from the service in February 2017. In that interim period, he had worked in London. During that time, he had no involvement with Safer Cornwall, nor the policy and practices of the Devon and Cornwall Police. Prior to his appointment records were checked to ensure that Paul had no involvement with those police resources involved in this case.

9.4 Paul has been trained as a DHR Chair, is a member of the DHR network and has attended AAFDA[6] webinars.

[6] Advocacy after fatal domestic Abuse.

9.5 At regular intervals Safer Cornwall reviewed Paul's independence and the Panel were encouraged to challenge him to ensure that all aspects of the process were critically reviewed. No issues were identified by those commissioning the review or by panel members which would have indicated that his independence had been compromised.

10.0 Parallel Reviews

10.1 Following the police investigation the death of Adult A was referred to the HM Coroner's office. At the time of submitting the report there has been no date set for inquest.

11.0 Equality and Diversity.

11.1 The review adheres to the Equality Act 2010 and all nine protected characteristics (age, disability, gender re-assignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex or sexual orientation) were considered by the Panel as part of the terms of reference and throughout the review process.

11.2 It is acknowledged that Domestic Homicides (DH) are overwhelmingly known to affect women[7] in that they are significantly more at risk of being killed by a partner or family member than men[8].

11.3 Adult A was a white Polish national and a heterosexual. Adult A was aged forty-seven at the time of her death.

11.4 Adult B was also a Polish national and a heterosexual. Adult B was aged forty-seven at the time that Adult A died.

11.5 As far as the Panel has been able to determine, Adult A did not hold any strong religious beliefs. There were clear language barriers identified in previous encounters with agencies and the impact of this will be discussed in section 16.

11.6 From the limited contact that agencies had with Adult A it was stated the British culture was completely alien to her way of living and that she found it difficult to integrate within the community. It could not be ascertained if her experience as a Polish national would have influenced her views and decision making in respect of domestic abuse.

11.7 There is no evidence that would indicate that Adult A or Adult B were directly discriminated against by services or individuals with whom they came into contact with.

11.8 Barriers to accessing services will however be discussed in paragraph 16.5.

[7] Ruuskanen and Kauko, 2008.
[8] In the year ending March 2016, there were fifty-seven male and 113 DH victims in England and Wales, representing 14 per cent of all male and 65 per cent of all female homicide victims (ONS, 2018b)

12.0 Dissemination

12.1 Following approval from by the Home Office the final report will be disseminated to the following organisations/partnerships;

- Cornwall County Council
- Safer Cornwall Partnership
- Devon and Cornwall Police
- Cornwall Adult Social Care
- Cornwall Housing
- Safer Futures
- NHS Kernow CCG
- Cornwall Foundation Trust
- We are with You (Drug and Alcohol Support Service)
- Vesta -Specialist Family Support CIC- Nominated representative only

12.2 In accordance with Home Office guidance all agencies and the family of Adult A are aware that the final overview report will be published. Although key issues have been shared with specific organisations the overview report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group.

12.3 The content of the overview report has been suitably anonymised to protect the identity of the female who lost her life and relevant family members.

12.4 In line with the Home Office guidance the family of Adult A (should they agree to contact) will be involved in agreeing the publication date for this report and they will be provided with the final version of the report should they wish to review it prior to publication. Safer Cornwall have offered to have the report translated into Polish.

12.5 Once agreement has been reached the report will be disseminated to all organisations detailed in paragraph 12.1.

13.0 Background Information (The Facts)

13.1 Both Adult A and Adult B were Polish and the police investigation identified that they had been residing in the UK since at least 2013. The couple lived locally in rented accommodation and had one son who would visit them on a regular basis.

13.2 The couple lived in a small mid terraced house which was described by professionals as being dark, damp and sparsely furnished.

13.3 Adult A's mother, father, brother and sister all lived in Poland and she had one brother who lived in England. She also had two nephews and a niece who were living in the United Kingdom. Contact with her family had diminished over time although the review author was unable to establish why this was had occurred.

13.4 Both Adult A and Adult B were known to regularly drink alcohol (Safer Futures/Police records).

13.5 Adult A was described as living a lonely life which revolved around working hard and caring for her family. She had no known friends.

13.6 There were four reported incidents of domestic abuse to the Police. These incidents occurred between December 2013 and December 2017 and on two occasions resulted in physical injuries being inflicted on Adult A by Adult B. Neighbours reported that on a number of occasions they had to call the police due to shouting being heard.

13.7 In November of 2017 Adult A was assaulted by Adult B and he was subsequently remanded in Police custody. Adult B appeared before a court for the offence of common assault and received a suspended sentence. At that time Adult A's case was deemed to be high risk and referred to MARAC.

13.8 In early March 2020, Adult B called his nephew and asked him to call an ambulance. Adult B stated that his wife had been 'injured really badly'. After verifying the exact address his nephew called the ambulance service and stated that there was a female at the address who was unconscious and not breathing. Adult B later walked into a police station and explained that there was a body at his home address. When Police attended the address they found the body of Adult A lying at the bottom of the stairs.

13.9 The paramedics who were already at the house explained to the officers that the female was deceased and that they had pronounced life extinct. The paramedics explained that Adult A had been found face down at the bottom of the stairs and that there was blood evident on the floor beneath her. The paramedics had also noted that there was a footprint on the stairs in blood but that the deceased was not wearing any footwear.

13.10 Later that day, Adult B was arrested on suspicion of murder. Adult B was later interviewed by the police but he denied murdering his wife. Adult B was released from police custody whilst further enquiries were carried out.

13.11 A forensic postmortem of Adult A's body was carried out, but the results were inconclusive. The police continued to investigate the incident but deemed that Adult A's death was 'unexplained'.

13.12 Following the police investigation no charges were brought against Adult B and the case was referred to HM Coroner.

13.13 Adult A had little contact with other statutory agencies. She was admitted to hospital with high blood pressure in 2017 and was seen by her GP for severe hypertension, chest pain and other minor ailments on five occasions (2014-2019). Adult A stated that despite the treatment that she had received she would often faint. In March 2017 she

had mentioned to her doctor that she was suffering from low mood. There are no records of contact with third sector agencies during the period covered by the review.

14.0 Chronology

14.1 The chronology date set for this review was from July 2009 and March 2020 as these dates provide a sufficient time span that captures Adult A's, and Adult B's interaction with services. Only issues of relevance have been included in the chronology below.

Date	Circumstances
01/07/09	Adult A attended her local police station and stated that she had left her husband due to the violence in her relationship. Adult A stated that she was serving divorce papers that day and she was expecting trouble. No incidents were reported overnight and therefore the incident was closed.
22/12/13	Police attended a report of an assault. At that time Adult B was described as estranged and had attended the home address drunk. Adult A had also been drinking alcohol. A verbal argument had taken place. Adult B punched Adult A in her face. Adult C witnessed the assault and had intervened. Adult C was also assaulted. Both Adult A and Adult C received visible injuries. When Adult B was interviewed he claimed self-defence. Adult A gave a statement in which she stated that she did not believe that she had been assaulted. Adult C gave a statement that largely corroborated that of his mother but also stated that he did not wish to attend court. As a result of this, a police gatekeeper made the decision that this case could not proceed and no further action was taken.
21/02/17	Police attended a report of a domestic abuse incident at the home address of Adult A. There had been a verbal argument between Adult A and her husband. Adult B left the address. Advice was given to both parties. DASH was declined but from the information that police officers had received they classified the incident as low risk.
02/11/17	Police attended the home address of Adult A and Adult B following a report of an assault. Adult B had assaulted Adult A whilst she lay in bed. He had punched her to the head, legs and body. Adult B had also smashed Adult A's head on a table. Later the same day Adult B assaulted Adult A again by punching her to the head causing visible injuries. Adult B was arrested and denied the assault. Adult B was charged with common assault and remanded in police custody. Adult A did not want a DVPN[9] as she wanted her husband home with her, stating that she was reliant on him and needed him to survive. Adult A believed that after spending a few hours in a police cell he would become a non-violent person. The DASH completed with Adult A was graded as high risk.

[9] Domestic Violence Protection Notice (DVPN) is an emergency non-molestation and eviction notice which can be issued by the police, when attending to a domestic abuse incident, to an individual engaged in abusive behaviour.

02/11/17	A joint visit was made to see Adult A at her home address. This visit involved a police domestic abuse officer, IDVA and interpreter. Relevant risk assessments and safety plans were completed. Adult A disclosed that Adult B became violent only when in alcohol, was very remorseful after an incident and then claimed that he couldn't remember hurting Adult A. Adult A stated that Adult B was the only person who brought an income into the household. She stated that he controlled all of the finances and did not allow her to work. Adult A stated she had become very isolated. The IDVA observed that Adult A seemed desperate for Adult B to return home and requested her statement to the police be retracted.
08/11/17	Case discussed at MARAC. All relevant agencies attended the meeting. There was extensive discussion about Adult B's controlling and coercive behaviour and Adult A's isolation. Identified risks were discussed including financial, economic abuse and the impact of alcohol on their relationship. There were also recognition of cultural differences and the need for additional support in terms of a Polish speaking professional. Community support and signposting options were discussed and it was apparent that these had been offered to Adult A. The DAO/IDVA had established a good working relationship with Adult A.
09/11/17	A joint visit involving police domestic abuse officer and IDVA was completed. The decision was made that Adult A should be provided with details of a Polish support group.
15/11/17	Information received that Adult B had received a suspended sentence. A request had been made for Adult B to complete healthy relationships work on a 1-1 basis with an interpreter as the building better relationships program was not suitable due to language barrier (*There was no evidence identified by the Panel that this work was completed and this will be explored in Section 16*).
20/11/2017	Case closed by FirstLight (now Safer Futures) – IDVA work completed, safety advice and numbers given to Adult A for future support. Case records state there was ongoing support from Addaction[10]. The IDVA identified the difficulty engaging with Adult A due to the language barrier and the need for a translator.
09/12/17	Police received a third hand report from a niece of Adult A explaining that she had received Facebook messages from her auntie saying that she was still alive and not going to be 'there tomorrow'. Police attended the home address and spoke to Adult A and her husband. Both were heavily intoxicated and through a translation application they explained that nothing had happened that evening between them. Adult A's brother attended the address and managed to call a family member who spoke fluent English. This family member translated and again it was explained that nothing had happened that evening. The family member (niece) believed that Adult A

[10] Addaction (now We Are With You) - provide free and confidential support to people experiencing issues with drugs, alcohol or mental health.

	was under the influence of alcohol. The niece later stated that she didn't think that the messages 'had any meaning'. From the records held it would appear that her statement was taken as meaning that she didn't believe that there was any real threat to Adult A. Words of advice were given. A DASH risk assessment was completed and no further action was taken.
March 2020	Adult A was found deceased.

15.0 Overview

15.1 This overview will summarise what information that was known to the agencies and professionals who were involved with Adult A and her family. It will also include any other relevant facts or information about Adult A and Adult B.

15.2 There is extremely limited information available in respect of Adult A and her relationship with her husband.

15.3 Adult A lived in a small terraced house in Cornwall and led a very isolated life. She had no known friends and contact with neighbours was limited. The couple's son used to visit the home address and Adult A would on occasions use social media to converse with her siblings and a niece. The contact with her niece stopped in 2017 although it is not known why this had occurred.

15.4 A large number of Adult A's family lived in Poland although she did have a brother and his family living locally.

15.5 Adult A was described by those who had engaged with her as unkempt and she would have food stains and dog hairs on her clothing. The home address was described as very dirty and the cooker in the house was not working.

15.6 Police records show that Adult A had reported her husband as being violent and abusive as far back as 2009. It is unclear as to the extent of violence that she endured and where it had occurred. At that time she had stated that she was seeking a divorce (there is no further information contained in agency records which would explain why the divorce was never progressed).

15.7 In terms of her health Adult A was known to have high blood pressure but there were no other recorded issues of note in health records. The DASH records completed in 2017 show that she was depressed and that she had on one occasion tried to jump off a cliff at a resort close to where she lived. This information was not recorded in the records held by other agencies.

15.8 At the time of her death Adult A was working at a commercial laundry and linen service. She had been employed there since the 7th of May 2019 and worked on a team consisting of six other people. None of her work colleagues spoke Polish and she was described as speaking very little English.

15.9 Adult A had previously been employed at a food processing plant (from the 13th of September 2015 to the 28th of May 2016). She left this employment after failing her probationary period.

15.10 Adult A's employers stated that she had a very poor attendance record and she had stated that her absences were due to her not understanding the rota. Adult A had no friends at her workplace and she had not mentioned any personal issues to those that had contact with her.

15.11 The couple were not known to Adult Social Care services.

15.12 Both Adult A and adult B were known to drink alcohol on a daily basis. Those professionals who had contact with Adult A described that both adults would drink excessively. This will be explored further in the following section.

16.0 Analysis

16.1 This part of the overview will examine how and why events occurred, the information that was shared and the decisions that were made. This section will also look at the actions that agencies took when coming into contact with the couple. It will consider whether different decisions or actions may have led to a different course of events. The analysis section seeks to address the terms of reference and the key lines of enquiry within them. It is also where any examples of good practice are highlighted.

16.2 This analysis considers the previous sections within this report and the content of the chronology of events. The information obtained from the investigation into Adult A's death has also been used in this analysis.

16.3 <u>Evidence of Domestic Abuse in Adult A and Adult B's relationship</u>

16.3.1 From the information that has been identified as part of this review the first area for analysis was to determine the extent that Adult A was subjected to abusive and/or coercive or controlling behaviour in her relationship with her husband (intimate partner violence), and whether there was any evidence that this led to her death.

16.3.2 There is little known about Adult A's childhood or wider family circumstances. There has been nothing found during the review to suggest that she experienced domestic abuse in her childhood.

16.3.3 From the records held by the police there is evidence that Adult A had disclosed that her relationship with Adult B was abusive and violent as far back as 2009 (crime records dated 01/07/09). At that time Adult A had attended her local police station stating that she was seeking a divorce. Unfortunately the Police at that time failed to follow process and lacked professional curiosity in that it would appear that they did not ask any further questions and they failed to refer her to other support agencies. The Police have acknowledged that questions should have been asked on this occasion about the extent of violence and where the offences had taken

place in order to obtain a full history about the abuse that she had suffered. A DASH form should have also been completed at that time and referrals made to appropriate support agencies as it is recognised that leaving a relationship is a high risk[11] factor that can lead to homicide. At that time police failed to follow the procedures that are in place to protect victims and this was poor practice.

16.3.4 The Police chronology has acknowledged that 'the importance of that first report of domestic abuse and how professionals respond to this should not be overlooked. This has also been highlighted in research which has identified that 'at the point that a victim gets help, the abuse is likely to be escalating…. and cutting the time it takes to help victims and their families is critical to stop murder, serious injury and enduring harm'[12]. Research has shown that it is likely that there was a significant history of abuse within this relationship before this date and that many victims may wait years before they seek help[13]. From the little information that is held by agencies it is difficult to determine the true effect on Adult A of this first encounter with professionals although what can be certain is that it was an opportunity missed in terms of encouraging her to trust the services that were available to support her.

16.3.5 There were two reported crimes where the information recorded at the time clearly indicates that Adult A had been assaulted by Adult B (22/12/13, 02/11/17). There is also a recorded domestic abuse incident (21/02/17) where Adult A was identified as being verbally abusive to her husband and a fourth incident where Adult A had contacted a family member via Facebook stating that 'she was still alive and not going to be here tomorrow'. On these occasions police followed correct procedures, assessed the risks (although this process was frustrated due to language barriers) and initiated appropriate action at the scene. These inquiries included contact with family members and neighbours in order to enhance evidence gathering opportunities. On occasions the follow up process was less effective as described in paragraph 16.3.8.

16.3.6 DASH records show that Adult A was afraid that her husband would kill her and that he had made threats in the past to do so. Adult A had stated that Adult B had attempted to strangle her with his hands and that the level of violence was increasing in the relationship. She stated that it was happening every weekend.

16.3.7 The Domestic Abuse Officer (DAO) who had supported Adult A described her as being petrified of her husband to such an extent that she had offered to take her to London in order that she could catch a bus back to her family in Poland. The identified threats and risks involved were acknowledged by those specialised domestic abuse professionals who had contact with Adult A and as a result support was offered to her. Adult A's case was also referred to the MARAC process in 2017.

16.3.8 Following a reported incident on the 22nd December 2013 the police had significant problems in trying to source an interpreter for Adult A and this resulted in the officers who had attended the address submitting a DASH form which detailed their own

[11] Refuge (2020) Women are at the greatest risk of homicide at the point of separation or after leaving a violent partner.
[12] Safelives (2015)
[13] SafeLives (2015),

views on the issues within the relationship. This resulted in a 'defaulted'[14] medium risk DASH. Police records state that a further DASH would be completed with an interpreter at a later date but this failed to take place. There was no rationale recorded within police records as to why the additional DASH was never completed and from records no reminders were set or requests passed on to ensure that this task was finalised. As a result of this failing there was no consent to share information and no automatic referrals were ever made to IDVA services (Safer Futures confirmed that they had no referrals). This was poor practice and was a missed opportunity to obtain additional information, offer safeguarding advice and take action to mitigate risks.

16.3.9 Following the incident in 2013 Adult B was arrested but on reviewing the evidence available to them the police decided that further enquiries were necessary. The ability to conduct enquiries was severely hampered as there were no interpreters available and this led to the police making the decision to give Adult B bail. At that time Adult B had bail conditions not to contact Adult A (either directly or indirectly) and not to attend their home address.

16.3.10 Efforts were made by officers to arrange for further statements to be taken from both Adult A and Adult C. Both refused to provide statements and as a result, a police gatekeeper made the decision that this incident did not meet the required evidential test. No further action was taken against Adult B. Access to interpreters is acknowledged as being an issue in the report provided by the police. Research shows that such delays adversely impact on the outcomes of such cases and that individuals engaging in abusive behaviour can adversely influence a victim's decision about progressing their complaint in the interim period[15]. The review identified that Adult A was subjected to abuse including coercive and controlling behaviour and this would have impacted on her decision to provide a statement to the Police.

16.3.11 Prior to any charges being authorised following the incident that occurred on the 2nd November 2017 discussions were held with Adult A regarding her safeguarding and the use of a DVPN. Although on this occasion Adult A stated that she did not want a DVPN there was clear evidence of good safeguarding and legislative knowledge by those officers dealing with the case in an attempt to protect Adult A from further abuse. This should be seen as good practice. In this case a DVPN was not necessary as charges were subsequently authorised.

16.3.12 As part of the review process the Panel considered whether Adult B was controlling or coercive[16] in his relationship with his wife. The Cross-Government definition of domestic abuse and abuse[17] outlines controlling or coercive behaviour as follows;

[14] Defaulted DASH – This DASH is completed by attending officers on the knowledge they have gained from those involved in the incident. Such a DASH is completed when the victim states that they do not want to assist with its completion.

[15] Farmer E, Callen S (2012); Barrow-Grint (2016)

[16] Controlling or Coercive Behaviour in Intimate or Family Relationship Statutory Guidance Framework; Dec 2015; Home Office

[17] Domestic abuse; Home Office (2016)

'*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'.*

16.3.13 The impact of coercive control on an individual's mental and social wellbeing is now considered to be so serious that it became an offence in law under the Serious Crime Act 2015.

16.3.14 The components of coercive control can include behavioural traits such as:

- Deliberate use of alternative moods.
- Excessive jealousy and possessiveness.
- Isolation-preventing partner from seeing family or friends.
- Control of the partner's money.
- Control over what the partner wears, who they see, where they go, what they think.

Controlling and coercive behaviour is known to be a key marker for fatal domestic violence[18] which is why it is an integral part of the DASH risk assessment process.

16.3.15 Adult A had disclosed to an IDVA (02/11/17) that Adult B controlled all of the finances and that he did not allow her to work. She stated that as a result of his behaviour she had become very isolated.

16.3.16 Adult A had also stated in a DASH completed in 2017 that Adult B had forbidden her from seeing friends and family including her sister when she had travelled to the UK. Adult A also stated that she was also prevented from having a phone[19] and from going to the shops. She stated that 'I only eat what he buys'. In her words she felt like 'a prisoner in her own home' but was reliant upon him and 'needed him to survive (police records 02/11/17).

16.3.17 Despite the restrictions placed on her life by Adult B Adult A was able to obtain a a mobile phone (believed to have been provided by her son). The review was unable to verify when she had taken possession of this and whether her husband had knowledge of its existence. The Police investigation did identify that she was able to use social media to contact her family, although the extent of that access and whether it was controlled by Adult A was unable to be determined during the review.

16.3.18 Adult A had also stated in a DASH form that Adult B had on one occasion persuaded her not to report him for breaching his restraining order. All of the above would seem to indicate that Adult B had considerable control and influence over his wife. The review was however unable to identify any record of a restraining order being granted or why Adult A would have made such a remark.

[18] Myhill, A and Hohl, K (2016)
[19] The police investigation following Adult A's death showed that she did in fact have access to a phone at that time. This would appear to have been purchased by her son.

16.3.19 The IDVA who had supported Adult A reflected that from what Adult A had said it would appear that she had accepted abuse and coercion as being an integral part of married life. This is not an unusual stance for some victims to take particularly those who have endured years of "intimate terrorism[20]" and that victims can underestimate their risk of harm from those individuals engaging in abusive behaviour and normalise coercive and controlling behaviours[21]. Those advising the review have also stated that such attitudes are compounded by the culture in Poland to domestic abuse which for some victims would provide additional barriers to reporting such matters due to stigma, family loyalty and the mistrust of agencies.

16.3.20 Despite the interventions that were put into place by the IDVA and DAO Adult A continued to state that she loved her husband dearly and that she didn't want him to get into any trouble. The review has been unable to determine whether these comments were made as an ongoing consequence of the coercive control that she had been subjected to over the years. Research[22] has also shown that due to the abusers acts of apologies and loving gestures between episodes of abuse then some victims will seek to believe that their partners are ready to cease their violent episodes.

16.3.21 Adult A was offered numerous support options (details of local and national support agencies including those specialised in supporting Polish families) but it would appear that she did not take them up. Those that dealt with her felt that this was due to her loyalty to her husband and the level of threat that she was constantly under. Adult A was provided with a personal attack alarm and appropriate flags and warnings were placed on agency systems. Such warnings ensure that those professionals that attended the home address of the couple were aware of the abuse that had been previously reported.

16.3.22 The DAO in the case surmised that Adult A did not have her own money or family and friends to support her should she have chosen to leave Adult B. Adult A acknowledged that she was totally dependent upon her husband in terms of finances and that she didn't see a way out. Financial abuse can occur when a 'perpetrator uses or misuses money which limits their partner's current and future actions and their freedom of choice'[23].

16.3.23 Adult A was also subjected to economic abuse[24]. Adult A did not allow her to work (affecting her ability to acquire economic resources) and did not allow her to have a mobile phone which consequently reduced her ability to access and use economic resources. Such actions also isolated Adult A from the community in which she lived and from her family. Women's Aid (2021) state that;

[20] Intimate terrorism -any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship" WHO
[21] Gibson 2019
[22] Rakovec- Felser (2014)
[23] Women's Aid 2019
[24] Economic abuse is a form of abuse when one intimate partner has control over the other partner's access to economic resources, which diminishes the victim's capacity to support themselves and forces them to depend on the perpetrator financially.

"Economic abuse is designed to reinforce or create economic instability. In this way it limits women's choices and ability to access safety. Lack of access to economic resources can result in women staying with abusive men for longer and experiencing more harm as a result."

16.3.24 In this case Adult A was totally dependent upon her husband and could see no opportunity to become independent without help. This was recognised by the DAO who had supported Adult A and she was provided with details on how to get a crisis loan to assist her in resolving this issue and this should be seen as good practice.

16.3.25 Police report that Adult A's family had stated that their contact with her had reduced over the years, particularly after the initial assault upon her by Adult B in 2013. This had been disclosed by Adult A to the DAO who had dealt with her case.

16.3.26 During the police inquiry Adult A's wider family stated that they had no specific concerns around her safety in relation to Adult B and if he was being abusive to her they believed that she would have told them. As identified in this report Adult A was loyal to her family and under the control of her husband. In such circumstances it is likely that she would not be in a position to report the abuse to her wider family members.

16.3.27 There were no disclosures of abuse to health services. In March 2017 Adult A did however present to her doctor with a number of ailments. At the conclusion of the consultation Adult A mentioned that her mood was low. It would appear that this statement was never explored further with her or if it was there is no record of what was said. This was an opportunity that was missed in terms of engagement, identifying abuse and exploring her family circumstances.

16.3.28 It is important that GPs are aware that individual, environmental and cultural differences may affect people accessing mental health support services. Such barriers include an inability to recognise and accept mental health problems, cultural identity, negative perception of and social stigma against mental health, language barriers and an imbalance of power and authority between service users and providers. GPs need to ask patients more detailed questions in order to explore the issue with them. This would not only aid their diagnosis but identify details about their family circumstances. Vesta - Specialist Family Support CIC have identified that conflicts in families and domestic abuse are often factors contributing to the poor mental health of the clients that they work with[25].

16.3.29 There have been a number of DHRs that have been published in Cornwall which advocated that the use of routine enquiry by Health services. In this case such an

[25] Vesta - Specialist Family Support CIC data from the Polish Domestic Violence Helpline suggests that over half of the victims (54%) suffered from depression and/or had suicidal thoughts and 70% felt isolated from family and friends (Wilcock, 2015 & 2017).

enquiry may have provided the opportunity to discuss the relationship that she had with her husband (**Recommendation 1**)[26].

16.3.30 Following the MARAC meeting held on the 08/11/17 Safer Futures made contact with Addaction (now We are With You) to request that they provide additional support to Adult A as they had a Polish speaking employee working for them. Addaction who had been present at the MARAC meeting had also suggested that a group called 'the Affected Others' may have been of benefit to the couple. The Affected Others' was a social event to discuss support, services and treatment programmes with other people dealing with similar issues. Addaction's records have been checked and they have no record of what (if any) contact was made and what additional support was offered. Safer Futures also do not have any records as to what support was provided. The representative from Safer Futures who sat on the Panel has confirmed that current working practices would ensure that such a referral would now be followed up.

16.3.31 Although the minutes/recording from the MARAC meeting have been reviewed the Panel have been unable to ascertain if the actions from that meeting had been followed up and finalised. Those on the Panel have also highlighted that Adult A's case would appear to have been closed prematurely and without confirmation that the support provided to her was adequate to meet her needs. This is poor practice in terms of record keeping and effective oversight through the MARAC process.

16.3.32 Safer Futures have acknowledged that ongoing support should have been documented and confirmed prior to case closure. They have reassured the Panel and the chair that current working practices and supervision is robust in terms of these actions (**Recommendation 2**).

16.3.33 Safer Futures are now moving towards a complex needs approach, where staff look 'outside the box' in order to meet victim's needs. The Safer Futures representative has confirmed that the service has grown since 2017 and now provides additional support via case co-ordinators. These co-ordinators now provide a tailored approach to victims' needs and would ensure that actions are followed up and finalised.

16.3.34 In 2017/2018 Safe Lives reviewed the MARAC process in Cornwall and identified a number of recommendations and actions to improve the service. As a result of the recommendations that were made the MARAC in Cornwall has improved significantly in recent years. Under the new MARAC process, communication between agencies starts before the MARAC meeting and a lot of preparation work is completed. There is now a MARAC action grid and this captures clear actions and the outcomes in specific cases.

[26] Replicates another recommendation agreed as part of (DHR7) in Cornwall which also recommends promoting the use of routine and direct inquiry across all services.

16.3.35 On the 15th November 2017 Safer Futures records show that Adult B had received a suspended sentence in relation to the assault on his wife. A request (although it is not clear who made this request) had been made for Adult B to complete 'healthy relationships' work on a one to one basis. The review was unable to find any documentary evidence that Adult B had completed this course of intervention. This demonstrates poor follow up and/or inaccurate record keeping. This was an opportunity that was missed in terms of trying to get Adult B to modify his behaviour and reduce the associated risks linked to domestic abuse. Effective supervision and oversight should have identified that this work had not taken place. Panel members confirmed that working practices in the County have since been reviewed and changed. As a result of these changes such an omission would be identified through case management and supervision and addressed accordingly.

16.4 Alcohol

16.4.1 From the reports recorded in police records (22/12/13, 21/02/17, 02/11/17, 09/12/17) it would appear that both Adult A and Adult B would drink alcohol on a regular basis and on occasions to excess. This was also confirmed by their son and other relatives during the police investigation into the death of Adult A.

16.4.2 Information provided by Adult A would indicate that the two of them would drink alcohol every night. On the night before Adult A died Adult B had purchased a one point five litre bottle of vodka. He and Adult A drank the contents of the bottle, diluting it with juice. Adult B when interviewed by the police stated that he had drank six or seven vodka's before falling asleep. He believed that Adult A had drank more than he did on that night although this could not be confirmed.

16.4.3 The IDVA who had spoken to Adult A believed that the two of them used to drink vodka although the DAO believed that it was any type of spirit. Adult A had stated to the DAO that she only drank alcohol so that her husband wouldn't drink as much. It would therefore appear that Adult A saw drinking as a coping mechanism and a way of mitigating the risk of abuse. The use of alcohol would appear to have enabled her to escape from the troubles in the relationship.

16.4.4 From the information that is recorded it would appear that when intoxicated both individuals would become verbally aggressive and Adult B violent (22/12/13, 02/11/17). During a joint visit between police and IDVA services on the 02/11/17 Adult A had stated that Adult B would only become violent when drinking alcohol and that he was very remorseful afterwards. She also stated that he would claim that he could not remember hurting her. Adult A's son had also informed his family that when drunk his mother could also become volatile and argumentative, particularly at weekends. From the evidence reviewed this was likely to be a protective response to the verbal and physical abuse that she was enduring from her husband. Alcohol misuse is seen as a major risk factor for increasing levels of IPV[27].

[27] Gibbs et al (2020)

16.4.5 When Adult A was seen by the DAO she had stated that all she wanted was help for her husband to stop him from drinking. Adult A believed her husband would complete an alcohol treatment programme if offered one, although it would appear that this support option was never made available to him. The Safer Futures representative on the Panel has confirmed that processes are currently in place to provide support, guidance and literature to victims to enable abusive partners to voluntarily refer themselves to such programmes. Improvements have also been made in terms of the liaison with the court IDVA so that treatment programmes can be considered as part of sentencing options. Safer Futures are also working with We are With You to review referral pathways and therefore the Panel felt there was no requirement to duplicate this recommendation.

16.4.6 Forensic samples taken following Adult A's death identified that she had high levels of alcohol in her blood at the time that she had fallen. The levels indicated could according to a toxicologist have induced' confusion, stupor or coma with shallow breathing and risk of death'.

16.4.7 The importance of clear and consistent pathways to help victims and individuals engaging in abusive behaviour cannot be underestimated[28]. In terms of improving the services available to individuals engaging in abusive behaviour (whose risk may increase through alcohol or drugs misuse), Safer Futures (Firstlight and Barnardo's) and We Are With You have developed a domestic abuse and drug and alcohol protocol and action plan. This development, which will see the services co-located, will align the two agencies, improve joint support planning, and provide integrated training and learning groups. Consideration is also being given to adopting a model which uses behaviour change workers to support individuals with complex needs through assertive outreach approaches.

16.4.8 The Vesta - Specialist Family Support CIC representative on the Panel identified that some individuals from diverse communities, including those in the Polish community who are victims of abuse, may be reluctant in engaging with such programmes. Those delivering the programmes will therefore need to be cognisant of the complexities of their needs, the risks[29] and that to be effective they may need to be delivered in their native language.

16.4.9 Those working in the county have acknowledged that a lot of work takes place in respect of referral pathways and assertive outreach for those victims with more complex needs. However, these services are not as developed for those engaging in abusive behaviours **(Recommendation 3)**.

16.5 <u>The Polish Community</u>

[28] Iriss (2020)

[29] Suicide rates of Polish men in Scotland are significantly higher than Scottish men – 31.5 vs 19.4. Factors contributing to suicides among Polish men included employment status, financial status, healthcare access, alcohol and substances misuse, relationships, police and legal involvement (Gorman at all, 2018). Between 2011-18 5 out of 12 Polish prisoners convicted for domestic violence cases killed themselves. Poland has the highest levels of familicides involving partner and children in Europe (Matusiak, 2019)

16.5.1 Although it is not known exactly how many Polish nationals there are living in Cornwall and the Isles of Scilly data from the EU settlement scheme shows that 2,160 Polish nationals were registered in the County (Home Office, Nov 2020). Information from the local Authority and the Police appears to show that the Polish community within Cornwall is largely migrant and they are concentrated in specific areas within the County.

16.5.2 The true extent of abuse within the Polish community was difficult to determine due to current recording practices in relation to the way that agencies record nationalities. Numerous nationalities can be categorised under one generic term such as 'White European' and as a consequence some groups are completely hidden in official statistics. It is important that agencies accurately record nationalities in order that they can identify trends in domestic abuse and offer services that meet specific victim needs. In this case RCHT, CFT, Housing and Police all had systems in place to record nationality and the fact that Adult A and Adult B were Polish. Safer Futures identified that their diversity data needed to be more specific to accurately reflect demographics and that this would enable them to change their approach to effectively meet client need **(Recommendation 4)**.

16.5.3 The diverse communities officer and other agencies confirmed that many of the Polish women in the County do not speak English. There are a lot of factors contributing to some individuals from diverse communities not using or learning English. This can include a short stay in the country, caring duties, long working hours and financial constraints (Johnson, 2015). There is also an acceptance that language is often used by perpetrators to exert abuse, e.g. they ridicule partners who try to speak English which discourages them from learning it. This language barrier can prevent women from knowing about and accessing domestic abuse and other welfare services.

16.5.4 Concerns have been raised that Adult A's isolation was, in part, due to cultural barriers and an acceptance that domestic abuse was part of her family life[30]. The Vesta - Specialist Family Support CIC representative on the Panel has stated that domestic abuse continues to be hidden within the community and that there is little trust of mainstream services. The review has been unable to verify whether Adult A had such a mistrust or that she was aware of the services available to support her.

16.5.5 The Vesta - Specialist Family Support CIC representative also highlighted that in their experience some domestic abuse services can be restrictive in their approach to the needs of victims from ethnic communities. Polish clients often need far more support for practical issues such as housing and finance. Signposting to other services is often not enough and without effective interpreter services clients find it difficult to access the support that they are offered. This process often leaves the client feeling that no one is able to help them and consequently they are then seen as voluntarily disengaging with services. This is a perpetual process that means that

[30] Notes from Poland (2020)

those in the community that suffer from abuse are unable to break the cycle or have confidence in the services that are available to them. Such barriers can be overcome by ensuring that where possible domestic abuse support services have a workforce that reflects the community that they serve. The Vesta - Specialist Family Support CIC representative identified that the most effective way of supporting victims is to make the IDVA service accessible by employing a Polish speaking domestic violence worker. As an organisation they have identified that the employment of such a worker will significantly increase the numbers of Polish clients using the service and improve engagement opportunities.

16.5.6 The Panel identified that language is a barrier to support and that those in the Polish community often prefer to seek support from Polish speaking professionals in private practice, both here in the UK and in Poland. This means that the true extent of abuse and victimisation is often not apparent to mainstream services.

16.5.7 The Panel acknowledged that there are issues with sourcing interpreters in a timely fashion in Cornwall for all agencies. The true impact of this on victims of domestic abuse could not be verified. Agencies did however accept that where there is a quicker response then it is highly likely that there would be better outcomes for victims of abuse. Agencies in Cornwall should therefore look at reviewing and developing interpreter services that are flexible to meet current and future needs. The Vesta - Specialist Family Support CIC representative on the Panel also identified that professionals working with foreign nationals would also benefit from completing training on using interpreters and this should be considered as part of that review **(Recommendation 5).**

16.5.8 The Police have commissioned interpreter services in line with National approved practice. These services involve freelance interpreters and the procurement frameworks that govern them and their operational effectiveness are not suitable for the needs of the Police. This case did highlight that operational officers can, on occasions, have problems in appropriately sourcing interpreters (paragraphs 16.3.8/16.3.9). At present the commissioning arrangements for this service are under review on a national basis and the Force concerned in this case are looking at the benefits of what is being proposed. Such a move would ensure a consistent and standardised approach to the recruitment, training and deployment of interpreters which would meet the needs of victims **(Recommendation 6).**

16.5.9 The Panel members further acknowledged that any interpreters used in relation to domestic abuse cases would benefit from domestic abuse training to ensure that they are meeting the needs of the victim and that they are eliciting all of the information required by agencies to progress a case (**Recommendation 7**).

16.5.10 In terms of the availability of information for non-English speaking victims' agencies have confirmed that this is an issue. Safer Futures have recognised that the majority of literature available to professionals and victims is not inclusive and that work needs to take place to ensure that materials are translated for identified groups. The Housing representative on the Panel stated that their organisation was working on

having documents translated. The police representative also stated that they can access appropriate material for use with victims of abuse from diverse communities. The availability of multilingual literature across all agencies relating to domestic abuse services was found to be variable (**Recommendation 8**).

16.5.11 Efforts have been made by the police in terms of breaking down the barriers in the Polish community by employing two members of staff who regularly interact with migrant workers. These members of staff initiate contact through those main employers who utilise the Polish communities' skills in the County. The information provided to them includes domestic abuse awareness and signposting to services. This should be seen as good practice.

16.5.12 There was a view by those professionals that had contact with the family in this case that more needs to be done by agencies to instil confidence in Polish women to come forward and talk about their experiences and to improve their knowledge of the support services that are available to them. Such intervention would increase confidence in the community and improve intervention opportunities. It was felt that this could be achieved through targeted intervention at the main places of employment i.e. a meeting once a month within one of the two main workplaces in the County where all welfare and support issues could be addressed. Professionals felt that the approach to introducing domestic abuse awareness should be carefully considered so as not to deter people from attending (**Recommendation 9**).

16.6 Operational Practice, Policy and Procedure

16.6.1 The details provided by RCHT have identified that when Adult A was admitted to hospital in 2019 in relation to chest pain and diagnosed high blood pressure it was identified that there was a MARAC flag added to her records in 2017. These alerts apply to both adults and children within a household and ensure that staff are prompted to provide additional support and signposting. Where such a flag exists then the hospital IDVA is notified and this should be seen as good practice. The author of the RCHT chronology has however identified that as the flag had been added in 2017 it was outside the timeframe (one year) written in policy for contact (Safer Futures have confirmed that there was no contact with the hospital IDVA). The RCHT Panel representative has confirmed that the 'flagging' process is currently under review (**Recommendation 10**).

16.6.2 There was good evidence in records of IDVA contact in 2017 following a referral by the Police and that this individual initiated a face to face meeting at the earliest opportunity. Risk assessments, Severity of Abuse Grid (SOAG) and ISSP were completed in line with guidance and this should be seen as good practice. Contact was made with the support of an interpreter.

16.6.3 On the 09/11/17 a joint visit was made to see Adult A. On this occasion Adult A was provided with the details of a Polish Support Service by the IDVA. Research[31] has shown that many minority ethnic women experiencing domestic abuse/violence prefer to access support from a specialist BAME service and this was recognised by the IDVA and DAO. Safer Futures have however acknowledged that an area of learning for their organisation would be to initiate contact themselves for the client and arrange initial contact. This practice would assist in overcoming perceived barriers to help, support and engender confidence in using services **(Recommendation 11**).

16.6.4 The police DAO has also suggested that frontline officers often fail to appreciate the complexities of abuse and the value of the DASH risk assessment when dealing with victims. In those cases where there is no immediate risk to the victim and where the individual engaging in abusive behaviour is not at the scene there was a view that such cases could be dealt with by specialised officers/support staff via the telephone. This would have negated the issues identified in paragraph 16.3.8 where a further DASH was not completed and Adult A signposted to services.

16.6.5 At present it is recognised that more work needs to take place in terms of reaching out to all communities in Cornwall in respect of domestic abuse. Cornwall has developed 'a vision' in relation to equality and diversity'[32] and has implemented a Multi-Agency, Equality, Diversity and Hate Crime Group. This groups terms of reference includes the following;

- Facilitate effective communication with, and between, the diverse communities of Cornwall and Isles of Scilly,
- Promote fairness, justice and equal access to services for all,
- Promote awareness of and respect for the rights of all individuals.

It is therefore suggested that Safer Cornwall works with this group to identify opportunities to improve domestic abuse services, align strategies[33] and improve the training of frontline staff in the county to ensure that they are sensitive to cultural needs **(Recommendation 12).**

17.0 Conclusions

17.1 From the information that was made available to the Panel it would appear that Adult A found herself in a situation where she could see no alternative but to stay with her

[31] In a survey of BAME women accessing domestic abuse/violence support services, found that 89% preferred a specialist BAME service. Thiara, R. & Roy, S. (2012) Vital Statistics 2: Key findings on black, minority ethnic and refugee women's and children's experiences of gender-based violence Imkaan. 8 Thiara, K. (2011) Refuge: Eastern European Community Outreach Project Thiara, K. (2011) Refuge: Eastern European Community Outreach Project Independent Evaluation Report Page 17 of 31 Copyright © 2015 Standing Together Against Domestic Violence.

[32] Cornwall Wide Equality Objectives 2018-2022

[33] Safer Cornwall Domestic abuse and Sexual Violence Strategy (2019).

husband despite the abuse that she was suffering. Adult A felt financially and socially dependent upon him.

17.2 Adult A had suffered from domestic abuse over many years and the risks of abuse would appear to have escalated when Adult B drank alcohol.

17.3 Adult A's family have stated that they were unaware that she was in an abusive relationship with her husband and believed that she would have spoken out had she been a victim. The review has identified that it is likely that she remained 'silent' due to family loyalty, and the mistrust that some parts of the Polish community have in relation to dealing with agencies.

17.4 The cause and circumstances of Adult A's death remains 'unexplained'. There is no recorded evidence of an escalation to that risk in the days leading up to her death and no one could have foreseen the tragic events that occurred on the day of her death.

17.5 The review has identified a number of areas of learning in respect to agency response to the domestic abuse incidents reported by Adult A. When Adult A initially approached the police there was a lack of professional curiosity and a failure to follow established procedures. The subsequent responses by all agencies were hampered by the inability to source interpreter services.

17.6 Those involved in the MARAC process failed to set appropriate actions and ensure that those that were identified were effectively followed up. Adult A's case would appear to have been finalised without a true appreciation of the complexities of her situation and an effective risk management plan being put into place. The MARAC process has since been strengthened by the Safer Cornwall Partnership.

17.7 The review has identified that agencies could work harder to adapt current service provision to meet the needs of diverse groups living and working in the Cornish community.

17.8 Since the date of Adult A's death the MARAC process has continued to evolve in the County and is now robust in its approach to protecting victims. Agency policy and procedures in relation to domestic abuse would also appear to be comprehensive.

18.0 Learning/Recommendations

18.1 The learning opportunities identified in this case are listed below and have been translated into recommendations;

- Learning opportunity 1 (Recommendation 1)

  In March 2017 Adult A had an appointment with her doctor and during this consultation her family circumstances were not explored. There have been a number of DHR's that have been published in Cornwall which advocate that the use of routine enquiry by Health services should be promoted. In this case such an enquiry may have provided the opportunity to identify domestic abuse and signpost her to services.

Recommendation 1 – Safer Cornwall and Kernow Clinical Commissioning to work together to improve the responses of General Practices to domestic abuse through training, the establishment of care pathways, and an increase in GP referrals to specialist services and the MARAC.

- Learning opportunity 2 (Recommendation 2)

Opportunities were identified by the review to improve the recording practices within Safer Futures in relation to the closure of cases and resulting actions from the MARAC.

Recommendation 2 – Safer Futures to audit and review current recording practices to ensure that the decisions to close cases are defensible and that MARAC actions are finalised effectively and the rationale recorded.

- Learning opportunity 3 (Recommendation 3)

Referral pathways and assertive outreach services are currently limited within the partnership for those engaging in abusive behaviours.

Recommendation 3 – Safer Futures and DASV commissioners to review current referral pathways and identify opportunities for improving services for individuals engaged in abusive behaviour.

- Learning opportunity 4 (Recommendation 4)

Safer Futures identified that the true extent of abuse within the Polish community was difficult to determine due to current recording practices. Accurate recording of such information would enable agencies to track and forecast demographics and to implement appropriate changes to meet the needs of clients.

Recommendation 4 – Safer Futures to review and amend current recording practices to ensure that nationalities are accurately recorded for all cases.

- Learning opportunity 5 (Recommendation 5)

The Panel also acknowledged that there are issues with sourcing interpreters in a timely fashion in Cornwall.

Recommendation 5 – Safer Cornwall Partnership to work with Health providers, Safer Futures, Housing and Adult Social Care to review and implement changes to improve local interpreter services in the County.

- Learning Opportunity 6 (Recommendation 6)

This case highlighted that operational police officers can, on occasions, have problems in appropriately sourcing interpreters.

Recommendation 6 – Devon and Cornwall Police to review current commissioning arrangements for interpreters and conduct an audit of domestic abuse cases that required an interpreter in terms of impact upon the outcomes for victims.

- Learning opportunity 7 (Recommendation 7)

The Panel members acknowledged that interpreters used in relation to domestic abuse cases would benefit from domestic abuse training.

Recommendation 7 – Safer Cornwall Partnership to work with Health providers, Safer Futures, Housing and Adult Social Care to review viability of training for local interpreters in domestic abuse.

- Learning opportunity 8 (Recommendation 8)

The availability of multilingual literature across all agencies relating to domestic abuse services was found to be variable.

Recommendation 8 –Safer Cornwall Partnership to work with Health providers, Safer Futures, Housing and Adult Social Care to review and improve local domestic abuse literature for appropriate foreign national groups based on the demographics in the community.

- Learning opportunity 9 (Recommendation 9)

There was a recognition in this case that more needs to be done by agencies to instil confidence in Polish women about the services available to them. This would assist them to come forward and talk about their experiences and improve their knowledge of domestic abuse services.

Recommendation 9 - Safer Cornwall Partnership, working with local specialist service providers who have experience of supporting Eastern European women experiencing domestic violence/abuse, to identify the most effective way to increase awareness of domestic abuse, and support services, within that community and to develop an action plan to implement this.

- Learning opportunity 10 (Recommendation 10)

The current MARAC flagging process in the hospital needs to be reviewed to ensure that all victims of domestic abuse are identified and provided with appropriate support.

Recommendation 10 – RCHT to review the effectiveness of the MARAC flagging process and where appropriate implement identified changes.

- Learning opportunity 11 (Recommendation 11)

  As part of the review Safer Futures acknowledged that practice should change to ensure that staff working on cases initiate contact on behalf of clients with other specialist support services. This practice would assist in overcoming perceived barriers to help and support and engender confidence in using services**.**

  Recommendation 11 – Safer Futures to review current processes to ensure that staff make contact with specialist support services on behalf of clients.

- Learning opportunity 12 (Recommendation 12)

  The review identified that Safer Cornwall should work with the Multi-Agency, Equality, Diversity and Hate Crime Group to identify opportunities to improve domestic abuse services, align strategies and improve the training of frontline staff in the County.

  Recommendation 12 – Safer Cornwall should work with the Multi-Agency, Equality, diversity and Hate crime Group to identify and implement opportunities to improve domestic abuse services , align strategies and improve the training of frontline staff in the County.

Glossary

AAFDA - Advocacy after fatal domestic Abuse.
CCG - Clinical Commissioning Group.
CFT - Cornwall Foundation Trust.
DAO - Domestic Abuse Officer.
DH - Domestic Homicide.
DHR - Domestic Homicide Review.
DAO – Domestic Abuse Officer.
GP - General Practitioner.
IMR - Independent Management Review.
IPV- Intimate Partner Violence
MARAC – Multi Agency risk assessment conference.
NHSE - National Health Service England.
RCHT - Royal Cornwall Hospitals Trust.
RE - Routine enquiry.
SOAG – Severity of Abuse Grid

Bibliography

Barrow-Grint K (2016): Attrition Rates in Domestic Abuse: Time for Change? An application of temporal sequencing theory; Policing: A Journal of Policy and Practice, Volume 10, Issue 3, September 2016, Pages 250 263, https://doi.org/10.1093/police/pav054

Domestic Violence and Abuse: Multi Agency Working; Public Health (NICE) Guideline [PH50]; 2018.

Farmer E, Callen S (2012) Beyond Violence; Breaking cycles of domestic abuse; The centre for Social Justice; London iSBn: 978-0-9573587-0-6

Cornwall County Council; Cornwall Wide Equality Objectives 2018-2022

Gibbs A, Dunkle K, Ramsoomar L, Willan S, Nwabisa Jama Shai, Chatterji S, Jewkes R (2020) New learnings on drivers of men's physical and/or sexual violence against their female partners, and women's experiences of this, and the implications for prevention interventions, Global Health Action, 13:1, DOI: 10.1080/16549716.2020.1739845

Gibson, J (2019), Rapid Response: Intimate Terrorism;
BMJ 2019; 367 doi: https://doi.org/10.1136/bmj.l6275 (Published 31 October 2019)

Home Office. (2015) Controlling or Coercive Behaviour in Intimate or Family Relationship Statutory Guidance Framework; Dec 2015; London. Home Office.

Home Office (2016) Domestic abuse and Abuse guidance; London.Home Office

Home Office. (2016) Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews; December 2016; London. Home Office.

Home Office (2020) EU Settlement Scheme Quarterly Statistics; London. Home Office

Iriss (2020) Using Evidence for Change: Domestic Abuse; Iriss 17june 2020

Krug, E.; Dahlberg, L.; Mercy,.; Zwi, A.; Lozano, R (2002). World report on violence and health*. Geneva, Switzerland:* World Health Organization*.* ISBN 9789240681804*.*

Myhill A, Hohl K.(2016) The "Golden Thread": Coercive Control and Risk Assessment for Domestic Violence. Journal of Interpersonal Violence. 2019;34(21-22):4477-4497. doi:10.1177/0886260516675464

Notes from Poland(2020)'Over 60% of Women in Poland have experienced domestic violence, finds leaked report. Aug 17

ONS (2018b) 'Homicide in England and Wales: Year ending March 2017', available onlineat https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2017#which-groups-of-people-are-most-likely-to-be-victims-of-homicide.

Rakovec-Felser Z. Domestic Violence and Abuse in Intimate Relationship from Public Health Perspective. Health Psychol Res. 2014 Oct 22;2(3):1821. doi: 10.4081/hpr.2014.1821. PMID: 26973948; PMCID: PMC4768593.

Safer Cornwall Domestic abuse and Sexual Violence Strategy (2019).

SafeLives (2015) Getting it right First time.

SafeLives (2015), Insights Idva National Dataset 2013-14. Bristol: SafeLives

SafeLives. (2019) Safe and Well: Mental Health and Domestic Abuse.

Women's Aid (2019) The domestic abuse report 2019: The Economics of abuse. Bristol Women's Aid.