Overview report

A Domestic Homicide Review concerning the death of ROSITA (pseudonym)

(September 2021)

Author – Jackie Dadd

Date completed – April 2022

Family tribute to Rosita

It feels like years, but it has only been few months,
And yet that is still too long.
I still love you the same as if you were still here with me, laughing during the good times and crying during the bad ones.
I miss being able to call you any time, to receive the message. I miss you asking my advice or just want me to listen what is on your heart.
Even we lived very far apart, you have been not only my sister, but also best friend.
We had our own set of friends and our own set of goals for our lives, but that still didn't change the fact that we were closest, sister and brother forever.
There was nothing that I wouldn't do for you and nothing that you wouldn't do for me, I miss being your big brother, you were always looking up to me, I miss you sister.
Very often I'm talking to you same as you were here and lighting up the candle every day.
I always wish you were still here with me enjoying life and you still had a lot ahead of you in your life. Sad you haven't experienced to be mom, I know you would make a perfect one, because you were very loving and caring person.
It hurst my heart, and feel so empty without you...
And I can really understand why God would want such a beautiful angel on his side from now until eternity.
Just know that I love and miss you,
And this is the tribute to you, my dearest sister and my best friend...

Big brother.

The Domestic Homicide Review Panel and the members of the Safer Peterborough Partnership Board would like to offer their sincere condolences to the family of Rosita, who have lost their loved one in tragic circumstances, and which has caused this Review to take place. They have been left with a huge gap in their lives.

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Preface

The key purpose of any Domestic Homicide Review (DHR) is to examine agency responses and support given to a victim of domestic abuse prior to their death and to enable lessons to be learnt where there may be links with domestic abuse. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The victim's death in this case met the criteria for conducting a DHR according to Statutory Guidance1 under Section 9 (3)(1) of the Domestic Violence, Crime, and Victims Act 2004. The Act states that there 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 was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death".

The Home Office defines domestic violence as:

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

Controlling behaviour is:

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

Coercive behaviour is:

An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. The term domestic abuse will be used throughout this review as it reflects the range of behaviours encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

Recommendations will be made at the end of this report, however, there has been an ongoing action plan introduced by the panel, parallel to this review to ensure that the areas that can be immediately addressed have not incurred unnecessary delay.

Section 1 - Introduction

1.1 The commissioning of the review

1.1.1 This review is into the death of Rosita, a Lithuanian female, who was found hanging by her husband in September 2021 in Peterborough. The Police have investigated the circumstances and have submitted a report to the Coroner with a finding that the death was non-suspicious and the cause was suspected suicide by hanging. The Coroner's inquest has been opened and adjourned awaiting the completion of this review.

Following information a day later from Rosita's brother to the coroner in relation to domestic violence in the household of Rosita, the coroner contacted the Police and a referral was made to Safer Peterborough Partnership on 20th September 2021 and following a meeting held on 4th November, 2021 with representatives from a number of authorities and the voluntary sector, a decision was made to undertake a Domestic Homicide Review as the definition in Section 9 of the Domestic Violence Crime and Victims Act (2004) had been met.

1.1.2 Contributors to the review

Agency	Contribution
Cambridgeshire Police	IMR, Panel member
Cambridge and Peterborough NHS Foundation Trust (CPFT	Panel member
Peterborough Community Safety Partnership	Oversight
Cambridgeshire County Council IDVA Service	Summary report, Panel member
Refuge	Panel member
Cross Keys Homes	Summary report, Panel member
NW Anglian NHS Foundation Trust	IMR, Panel member
East of England Ambulance service NHS trust	IMR, Panel member
Cambridgeshire and Peterborough DASV Partnership	Research data of local DHRs, Panel member
NHS Cambs and Peterborough Clinical Commissioning Group (CCG)	IMR, Panel member
Cambridgeshire Women's Centre	Scoping

1.1.3 Review Panel

The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of reports and chronology. Individual Management Reviews (IMRs) have been requested and supplied:

1.1.4 – The panel comprised of the following: -

Name	Area of responsibility	Organisation
Vickie Crompton	Domestic Abuse and Sexual Violence partnership manager	Cambridgeshire County Council
DI David Savill	Public Protection	Cambridgeshire Police
Gemma Wood	Assistant director of operations	Cross Keys Homes
Emma Foley	Peterborough City Hospital – Adult Safeguarding Practitioner	NW Anglian NHS Foundation Trust
Linda Coultrup	GP practice representative. Named Nurse Safeguarding Adults Primary Care	NHS Cambs and Peterborough Clinical Commissioning Group (CCG)
Julia Cullum	Domestic Abuse and Sexual Violence partnership manager – IDVA Service	Cambridgeshire County Council
Karen Smith	Mental Health – Domestic Abuse Lead	Cambridge and Peterborough NHS Foundation Trust (CPFT)
Mandy Geraghty	Senior Operations Manager	Refuge
Alina Jablonske	Specialist IDVA for Eastern European migrants	Cambridgeshire County Council IDVA Service
Rebecca D'Cruze	Ambulance service strategic safeguarding specialist	East of England Ambulance service NHS trust
Jim Bambridge (2nd panel meeting onwards)	MCU Review officer	Cambridgeshire Police

1.1.5 - All members of the panel and authors of the IMR's have complete independence from any subject in this review. Following careful consideration by the Review Chair and Panel, it was agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided for the overview. Thanks goes to all who have assisted and contributed to this review with their valued time and cooperation.

1.1.6 – Author of the Overview report

The chair of the review panel and author of this report is Mrs Jackie Dadd, an independent consultant who is independent of the organisation and agencies contributing to this report. She has no knowledge or association with any of the subjects in this report prior to the commissioning of this review. She is a retired Detective Chief Inspector with Bedfordshire Police with vast experience of safeguarding and domestic abuse related issues and has been involved in the DHR process since its inception in 2011. She has completed the Home Office online training, the Continuous Professional Development accredited AAFDA DHR Chair training and is a member of the AAFDA DHR network, regularly attending the monthly forums for CPD and discussion.

1.2 Purpose of the review

1.2.1 - The purposes of a DHR are to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice.

1.2.2 - DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners' and criminal courts, respectively, to determine as appropriate. DHRs are not specifically part of any disciplinary inquiry or process. Part of the rationale for the review is to ensure that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and domestic abuse. The review also assesses whether agencies have sufficient and effective procedures and protocols in place which were understood and adhered to by their staff.

1.2.3 - The death of Rosita has been presented to the Coroner as potential suicide. This review will ascertain whether domestic abuse could have been the cause or a contributory factor to this. It is not to apportion blame, but to view the circumstances through the eyes of Rosita.

1.3 Timescales

1.3.1 – Cambridgeshire Police made a referral for a DHR to Safer Peterborough CSP on the 20th September 2022 following them being contacted by the Coroner's office who raised concerns of the domestic abuse in Rosita's history that they had been made aware of from Rosita's brother.

1.3.2 - On 4th November 2022, Safer Peterborough Partnership, in accordance with the December 2016 Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews commissioned this Domestic Homicide Review. The Home Office were notified the same day.

1.3.3 - Mrs Jackie Dadd was commissioned to provide an independent chair and author for this DHR on 11th November 2021. Three separate panel meetings then took place. The completed report was handed to the Safer Peterborough Partnership on 25th April 2022.

1.3.4 – Table outlining timeline of review

September 2021	Rosita was found deceased at her home address
20/09/21	Police referred incident for consideration of DHR to Peterborough CSP
04/11/21	Decision to commission a DHR made by Central Beds CSP and partners
04/11/21	Home Office notified of decision to commission DHR
11/11/21	Mrs Jackie Dadd commissioned as Chair and Author
16/12/21	First panel meeting
23/02/22	Second panel meeting
01/04/22	Third panel meeting
25/04/22	Completed report handed to Peterborough CSP by Author

1.4 Terms of Reference

The full Terms of Reference can be found in Appendix A at the conclusion of this report. The Terms of reference were discussed and agreed upon during the first panel meeting on 16th December 2021.

1.4.2 - It was agreed that the main areas of focus would be based on:

a) Domestic abuse in any form had been the causation or a contributory factor to Rosita taking her own life
b) Service and agency provisions for domestic abuse within Peterborough, specifically for the Lithuanian community
c) Services and agencies provisions for suicide and those contemplating taking their own life within the Peterborough area
d) What progression and implementations have been made since the previous DHR reports surrounding Lithuanian females in Peterborough and surrounding areas?

1.4.3 - It was agreed by the panel that the scoping dates would take place from Rosita's arrival in Peterborough until the date of her death. This was due to the fact that although there is information provided of abuse both in Lithuania and on her arrival to the UK at an unlocated farm, these were not reported to any health officials or the Police. (information provided by her brother)

1.5 Subjects of the review/Family and friends' involvement

1.5.1 - In accordance with Home Office guidelines to ensure confidentiality, pseudonyms have been utilised throughout this report for the following:

Rosita - Deceased, who was a Lithuanian female aged 28 years at the time of her death.

Jurgis - Husband, a 35-year-old, Lithuanian male, living with Rosita in same household.

Aras - Elder brother to Rosita and only sibling, who lives in Norway.

Daina – Lithuanian friend living in the North of England

Address – Name of City provided as Peterborough

1.5.2 - The family of Rosita, represented by her brother, Aras, wished to be fully engaged with the review and the author would like to express their gratitude for the significant contribution and assistance provided throughout. The pseudonyms used in this report were agreed by Aras as he did not wish to choose them himself.

1.6 Parallel reviews

1.6.1 - The Coronial process is taking place parallel to this review.

Rosita's death was reported to the Coroner by the Police and a file was opened on 13/09/21. The report submitted stated that the death was considered to be non-suspicious. Early on, the coroner was alerted by Aras that there was domestic violence in the home and that he had suspicions surrounding Rosita's death. Conversations took place with the police and a standard post-mortem was eventually settled on. The result of that post-mortem examination was: -

1a) Hanging

There were no injuries or trauma to the deceased indicating or suggesting any third-party involvement in the death. Toxicology tests determined that there were no intoxicants present in the deceased's blood.

The coroner has suspended the coronial investigation pending the outcome of this review.

1.6.2 - Safer Peterborough Partnership, in accordance with the December 2016 Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews commissioned this Domestic Homicide Review.

The decision to hold a DHR was taken on 4th November 2021. The Home Office was notified of the decision in writing on the same day.

1.6.3 - Mrs Jackie Dadd was commissioned to provide an independent chair and author for this DHR on 11th November 2021. Three separate panel meetings then took place. The completed report was handed to the Safer Peterborough Partnership on 25th April 2022.

1.6.4 – Table outlining timeline of review

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Home Office guidance states that the review should be completed within six months of the initial decision to establish one.

1.7 Equality and Diversity

1.7.1 - The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010 and found only two to be relevant to this case. It was considered that Rosita's sex was relevant to the review as 3-10 women a week die of suicide where they have suffered domestic abuse and in 2017, eighty-three per cent of victims reporting coercive control to the police were female (Office for National Statistics, 2017).

1.7.2 - Race was also considered to be a relevant characteristic within this review due to the percentage of Lithuanian females in previous DHRs for Peterborough. There are lessons to learn regarding culture and language, but these are not listed within the Equality Act 2010 as 'protected characteristics.'

1.7.3 - There was clear controlling and coercive behaviour from Jurgis towards Rosita throughout their relationship outlined within this report. Jurgis had been a male, raised in Lithuania in which it is openly accepted that domestic abuse, which is the second highest crime type in the country, is a result of deep social problems. New laws are only now being legislated in the areas of domestic abuse offences and therefore, Jurgis' upbringing will have been at a time when this behaviour was not recognised in a negative way or addressed within his family or community. His lack of knowledge of the English language when entering England, would mean that he may not have been aware of the attitudes towards this behaviour and as it mainly happened within their home and Rosita did not openly disclose how she was being treated, Jurgis' ignorance to his behaviour was not challenged or dealt with.

1.7.4 – This review outlines the difficulties in which non-English-speaking migrants may face when trying to access information on services both through leaflet/poster literature and on websites. Therefore, had Jurgis recognised his behaviour and wanted to seek help, he may

have found it difficult to identify what help was available and where to look, particularly because of the language barriers.

1.8 Dissemination

Recipients who received copies of this report before publication:

Panel Members (listed in 1.1.4)

Family Members

1.9 Contextual background

Peterborough is a cathedral city and unitary authority next to Cambridgeshire with a population of 202,110 recorded in 2017. Due to the results of the census 2021 not yet published, it has been difficult to provide an exact number of Lithuanian residents in Peterborough.

The last robust data source on the number of residents in Peterborough from Lithuania is Census 2011, which recorded 3,712 persons whose country of birth was Lithuania, which was 2% of Peterborough's total population (183,631) at that time.

An alternative source of data is the Office for National Statistics (ONS) which produces population estimates by nationality and country of birth for individual countries. In the latest release of these estimates (July 2020 to June 2021) the estimated population of Peterborough whose country of birth is Lithuania is 1,000. However, please note that this estimate should be used with caution as it has a wide confidence interval and also these ONS estimates do not include all usual residents (some communal residents are excluded).

Another alternative source of data that can provide an indication of the number of Lithuanian residents would be referring to the number of applications to the EU Settlement Scheme. In the latest release of these statistics (from September 2021) there were 12,140 applications in Peterborough from Lithuanian nationals from August 2018 to September 2021, suggesting that the number is higher than that reported in the ONS census data. Again, it should be noted that this data is not an estimate of population and should be used with caution. More than one application can be submitted by the same person, and in addition, this data takes no account of residents' activity since the application was submitted (for example, they may have subsequently moved away).

Rosita's death is the seventh domestic homicide in Peterborough since the introduction of legislation mandating Domestic Homicide Reviews in 2011. Of these seven reviews, four have involved a Lithuanian female victim. In addition, there has also been a review of a Lithuanian female death in the Fenland CSP which is in Cambridgeshire's jurisdiction. This is a significant concern and will form part of the analysis and recommendations from this DHR.

At a press conference on the International day for the Elimination of violence against women in 2019, the Deputy Commissioner in Lithuania reported that domestic violence was the second most common crime in Lithuania. The most common court ruling in domestic

violence cases, separating the abuser from the victim, can often be impracticable in rural areas where they live in one house and have nowhere to move. While women are often victims of physical abuse from their partners, there are other forms of violence that receive less attention.

“Psychological violence, sexual violence, economic violence remain completely invisible and unacknowledged in our society,”

He says that domestic violence is a result of deep social problems and victims often have widely unequal access to relief services. (Reference: Gytis Pankūnas, LRT.lt**2019**.11.25 17:54)

Lithuania is now making progress with both legislation and recognition of domestic abuse.

The Safer Peterborough Partnership have the legal responsibility for DHRs within their area and have been the only CSP within Cambridgeshire to not have a dedicated community safety officer that has ownership of DHRs to review, analyse and complete subsequent actions. In April 2021, the DASV partnership took over a centralised DHR process for Cambridgeshire and Peterborough to work with this role in the other areas. If they are aware of any gaps within Peterborough, they will aim to ensure the work is completed and are able to analyse issues across Cambridgeshire and Peterborough for wider implementation and uniformed processes.

Suicide rates in all districts within Cambridgeshire and Peterborough are statistically similar to England for the three-year period 2017-19. However, all have seen an increase in suicide rates from 2015-17 to 2017-19.

In Cambridgeshire, since May 2018, nine suicides relating to domestic abuse have been considered as requiring a DHR.

The DASV worked alongside Public Health to review the correlation of suicide and domestic abuse in which the outcomes form part of the Cambridgeshire suicide prevention strategy, published February 2022.

Research showed:

1. Domestic Abuse is a factor in around 12.5% of female suicide attempts
2. 25% of those in Domestic Abuse services have felt suicidal due to the abuse
3. Domestic Abuse victims are 8x more at risk of suicide than the general population
4. 50% of Domestic Abuse victims who attempt suicide will undertake further attempts within a year
5. 20% of DA Victims attempting suicide are pregnant
6. A third of female suicides are subject to domestic abuse
7. “Suicidal acts…… are more likely where feelings of defeat and entrapment exist alongside beliefs that neither rescue or escape are possible” Williams (2001)
8. 3-10 women a week die by suicide where they have suffered domestic abuse

Section 2 – The Facts

2.1 Background to death of Rosita

2.1.1 - Rosita was born in Lithuania and grew up in a house with her grandparents, parents and her only sibling, her brother, Aras who was ten years her elder. They didn't have a lot in common when she was younger due to the age gap but became very close in their adult years. Aras moved out of the family home when Rosita was 10 years old.

2.1.2 - She was not a problematic child and had lots of friends, with her best friend being her cousin, who still lives in Lithuania, although they had fallen out in recent years. Aras described that as they grew up, they witnessed their father abuse their mother.

2.1.3 - 'Mother was fine but difficulties with father'. He would abuse Rosita with words but not physical violence but did use physical violence on their mother. Rosita would see the bruises on their mother, but Aras was unsure if she had ever actually seen violence take place. Their father was Russian, and alcohol and violence were linked in his behaviour according to Aras. Aras would tell his mother to report it to the Police, but she never would. She was 'always protecting our father'.

Aras explains 'we came from a poor family with a need to grow up fast and start working. We had the pressures of this'.

2.1.4 - Rosita always had lots of friends and would meet them on weekends. It was at a house party in 2013, when Rosita was 20 years old that she met Jurgis. He was seven years older than her and was married with a young child although his marriage was ending at the time.

2.1.5 - On one occasion, whilst at their parents, her father's friends complimented Rosita on how well she had grown up. Jurgis took this the wrong way and had been drinking. He began to fight with them and when they got into the car to leave, he strangled Rosita, choking her and he hit her. He later went back to the fathers' house with his friends to have a fight. None of this was reported to the police. Aras couldn't understand why he would have done this as Rosita stood by him against her parents at the time. Aras was living in Norway by then.

2.1.6 - Rosita and Jurgis moved to the UK for a better future soon afterwards in May 2015. Whilst working on a farm somewhere in England, the farm workers and Jurgis had been drinking a lot and Jurgis attacked Rosita, breaking her nose and tooth. Rosita didn't report this or seek medical assistance as she was too scared Jurgis would 'go to jail'.

2.1.7 - Both were granted leave to remain in the UK. Jurgis in May 2015 and Rosita in June 2015.

Rosita arrived in the UK being able to speak broken English but on applying for jobs, realised she would need to speak English fluently and so she enrolled at City college, Peterborough when they arrived there. They lived in two known addresses in Peterborough, the latter of which was a two bed, semi-detached house, privately owned and rented by Jurgis and

Rosita. Only the two of them lived there with two cats. There is no record of any environmental or pollution complaints. Contact with the owner of the property has not been possible. It was just the two of them, with the second bedroom being Rosita's beauty room in which she would complete Instagram make up and fashion blogs for which she had over 10,000 followers and was an influencer and model.

2.1.8 -Rosita and Jurgis were married in the UK on 1st September 2017. It was small and no family attended as they are all living in other countries. Aras knew that they had always had discussions and fights but never thought it was physical. Rosita would later disclose to Aras that it was mostly driven by Jurgis drinking and how he behaved afterwards. Jurgis stopped drinking for a while after they were married because of this as he realised that this was when he became aggressive and would make unfounded accusations to Rosita on the way she dressed and behaved being for the purpose of other men and not him. These comments would make Rosita wary of what she was doing and made her worry over her Instagram modelling which she knew Jurgis only allowed to continue as it would make them money.

2.1.9 - He knew that Jurgis didn't want her to change jobs after she obtained her security licence and stopped her going to a job interview. If he gave her a lift to work, he would make her pay him £5. Jurgis worked in a car wash somewhere in Peterborough.

2.1.10 - About two and a half months before she died, Rosita started opening up to Aras about her relationship. They had always spoken frequently on the phone, skype and messaging and he knew that Rosita would send money back home to help, when she could.

2.1.11 - Rosita began to inform him of the violent incidents that are aforementioned. Aras thinks she probably didn't tell him before as he was very protective of her and she didn't want to cause problems. She sent him screen shots of messages that Jurgis had sent her in Lithuanian saying that Rosita needed to shave her head in order to prove her love for him. Jurgis also tells her to cut all her ties with her friend Skaiste and if not, she'll go back to sleeping on the floor in the spare room. This was punishment for her after she had gone out drinking with her friend and the police took her home after being assaulted. Jurgis blamed her for this. Another message says that she has 15 minutes to get home or else. He then says he is going to carry on cutting her clothes and if she isn't home in ten minutes, she'll be making a big mistake and he'll destroy her. Another text is telling her that she must get his name tattooed on her. Rosita also forwarded photos to Aras of her cut up clothes and the floor she was being made to sleep on.

2.1.12 - Aras encouraged her to go to the Police and she told him that she had threatened Jurgis she would tell the police and he would go to jail, but she never did as she would calm down after a few days. Jurgis never used to go out and would always be at home. Rosita paid the majority of the bills and household items as she earnt more than he did.

2.1.13 - Rosita mentioned a few times in August 2021 that she 'couldn't handle all this' but Aras believed this was with respect to her marriage and not a wish to end her life. She was happy otherwise and worked hard. Rosita only ever complained about Jurgis, nothing else. She told Aras that her and Jurgis had been fighting every day for the last two months.

2.2 Circumstances of the death of Rosita

One day in September 2021, Rosita was working a day shift in her role as a security officer at a distribution centre in Peterborough. She was due to finish at 6pm that day. During her break, about 4pm, Aras had a facetime call with Rosita. During the call, Aras said that Rosita did not show sadness and was happy and smiling.

Aras made mention of an argument he had with his girlfriend, and this led to Rosita saying that she was going to speak to Jurgis when she got home from work that evening in the context that it was about their relationship and Aras asked her to ring him afterwards to let him know how it went, to which she said that she would.

Around midnight that evening, the ambulance service received a 999-call stating that a patient had been found hanging by her partner who cut her down using a knife. No other details were known.

When the solo crew attended, Jurgis opened the door and was agitated, holding a large knife. He entered and found Rosita, lying supine on the living room floor with a ligature mark to her neck.

Despite crew recognising signs of death in Rosita, Jurgis aggressively requested the crew attempt resuscitation. Due to the crew at this stage being solo, and their concerns for their own safety, brief CPR was commenced whilst awaiting back up. When back up arrived, the knife was removed to the kitchen area and CPR was discontinued as rigor mortis had set in.

Jurgis continued to attempt CPR chest compressions and mouth to mouth ventilations, refusing to leave Rosita. He was agitated and the police were called to assist. A strong smell of alcohol had been noted on the crew's arrival and a half empty vodka bottle was on the floor in the front room. There was a handwritten note in Lithuanian pinned to the boiler housing. The Police arrived and took over the investigation.

Aras never received a phone call back from Rosita.

Following her death, Rosita's friend, Daina began to collect money via Facebook from the Lithuanian communities to assist with flying her body home and the funeral costs. This is something that is common in these circumstances. Around £3000 was raised and was given to Jurgis for this purpose. Jurgis kept the money and the costs have had to be covered by Rosita's family.

Jurgis returned to Lithuania in time for the funeral. He held several conversations with Rosita's parents, telling them that Rosita had tried to take her own life at least ten times before. He told Aras that no letter had been written and later, sent him a copy of an abortion letter which he found in Rosita's belongings after her death. He told Aras he knew nothing about this.

2.3 Individual management reviews (IMR's)

2.3.1 - Rosita and Jurgis had very little contact with agencies. IMR's were requested from the following organisations because they had come into direct contact with Rosita or Jurgis.

NHS Cambridgeshire and Peterborough CCG (GP)

2.3.2 - Jurgis – Jurgis registered with a Peterborough practice (same as Rosita) on 1st February 2016. He is recorded as Lithuanian as his first language but English speaking. An interpreter was utilised for his first appointment. The practice employ staff fluent in Lithuanian, which is based on their patient's demography, language and cultures and are utilised as interpreters during appointments as required.

His records show that he was continually recorded as 'nil drinks a week' in relation to alcohol.

His medical history shows little relevance to this review; however, he was not always compliant with treatment, failing to collect prescriptions and on one occasion, stated that he wanted probiotics rather than the prescribed antibiotics.

DA was not a consideration as there was no reason obviously presented for a practitioner to consider this question.

2.3.3 – Rosita – Rosita registered with a Peterborough practice on 29th January 2016 stating an interpreter was required. The practice provides interpreters for face-to-face appointments as required and staff who are Lithuanian can translate if required. As time went on, there was no longer a requirement with her English. Rosita was not on any regular medications including any form of contraception and did not present to the practice in the last year of her life. Rosita was an infrequent attendee at the practice and abuse was not disclosed.

During the time she was registered, there was a physical health theme that potentially could have been linked i.e. frequent painful urination and abdominal pain, including during intercourse, but no indication from Rosita to suggest any rough or forced intercourse, so speculation only. There was one occasion where Rosita was tested for any sexually transmitted infection (STI) which was reported as negative in which Rosita chose to be informed by SMS, suggesting that she was not afraid for information to be stored on her phone if her husband did indeed have access or was to see it.

2.3.4 - During the five years Rosita was registered at the practice, there were four work related injuries recorded, all that were explained with a *justifiable rationale*, and all affected parts of the body. A muscular chest sprain lifting heavy packages, a burn to her hand and arm this was understood to have occurred whilst working at a large supermarket although the entry in the notes is a little unclear. A toe injury following a heavy weight being dropped on her foot and a shoulder muscle strain following a jerk from a machine moving chickens, this injury was not reported to the GP initially as she attended the Minor Injury Unit (MIU). The MIU recorded that she had attended alone and no safeguarding concerns. Mobile contact number clarified.

The practice representative advised work related injuries are not an unusual occurrence with this cohort of patients as they are generally manual workers, so the frequency of injuries is not uncommon and the quantity, four, in five years, was not considered excessive as in addition to this they were also different areas of the body affected.

There is no record of a broken finger on practice notes following attendance at the local hospital in August 2021. Usually there would be a discharge notification from A and E to the GP surgery.

2.3.5 - On one occasion, Rosita admitted to unprotected sex and she took 'a pill' a few days after this, presumed to be an emergency contraception pill as she reported subsequently bled vaginally. There is evidence of a termination of pregnancy in 2021, organised through the British Pregnancy Advisory Service (BPAS). This is a confidential service, and information is not routinely shared with the GP. A discharge summary was provided for Rosita should any after care be required. It has been confirmed the GP Practice were not aware of this procedure, based on the confidential nature, which is routine practice with BPAS and therefore there is no reference to this within her medical records.

Following a conversation with the BPAS Safeguarding Lead, a verbal report identifies Rosita self-referred to the service by phone and this conversation incorporated a consultation with the appropriately qualified practitioner - nurse/midwife. A precis of the consultation involved the pregnancy options, discussion of her medical history and if the termination was her choice, and did she feel safe at home – YES. These questions were repeated when she was seen face to face in the clinic for her next appointment.

2.3.6 - Not all clients are seen face to face, some have a prescription sent to a dedicated pharmacy for collection however, as Rosita required an ultrasound scan to confirm how many weeks pregnant she was, she attended for a dating scan. She also collected her medication to terminate the pregnancy.

Two doctors sign the consent form once the information provided by the client has been assessed, which includes the reasons for the termination which must adhere to the Abortion Act 1967; considering all her options 'she did not feel ready, she stated she was training to be a police officer, was living with her cousin and mentally was not ready.'

However, the address was recorded as the documented address she shared with her husband and no previous mention of a cousin living at this address, also no information shared to suggest she was a trainee police officer.

She also stated there was no coercion and no abuse.

2.3.7 - The procedure Rosita had was a medical termination of pregnancy; https://www.bpas.org/abortion-care/abortion-treatments/the-abortion-pill/abortion-pill-up-to-10-weeks/. These medications cause abdominal cramping and vaginal bleeding. As this cramping can be very painful, strong analgesia is also prescribed. A discharge summary is given to the client detailing the medications prescribed, the exact gestation of the pregnancy and the date terminated. This is for the sole use of other professionals in the eventuality of any post-procedure complications e.g. excessive bleeding. This is not sent

routinely to their GP practice; the surgery therefore had no knowledge of this prior to this enquiry. It was reported by the husband that he found the discharge summary after Rosita's death when sorting through her documents and claimed he had no prior knowledge of this pregnancy or procedure.

Rosita did not demonstrate any signs of anxiety or depression that were documented and nothing was discussed with her GP in relation to this and there were no medications or mental health referrals therefore, the GP was unlikely to identify any risk of suicide based on the information shared with them.

Learning points - Rosita made an ambiguous comment regarding the burn, "…….she is model in London and like to report this incident. work is aware - works in a large supermarket."

It is understood she sustained the injury at work in a large supermarket, but Rosita stated she was working as a model (which was a known ambition) and therefore concerned about the impact of the burn, adding clarity to the comment she would 'like to report this incident. work is aware.'

This is ambiguous as it can be interpreted differently by each reader. It would have been helpful if the next practitioner made an entry in their record to provide clarity but also would have provided evidence of professional curiosity. This would have been considered good practice, so a potential lost opportunity and a consideration for learning.

2.3.8 - Good practice:

Examples of good practice include follow up of scheduled and overdue smear appointments, follow up of a 'did not attend' orthopaedic appointment by SMS and documented as for discussion during her next routine appointment. Also, permission was requested to send her smear and vaginal swab results by SMS.

BPAS asked directly if the patient feels safe at home and if there was any coercion or abuse and recorded it appropriately on the notes. The MIU also asked if the patient felt safe in her home and recorded it appropriately.

The practice employ staff fluent in Lithuanian and are used as translators at face-to-face appointments to address potential inequality and reflect the patient's demography, eliminating the need for family/friend interpretation.

After the suicide of Rosita, there was significant concern over Jurgis' mental health. The communications between the police and the practice appear to have been of an exceptional standard, and immediate actions to support were taken.

Following this incident, the CCG organised presentations to all Primary Care staff from both the Health IDVAs and the Lithuanian IDVA. Monthly training sessions are undertaken with a plan to reflect lessons learnt from DHRs and other reviews. The previously mentioned presentations being examples of this. In addition to this the Primary Care monthly Newsletter contains a 'Spotlight on DHRs' and each month a lesson learnt is shared often with a suggestion to address the lesson – e.g., patients' that DNA – A suggestion to run a

report identifying all patients that have not attended 3 or more appointments in any 3 month period to raise awareness of those frequently not attending appointments as it has been identified there is often a link with DNA's and abuse/homicides.

2.3.9 - Each GP Practice should have a policy on DA and all GPs and other clinicians are required to evidence their Safeguarding training meets their statutory requirement, which varies dependent on role undertaken, minimum is 8 hours training at Level 3 for clinicians (there are differing levels based on staff groups). The safeguarding team provide a single point of contact for all safeguarding enquires and primary care have two dedicated named nurses for adults and children respectively although they advocate a think family approach. In addition to this they offer a fortnightly safeguarding drop-in session.

To ensure primary care are supported with their approach to asking about DA within their consultations, they have encouraged all staff to be professionally curious as asking the question about DA should be meaningful, to encourage disclosures, not a standardised question. The links to external training are advertised through a Newsletter and on the GP Training Hub. JUST ASK is frequently promoted – if you hear it, see it, suspect it JUST ASK. All lessons learnt are discussed with real examples as this has been identified as the most effective method. These discussions are also shared with those present and the safeguarding newsletter is aimed at all staff so the learning is widely shared. Reflected in writing within notes shared and the Newsletter to capture all staff.

2.3.10 - NW Anglia NHS Foundation trust (Peterborough City hospital)

Rosita's presence at the Emergency Department (ED) was very infrequent. There are only three recorded attendances, with two of these being in 2018 and only one recently in August 2021. Only one of these was due to an injury in which Rosita reported it was an injury at work. (12/04/18 Toe injury)

Record - At 14.41hrs on 14th August 2021, Rosita attended ED with an injury to her finger following an assault at 2300hrs the night before. She reported that she went to the pub after work and had a few drinks. She can't remember much but she was assaulted behind Tesco by some men. Another group of men stopped them and called the police who took her home. She advised that police are fully aware and she will talk to them again today. Rosita was unsure how she had hurt her finger and was discharged home stating she lived with her cousin.

On 16th August 2021, Rosita was called and asked to return to ED as the x-ray of her finger had been reviewed and a fracture was seen. A splint was provided, and she was discharged home with a follow up appointment on 20th August for the fracture clinic which she failed to attend.

2.3.11 - Good practice:

The local acute hospital Trust have up to date policies and procedures on domestic abuse and now have an IDVA (employed by the IDVA service) that spends sometime within the

hospital. If an interpreter is required, then this is offered and can be arranged. Leaflets on domestic abuse are offered to patients and are provided in other languages if required.

There has been some generic safeguarding training including domestic abuse for the ED staff and others in the trust assisted by the IDVA service and Partnership.

2.3.12 - East of England Ambulance Service NHS trust (EEAST)

The EEAST have identified one related attendance during the specified period.

A 999 call was received at 00:08:08. The call was categorised as a C1 and coded as a 9 Cardiac Arrest. Cat 1 – Immediately life-threatening injuries and illnesses. Patients will be responded to in an average (mean) time of seven minutes, and within 15 minutes at least nine out of ten times (90th percentile). Resources with their dispatch and arrival times are detailed as following:

Resource	Enroute	Arrival
NR772	00:09:25	00:12:22
NAF426	00:11:42	00:16:43
NO071	00:15:10	00:20:14

First to arrive on scene in 2 minutes and 57 seconds was a Leading Operations Manager (LOM)

Officers report:

Patient (Rosita) found hanging by her partner, who cut her down using a knife and called 999. Events prior to incident unclear. Partner opened door to crew, presenting as agitated and upset holding a large knife.

Patient was lying supine (on her back) on the living room floor, ligature mark to neck.

Despite crew recognising signs of death in respect of patient, Partner aggressively requested crew to resuscitate. Due to crew at this stage being solo, and their concerns for their own safety, brief CPR was commenced whilst awaiting back up.

Upon back up arriving, knife was removed into kitchen area. CPR discontinued by crew at this stage. Rigor mortis set in.

Partner continued to attempt chest compressions and mouth to mouth ventilations. Partner agitated and refused to leave patient's body. Police assistance requested 00:22:07. Police arrived on scene. Strong smell of alcohol noted on crews' arrival and half empty vodka bottle on the floor in front room.

Patient deceased on arrival. Unfortunately, due to safety concerns, first on scene felt so threatened by the partners behaviour and demands to perform CPR on the deceased patient, CPR was carried out solely to ensure their own safety until further assistance arrived on scene.

EEAST have policies and procedures in place for safeguarding. The creation of these policies is referenced by national and regional guidance. Their policies are updated yearly to reflect the dynamic changes within the safeguarding setting. The safeguarding team keeps a strategic overview of all safeguarding partnerships across the Eastern region and where necessary and appropriate Trust policy & procedures are changed where a need is identified.

2.3.13 - Good practice:

Critical incident packs distributed to crew to ensure they felt supported and after care provided. Body left in the care of Police.

2.3.14 - Cambridgeshire Police

There has been limited contact between Rosita, Jurgis, and the Cambridgeshire Constabulary: There are no recorded references to either Rosita or Jurgis in 2016, 2017 or 2018. Summarily the recorded references are as follows.

- 02/03/2019 – Jurgis's vehicle was impounded under road traffic regulations from an unrelated road traffic incident.
- 14/04/2021 – Rosita is named as a potential witness by a work colleague to an alleged hate incident at their workplace. Neither Rosita nor other staff members nominated by the complainant were contacted as the report was filed as a 'non-crime incident' with no further action taken by the police.
- 14/08/2021 – A report is made by a member of the public of Rosita having been subject of an alleged assault after leaving a local night club.
- September 2021 – Report from ambulance control to the police of a sudden death by apparent suicide, discovered and reported by Jurgis.

In view of the apparent suicide of the victim the author of the IMR has examined all calls for service to the two addresses resided at by Rosita and Jurgis during the relevant dates within the period of this review. The Police are satisfied that there are no overt, disguised, or other incidents showing or inferring a background of domestic abuse between them. Possible variations in the spelling of both the victim's and her husband's names have been searched.

The circumstances of her tragic death are that she was discovered by her husband, hanged from the banister by her dressing gown cord.

2.3.15 - Relevant references:

1. 14/08/21 - At 3.20am, a report was made by a third party of Rosita having been subject of an alleged assault after leaving a local night-club.
The person reporting this incident was a member of the public who had discovered Rosita in a distressed state outside of a local nightclub. She had flagged their car down as they were passing the location. She reportedly had a cut to one of her fingers and said that she had been approached by 2 or 3 men of Eastern European origin and that the men had asked her for 'sexual favours'. The passing members of the public put Rosita in their car and contacted the police, one remaining with her with the other following the 'suspects' to point them out to the attending officers. 'Live-time' monitoring of the incident was provided through the

City Councils CCTV control. When officers attended, they found Rosita to be intoxicated and it is unclear as to what the full extent of the occurrence was. No complaint of assault was made by Rosita and no obvious offences were established. No first aid or medical treatment was provided. No offenders identified.

Although no criminal offence was established added to which Rosita did not make any allegation to the officers of an assault, the officers decided to take her to her home for her own welfare as they considered her to be vulnerable due to her apparent alcohol intoxication. There is no indication that any interpreting services were required by the attending officers. The incident was closed with no further action taken and is noted to have occurred just 4 weeks before her tragic death.

The reviewing officer has contacted the reporting/attending officer in the incident of 14th August 2021 to establish further information concerning the circumstances and how Rosita came to be on her own at that time. In response the officer indicated that the males that had approached Rosita in the first instance were complete strangers to her. The exact details of what they had said to her was not apparent as Rosita was heavily intoxicated (through alcohol) and said she had been at the night-club. The men had approached her as she was leaving the location and she was not accompanied by anybody at that time. The officers were of the understanding that they had taken her to her mother's address although the officers did not engage with anybody at that address. No mention was made by Rosita of her husband, and she made no disclosures. It is also not apparent who, if anybody was at the night-club with Rosita or how she became to be on her own at what was a very late hour, making her even more vulnerable. This is mentioned due to the VAWG principles.

2. The sudden death investigation - When officers attended the report of the sudden death (in an incident referral by Ambulance Control) the author understands that no 'flags' were identified from the referring agencies records of any previous or historical concern at the time of the despatch of paramedics and there was no history of domestic abuse or domestic violence (DA/DV) referenced against the address, Rosita or Jurgis in Constabulary records[1]. The respective control rooms cross referred the incidents accordingly which was good practice.

Officers spoke to Jurgis about the circumstances.

In September 2021, Rosita was working as a security officer at a commercial distribution warehouse. This was a 12-hour shift. She left for work at around 5.30am. at which time Jurgis was at home.

Jurgis stated that he remained at home that day but left at around 5.30pm which was before Rosita was due to return home from work. She would have arrived home after her shift had finished, which would have been around 6.15 pm. Jurgis stated that he had arranged to meet a friend and that he spent the evening in his company before he returned home around midnight.[2] On entering the dining room at their home, he discovered Rosita

[1] The policing systems will 'flag' locations/addresses/nominals etc. in what are known as 'significant markers' which are embedded tags for safeguarding purposes which will include domestic abuse.
[2] Data supports the movements of Jurgis' mobile phone during that period in line with his disclosures to the officers investigating the sudden death.

hanged by her dressing gown cord from the staircase. He took a knife and cut her down, attempted resuscitation and contacted the emergency services.

Jurgis was heavily intoxicated when the first responders attended the scene. He was distressed and emotional, albeit officers attributed much of this to his shock and upset having discovered his wife hanged.

Police officers began enquiries. The scene was attended by a supervisory officer and the duty Senior Investigating Officer, a Detective Inspector was informed and monitored the incident but was not requested to attend. A scenes of crime officer attended under policy and took photographs of the scene and the deceased. Several exhibits were taken by officers.

Officers were not made aware of any background of domestic abuse from within the data available from the police systems.

The attending officers determined that there was no apparent suspicious circumstances or third-party involvement, completed necessary enquires at the scene and referred the case to the HM Coroner. No referral was made to the Public Protection Department since there was no recorded history of domestic abuse. A post-mortem determined that the cause of death was due to hanging. There were no injuries or trauma to the deceased indicating or suggesting any third-party involvement in the death. Toxicology tests determined that there were no intoxicants present in the deceased's blood.

No medication was found by the attending officers, there was no suicide note although officers recovered a single page hand-written note pinned to the boiler housing which Jurgis identified was in the deceased's handwriting. This note was later shown by the attending officers on 12/09/21 to a Lithuanian speaking officer for translation who stated that the content did not suggest that it was an obvious suicide note.

This note was not referred to the coroner at the time, but a copy has since been provided to the coroner by the reviewing officer (See Appendix C).

2.3.16

The note is undated and has been fully translated as follows:

Perhaps to write this on the piece of paper is not the best idea, but I don't feel that I can express myself looking into your eyes.
I know that I failed with you as a woman, and I didn't treat you in the way you deserve.
I do understand that until now it was my mistake and I know that this disappointed you and that you most likely don't want to see me.
I don't even want to look in a mirror, after what I've done, but my feelings towards you are stronger than guilt, anger and sadness.
And this is why I want so much that you would have me back and I want to be happy, like we were before, because my life without you is empty, you are second man in my life and this is very important for me and I never betrayed you or would betray.
Please allow us to make up. I love you, maybe I don't know how to express that, but this is what we can learn together.
Please forgive me. I apologise that I placed you in second place, when you had to be first.

Please forgive me, I was selfish!
I'm asking you not to ruin our marriage. The easiest option would be to separate rather than to fix it.
We can become best friends, not just husband and wife! And to have a mutual agreement about alcohol, about going out together, about spending time together and that we need to talk more often about everything and to be more tolerant [more understanding of each other-LP*] I don't want to lose you as we experience good and bad together, we had good times, and bad times! Now I'm asking you to save our marriage!*
If you'd like, instead of what you have asked, I would like to have a tattoo with your name and surname on a visible part of the body to prove that I really do love you!

During the reporting of the sudden death, the attending officers also made an adult at risk referral in respect of Jurgis, identifying a concern that he had stated to the attending professionals that he wanted to take his own life and to be with his wife. The narrative of the referral also mentioned that he needed to take care of 'his' 13-year-old son. This information was not broadened on the report. Officers did not consider that he presented a significant risk to himself but correctly observed that a safeguarding referral should be made which was good practice.

2.3.17 - The attending/reporting officer recalled the comment being made by Jurgis concerning the child but has been unable to provide any further information to provenance this disclosure. It was confirmed that there were no other occupiers of the address other than Rosita and Jurgis and no indication that a child was or had been present within the household.

A witness statement was obtained from Jurgis by officers in which he outlined his movement with the following narrative. – *"[Rosita] had mentioned quite a few times before about doing something like this. We had been arguing quite a bit recently and during these arguments she had told me she would do something like this, but I thought she was just trying to scare me, and I never thought she would actually try anything. We hadn't argued on ****** September 2021 as she had been at work, but we were arguing quite a lot and we had discussed divorcing each other but hadn't put anything in motion."*

"She mentioned to me once before that she had tried cutting her wrists, but this had happened before I had even met her back in Lithuania. I know she had been to see the doctor a few times about mental health problems but to my knowledge, she hadn't been diagnosed with anything and wasn't taking any medication."

"Even though [Rosita] had mentioned things about hurting herself before, I certainly never thought she would do this which is why it has come as such a shock to me."

Jurgis openly alluded to arguments occurring between them but fell short of making any other disclosures concerning their relationship or any admission of abuse. What was not included in the narrative of his statement was that in the sudden death report submitted by officers, Jurgis had disclosed that he had received and exchanged text messages with Rosita the nature of which he said were arguments, on the evening of her death. Those messages were not read, translated, or copied as part of the sudden death record.

2.3.18 - Consequently, following preliminary investigations, the death was treated as being suicide. There have been no referrals to the Constabulary from any other agencies concerning Rosita or Jurgis.

A few days later, a friend of Rosita's referred to as Daina in this report contacted the Cambridgeshire Constabulary Incident Management Unit via the web-chat facility. Daina asked for further details concerning the death of Rosita and was referred to speak to the officer preparing the coroner's file. The incident report narrative from her is – "*I know she couldn't do anything like this. I find out that her husband was beating her. Abusing physical and mentally. I know she was scared of him. She wanted to divorce but he didn't let her go. Many of her friends in Peterborough know she was scared of him. I know there is screenshots of [Rosita's] and her husband conversations where he is frightening her. On Saturday after work, they were meant to have a conversation about relationship and hours later she was found dead."*

There is no record of any further contact being made with Daina by officers in response to her original contact. The duty Sergeant forwarded the information to the Coroner's office.

2.3.19 - On 04/01/2022, the author of the IMR contacted Daina. It was apparent that Daina was able to converse freely in English. Daina confirmed that she had not spoken to an officer since making her initial contact with the Constabulary in September 2021 and she was surprised that this had not happened.

Daina had discovered that Rosita had died from information that had been posted on social media, although the details of this was not broadened in conversation. It became apparent that she had also been in communication with Rosita's brother since learning of her death.

Daina described Rosita as being friendly, physically fit, healthy and she had a great determination to be successful and had plenty to live for. She had a lot of friends at work. She was very independently minded and intelligent and was driven to making a secure future for her as well as supporting her family in Lithuania.

Although Rosita was keen on keeping fit, she had recently sustained a punctured lung but had recovered well (not in medical history) and was continuing exercising regularly and enjoyed running. Daina had no further information concerning that injury and the author did not probe this any further. This is not recorded on any of Rosita's medical notes and would have required medical treatment.

Daina went on to describe Rosita's husband Jurgis as being jealous and that he was *"really horrible, he was not a good person and he beat her"*. Daina thought that Rosita's death was "*completely out of expectation she would do something like this".*

When asked specifically about the information that she communicated on the day she died concerning the allegations she disclosed of domestic abuse, Daina stated that although she did not have the information first-hand from Rosita, much of that information had been shared openly on social media by Rosita's friends and work-colleagues in Peterborough, suggesting that Rosita had regularly confided in them. She was however aware that Rosita and Jurgis were due to discuss their relationship on the evening that she died.

Daina added in a further communication to the reviewing author on the 05/01/2022 that Rosita had more recently suffered a broken finger but that at the time, nobody at her

workplace had picked up on the potential relevance of this and she understood it was not reported to the police. She was unclear if Rosita had received any medical treatment for the injury at the time and was suggesting that this was not accidental. She believes that Rosita would not have reported this because of her fear of Jurgis. The inference was that he was controlling of her, and Daina had heard that he was taking drugs, the type of which were not disclosed but she inferred that the combination of drugs and alcohol used by him made him aggressive.[3]

2.3.20 - In respect of the contact made to the Metropolitan Police the same day by Aras which was then forwarded to Cambridgeshire Police and her friend Daina two days later, which appear to have been made independently of each other, both suggest that there is a probability of a hidden background of domestic abuse by Jurgis against Rosita. These unsolicited reports are the first occasion that indicates the potential presence of domestic abuse within Rosita and Jurgis's relationship.

Good practice:

The Constabulary has invested significantly in ensuring that front-line services are well-equipped to deal with domestic abuse which accords with the Constabularies policing priorities. One of those key priorities is to; '*Safeguard the Vulnerable with a focus to Domestic Abuse'*.

In April and June 2021, two additional safeguarding functions were introduced in Cambridgeshire to support frontline decision making. The Early Intervention Domestic Abuse Desk (EIDAD) went live in June 2021. This function exists from the point the call is received from any source by the Force Control Room (FCR). When identified as a domestic abuse incident, the EIDAD will commence a research package which will involve identifying previous domestic related incidents, warning markers for parties at the address and any previous MARAC involvement. This information is then formulated into a research package which is then sent to the attending officer. Officers can also liaise with the research team directly from the scene. The purpose of the EIDAD is to improve frontline decision making by providing staff with as much information as possible to make informed decisions at the scene. This also builds in an additional layer of safeguarding from a dedicated team.

Part of this response includes ensuring that staff attending suicides are informed of any background of domestic abuse by the FCR in the first instance to ensure the reporting of such fatal occurrences are made to the Public Protection Department.

The FCR did perform historical checks of the address as accords with best practice and as no significant markers were recorded, there was no indication of any history of domestic abuse involving Rosita or Jurgis.

In moving forward, the Constabulary has commissioned a project to examine each phase of a domestic abuse investigation, from the point that a victim contacts the police to the conclusion of the court process and beyond, with a view to improving safeguarding and investigative performance. To fully understand the challenges experienced at the frontline, focus groups have already taken place and a whole-force survey will be conducted so that

[3] This may have been as a consequence of Daina's contact with Aras since her death.

every member of staff, regardless of role, rank, or responsibility, will have the opportunity to have their say.

Training inputs designed to address gaps in experience and knowledge will also be delivered and checklists for each stage of the process will be produced to support decision-making, both at the scene and throughout the investigation.

A DA scrutiny group is held to enable review of investigations and ascertain learning points for wider dissemination.

2.4 Summary Reports

In addition to the IMR's, the remainder of the panel were asked to provide responses in relation to previous recommendations of the DHRs in the area involving females from Lithuania in what action had been taken or barriers they had faced in doing so.

2.4.1 - DASV and ISVA service

Establish whether communication in relation to DA support is available and effective within the Lithuanian community in Peterborough

Since January 2021 the IDVA Service has employed a Lithuanian speaking IDVA. This has been in response to previous DHRs in Peterborough, which have highlighted the issue of support for Lithuanian victims of domestic abuse. This has replicated support in the rest of Cambridgeshire where a Polish and Russian speaking IDVA have been in post for a number of years.

Outreach domestic abuse support is currently available through Refuge and Peterborough Women's Aid, both of which take self-referrals and have worked to raise their profile across Peterborough. Neither of these organisations have specialist workers for Lithuanian speakers but do use translators wherever needed. They can also refer into the specialist IDVA if this is felt to be beneficial.

How accessible were the services for the deceased?

The IDVA Service traditionally take referrals from professionals only. Outreach services are available for anyone wishing to self-refer. Most referrals to IDVAs come following a police incident.

This obviously creates a barrier for those seeking support, where English is not their first language, and links have been developed with Lithuanian community groups to enable them to refer directly.

Establish availability and accessibility of services for perpetrators of Domestic abuse prior to conviction and thereafter

Perpetrator provision has been limited across the county due partly to lack of funding and partly to a lack of evidence as to what works in those circumstances.

Probation offers the Building Better Relationships programme after conviction and there are also 2 pathways for out of court disposals. The first of these is the CARA programme for first time offences, where there is no coercive control. Recently a Healthy Relationships programme, delivered by Probation has also been funded for where there might be some coercive control. Victims are offered support from the IDVA Service.

Recent funding has also allowed for development of a Stalking Intervention Programme. The Family Safeguarding programme through Children's Services also has a perpetrator element.

Establish accessibility of services for those contemplating suicide and bespoke training in relation the effects DA may have towards this.

Suicide training has been delivered to all specialist domestic abuse workers within the past year by CPSL MIND in January 2021 and in the spring, was also delivered to Peterborough Samaritans and Lifecraft (who run a mental health helpline)

Cross reference Recommendations of previous DHRs as to whether recommendation was implemented and ascertain the effectiveness

The Safer Peterborough Partnership should confirm the level of training accessed by staff across agencies in recognising potential signs of domestic abuse. This is particularly important when there are vulnerabilities or language issues with potential victims.

Domestic Abuse training is available through the Safeguarding Board. The local authority also delivers specific domestic abuse training, as do most other agencies.

The CSP should explore opportunities to display key messages (in several different languages) demonstrating that domestic abuse is wrong and that support is available; at public locations such as GP surgeries, libraries, Accident & Emergency departments and housing offices.

The DASV Partnership have a range of posters and leaflets that are available through the website and in hard copy. This includes posters and information leaflets in Lithuanian.

Resourcing of interpreting services across the Partnership should be reviewed to ensure they are fit for purpose and available based upon demand. Collaboration opportunities should be explored.

Local authority staff can access interpreting services through a central contract.

The Safer Peterborough Partnership should develop a communication strategy involving communities, private landlords, voluntary groups, employers and employment agencies highlighting the importance of reporting domestic abuse to enable earlier intervention and help statutory and third sector agencies to safeguard and support victims of domestic abuse.

The DASV Partnership has a communication strategy and plan that is developed in association with local partners and organisations. Due to a number of recommendations made for a DHR in the Fenlands following the death of a Lithuanian female, the IDVA service launched a team of health IDVA's in January 2022 to take referrals at any risk level from any health service. Their role is also to encourage health professionals to routinely enquire about domestic abuse and respond appropriately. The health IDVA team will work with GP Practices to encourage referrals and sharing of information with consent. They will also ensure that GPs are aware they can share without consent where the risk is assessed as high. This is covered in the MARAC Information Sharing Agreement.

They also employed a Lithuanian speaking IDVA, funded due to a previous DHR recommendation. This IDVA supports all risk categories as opposed to the remainder of the IDVA service who only support high risk to ensure Lithuanian victims are understood.

2.4.2 - Cross Keys homes

Cross Keys Homes (CKH) are a Social Landlord with over 12,000 units, mostly in the Peterborough and Cambridgeshire area in which of those residents who have shared their nationality, 1.6% of those residents stated that their nationality was Lithuanian. CKH have not had any previous dealings with any of the subjects or addresses in this review but provided an insight into the Terms of reference subjects relating to the community and previous DHRs.

CKH are currently working towards Domestic Abuse Housing Alliance (DAHA) accreditation which they hope to gain by summer 2022.

CKH has a stand-alone policy and procedure for residents experiencing domestic abuse, a separate policy and procedure for employees and a dedicated team to manage cases and attend MARAC meetings. Policies and procedures have been developed/ updated recently in accordance with the Domestic Abuse Housing Alliance, eight priority standards. The organisation has been working towards accredited status (assessment due March 2022).

Staff receive a three- tier training programme for employees covering basic awareness, DASH training and enhanced safe at home training.

They utilise interpretation services and can access colleagues who can support with interpretation and translation.

2.4.3 - Cambridge and Peterborough NHS Foundation Trust (CPFT)

In September 2021, a full-time post was financed to support CPFT staff with domestic abuse cases. They have written policies specific to this area and have created a page on the CPFT intranet for staff to enable them to find links to support agencies and information on how to ask patients questions in relation to if they are experiencing domestic abuse.

They have integrated DA champions who are staff working on wards and in the community who have an interest in DA work and are the first line for other staff to come to for guidance. They are supported monthly in a group by the safeguarding team.

Record keeping has been updated with a domestic abuse template within the safeguarding node and plans are being made to install a pop up when staff open a patients record to prompt staff with 'Have you asked about domestic abuse?'

2.4.4 - Employment

Rosita had been employed by a security agency for over a year and worked for them providing physical security at a distribution depot in Peterborough as part of a small, mainly male dominant team. She worked a shift pattern of three days, three nights and three days off with the same team in which she was described as popular. Both the HR department and her line manager have been spoken to.

The agency does not have a domestic abuse company policy and home life isn't typically discussed or asked about in one to ones with staff. There isn't a particular awareness in relation to domestic abuse and they have not received any training on this issue. The company fully assisted with this review and are open to implementing awareness of domestic abuse in their workplace.

2.4.5 - Rosita had no recorded injuries or accident at work at this employment and did not have any sick days recorded. She did not really speak about her home life and was quite private but was very open when talking about working matters and issues. She had begun to work on the reception with a view to progressing for promotion. Rosita wore a uniform and regularly wore short sleeve tops. No injuries were ever noticed by her colleagues.

Rosita had an injury to her fingers last summer in which she told her employers that she had received it working on the doors at a town centre pub one night by an aggressive customer. She informed them that she was receiving hospital treatment for the injury but did not have any time off work for this.

Direct colleagues of Rosita preferred not to be spoken to but have all expressed their shock of the circumstances of her death as they had not seen any signs to make them concerned. There were also no signs or disclosure of domestic abuse towards Rosita in the workplace with any colleague or management.

2.4.6 - The distribution Centre has been contacted but have not responded to the authors request to speak to them or converse in relation to this review. It is not known as to whether they consider Domestic abuse awareness as an employer, support for employees or have a policy in place.

Rosita worked as door security at a venue in Peterborough City centre, but it is not known where and her employers have not been traced or spoken to. This is the same situation in

relation to her potential previous employers, a large supermarket, as it is not possible to locate where she worked.

Section 3 - Analysis

3.1 Family and friends' involvement and perspective

3.1.1 - Rosita has a mother and father who live in Lithuania and do not speak English. Her mother has been ill for some time and has worsened since learning of her death. Her brother Aras lives in Norway due to work and can speak, read and write English. It was agreed that he would be the sole contact and vocal point for the family to prevent any further anguish being caused to their parents. He was informed of the review shortly after the commissioning of the DHR via email by the specialist Lithuanian IDVA on behalf of Peterborough CSP which outlined the reasons for the review and provided information on support agencies including AAFDA.

3.1.2 - Rosita's husband, Jurgis, returned to Lithuania soon after her death and his whereabouts is not known and therefore, he has not had an opportunity to contribute to this review.

3.1.3 - Aras has provided the majority of the background information for this review but was uncertain of some dates. Rosita's death has been hard on him and the family. He initially spoke to a Lithuanian speaking IDVA and was offered support through AAFDA by the Author during one of a number of Microsoft Teams meetings and was emailed a leaflet. The Author also made enquiries through AAFDA for support networks in Norway. Aras was spoken to in detail by the Author about all options available for support but has chosen not to take up this advocacy as he is currently receiving counselling through his doctor and seeks comfort from his girlfriend and dog. He would prefer this due to living in another country. Aras also declined to attend any panel meetings and preferred for updates to be provided by the Chair afterwards as he did not want it to affect his work.

3.1.4 - He remembers his sister as the beautiful model she was, always popular with lots of friends. She chose not to have too many Lithuanian friends in the UK as they always seemed to be involved in drama.

Rosita had always wanted children but discussed this with Aras in 2019 and they both thought it was not a good time due to the drinking of Jurgis and the constant arguments. He was not aware of the abortion in April 2021 but thinks this may be the reason why she did this.

3.1.5 - He was not aware of Rosita speaking to any professionals but felt that she was being emotionally abused as Jurgis had tried to make her shave her head and be tattooed in order to prove her love which someone should not have to do. Jurgis would constantly nag her until she gave in and particularly if he knew she had a migraine. He also made her sleep on the floor in the spare room for some days whilst he slept in the comfortable bed in the main

bedroom as punishment for going out and being assaulted. He blamed her for this and throughout their time in the UK, often reminded her that he had left his son in Lithuania for her. Jurgis was always right, and Rosita was always wrong.

3.1.6 - Aras never thought that Rosita would take her own life, especially if she was sober, but could understand it more if she had been drunk.

'In my heart, I do believe someone else is involved'.

Whilst at the funeral, Jurgis informed her parents that Rosita had tried to take her life at least ten times during their relationship. Aras has confirmed the handwriting on the letter is Rosita's.

Aras and his family feel frustration that Jurgis will not receive any consequence of this and fear that he will go and do the same to someone else he gets into a relationship with as he has now heard that he had the same problems with his first wife. They hope that this review will assist others in some way so that they do not suffer.

3.1.7 - Aras, on behalf of the family has been provided the opportunity to comment on the draft report and has stated that it is an accurate portrayal of his information and that he is happy with the content. On offering a translation for his parents, he stated that he would prefer to translate it himself and explain it to them.

3.1.8 - Rosita had a friend named Skaiste who has not responded to attempts to contact her. Her friend, Daina has spoken with the Police during this review and her input has been recorded.

3.2 Terms of reference areas

3.2.1 - Has domestic abuse in any form been the causation or a contributory factor to Rosita taking her own life?

Rosita's outward appearance to people she interacts with is fun loving, happy and popular which is in stark contrast to how she portrays in the letter found at her suicide pinned to the boiler housing. This letter alludes to issues in their relationship with her being submissive and Jurgis openly admits to the police of arguments in their relationship and in particular by text earlier that evening. Rosita had informed her brother that she was going to have a discussion with Jurgis that evening when she returned from work just two hours before finishing and seemed happy. It is not known what catalyst had made Rosita take the final decision to end her own life.

3.2.2 - Violent acts causing her injury to have been disclosed to her brother, Aras and the family saw in the early stages of their relationship, the temper and behaviour Jurgis was capable of after consuming alcohol, which appeared to be constant throughout their relationship. Similarities of this aspect in the culture of some Lithuanian males can be seen in previous DHRs within the area, where the consumption of alcohol has exacerbated their abusive and violent behaviour. There were numerous examples disclosed by Rosita to Aras

of controlling and coercive behaviour, such as the constant demands of demeaning behaviour to prove her love, made through acts like wanting her to tattoo his name on her body and shave her hair.

Punishment by making her sleep on the floor in the spare room for a week and cutting her clothes in response to her going out socialising with friends were common behaviour, although Rosita worked and earnt her own money that paid for the majority of the household bills. This behaviour was in slight contrast to previous DHRs in the area with a Lithuanian male perpetrator as they were more indicative of violent behaviour, although the full context of violence towards Rosita may not be known as she did not disclose her beating and injuries at the farm for many years.

Rosita's friends and family speak of her wanting children yet having had a conversation with her brother over two years prior, Rosita chose to have an abortion without telling anyone in the six months before her suicide having agreed with her brother it was not a relationship to bring a child into. This would indicate based on recent admissions, that the situation had not improved and the final 'opening up' to her brother in the last two months of her life would suggest it had deteriorated to the point she could no longer keep it to herself.

It has been noted that there have been a number of occasions whereby Rosita has not told the whole truth when speaking to authorities including her personal information of the fact that she was a trainee Police officer and living with her cousin to BPAS and then her living with her mother to the police when they gave her a lift home but changed it to the cousin the following day at hospital with her injured finger. This could be taken by a lay person as her potentially being untrustworthy in what she says, however, this is indicative behaviour of someone who is the victim of domestic abuse and not only does not wish to disclose the fact but also wants to hide the fact and protect invasion into her home life as it is not known whether this would have put her at further risk. This could also be a factor to be considered on the occasions she has sought medical assistance and whether her account of how she obtained the injuries or conditions were accurate or hiding something.

3.2.3 - How effective are services and agencies provisions to domestic abuse within Peterborough, specifically for the Lithuanian community?

Cambridgeshire and Peterborough provide numerous provisions in relation to support for domestic abuse, led by the Domestic Abuse and Sexual Violence partnership (DASV) which brings together statutory and voluntary organisations for a holistic approach to problem solving. It also provides learning across the CSP's within Cambridgeshire which assists the Safer Peterborough Partnership learning from others and implementation of County wide procedures and processes. The DASV has now taken ownership for the overview and analysis of DHRs for Cambridgeshire to link in with the CSP's which is good practice that could be mirrored in other counties.

It has been recognised, due to previous DHRs that there is a need for additional support within the Lithuanian community with the funding for a Lithuanian speaking IDVA who currently has a large workload of Lithuanian victims and is struggling to support them all.
3.2.4 - The remainder of Cambridgeshire have an Eastern European IDVA (A8) to assist with the demography of population, but there is a gap in this role at this time which is covered across the team. She states that many of these victims inform her that the police seem to try and talk them out of making a complaint, telling them that it is unlikely to go to court. During discussion, it would appear that this isn't a specific issue with the Lithuanian community but victims in general whereby the choice of words used to be open and transparent with victims is portrayed in a negative way with young, frontline officers and that it is a cultural issue that needs to change so that the information is provided in a positive manner. This has been identified by senior officers and should be integrated into the 'one step further' attitude at incidents to all assist in the wider thinking for collation of information to negate having to re-investigate at a later date. (Recommendation refers)

3.2.5 - All Organisations have embraced the need to be able to speak to others in their own language if they cannot sufficiently speak English as it is essential to ascertain an accurate translation of what is being said. All have translation services such as language line that they can utilise and the majority now have employees from the Lithuanian community who assist with interpretation and are representative of the demographic in the Peterborough area.

All websites of the Organisations have excellent literature on domestic abuse and support services; however, the majority do not have any form of translation. The IDVA service have google translate on their website but there is concern that this translation may not provide the right context of the information provided. The DASV website includes useful leaflets and literature translated in Lithuanian amongst other languages for DA, but it is not very user friendly to find them and therefore would be even harder to access for someone who did not have English as their first language. This appears to be the same situation nationally. Refuge national helpline replied when asked how they would work with clients,

'We would use Language Line. Although we advertise the use of interpreters on our site and on social media, we are very conscious having our Helpline website in English is limiting, so we've developed a Language Selector (see top right had corner globe icon) and currently have 3 additional languages on there with plans for more in future. ' (Recommendations refer)
3.2.6 - The specific questioning by BPAS of whether the abortion was Rosita's choice and did she feel safe at home shows excellent practice on presenting an opportunity for discussion and disclosure. The Minor Injury Unit (MIU) also showed good practice in asking if she felt safe at home and also noting that she attended alone on her notes. However, the fact that on only two occasions when coming into contact with authorities, there has been any professional curiosity or questioning causes concern. Opportunities to provide conversation for disclosure have been missed during GP appointments, hospital attendances and Police contact following the assault incident although the latter may not have presented itself at the time. The broaching of the subject by GP's has been recommended in several previous DHRs in differing guises. The safeguarding people team at the CCG delivered a webinar discussing what can be achieved during a ten minute consultation. This explored options to

see patients alone, prior to the national lockdown due to COVID19, phrases to guide, professional curiosity and to make patients feel safe enough to make any disclosures. Virtual appointments have been discussed multiple times with primary care and suggestions are frequently made to ensure practice is as safe as can be. Using key phrases e.g. Are you alone, is it safe to talk, is there a better time to call. Options of face-to-face appointments only and this is recorded on the patient record and video calls are both an option. This is a national challenge, not specific to Cambridgeshire and Peterborough geographical area. (Recommendation refers)

3.2.7 - The lack of questioning is coupled with the lack of professional curiosity and acceptance of circumstances on face value. Rosita attended the GP surgery for four separate injuries and although this may not be excessive in the time frame, the practice safeguarding leads comment that this amount and type of injury is significantly less than is regularly seen with this cohort of patient. This may suggest that DA may not be considered within this cohort, even if it had been more and there is a potential that the GP would not have gone back through data/notes to recognise a pattern of 'work related' injuries being reported. Each patient and their presentation are thoroughly assessed enabling them to reach their decision.

Factors were present that may have indicated to authorities that they needed to 'think wider' and ask further questions in relation to Rosita providing conflicting information to what was on record. She informed the Police on the night of her assault that she lived with her mother yet stated the following day to the hospital that she lived with her cousin, whilst the GP's records show that she lives with her husband. There is also the factor of occupation provided to BPAS being contradictory to the information known. BPAS is a private clinic and therefore does not share information to be recorded on a patients' health record with the NHS except in specific circumstances. This could be a risk if the whole medical history is not held as one, however, the whole medical history is not currently held in one place and the need for private practices as a 'safe place' to obtain medical treatment rather than not is seen as a necessity which outweighs this risk. Although hindsight has been avoided in this review in relation to identifying patterns, it is felt that even though there are many sharing agreements and working together practices, there are still opportunities for identifying patterns that may cause concern or create curiosity that are not occurring due to information being held in isolation. The broken finger on 12th August 2021 held on record at the hospital is not on the GP records for example, although practice is usually for any ED attendance to be shared with the GP.

3.2.8 - Following the Police attendance for Rosita's death, Aras spoke to the Police on the same day and informed them of a history of domestic violence and that he thought that this would have been something to do with her death. Similarly, Daina contacted the Police by webchat asking questions and strongly outlining her belief that this may not be suicide due to the history of abuse in the relationship. Both of these pieces of information would have confirmed there had been disclosures from Rosita that she suffered domestic abuse in her relationship and should have formed part of the coroner's investigation and file. However, no information from either person was passed on to anyone in the Organisation and no one

contacted Daina following her webchat for either acknowledgement or further information. This would have been an early indication that a DHR referral was required.
(Recommendation refers)

3.2.9 - How effective are services and agencies provisions to suicide and those contemplating taking their own life within the Peterborough area?

A dedicated piece of work has been ongoing by a large number of partners, led by Public Health in Cambridgeshire and Peterborough to publish a suicide prevention strategy and Four-year plan around one basic principle: 'Suicide is preventable'

Their ambition is –

Every person in Cambridgeshire and Peterborough has access to the right care and support, from both the mental health system and their communities, to ensure that they do not die by suicide.

During this project, it has been rightly identified and confirmed of the links between domestic abuse and suicide as the statistics outlined in 1.6 of this report. Due to this research, the DASV Partnership Manager is now a member of the Suicide Prevention Group and they work together to examine how future deaths may be prevented. Also, the Public Health Lead for suicide will be invited to sit on all DHR Panels examining suicide.

Support services including Samaritans and Lifecraft have received training and awareness of the effect of domestic Abuse.

The CPFT representative for mental health did not attend the second review panel meeting and the CPFT have provided minimum information for this review so the information has been taken from the DASV manager and the Suicide prevention strategy.

The Police have a Homicide, sudden and unexplained death procedure (BCH09/009) which has a theme throughout of

If in doubt treat as murder - In accordance with

the Murder Investigation Manual / Authorised Professional Practice

3.2.10 -This is to prompt officers to think broader on attending a scene and not take things on face value. In relation to suicide, it states:
In the case of suspected suicide an early call should be made to the local crime dept to request attendance. In most cases of suicide, the Coroner's referral and subsequent file should be completed by a crime Officer as this type of incident is likely to require a more involved investigation.
The Senior Detective must be notified (by the Duty Supervisor) of the following as a minimum: Suspected Suicides (where the Duty Inspector is not entirely satisfied that there was a deliberate and unassisted intention for the deceased to take their own life).

The officers attending were informed prior to their arrival that there was no recorded history of DA as per protocol and had been informed they were attending a suicide via the ambulance service. Once at the scene, there were several indications that the suicide may be related to a history of domestic abuse including, the erratic/aggressive behaviour of Jurgis, his admission of arguments in the past and via text that specific evening and the note found that was dismissed as a suicide note but clearly showed issues in the relationship by the way it was written. No further investigation took place outside of the attendance at scene at that time and no mention of DA was mentioned in the coroner's report that was immediately submitted as death by suicide. Mental health triage is available within the FCR and although it is not known whether this was checked, this would have clarified that there were no mental health issues recorded in Rosita's history. Following further investigation, it is clear this is not a missed homicide but a lack of wider thinking of why the suicide may have occurred. (Recommendations refer)

3.2.11 - What progression and implementations have been made since the previous DHR reports surrounding Lithuanian females in Peterborough and surrounding areas?

Each organisation now has a bespoke DA policy providing structure and guidance for their response and service, although not particularly relevant within this DHR due to lack of agency involvement.

Although the DASV partnership is positive, it is apparent that the absence of a dedicated Community safety officer within the Safer Peterborough Partnership, unlike all other CSP areas in Cambridgeshire has had a detrimental effect on the area with many of the recommendations of previous DHRs, specifically relating to the Lithuanian female victims, not being progressed or only partially and the action plan from the most recently published overview report in 2021 has been mislaid and not been available to this review panel. (Recommendations refer)

3.2.12 - The implementation of a Lithuanian speaking IDVA as aforementioned highlights the effectiveness of recommendations from previous DHRs to obtain funding and provides the balance of addressing some of the needs of the Lithuanian community based on the DHR ratio with the remainder of victims suffering from domestic abuse within the area.

Communication and links with the Lithuanian community from all those in the DASV partnership have not particularly progressed since the last DHR of a Lithuanian female published at the beginning of 2021. Very few groups in the area are known of and there isn't a focal point in the community as a conduit to spread awareness of DA. Although work has begun with posters in Lithuanian in public places, communication need to be expanded and also include employers and businesses in the area as they do not appear to be able to identify DA or provide awareness to their employees. (Recommendation refers)

No activity has taken place to identify or ascertain specifically why Lithuanian females present as more of a risk to domestic abuse related deaths than any other person in the

area and how we get them to reveal the abuse they are experiencing. (Recommendation refers)

3.3 Other areas for analysis

When Police were called at 03.20am to the incident involving Rosita in August 2021, it was due to a member of the public stating that a female (Rosita) was distressed, injured and had been asked for sexual favours, immediately being apparent that this was a vulnerable female. Although no complaint of assault was made by Rosita, the injured finger was noted by the officers on the closure of the report and they took her home to what she had stated was her mother's address, which was in fact the address she lived at alone with Jurgis. The officers obtained very little information from Rosita who was intoxicated but it is not clear whether this was the reason or the lack of questions asked. Following this incident, Rosita had a confirmed fracture to her finger by the hospital and was made to sleep on the floor in the spare room for a week by Jurgis as punishment for what had happened. There was no investigation following her being dropped at home and no crime recorded.

Cambs Police have reviewed this matter. The officers attending identified Rosita's vulnerability in taking her home which is a positive thing. However, the officers have not complied with the Home Office crime recording standards by not recording a crime as they were aware that there was an assault causing injury, regardless of the extent. The Police are satisfied that the process in place and communication and literature on this matter are totally sufficient and that this is down to the individuals not complying and will be addressed internally.

The second part of the process is the Crime Desk incident review (CDIR) in the Force control room to take place to ensure that all processes have been complied with and crimes recorded when they should have been. This did not identify a that a crime to be recorded was outstanding. Again, the process has been reviewed and Cambridgeshire Police are satisfied that it is fit for purpose and that this was down to individual error which will be addressed internally. Additional training will be offered to those involved if required.

Section 4 – Conclusions and Recommendations

4.1 Conclusions

4.1.1 - Rosita had grown up in a house witnessing her father domestically abusing her mother and being emotionally abused by her father herself. She knew her mother's views that this should not be reported or told to anyone in order to protect the abuser from getting into trouble. She only began disclosing her abuse to her brother, a few months before her death but was able to send him screen shots of messages she had received and photos of cut up clothes and living conditions to help visualise her suffering. It was evident that this had been happening throughout the eight-year relationship dating back to when they were still in Lithuania. The unreasonable demands of tattooing his name, shaving her head and punishing her for nights out show controlling and coercive behaviour along with

the constant arguing and bickering to show Rosita was suffering from emotional abuse along with sporadic physical violent attacks when Jurgis had been drinking. With no other known issues or stresses in her life and no mental health history, the conclusion is that the domestic abuse suffered was a cause or contributory factor to Rosita taking her own life.

4.1.2 - Rosita appeared to be a private person and did not disclose her personal circumstances to many people, only telling her brother, just how bad things had been over the years in the last couple of months of her life. Although there were missed opportunities to ask Rosita questions and seek disclosure, Rosita chose not to, even when she had opportunities with the MIU, Police and BPAS, and although it cannot be known whether she would have ever disclosed domestic abuse to the authorities due to her learned behaviour from her upbringing, the more questions asked and professional curiosity shown could have provided further opportunities to disclose and should be something that occurs and is considered automatically with professionals.

4.1.3 - Further work is required from authorities in relation to accessible information and support for Lithuanian victims of domestic abuse who may not be able to understand written English. However, it is felt that this was not a barrier for Rosita due to reports of her progression in the English language to a good standard and her proven ability to seek support when required in relation to BPAS.

Significant progress has been made in the training of professionals in relation to both domestic abuse and the links to suicide, however, long term succession planning must be in place due to the transient nature of staff within these organisations. However there is a statutory requirement for all staff within primary care to meet a minimum level of Safeguarding training dependent on their role, in conjunction with the Adult Safeguarding: Roles and Competencies for Health Care Staff 2018 (Ref- https://www.rcn.org.uk/professional-development/publications/pub-007069)

4.1.4 - The absence of a dedicated Community safety officer to deal with specific issues arising from DHRs in the Safer Peterborough CSP in contrast to the remainder of CSP's within Cambridgeshire has thwarted the implementation of previous recommendations from DHRs and identifying cross themes. The misplacement of the action plan from the previous DHR has also not assisted. By their own admission, the lack of accountability by the Home Office means that it is not prioritised against those areas that do have accountability. Going forward, the DASV will be able to provide the holistic analysis of DHRs within Cambridgeshire as a whole and ensure implementation across the County but will still require the assistance of Safer Peterborough CSP to be effective.

On attending what they believed to be a suicide with no recorded domestic abuse history, Police officers appeared to take the incident on face value and did not consider wider than ruling out homicide and did not consider what may have been a causation that led to the suicide. There were numerous indications of issues within the relationship that were ignored and not reported in the coroner's file. Also, the information passed to the Police on the same day, albeit not during the same night shift from the brother and a few days later from a friend outlining a history of domestic abuse was not forwarded or acted upon. These

two omissions caused a slight delay in a referral for a DHR and have caused delay in the coronial process as the coroner did not want to proceed as it was felt there had been avenues of enquiry that had not been completed which only came to light with Aras contacting them and informing them of the same information he had already provided to the Police. Had it not been for the Coroner raising the issue, a DHR referral would not have taken place.

4.1.5 - Regional work and the completion of a suicide prevention strategy and four-year plan evidences the realisation and commitment in this area. It has a strategic action plan incorporating the following actions:

1. All those who have made a suicide attempt to be asked about domestic abuse and sexual violence, and to be responded to appropriately.
2. Training in the impact of domestic abuse and sexual violence to all staff – in particular, those working in emergency medicine departments and liaison psychiatry
3. Wider understanding that those suffering domestic abuse and sexual violence who are expressing suicidal ideation, they are likely to be suffering psychological injury from the abuse, rather than having a psychiatric illness.

These are sufficient to progress and address the area of Domestic abuse and suicide within the area and will not be duplicated within this report.

4.2 Recommendations

National

1. **Home Office to provide a framework for CSP's to transparently demonstrate the timely delivery of recommendations and findings emerging from DHRs.**
   Following a DHR, a structured Home Office framework would greatly assist CSP's to drive timely completion of action plans and the implementations of recommendations by all agencies.

Local

2. **Professional curiosity of Domestic Abuse to be part of every consultation between a patient and their clinician when considering a potential safeguarding concern and recorded appropriately.**
   GP's possibly have more opportunity to speak to individuals alone, although this is not the norm for all cultures or individuals and more frequently it is unusual to see the same GP, making it harder to identify patterns in injuries, circumstances provided or the demeanour of the patient. The latter is less likely since COVID as many consultations are by telephone, occasionally video and less frequently face-to-face and this makes identifying domestic abuse more challenging. This is an area that has been documented in previous DHRs and professional curiosity could be explored further.

3. **The Safer Peterborough Partnership to undertake research to understand why Lithuanian females are more likely to suffer a domestic abuse related death than any other person living in the area.**
   With four DHRs relating to Lithuanian females out of seven DHRs carried out thus far in Peterborough, an understanding of the culture and why this may be happening is required in order to implement preventative measures and appropriate support. This includes knowledge of community groups in the area to work alongside to improve awareness of services and gain trust.

4. **The Safer Peterborough Partnership coordinates a campaign to increase public awareness of domestic abuse in Lithuanian translation.**
   This can be done through the websites of authorities, ensuring consistent messaging with the right context with similar route of access to avoid confusion. It should also include the display of Domestic abuse literature in Lithuanian translation in public places and working together with employers, pub landlords etc in the area.

5. **Implementation of a focal point for information gathering following members of the public providing information to Cambridgeshire Police with regards to any form of vulnerability.**
   When members of the public contact the Police with information regarding vulnerability or domestic abuse, this should not be filed at source but forwarded for review by specialists to ascertain who is the most appropriate recipient of the information and ensure they receive it.

6. **Cambridgeshire Police to have a communication strategy to ensure all officers are considering the reasons a person may have died by suicide when attending the scene and thereafter.**
   All officers attending suicide, no matter what rank must have the professional curiosity to think wider than eliminating homicide and taking circumstances on face value, ignoring indicators that may assist with why this may have happened and considering domestic abuse, even if it has not been reported or recorded previously.

7. **Cambridgeshire Police to undertake training for all staff regarding the use of appropriate and responsive language in all situations, focussing on a willingness to support and safeguard victims throughout the criminal justice process. This is to ensure officers speaking with members of the public and victims of crime, in particular, domestic abuse, phrase advice in a positive manner.**
   With the uplift of Police officers and frontline becoming less experienced, it is essential that officers are reminded and trained to be positive in their messages whilst being transparent and realistic when offering advice. A method of monitoring this can be through BWV which is mandatory when attending domestic incidents in Cambridgeshire.

8. **Cambridgeshire Police to review the current Homicide, sudden and unexplained death procedure (BCH09/009) to consider the requisite for the rank of Detective Inspector to attend all suicides.**
   Research into missed homicides is currently ongoing by academia and the current procedural document is not clear as to when a suicide should be attended and the experience of who decides whether it is non suspicious or not. Clarity is required within this document and the attendance of a Detective Inspector would assist this.

9. **Safer Peterborough Partnership to review their funding streams and posts to ascertain whether a dedicated Community safety officer for DHRs is required to assist the DASV.**
   This would mirror the remainder of Cambridgeshire and ensure focus was maintained on the specific issues that arise in DHR reports for that specific area.

10. **DASV to work with the suicide prevention leads to identify patterns of suicide that have also had domestic abuse in their history.**

    Due to the increasing amount of DHRs that are due to a victim taking their own life in this area, this research may assist in earlier identification and prevention methods.

Appendices

Appendix A

Terms of reference

a) The date parameters under consideration are from January 2016 to September 2021. (Based upon arrival in Peterborough).
b) This is to be reviewed as a suicide based on the investigation by appropriate authorities. The purpose is to establish if DA was a factor in the death of Rosita
c) Ensure the review seeks to involve the family in the process and takes account of who the family may wish to have involved as lead members. Identify any other people the family think may assist or be relevant in the review process.

d) Seek the involvement of employers and friends to provide contextualised analysis of the events.
e) Were procedures sensitive to the ethnic, cultural, linguistic, and religious identity of the deceased and the husband? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?
f) Establish whether communication in relation to DA support is available and effective within the Lithuanian community in Peterborough
g) How accessible were the services for the deceased/husband
h) Establish whether there are any barriers as to why agencies have no record of the deceased or husband. Do authorities raise the question of DA when they have direct access to individuals?
i) Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes following the review process.
j) Establish availability and accessibility of services for perpetrators of Domestic abuse prior to conviction and thereafter
k) Establish accessibility of services for those contemplating suicide and bespoke training in relation the effects DA may have towards this.
l) Cross reference Recommendations of previous DHRs as to whether recommendation was implemented and ascertain the effectiveness
m) Identify and highlight good practice for wider sharing
n) Panel to have a parallel action plan for expedited implementation where practicable during the review

Appendix B

Glossary

AAFDA: Advocacy After Fatal Domestic Abuse

CSP: Community Safety Partnership

CCG: Clinical Commissioning Group

CPFT: Cambridge and Peterborough NHS Foundation Trust

DA: Domestic Abuse

DASV: Domestic Abuse and Sexual Violence partnership

DHR: Domestic Homicide Review

GP: General Practitioner

IDVA: Independent Domestic Violence Advisor

IMR: Individual Management Review

MCU: Major Crime Unit

Appendix C

Note/letter recovered from the scene of the sudden death of Rosita.

Original note