NORTH EAST LINCOLNSHIRE
**Community Safety Partnership**

# Domestic Homicide Review Report

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Antoni
in April 2021

Chair: Gary Goose MBE
Report Author: Christine Graham
March 2023

# Preface

North East Lincolnshire Community Safety Partnership and the Review Panel wish at the outset to express their deepest sympathy to Antoni's family and friends. This review has been undertaken in order that lessons can be learned.

This review has been undertaken in an open and constructive manner, with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address, with candour, the issues that it has raised.

The review was commissioned by North East Lincolnshire Community Safety Partnership on receiving notification of the death of Antoni in circumstances that appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

This Overview Report has been compiled as follows:

**Section 1** will begin with an **introduction to the circumstances** that led to the commission of this review, and the process and timescales of the review.

**Section 2** of this report will **set out the facts** in this case, **including a chronology** to assist the reader in understanding how events unfolded that led to Antoni's death.

**Section 3** will provide **detailed analysis of agency involvement.**

**Section 4** will consider the part that **domestic abuse** played.

**Section 5** will analyse the **other issues** considered by this review.

**Section 6** will bring together **the lessons identified,** and **Section 7** will collate the **recommendations** that arise.

**Section 8** will bring together **the conclusions** of the Review Panel.

**Appendix One** provides the **terms of reference** against which the panel operated.

**Appendix Two** sets out the **ongoing professional development** of the Chair and Report Author.

Where the review has identified that an opportunity to intervene has been missed, this has been noted in a text box. Examples of good practice are highlighted in italics.

## Contents

# Section One – Introduction

## 1.1 Summary of Circumstances Leading to the Review

1.1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to 'Antoni', a 32-year-old resident of the North East Lincolnshire Community Safety Partnership (the CSP), prior to the point of his death in April 2021.

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

1.1.3 Antoni and his wife, Alicja, were Polish nationals who moved to the UK in around 2013. They had two children and lived in the CSP area with Alicja's mother.

1.1.4 In April 2021, Antoni and his wife, Alicja, were hosting a barbecue for Alicja's birthday. The event was attended by friends and family.

1.1.5 Earlier in the day, before the barbecue began, it is accepted that Antoni assaulted Alicja. He had kicked her, leaving a large bruise on her leg. During the party, a significant amount of alcohol was consumed by everyone, and Alicja was extremely drunk. The couple argued, and Antoni left the home. Alicja picked up a knife and chased after him to a nearby street about 80 metres away from their home. She was shouting at him and verbally abusing him. There, she stabbed him to his chest. Antoni died because of the injuries he received. The incident was captured on CCTV.

1.1.6 Alicja was arrested and charged with Antoni's murder. She subsequently pleaded guilty to the offence of manslaughter on the grounds of diminished responsibility. She was seen by two psychologists – one appointed by the prosecution and one appointed by the defence. Both psychologists agreed that she was suffering from a form of complex PTSD caused by incidents in her childhood, which could affect her behaviour in certain situations. The prosecution therefore accepted this plea, as they would not have been able to prove the requisite intention to kill required to secure a conviction for murder.

1.1.7 When sentencing, the judge referred to several factors that must be considered when passing sentence:

- Alicja's abnormality of mental functioning undoubtedly influenced her ability to exercise self-control.
- Alicja undoubtedly exacerbated the effects of her mental disorder by abusing alcohol; however, it was acknowledged that drinking alcohol was a symptom of her illness.
- She had previously sought help with her mental disorder.

1.1.8 The judge cited several mitigating factors:

- She had no previous convictions.
- She had showed genuine and significant remorse.
- She had suffered significant previous violence from Antoni.
- She was, or would be, the sole carer of the surviving children.

- There was an intention to cause very serious harm rather than to kill.

1.1.9 Alicja was sentenced to six years' imprisonment, with half to be served in custody and the remainder on licence. She was sentenced to a six-month concurrent sentence of imprisonment for the offence of possession of an offensive weapon.

1.1.10 It is within the context set out above that this review is established.

1.1.11 The review has considered agencies' contact and involvement with both Antoni and Alicja, from 1st January 2012 until the point of Antoni's death. The reason for this scope was to ensure that the review obtained all available information for their time in the UK and any information that was available regarding their relationship prior to this time.

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

## 1.2 Reasons for Conducting the Review

1.2.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.2.2 The review must, according to the Act, 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'.

1.2.3 In this case, Antoni was killed by his wife and therefore the criteria are met.

1.2.4 The purpose of the DHR is to:

- 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.
- 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.
- Apply these lessons to service responses, including changes to policies and procedures, as appropriate.
- Prevent domestic violence and homicide and improve service responses to 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 possible opportunity.

- Contribute to a better understanding of the nature of domestic violence and abuse.
- Highlight good practice.

## 1.3 Methodology and Timescale for the Review

1.3.1 On 4th May 2021, Humberside Police wrote to the Chair of North East Lincolnshire Community Safety Partnership advising of Antoni's death. This was a timely response and demonstrates a good understanding of the legislation.

1.3.2 The Domestic Homicide Core Group met on 12th May 2021 and was chaired by Helen Cordell, the Domestic Abuse Co-ordinator. Agencies briefly shared the information that was known about Antoni and his family. The Core Group considered the information shared and applied the full definition in its deliberations to establish whether a review should be undertaken 'with a view to establishing lessons to be learned'.

1.3.3 Based on the information shared, there was a unanimous decision from the panel to recommend that a full Domestic Homicide Review (DHR) needed to be completed. The Chair of the CSP thus took the decision to conduct a DHR based upon these recommendations. The Home Office was notified on 14th June 2021.

1.3.4 The Independent Chair and Report Author were appointed to undertake this review on 14th June.

1.3.5 The first panel meeting was held on 12th August on Microsoft Teams. The first meeting was attended by the following agencies:

- Clinical Commissioning Group
- Probation Service
- Humberside Police
- Navigo – Mental health provider
- NE Lincolnshire Council
- Northern Lincolnshire and Goole NHS Foundation Trust (NLaG)
- The Blue Door – Domestic abuse service
- We are With You – Substance misuse services

1.3.6 Apologies were received from NE Lincs Women's Aid.

1.3.7 At the meeting, after reviewing the panel membership, it was agreed that a representative of the education department needed to join the panel. It was also agreed that someone was needed to advise the panel in relation to the cultural issues. This is discussed later in the report. Prior to the first meeting, chronologies had been submitted.

1.3.8 Individual Management Reviews were commissioned from the following agencies:

- NE Lincs Council – Children's Social Care
- NE Lincs Council – Education
- Northern Lincolnshire and Goole NHS Foundation Trust (NLaG)
- Humberside Police

1.3.9 It was not possible to complete the review within six months, as it was necessary to wait for the criminal process to complete. Furthermore, time was taken in attempting to contact Antoni's family in Poland, as well as Alicja and her mother.

1.3.10 The Review Panel five times, and the review was concluded in April 2023.

## 1.4 Confidentiality

1.4.1 The content and findings of this review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the review has been approved for publication by the Home Office Quality Assurance Panel.

1.4.2 To protect the identity of the deceased, and their family and friends, the victim will be known by the pseudonym, Antoni.

1.4.3 Antoni's wife will be referred to as Alicja. Given that there was no family engagement with this review, the pseudonyms were chosen by the Chair of the Review based on them being culturally sensitive to their country of origin.

## 1.5 Dissemination

1.5.1 The following individuals/organisations will receive copies of this report:

- Organisations that contributed to the review
- Members of the Community Safety Partnership
- Office of Police and Crime Commissioner for Humberside
- Domestic Abuse Commissioner.

## 1.6 Terms of Reference

1.6.1 The review panel set out to:

- Consider the impact that COVID-19 lockdown had on service delivery.
- Consider the impact of COVID-19 lockdown on the couple's relationship.
- Consider the ethnicity of the couple and consider how this might have impacted on their access of services.

1.6.2 The full Terms of Reference can be found in Appendix One.

## 1.7 Contributors to the Review

1.7.1 Those contributing to the review do so under Section 2(4) of the statutory guidance for the conduct of DHRs, and it is the duty of any person or body participating in the review to have regard for the guidance.

1.7.2 All Panel meetings include specific reference to the statutory guidance as the overriding source of reference for the review. Any individual interviewed by this Chair or Report

Author, or other body with whom they sought to consult, were made aware of the aims of the Domestic Homicide Review, and the statutory guidance was referenced.

1.7.3 However, it should be noted that whilst a person or body can be directed to participate, the Chair and the DHR Review Panel do not have the power or legal sanction to compel their co-operation, either by attendance at the panel or meeting for an interview.

1.7.4 The following agencies contributed to the review:

- Probation Service – Panel membership
- Navigo (Acute mental health services) – Panel membership
- Northern Lincolnshire and Goole NHS Foundation Trust – Panel membership and IMR
- North East Lincolnshire Clinical Commissioning Group – Panel membership
- North East Lincolnshire Community Safety Partnership – Panel membership
- North East Lincolnshire Council (Adult Social Care) – Panel membership
- North East Lincolnshire Council (Children's Social Care) – Panel membership and IMR
- North East Lincolnshire Council (Education) – Panel membership and IMR
- North East Lincolnshire Council – Domestic Abuse Co-ordinator – Panel membership
- The Blue Door (specialist domestic abuse service) – Panel membership
- Women's Aid (specialist domestic abuse service) – Panel membership
- Crown Prosecution Service – Corresponding member of the panel
- We are With You (substance misuse service) – Panel membership

1.7.5 At the first panel meeting, it was identified that the panel did not have the necessary expertise to understand the Polish culture and any impact that this might have on the circumstances of this review. Therefore, through networks of the Report Author, an advisor with specialist knowledge of domestic abuse in Polish communities was identified. Through her role on the panel, the CSP met the costs incurred by her.

1.7.6 The DHR panel is grateful to Julia Kulak for her expertise in supporting women from Eastern Europe who have experienced domestic abuse.

1.7.7 All panel members were independent of any interaction with Antoni and his family.

1.7.8 As both Antoni and Alicja were employed locally, the Chair and Report Author wrote to both employers so as to engage with friends and colleagues, but also to understand their policies about domestic abuse. Despite two letters being sent to the managing directors of both organisations, no response was received.

## 1.8 Engagement with Family and Friends

1.8.1 On 13th October 2021, Antoni's brother was written to, in Polish, by the Community Safety Partnership advising him of the review. On the same day, a letter was also sent to Antoni's parents, once again in Polish.

1.8.2 On 1st November 2021, the Chair and Report Author wrote to both Antoni's brother and parents. These letters were translated into Polish. The Home Office leaflet and information about AAFDA (Advocacy After Fatal Domestic Abuse) were included: these were also translated into Polish.

1.8.3 No response was received and so, at the end of February 2022, the Family Liaison Officer was approached by the Report Author, with a view to obtaining a current update on engagement with the family. It was established that Antoni's sister was now the point of contact, and that translation was needed to engage with her. The Report Author established the linguist that had been used by the police so that, if she did choose to engage, a linguist could be used who had a rapport with the family and understood the circumstances.

1.8.4 On 21st April 2022, a letter was then sent, via email, to Antoni's sister by the Chair and Report Author. This, once again, included the Home Office and AAFDA leaflets. Unfortunately, no response was received.

1.8.5 Whilst the review would have welcomed the family's engagement, their wishes are respected.

## 1.9 Engagement with the Perpetrator and her Family

1.9.1 In March 2022, a letter was sent to Alicja in prison, via the offender management unit in the prison. This letter was shared with her, and she was given time to think about her involvement. In May 2022, a follow-up email was sent to the prison. Her offender manager spoke to Alicja about the importance of the review, but she did not feel able to engage: the review respects her position.

1.9.2 Alicja's mother was written to by the Chair and Report Author in October 2021, explaining the Domestic Homicide Review. When no reply was received, a further letter was sent in April 2022, inviting her to meet with the Chair and Report Author. Both letters were translated into Polish. No response was received, and the panel respects her position.

## 1.10 Review Panel

1.10.1 The members of the Review Panel were:

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| Gary Goose | Independent Chair | |
| Christine Graham | Independent Report Author | |
| Julia Kulak | Specialist Advisor | |
| Catherine Ainsworth* | Senior District Crown Prosecutor | Crown Prosecution Service |
| Susan Bunn | Head of Safeguarding | Focus Adult Social Care |
| DCI Emma Heatley Replaced by DCI Mark Skelton | Tactical Lead for domestic abuse and Lead for the safeguarding governance unit | Humberside Police |
| Ellie Walsh* | Assistant Director – Adult Acute Mental Health Services | Navigo – Acute Mental Health Services |
| Emma Kosakowska | Lead Practitioner, Safeguarding | Navigo – Acute Mental Health Services |
| Lynn Benefer | Deputy Head of Safeguarding | Northern Lincolnshire and Goole NHS Foundation Trust |

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| Julie Wilburn | Designated Nurse for Safeguarding Adults and Children | North East Lincolnshire Clinical Commissioning Group |
| Rebecca Freeman | Community Safety Partnership Manager | North East Lincolnshire Community Safety Partnership |
| Spencer Hunt | Assistant Director, Safer and Partnerships | North East Lincolnshire Council |
| Dawn Alaszewski | Head of Safeguarding | North East Lincolnshire Council |
| Beverley Compton | Director, Adult Services | North East Lincolnshire Council |
| Helen Cordell | Domestic Abuse Co-ordinator | North East Lincolnshire Council |
| Helen Willis | Safeguarding Children's Board Manager | North East Lincolnshire Council |
| Stewart Watson | Assistant Director of Safer and Partnerships | North East Lincolnshire Council |
| Jennifer Steel | Head of Pupil Support (Wellbeing and Safeguarding) | North East Lincolnshire Council |
| Nick Hamilton-Rudd | Head of the North & North East Lincolnshire Probation Delivery Unit | Probation Service |
| Steph Price | Chief Executive Officer | The Blue Door Support Service |
| Lisa Pidd | Contracts Manager | We are With You |
| Denise Farman | Chief Officer | Women's Aid |
| Kate Ransom | Support Manager | Women's Aid NE Lincs |
| Nicola Harrison | Outreach Support Worker | Women's Aid NE Lincs |

*Corresponding members

## 1.11 Domestic Homicide Review Chair and Overview Report Author

1.11.1 Gary Goose served with Cambridgeshire Constabulary, rising to the rank of Detective Chief Inspector: his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary led the police response to the families of the Soham murder victims. Gary was awarded an MBE for Services to Policing in the 2006 Honours List. From 2011, Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner, developing a performance framework.

1.11.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years, managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. As well as delivering training in relation to tackling anti-social behaviour, Christine has worked with several organisations to review their approach to community safety. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA, which involved her in observing and auditing

Level 2 and 3 meetings as well as engagement in Serious Case Reviews. Christine chairs her local Safer off the Streets Partnership.

1.11.3 Gary and Christine have completed, or are currently engaged upon, a number of Domestic Homicide Reviews across the country in the capacity of Chair and Overview Author. Previous domestic homicide reviews have included a variety of different scenarios: male victims; suicide; murder/suicide; familial domestic homicide; a number which involve mental ill health on the part of the offender and/or victim; and reviews involving foreign nationals. In several reviews, they have developed good working relationships with parallel investigations/inquiries, such as those undertaken by the Independent Office for Police Conduct (IOPC), NHS England, and Adult Care Reviews.

1.11.4 Neither Gary Goose nor Christine Graham is associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[1]

1.11.5 Both Christine and Gary have completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports, as well as DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse). Details of ongoing professional development are available in Appendix Two.

## 1.12 Parallel Reviews

1.12.1 The coroner did not reopen the inquest at the end of the criminal process.

1.12.2 There were no other parallel reviews.

## 1.13 Equality and Diversity

1.13.1 Throughout this review process, the panel has considered the issues of equality. In particular, the nine protected characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

1.13.2 In this case, the following were thought to be particularly pertinent.

1.13.3 **Ethnicity**

1.13.4 Antoni and Alicja were both Polish. The impact that this may have had on this case is discussed, fully, later within the body of this report.

[1] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

1.13.5 Research carried out in the UK, determined that whilst the proportion of domestic homicides amongst minoritised ethnic groups appeared to be high, further research was needed to establish the role of ethnicity[2].

1.13.6 **Male victims of domestic abuse**

1.13.7 The latest national statistics demonstrate that males are much less likely to be the victim of domestic homicide, with only 10% (39) of male homicides being domestic related. This is a similar proportion to the previous year[3].

1.13.8 In March 2019, Mankind Initiative produced key facts about male victims of domestic and partner abuse[4]. They found that:

- One in six-seven men will suffer domestic abuse in their lifetime.
- In 2017/18, 4.2% of men said that they experienced domestic abuse, and 0.5% of men said that they had experienced stalking.
  Of the men who had experienced domestic abuse:
- 12% of men had experienced three or more incidents of domestic abuse.
- 31.8% had suffered physical injury, and 41.2% had experienced mental or emotional problems.
- 11% of male victims had tried to take their own lives.

1.13.9 In a report, 'Making Legislation Work More Effectively for Victims' by IBB Solicitors[5], 34% of men stated that they had experienced being in a coercive or controlling relationship. They found that when asked about behaviours, men were just as likely to experience most of the issues asked about. There were some behaviours that men were more likely to experience than women:

- Monitored or controlled spending – 29% of men, and 11% of women.
- Suspected partner of spying on you or your activity – 30% of men, and 23% of women.
- Partner deprived you or limited your food – 24% of men, and 11% of women.
- Partner intentionally destroyed possessions or deleted emails or texts – 27% of men, and 20% of women.
- Partner hid or took away a phone/tablet/computer – 24% of men, and 14% of women.

1.13.10 Barriers to reporting or seeking help by male victims are discussed later in the report.

[2] Domestic Homicide Project Spotlight Briefing on Ethnicity, Perry et al., Vulnerability Knowledge and Practice Programme, June 2022
[3] Homicide in England and Wales: year ending March 2021, Office for National Statistics, February 2022
[4] Male victims of domestic and partner abuse, Mankind Initiative, March 2019
[5] Male victims of domestic and partner abuse, Mankind Initiative, March 2019

# Section Two – The Facts

## 2.1 Introduction

2.1.1 Antoni was 32 years old at the time of his death. Alicja, his wife, was 27 years old at the time. They had two small children. Very little is known about the couple, but both worked in factories locally. It is thought that they settled in the UK from Poland in around 2013. However, despite all the work done by this review and the police during their murder investigation, a confirmed date of arrival has not been established.

2.1.2 A chronology of information known to agencies follows. This is purely that which was known by agencies, as the review has been unable to supplement this with information from family and friends. Little has been established about their lives prior to arriving in the UK.

## 2.2 Chronology

2.2.1 This section will now look at what is known about any agency involvement with the couple from 2012 onwards. This ensures that all that is known about their time in the UK is included.

2.2.2 **2013**

2.2.3 In July, Antoni attended the Emergency Care Centre[6] (ECC) with a laceration to his right knee. He reported that had fallen onto a glass table about one hour earlier. There was a 4 cm laceration to his right knee, which was deep, with localised swelling. The wound was cleaned and closed with six sutures and a dry dressing. He was discharged, to be followed up by his GP.

2.2.4 On Christmas Day, Humberside Police were contacted with a report that a male and female were arguing on their front doorstep. It was reported that one of them had assaulted the other: this was witnessed by a juvenile neighbour who made a call to the police. When the police arrived, the couple were found to be Antoni and Alicja. It was noted by the officers that both were intoxicated. They admitted to having a verbal-only argument over festive issues. The officers noted no visible injuries on either party, and there were no complaints from either of them. Checks were conducted by the officers on police systems, which showed no previous records of domestic abuse. The welfare of the children was checked, and there were not considered to be any ongoing concerns.

2.2.5 The police report notes that a witness saw Antoni eject Alicja from the house with a suitcase. She had begun banging on the door until he opened it. She then stabbed at him with her keys, managed to get back inside, dragged him into the house, and kicked him. There was a toddler present. The toddler was knocked, which caused them to scream. The officer decided not to speak to the two witnesses, who had called the police, due to their age (12 and 13 years old). A DASH risk assessment was conducted, which deemed it to be medium risk. Advice was given in relation to alcohol consumption.

2.2.6 An information sharing log was created so that the information could be shared with Children's Social Care; however, the detective sergeant who reviewed the log, decided that it did not need to be shared. There is no rationale for this decision. No further action was taken; no arrests were made; and no further enquires were conducted.

[6] Accident and Emergency

2.2.7 **2015**

2.2.8 In July, Child 1 (who would have been three years old at the time) attended ECC with Alicja after sustaining a leg injury. Child 1 had a fall the previous day at the airport and had injured their ankle. Due to the language barrier, it was not possible to be clear about what had happened, as Child 1 was unable to mobilise. An X-ray identified a spiral fracture to the tibia. The orthopaedic registrar recommended admission, but Alicja preferred to take Child 1 home. An appointment was given for the fracture clinic (all of which were attended).

2.2.9 In November, Alicja was seen in the breast clinic. A support worker acted as a translator. After examination, Alicja was reassured and discharged back to her GP.

2.2.10 Alicja attended ECC on 7th December. She had been suffering with toothache for the past two weeks.

2.2.11 **2016**

2.2.12 A call was made to the police by Antoni on 15th October. He said that Alicja had attacked him, had cut his lip, and he had hit her back. Both Antoni and Alicja were present when the police arrived. Antoni was noted as being heavily in drink, and officers noted that Alicja had several marks on her body that officers felt were not consistent with Antonis's account.

2.2.13 It was established that Antoni and Alicja had been to a party, with friends, for their daughter's 1st birthday. Alicja had not consumed alcohol for over a year and had drunk at the party, which meant that she had got drunk easily. They had both been drinking and when they returned home, Alicja had become abusive, and she and Antoni began to argue in the street. Upon returning to the flat, Alicja had punched Antoni to the mouth, causing a small cut. Antoni had then then punched Alicja, causing reddening to her face. At the time, the children were in the care of Alicja's mother. Both children were found to be asleep, fit and well, and not believed to have witnessed the incident.

2.2.14 Antoni was arrested and made a full admission to punching Alicja. He did say that he was assaulted by Alicja first. Antoni received a police caution for this offence. No action was taken against Alicja, who was dealt with as the victim. There was a risk assessment conducted, which deemed it to be medium risk. There is no evidence of a referral to Children's Social Care being submitted.

2.2.15 **2017**

2.2.16 On 19th September, Alicja attended ECC with abdominal pain. She was 27 weeks pregnant. She was sent to the maternity ward for review.

2.2.17 In December, Alicja gave birth to a baby. She was discharged the following day.

2.2.18 On 28th December, Alicja was discharged from midwifery care.

2.2.19 **2019**

2.2.20 On 19th June, Antoni attended ECC. He reported that he had been drinking and fell onto a gate. He was complaining of right upper back pain, right sided chest pain, and shortness of breath and difficulty breathing. The accident had occurred two days earlier when he had

fallen onto a pile of bricks, having climbed onto a fence. The CT scan showed fractures to the 5th and 6th rib. He was discharged with analgesia, and a follow-up appointment to the fracture clinic was scheduled.

2.2.21 Antoni attended ECC on 16th September. He reported that he had fallen from a ladder and injured his hand two days earlier. The X-ray found a fracture. A fracture clinic appointment was given.

2.2.22 Antoni was then seen in the fracture clinic on 24th September. He was advised to keep moving his fingers within the level of discomfort and told to return in 3 weeks' time.

2.2.23 On 29th September, Alicja was arrested for drink driving and causing a collision. She was taken to ECC, via an ambulance, following the road traffic collision. She had driven at 50 - 60 miles per hour into a stationary vehicle and did not have a seat belt on.

2.2.24 Antoni was seen in the fracture clinic on 15th October (this being a follow-up from 16/09/19): he was being managed for a suspected fracture to the base of his right ring finger.

2.2.25 **2020**

2.2.26 On 29th February, a call was made to the police reporting that a male was assaulting a female, and that he was dragging her in the direction of a named public house. The report said that he was beating her badly and was kicking her in the head. The male and female were identified as Antoni and Alicja.

2.2.27 Alicja was located at home by police, who noted that she had red eyes and had been crying. She also had blood on her right ankle and a graze on her knee. Alicja told the officers that she had been pushed by Antoni and had fallen over. She told them that she had got drunk, as this was the first time that she had consumed alcohol in two years.

2.2.28 Officers spoke with witnesses who confirmed that Antoni had kicked her to the legs and head whilst she was on the floor and dragged her by the hair. Antoni was arrested by officers on suspicion of assault. A DASH risk assessment was conducted, and the case was deemed to be medium risk. The children were not witness to the assault. The log states that no referrals to Children's Social Care were made. Alicja did not accept a referral to domestic support services.

2.2.29 On the DASH form, it was noted that there had never been any violence between them and there were no children in the household, even though the officer had checked the address and the welfare of the children.

2.2.30 Officers spoke with Alicja in person, at her home address, regarding the assault. She said that she did not want to provide a statement of complaint in relation to the assault and did not want any of her injuries to be photographed.

2.2.31 Several witness statements were obtained as part of the investigation. One witness stated that they had seen Antoni assault Alicja by kicking her legs and dragging her around, before punching her to the chest. The other witness provided a similar account of Antoni kicking Alicja in the lower half of her body.

2.2.32 In interview, Antoni admitted to arguing and getting angry with Alicja. He said that they went to get some food from the pizza shop. She then sat on the floor, and when he tried to

drag her to her feet, it resulted in him dropping the food. He admitted kicking her in the backside out of frustration but also said that Alicja had slapped him across the face. However, he said that he did not want to pursue this allegation.

2.2.33 The CPS was approached for a charging decision. This was to be an evidence-led prosecution – using the evidence of the witnesses and the admissions made by Antoni in interview. The CPS stated that there was insufficient evidence to charge Antoni, and that the witness evidence was contradicted by the 999 calls and accounts provided to officers at the scene. The main witness said in the call to police, that he had seen Antoni kick Alicja in the head, which was not in his statement. This was also repeated to the attending officer. Moreover, the account provided by Antoni is corroborated by the second witness. When Alicja was spoken to, she also denied flatly that Antoni had kicked her in the head. The CPS lawyer also made mention of the caution received by Antoni in 2016, stating that, having read the circumstances, it is their view that it should have been Alicja cautioned for assault, not Antoni. They concluded that, in the absence of a complainant statement from Alicja, there was no realistic prospect of conviction. Antoni was subsequently released NFA.

2.2.34 On 23rd March, Antoni attended ECC with a history of a leg injury, after falling down approximately seven stairs. On examination, swelling to dorsum of foot was seen. The X-ray showed no obvious bony injury. The diagnosis was contusion to foot: he was advised to elevate and take pain relief.

2.2.35 **On 23rd March, the Government announced the first COVID-19 lockdown.**

2.2.36 On 6th April, the police were called to a report of a Polish couple fighting in the street and in the house. The caller described them struggling with one another, with the female trying to get the male out of the house, and the male trying to get back in. The caller said that, at one point, he saw the male punch the female in the stomach and put his hand around her neck. The police attended, but the couple denied that anything happened. They said that it must have been someone else. No complaints were made, and therefore no DASH was completed.

2.2.37 On 28th April, Alicja's GP referred her to a clinic for a non-relevant matter.

2.2.38 On 1st August, Alicja attended ECC with history of PV bleeding. There was, she said, no chance of pregnancy, and the bleeding had started 1-2 hours post sexual intercourse. Alicja said that it was just normal sex, not rough or abused. She was transferred to a gynaecology ward. When she was seen on the ward, it was determined that she had a labial tear, which she said was received post sex. After being observed for two hours, Alicja was discharged home, with wound care advice. She was advised to return if she had any concerns. It was considered by staff as being unlikely to have been caused within the bounds of normal intercourse.

2.2.39 On 12th November, Alicja had a follow-up in the breast clinic. Alicja said that she had a strong family history of breast cancer. She was reassured and discharged from clinic.

2.2.40 On 13th November, the police received a call from Alicja in which she reported that she had been assaulted by Antoni, who had punched in her face whilst in the house. The children were also present in the house when the assault took place. Alicja and Antoni had had an argument after having a drink in the evening, during which Antoni had punched her in the face. Alicja had no visible injuries. The police attended and spoke with Alicja and saw the

children. Alicja said that she did not want to pursue a complaint, and that she had panicked and called the police. Alicja decided to go and stay at her brother's house: with her mother being left to look after the children. Antoni was also left in the property. Officers then left, and no further action was taken. A DASH risk assessment was conducted, and the case deemed to be medium risk. Referrals were made in relation to the children (Op Encompass-Education and Children's Front Door – social care). Alicja declined a referral to domestic abuse support services.

2.2.41 The police made a referral to CSC on 14th November. The DASH risk assessment completed by the police, was provided to CSC on 16th November: it was graded as medium, and an assistant team manager carried out the initial screening of the referral. It was decided that a social worker (SW) would make safe contact with Alicja and gain consent to inform the Team Around Family (TAF) – to strengthen safety planning and gain checks from the school and nursery.

2.2.42 On 16th November, the school received notification of the above incident via an Operation Encompass referral. This was the first school day following the incident.

2.2.43 On 19th November, the children were allocated to a social worker by CSC.

2.2.44 On 20th November, Alicja's mother attended the enquiry office at Grimsby Police Station, with a child. She did not speak English and was therefore spoken to on language line. She told the police that she came to the UK from Poland to help her daughter with her children. She said that she was concerned about her daughter and her grandchildren, as her daughter's partner drinks and shouts at her. She was asked if there were any immediate concerns, to which she stated: 'No I just need advice'. The enquiry office staff contacted Children's Social Care for advice: they were told that they were aware of the family, as they had a social worker. The social care manager was spoken with, and Alicja's mother's contact details were provided. The manager said that they would ask a social worker to call her that day. Alicja's mother was updated, and no further action was taken.

2.2.45 On 23rd November, the social worker made a visit to the family home. As part of the meeting, Alicja gave permission for Child 1 to be seen alone at school. The social worker completed the checks with education on 26th November. Child 1 was seen by the social worker at home on 26th November.

2.2.46 Antoni and Alicja were seen, with the children, by a social worker on 30th November. A Single Assessment was completed on 21st December, with a recommendation for the case to be stepped down to Early Help. However, before the children were closed to social care, a further visit was undertaken, and the children were held at panel.

2.2.47 **2021**

2.2.48 On 12th January, the social worker visited the family home. Both parents, the grandmother, and the children were seen: they were supported by an interpreter. Alicja's mother said that things had calmed down at present, but that she was worried about the effect on the children from the arguing and drinking. She was worried what would happen if she had to go back to Poland. The social worker advised her that the parents would be asked to complete work with Early Help about the impact of domestic abuse and support for alcohol. She was happy with this plan, and she was given contact details so she could make contact if she had further concerns. Alicja and Antoni were spoken to, and the social worker

explained that there were concerns about what the children were hearing and seeing, and that they would like them to do some work with Early Help. The couple agreed to this.

2.2.49 On 22nd January, the social care intervention ended. The Early Help, TAF plan was put in place. The Early Help Service was to complete work with Antoni and Alicja around their relationship and to help them to understand the impact of domestic abuse.

2.2.50 On 5th February, the work was allocated to an Early Help practitioner, and it was agreed that there would be four sessions (for one hour per week) to look at the impact of domestic abuse.

2.2.51 The Early Help practitioner advised her manager, on 5th March, that Alicja had withdrawn her consent for the work. She said that it was no longer required, and that the couple needed to focus on their work. She said that she had no new concerns about domestic abuse. A management decision was made to end the Early Help intervention, as there had been no further incidents since the referral in November 2020.

2.2.52 It was then, in April, that Alicja killed Antoni – as summarised in section 1 of this report.

# Section Three – Detailed Analysis of Agency Involvement

The chronology set out in Section 2, details about the information known to agencies involved. This section summarises the totality of the information known to agencies and analyses their involvement. It is accepted that there will be some duplication of information within this section; however, this allows the reader to scrutinise individual agency involvement without the need for continual referral back to the previous section.

3.1 **HUMBERSIDE POLICE**

3.1.1 Antoni and Alicja had contact with the police six times over eight years. The first two incidents took place over a seven-year period: the first in 2013, then 2016, and then nothing until 2020.

3.1.2 In the incidents in 2013 and 2016, Alicja was treated as the victim, and Antoni as a perpetrator. The IMR author notes that this contrasts with the information available. In the 2013 incident, Alicja was described as stabbing Antoni with the keys and kicking him (albeit he had pushed her out of the house with a suitcase). In 2016, the incident refers to Alicja assaulting Antoni, causing injury. On this occasion, Antoni was arrested and cautioned.

| |
|---|
| Neither of these incidents resulted in referrals being made to Children's Social Care. |

| |
|---|
| Alicja was treated as the victim in both cases. On neither occasion, however, is there a record of her being given details about domestic abuse services. |

**Despite positive action being taken, there is no sense of completeness in the way in which these cases were dealt with. There was no referral to CSC, and no information about domestic abuse services was given.**

**The review is confident that, now that the Vulnerability Hub has been established, all officers going out to a domestic abuse incident will complete a DASH risk assessment that will be submitted to the Vulnerability Hub for a secondary, more in-depth, risk assessment. Furthermore, where children are involved, a referral to partner agencies will be triggered.**

**Moreover, in future, if a child is present or witnesses a domestic abuse incident, a separate crime will be raised and will record them as the victim.**

3.1.3 In 2020, there is a clear escalation in the domestic abuse that was reported to the police, with reports being made in February and November.

3.1.4 The first incident in 2020 was in February, when good, positive action was taken by the officers, and an arrest was made. A case for an evidence-led prosecution was prepared for the CPS. ***This is an example of good practice.***

There is, once again, no referral to Children's Social Care. The DASH recorded that there were no children, but this is clearly not the case, given the information on the previous incidents. There is a lack of professional curiosity shown by officers, both when speaking to Alicja and when reviewing previous incidents.

**The review is advised that to support the development of professional curiosity by officers, a new Domestic Abuse Standard Operating Procedure has been produced and circulated to all frontline departments. This procedure emphasises the need for professional curiosity and encourages officers to look beyond what is immediately presented to them when attending incidents of domestic abuse.**

**Further work is also being undertaken:**

- **A briefing document is being prepared, focusing on professional curiosity at a domestic abuse incident, with particular focus on children and unborn babies and the risks posed to them. This will be circulated to all frontline departments**
- **The Force is in the process of updating the DASH/S-DASH (Domestic Abuse and Stalking) risk assessment forms. The new forms (DARA/SST) will encourage greater professional curiosity, as officers will be less reliant on yes/no answers and will be required to use their own observations and professional judgement**
- **Professional curiosity will be a theme running through all multi-agency training, which will be monitored through multi-agency audits and reviews.**

**To ensure that the focus on professional curiosity becomes embedded, the Safeguarding Governance Unit will conduct regular domestic abuse themed audits, where professional curiosity will be a theme of the analysis.**

**Recommendation 1**

**It is recommended that children are visible in domestic abuse cases, that any children are fully documented, and referrals are then made.**

3.1.5 The review notes that, on this occasion, Alicja was offered a referral to domestic abuse services; however, she declined this.

3.1.6 The review notes that when Alicja called the police in November 2020, she had removed herself from the property and did not wish to make a statement. The children were checked, and referrals made, but there was no scope to pursue an evidence-led prosecution.

3.1.7 When Alicja's mother attended the police station, the enquiry office staff took positive action in engaging an interpreter and telephoning Children's Social Care, who said that a social worker would be in touch with her later in the day.

Best practice would have been for an officer to have attended the front desk to speak to Alicja's mother – to take all the details and liaise with Children's Social Care.

**Recommendation 2**

**It is recommended that when a third-party attends to report domestic abuse, that consideration is given to whether an officer should attend and obtain the details.**

3.1.8 This incident took place during the COVID-19 lockdown; however, there is no evidence that this impacted upon the service that Alicja's mother received.

3.2 **NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST (NLaG)**

3.2.1 Antoni and Alicja had a number of interactions with NLaG. These are detailed in the chronology, and this section will focus on those that require further analysis.

3.2.2 In July 2013, Antoni was seen with a laceration to his right knee after falling onto a glass table. This injury was severe enough to need six sutures.

3.2.3 Antoni was seen again in September 2019, when he had been drinking and had fallen onto a pile of bricks after climbing onto a fence.

> The documentation was comprehensive regarding the injury and treatment but lacked evidence to support a level of professional curiosity about how Antoni came to fall onto a glass table and fall onto a pile of bricks after climbing over a fence. The IMR author notes that it is not known if domestic abuse played a part in either injury; however, with hindsight, professionals needed to be more inquisitive and document how the injuries were sustained.

3.2.4 In July 2015, when Child 1 attended having had an accident at the airport, the records said: 'poor historian due to language barrier', but it is not clear if this referred to Child 1 or Alicja. Alicja preferred to take Child 1 home rather than being admitted, as recommended by the orthopaedic registrar.

> The use of an interpreter should have been considered, particularly to explore why Alicja preferred to take Child 1 home rather than allow admission. If staff felt that the mother (Alicja) was not acting in the best interests of the child by taking her home, then a discussion should have been held with Children's Social Care.

3.2.5 No safeguarding concerns were raised at the time of the injury, nor the history of the injury given. However, with hindsight, we know that there was domestic abuse in the home. If staff in A&E had been aware of the domestic abuse, it may have given rise to further scrutiny around this admission.

3.2.6 In 2017, Alicja was pregnant with Child 2 and was seen by maternity services. Routine questions about domestic abuse were asked of her during her pregnancy. Alicja denied any domestic abuse in her relationship with Antoni.

**The review notes that routine questioning is well established within the maternity department and is recorded within the mother's electronic maternity record (CMIS). *This is an example of good practice.***

**Recommendation 3**

**It is recommended that, via training and supervision, staff are reminded that when an adult presents to ED with injuries and concerns/behaviours that could impact on the care of dependents, a discussion is to be held with the safeguarding team to support with appropriate signposting and referral.**

3.2.7 In August 2020, Alicja attended ECC and was treated with seven sutures for a labial tear that was post coital.

> The Ward Manager and Clinical Nurse Specialist who were interviewed by the IMR author, both confirmed that this presentation would have raised alarm bells, but the two doctors that saw Alicja, showed no professional curiosity to explore further with her the possible causes of the injury.
>
> Both doctors were locums and no longer work for the Trust.
>
> There is no evidence that domestic abuse was asked about, and Alicja's explanation about it having occurred following normal sexual intercourse, does not appear to have been sensitively challenged by the doctors as being unusual.
>
> Alicja was observed on the ward for two hours, which afforded plenty of time for this to be discussed in more detail with her and for her to be given the opportunity to speak to an Independent Sexual Abuse Advocate (ISVA). As there is no documentation to support this, the IMR author and the review must draw the conclusion that it did not happen.

**With hindsight, a discussion with the safeguarding team, within NLaG, would have opened the opportunity for professional curiosity and may have provided the opportunity for Alicja to be signposted to support services.**

**Recommendation 4**

**It is recommended that the Trust implements a Quality Improvement Project designed to encompass and discuss selective/routine enquiry for both male and female patients across the Trust.**

**Recommendation 5**

**It is recommended that training is provided by the Independent Sexual Abuse Advocate and Humberside Sexual Assault Centre to gynaecological and A&E staff, to increase awareness of the service.**

3.2.8 **Language barriers**

3.2.9 Antoni and Alicja's first language is Polish. On occasions, this had been a barrier. This had been managed on occasions, but not consistently, with the use of an interpreter. When Alicja attended A&E with the vaginal laceration, whilst the language barrier was identified, it does not appear to have led to an interpreter being arranged for when she was transferred to a ward for examination and treatment. There is nothing in the notes to suggest that this

was a barrier; however, as it was not possible for the IMR author to speak to the doctors, the review is not able to comment on whether this was a barrier.

**Recommendation 6**

**It is** recommended that a supply of literature in key languages is made available to staff to use within the Trust, together with promotion of the use of interpreting services.

3.2.10 **The impact of COVID-19**

3.2.11 Lockdown impacted on service delivery within the Trust – reducing face-to-face outpatient consultations and providing virtual outpatient appointments. Alicja was offered this service by the breast clinic. The use of virtual outpatient sessions, although necessary and successful for some patients, does raise the question of possible abuse within the family home being missed, due to the patient not having the opportunity of talking freely because partners may be present. This was addressed within the Trust via the domestic abuse guidance. This was updated to inform staff of the importance of checking who was present during virtual consultations and picking up cues when patients/staff could not speak freely.

## 3.3 NORTH EAST LINCOLNSHIRE COUNCIL – EDUCATION DEPARTMENT

3.3.1 On behalf of the review, the Head of Pupil Support has sought feedback from the school, regarding the children's engagement, that may assist the review.

3.3.2 The first indication that the school had of any domestic abuse was via an Operation Encompass report that the school received on 16th November 2020. When an Operation Encompass report is received, the information is shared with relevant staff so that the pupil can be supported. It is then filed in the record system. No discussion is initiated with the child or parents.

3.3.3 Alicja attended all school meetings and was supported by a Polish teaching assistant (with interpreting). Antoni was rarely seen in school, but Alicja stressed that this was due to working shifts and was not that he was disinterested. The school described that Alicja 'kept herself to herself' but believed this was purely due to the language barrier. Alicja was very happy to approach the teaching assistant if she needed assistance with anything.

**The report is aware that the school has 15% of children (in the whole school) with English as a second language (ESOL).**

3.3.4 The school described the oldest child as quiet, always in the background, and could easily be overlooked, as they were compliant and well-behaved in class. They did not have a lot of confidence and arrived at the school with very little English. Since the death of their father, the child has been coming out of their shell and is more confident and engaging in lessons, even answering questions. They have become an active member of the chaplaincy team and is described as vocal and confident in this group. The safeguarding lead described them as happier in their demeanour.

3.3.5 The children never spoke of any problems at home.

**There are no specific recommendations for this organisation.**

## 3.4 NORTH EAST LINCOLNSHIRE COUNCIL – CHILDREN'S SOCIAL CARE

3.4.1 There was one period of intervention from November 2020 to January 2021, following a referral by the police. Both the police and the social work manager graded the incident as medium risk. Alicja had taken the children to her brother, and this was seen as a protective measure for the children. Upon receipt of the referral and background information, CSC deemed the family to be 'amber' rag rate, and a Child and Family Assessment (under Section 17 of the Children Act 1989) was completed. Antoni and Alicja gave their consent to this assessment; therefore, it was not deemed appropriate to escalate to a Section 47 Child Protection Strategy Meeting/S 47 Child Protection enquiry.

3.4.2 The social worker completed two visits with the family and saw both parents, the children, and grandmother: they were supported by an interpreter. The social worker saw Child 1 alone and viewed grandmother as supportive of Child 1. The child was seen at home rather than at school, as the parents did not consent to the child being seen in school.

**The review notes that, as this was a Section 17 assessment, permission was required by the parents about where Child 1 was seen.**

3.4.3 During the assessment, the children reported to the social worker that they felt scared when mummy and daddy argued. This demonstrates that arguing between the parents was part of the normal lived experience.

3.4.4 The social worker consulted with the school throughout the assessment period. The school advised that Child 1 had emotional/pastoral support in school. It is possible that they were worrying about their parents and witnessing domestic abuse and alcohol use in the home.

> There is no further information in the assessment about why this was. The review agrees with the IMR author that this should have been explored further, and that the information triangulated with what was known at the point of referral and included in the assessment.

**The review agrees with the IMR author that support for the children should have been arranged for the children, whether from CSC or the school.**

3.4.5 When undertaking the assessment, both parents were seen together with an interpreter present. They were seen in person so there was no impact of COVID-19 to this part of the assessment.

> Antoni and Alicja should have been seen separately, which would have allowed them to speak openly about the relationship and could have led to disclosures of domestic abuse. This would have been good practice on all occasions, but Alicja had declined to make a police statement and had said that she was separated from Antoni. However, by the time of the assessment, the relationship had resumed.
>
> This information was not shared with the police, and a Strategy meeting could have been arranged.

**Recommendation 7**

**It is recommended that in cases of domestic abuse, partners are always seen separately as part of an assessment.**

> Throughout the assessment, there was no discussion with health colleagues to ascertain any history of alcohol misuse or mental health difficulties. This would have been pertinent to the social care assessment and child protection planning.

3.4.6 The assessment was completed within the required timescales. The safety plan included grandmother, ***which is an example of good practice***. The children appeared to be well cared for, and the home was clean and appropriate. Antoni and Alicja were able to verbally express the harm that could be caused to the children by further incidents. There was good management oversight of the case.

**The IMR author has questioned whether the assessment should have been completed under S47 of the Children' Act 1989, so that a Strategy meeting was held at the outset. This would have enabled social care to see the children alone, outside the home, and Health would have been at the meeting.**

3.4.7 Alicja removed her consent for the Early Help support, and at this point, there had been no further incidents; therefore, the threshold for escalation to S47 was not met. However, had CSC been aware of the incident in February/March 2020, the threshold would have been met and work would have continued, despite Alicja withdrawing her consent.

# Section Four – Domestic Abuse

4.1 A Domestic Homicide Review is charged with identifying a trail of domestic abuse. In this case, Alicja, the perpetrator of the homicide was, in fact, as far as the information that is known suggests, the victim of domestic abuse. This will be explored further.

4.2 The first time that the couple came to the attention of the police was in December 2013. On that occasion, when police records were checked, there were no previous records of domestic abuse. Therefore, it is assumed that this is the first time that the police were aware – albeit the call had been made by the third party, so it may not have been the first time when there was domestic abuse.

4.3 As part of the police investigation, neighbours were spoken to. They spoke about incidents that they had witnessed. The names of the witnesses and the dates of the incidents are not known, but they are included here to provide context, whilst accepting that these testimonies have not been tested.

4.4 It is not clear, in the information that is known to the review, whether there was clearly a victim and a perpetrator, or if both were, at times, the victim and the perpetrator. The review has considered the incidents that were reported to the police, and this question will then be revisited.

4.5 **Incidents where it is thought that Alicja was the primary aggressor**

4.5.1 The first call to the police was in December 2013, when a juvenile called the police because Antoni and Alicja were arguing on the doorstep. Although the caller said that one had been struck by the other, when the police arrived, they both said that it had been a verbal argument about the festivities. Both were in drink; no complaints were made; and no visible injuries were observed. The welfare of the children was checked, and they were fine.

4.5.2 The police report notes that the witness said that Antoni had tried to eject Alicja from the house with a suitcase. She had then banged on the door until he opened it. She had then stabbed at him with her keys and had managed to get back into the house. She had then dragged Antoni into the house and kicked him. A toddler was knocked over in the altercation and began to scream. A DASH risk assessment was completed and assessed as medium.

4.5.3 A neighbour told the homicide investigation that they had seen Alicja attack another female by 'beating her to a pulp' and, on another occasion, fighting with a male who was visiting the address. This witness said that, in their opinion, Alicja was the most 'dominant', and they had seen Alicja punch her husband many times. This witness said this was a regular occurrence when the couple had been drinking alcohol.

4.5.4 Another witness reported seeing Alicja and Antoni outside their property. Alicja began to shout loudly at Antoni, and he started to walk away. Alicja had then picked up a lawnmower and threw it at him with such force, that it hit the small garden wall and knocked a brick from the top. Alicja had then continued to kick her husband.

4.5.5 Another neighbour described Alicja as being a lot more aggressive towards her husband and having a terrible temper.

4.5.6 The homicide investigation was told by a neighbour that, on one occasion, Antoni had been in his garden, and he had gone into the neighbour's garden to help cut back some bushes. Alicja had come storming out of the house and grabbed Antoni by his T-shirt and started to 'shove' him towards the front door. The couple went inside, but a few minutes later, Antoni came out and sat on the doorstep whilst Alicja was throwing his clothes at him. It was reported that he sat there for hours.

4.6 **Incidents where it is thought that Antoni was the primary aggressor**

4.6.1 In February 2020, the police were called to a public house to a report of a male assaulting a female. The report said that he was beating her badly and kicking her in the head. The couple were identified as Antoni and Alicja.

4.6.2 When Alicja was found at home by officers, she had red eyes and had been crying. She had blood on her right ankle and a graze on her knee. She said that Antoni had pushed her, and she had fallen over. She said that she had got drunk, and that this was the first time she had consumed alcohol in two years.

4.6.3 Witnesses said that Antoni had kicked Alicja to the legs and head whilst she was on the floor and had dragged her by her hair. He was arrested on suspicion of assault. The DASH risk assessment was assessed as medium.

4.6.4 In interview, Antoni said that they had been arguing, and he had become angry with Alicja. He said that they had gone to get some food from the pizza shop. She then sat on the floor, and when he had tried to drag her to her feet, it resulted in him dropping the food. He admitted kicking her in the backside out of frustration but also said that Alicja had slapped him across the face. However, he said he did not wish to pursue this allegation.

4.6.5 As the witness statements did not corroborate the initial report to the police that Antoni had been kicking Alicja in the head, he denied it, and she said that it had not happened; therefore, on CPS advice, he was released with no further action.

4.6.6 In April 2020, the police were called to a report of a Polish couple fighting in the street and in the house. The caller described them struggling with one another, with the female trying to get the male out of the house, and the male trying to get back in. The caller said that, at one point, he saw the male punch the female in the stomach and put his hand around her neck. The police attended, but the couple denied that anything had happened. They said that it must have been someone else, and no complaints were made.

4.6.7 In November 2020, Alicja called the police and reported that she had been assaulted by Antoni. She said that, whilst in the house, Antoni had punched her in the face. She said that the couple had been arguing after having a drink, and Antoni had punched her in the face. She had no visible injuries. When the police arrived, she said that she had panicked and called the police but did not now wish to make a complaint. She was going to stay at her brother's house, and her mother was going to stay with the children. No further action was taken, and the risk was identified as medium risk.

4.6.8 Finally, when Alicja was being transported to custody after the fatal incident, she said that Antoni 'punches her every day'. She reiterated this in interview, saying that he used to 'beat her up' and had hit her prior to her stabbing him.

4.7 **Incidents where both were aggressor and victim**

4.7.1 In 2016, the police were called by Antoni, and he said that Alicja had attacked him, and he had hit her back. It was established that they were having a birthday party for their child. Both were heavily in drink. When they had returned home, Alicja had become abusive, and they had begun to argue in the street. Antoni said that when they went indoors, Alicja had punched him to his mouth, causing a small cut. Antoni had then punched Alicja, causing reddening to her face.

4.7.2 Antoni was arrested and made a full admission to punching Alicja, but he did say that Alicja had assaulted him first. He received a police caution for this offence. No action was taken against Alicja, as she was dealt with as the victim. A risk assessment deemed it to be medium risk.

4.7.3 A witness reported that they had witnessed domestic incidents between Alicja and Antoni, with them pushing and shoving each other and, on occasions, 'really going for each other having full fights where they have punched and kicked each other'.

4.8 **Concerns of Alicja's mother**

4.8.1 A few days after the incident in December 2020, Alicja's mother attended the police station. She was spoken to through an interpreter and said that she was worried about her daughter and grandchildren, as Antoni drinks and shouts at her. Alicja's mother potentially put herself at risk by attending the police station: an indication of just how seriously she viewed the situation.

4.8.2 When she spoke to the social worker in January 2021, she said that things had calmed down, but that she was worried about the effect on the children from the arguing and drinking. She was worried what would happen if she had to go back to Poland. She was told that the couple would be asked to complete work about the impact of domestic abuse and alcohol. She was given a number that she could call if she was worried, and she was happy with this plan.

4.9 **Possible sexual abuse**

4.9.1 In August 2020, Alicja attended hospital with a labial tear that she said was post coital. The IMR author and those who were interviewed, felt that this was not a plausible explanation for a tear needing seven stitches and was unlikely to have occurred because of regular intercourse. No questions were asked about domestic abuse, and there was a distinct lack of professional curiosity. Whilst the review can draw no conclusion about how this occurred, the possibility of sexual abuse cannot be ignored.

4.10 **Who was the victim and who was the perpetrator?**

4.10.1 This is not a straightforward question to answer. If the potential sexual abuse is taken as evidence of abuse, then the serious nature of this would incline one to believe that Antoni was predominantly the perpetrator.

4.10.2 On the other hand, the CPS lawyer who reviewed the incident in February 2020, expressed the view that, on that occasion, Alicja should have been cautioned rather than Antoni.

4.10.3 Situational couple violence is described by Johnson (2008)[7] as having a completely different dynamic to intimate terrorism (that is embedded in a general pattern of coercive control). Situational couple violence is the type of violence that is not about general control but comes from an escalation of specific conflicts. Websdale (2010)[8] expands on Johnson's description and says that in these scenarios, violence is not used by either party as an ongoing campaign to intimidate or strictly regulate the partner.

4.10.4 Johnson asserts that, in the case of frequent situational couple violence, the relationship may involve areas of conflict that continue to be unresolved and either or both partners may regularly choose to resort to violence in the context of these conflicts.

4.10.5 We do not know enough about the relationship between Antoni and Alicja to know if there was coercion and control from one to the other, but there is sufficient evidence to suggest that both were responsible for the violence between them. It would also be speculation to consider what might have been the cause of the violence between them; however, we do see that on each occasion when the police were called, either Antoni, Alicja or both were described as in drink. When Alicja's mother spoke to both the police and social services, she intimated a link between alcohol and the physical abuse.

4.10.6 Research has found that between 25% and 50% of those who perpetrate domestic abuse, have been drinking at the time of the assault[9], and cases involving severe violence are twice as likely to include alcohol[10].

### 4.11 Support offered to Antoni and Alicja

4.11.1 It is noted that at neither of the incidents in 2013 and 2016, was Alicja given any details about domestic abuse services available to her. However, in 2020, Alicja was offered a referral to domestic abuse services; however, she declined this.

**The review is satisfied that, in the intervening years, training has taken place, and officers now understand the importance of offering a referral to domestic abuse services.**

> That said, when Alicja declined a referral to domestic abuse services, it would have been good practice to leave the details with her, in case she later decided that this was something she wished to pursue.

**Recommendation 8**

**It is recommended that all officers are reminded of the importance of not only offering a referral to domestic abuse services but also leaving details with a victim who declines a referral.**

4.11.2 On each occasion that the police were called, it was noted that one or both were in drink. There is no evidence that details about alcohol support services were provided.

[7] Johnson M P, A Typology of Domestic Violence, Northeastern University Press, 2008
[8] Websdale N, Familicidal Hearts, Oxford University Press, 2010
[9] Bennett L and Bland P, Substance Abuse and Intimate Partner Violence, National online recourse centre on violence against women, cited in Alcohol, Domestic Abuse and Sexual Assault, 2014, Institute of Alcohol Studies
[10] McKinney C et al (2008), Alcohol Availability and Intimate Partner Violence Among US Couples, cited in Alcohol, Domestic Abuse and Sexual Assault, 2014, Institute of Alcohol Studies

**Recommendation 9**

**It is recommended that officers are reminded to provide details of alcohol support services.**

4.12 **DASH risk assessments and referrals to MARAC**

4.12.1 During its discussions, the panel was concerned that each of the DASH risk assessments completed, were graded as medium. There was a concern that each incident was taken in isolation, and the cumulative effect of repeat incidents was not identified.

4.12.2 The DASH risk assessments were completed as follows:

- December 2013
- April 2016
- February 2020
- November 2020

4.12.3 The review asked for an explanation about how incidents were assessed, and decisions made to refer to MARAC.

4.12.4 Officers attending a report of domestic abuse will have to complete a DASH as standard procedure. This is to be completed with the victim to ensure the correct information is recorded. This DASH will provide a risk grading of standard, medium, or high, depending on the number of 'yes' answers given and professional judgement. All officers are trained to complete a DASH risk assessment.

4.12.5 Once completed, this risk assessment is submitted through to the Vulnerability Hub (at the time of the homicide, this went to the Domestic Abuse Unit who are now part of this team). Here, a secondary risk assessment is conducted. This secondary assessment is a more comprehensive review and will look at, for example:

- Any previous domestic abuse history
- Frequency and severity of offending, including any escalation or identifiable tigger events (break up, children, etc.)
- Alcohol and drug dependency
- Engagement with support services.

This list is not exhaustive.

4.12.6 This then forms part of the secondary risk grading. If the grading is high, then a referral to MARAC will be made, as well as any other referrals as required/appropriate (Children's Social Care, etc.).

**The review notes that, as the risk was assessed as medium on each occasion, no referral was made to MARAC. The timeframe between each incident reported was not short enough for a possible escalation in incidents to be considered.**

4.13 **Male victims of domestic abuse**

4.13.1 The report has already considered the prevalence of domestic abuse amongst men; however, in this section, the review will explore this in more detail. The review is less

concerned with the numbers of men who experience domestic abuse and more with the *impact* that domestic abuse has on them. The impact of domestic abuse on men cannot be underestimated. Tsui (2014)[11] found that men reported suffering physical injuries, loss of self-worth, and suicidal ideation. Despite these findings, the status of 'victim' does not seem to apply to men and women equally (Seelau, Seelau and Poorman, 2003)[12]. It may be that these attitudes are influenced by social constructed normative perceptions of masculinity and femininity. Gender-based stereotypes portray that men are dominant, strong, and aggressive – more compatible with the role of the abuser. Women are portrayed as weaker, more vulnerable, and in need of protection – more in line with the role of victim[13].

4.13.2 Some researchers have suggested that one of the problems in understanding the domestic abuse experienced by men, is where it is positioned in the debate. It has been said that, generally, the experiences of men are compared with the experiences of women, when it is more meaningful to compare the experience of an abused man with the experience of a non-abused man[14]. Hester et al. (2015) found that men experiencing domestic abuse, exhibit anxiety and depression two or three times greater than those with no domestic abuse experiences[15].

4.13.3 To understand men's experience of domestic abuse, particularly coercive and controlling behaviour, it is important that we accept that men *experience* this in different ways to women. It is well documented that, for women, one of the overwhelming effects of abuse and coercive control, is fear and the danger that the abuse leads them to fear. Nyberg (2014) found that, based on interviews with men who had experienced domestic abuse, men talked about the greater impact of emotional behaviour rather than fear. In particular, the aspects of being belittled and humiliated, which they reported that their female partners were using to control them[16]. Research undertaken by Hester et al. (2017) concluded that men do not experience abuse that is fear-inducing or dangerous, but they did feel sad and had to watch what they said or did, and it affected the sexual aspect of their relationships.[17] It could be argued that the emotional behaviour the men experienced was situated in a wider patriarchal context where, as a consequence, the men felt their positioning as men slighted and undermined and their 'entitlement' dented, but did not feel in fear or danger of their life (Hester, 2010)[18]. Langhinrichsen-Rohling (2010) suggested that a typology that equates coercive control with fear as a determining factor, may underestimate the prevalence of interpersonal violence experienced by men – as men are socialised not to express vulnerability[19].

4.13.4 Nyberg raises the question of whether there needs to be another way of categorising men's experiences of domestic violence and abuse – placing greater emphasis on emotional abuse. Over the past few years, there has been debate (bordering on antagonism) between those who work with female and male victims of domestic abuse. These debates have tended to polarise the subject of gender-based domestic abuse and can be in danger of suggesting that abuse by one or other is greater or more important. To redefine the abuse in a way that

[11] Cited in Bates, Elizabeth, 'Walking on Eggshells': a qualitative examination of men's experiences of intimate partner violence, 2019, University of Cumbria
[12] Ibid
[13] Ibid.
[14] Herzberger 1996 cited in Bates, Elizabeth A (2017), Hidden victims: men and their experience of domestic violence, University of Cumbria
[15] Is coercive controlling violence? A cross-sectional domestic violence and abuse survey of men attending general practice in England, Hester et al., 2017, University of Bristol
[16] Cited in Ibid.
[17] Ibid.
[18] Cited in Ibid.
[19] Cited by Professor Louise Graham-Kevan, University of Central Lancashire, in a presentation Male Victims of Coercive Control (July 2021)

acknowledges the abuse experienced by men and the impact that it has on them, may go some way to redressing the argument and allow debate (and more importantly, support) in a less emotive way. To find a means of describing men's abuse may go some way to reduce the challenge of those campaigning on behalf of female victims that say: 'but what about men?'

4.13.5 Domestic abuse is abhorrent regardless of who is experiencing it. To find a way to explain and frame the abuse experienced by men, in a way that is more meaningful for them, rather than to 'lump' them into the women's sector and leave them saying: 'what about us?', would be far more constructive and empowering for both men and women. Mankind Initiative has called for the 21st century approach to be – Gender-informed, Gender Inclusive, and Non-ideological[20].

4.13.6 The legal definition acknowledges the gender neutrality of domestic abuse. However, the review notes that domestic abuse and coercive control are based, in Government policy, under the Violence Against Women and Girls strategy: this further contributes to the 'them and us' mentality, which is unhelpful and detracts from the important issues.

**Recommendation 10**
**It is recommended that the Home Office revisits the positioning of domestic abuse and coercive control experienced by men, in order that it is understood in its own context and not in conflict with abuse experienced by women.**

4.14 **Services for men in North East Lincolnshire**

4.14.1 Women's Aid NEL[21] provides support for both men and women, with access to their support workers. Details are provided of the national Male Advice and Enquiry Line.

4.14.2 However, a review of the website indicates that it is not clear that support is available to men as well as women. Details were found in the following places:

- *Support available* – seventh item
- *Domestic Abuse* – 'Who are the victims?'
- *Domestic Abuse* – 'Male victims of domestic abuse? (The last item at the bottom of the page).

**The review considers that, having found the Women's Aid NEL site on an internet search, it would assume that it is for women and would probably not search through the site to find the sections above.**

**Recommendation 11**
**It is recommended that Women's Aid NEL considers making it clearer on their website, particularly on the home page, that support is also provided to male victims.**

**Recommendation 12**
**It is recommended that the visibility of support available to male victims is increased.**

[20] Mark Brookes, Mankind Initiative, July 2021
[21] https://www.womensaidnel.org/

# Section Five – Further Analysis

5.1 **THE PART THAT THEIR ETHNICITY AND CULTURE PLAYED**

5.1.1 In this section, the review will consider how those from Eastern European countries may be impacted by the intersection of their culture with UK culture and services, particularly in relation to domestic abuse.

5.1.2 **Language barriers**

5.1.3 English was not the first language for Antoni, Alicja, or their families, and this may have impacted on their ability to understand material that was available to them.

**Recommendation 13**
**It is recommended that, as part of the Family Hub Transformation Project, printed and online materials are generated in Polish and other languages.**

**Recommendation 14**
**It is recommended that in future, domestic abuse commissioning specifications include a requirement for key messages to be provided in common languages, and the use of translation services to be incorporated.**

5.1.4 **Understanding domestic abuse**

5.1.5 It is important that we remember when we are supporting victims of domestic abuse from Eastern European countries that their understanding of what is abuse will be significantly impacted by the difference in the law.

5.1.6 The review has been informed that home and marriage are seen as a private place, and victims can struggle to understand that the police would be interested in their abuse and would act. They do not realise that they can call the police.

5.1.7 The report has discussed earlier, the challenges of language and the need for an increased use of interpreters; however, the review considers that the issue of language goes much further, and is more complex, than just providing an interpreter would address.

5.1.8 The review acknowledges the frustrations that practitioners will face in trying to access interpreting services when they need them. Whilst there is no indication in the information provided to this review to suggest that Alicja or Antoni were ever asked to bring along someone to interpret for them, it is imperative that all practitioners fully understand the danger of this, albeit that it might have been suggested with the best of intentions. Family members should never be used for interpreting.

5.1.9 Even when an interpreter is used, it is crucial that services understand that there is not a word in Polish that describes domestic abuse in the sense that we would mean. There is no direct translation for 'isolation' or for 'coercive control'. Therefore, it is not sufficient to just ask if a person has experienced domestic abuse. We must adjust our language so that we are sure that we are talking about the same things. Practitioners should take time to be more specific in their questions and take the time to give examples. If the person continually

says that 'yes they understand', then this may be an indication that they do not, in fact, understand and should not be taken at face value.

**Recommendation 15**
**It is recommended that all agencies provide a briefing for their staff – clearly explaining the need to bear in mind the misunderstandings that can occur because of the lack of translation for 'isolation' and 'coercive control'.**

**Recommendation 16**
**It is recommended that the requirement to use professional interpreters is added to training.**

**Recommendation 17**
**It is recommended that Information is provided, in commonly spoken languages, on what domestic abuse is (including controlling behaviours), navigating services, and myth busting.**

**Recommendation 18**
**It is recommended that a multi-lingual awareness raising poster is designed, which uses the commonly spoken languages on one page.**

5.1.10 It is important to understand that, as in the UK, there is a level of stigma attached to disclosing difficulties such as mental health or substance misuse. There is a fear of judgement by their own community. For example, if a mother shares problems that her children may be having, that are a normal part of childhood development, they will be seen as a bad mother.

5.1.11 **Isolation and coercive control**

5.1.12 When a family moves to the UK, they may experience isolation from life in the UK. For women experiencing domestic abuse, this isolation may mean that they do not know where to go to buy food or access medical treatment, even from emergency services. Families may struggle in communicating with their children's schools. Women experiencing coercive control, may be told, for example, that they can only go to culturally specific shops.

5.1.13 Those experiencing coercive control, may be told by their abuser that if they go to the police to report abuse, they will be asked about their nationality and then be told that they don't respond to those from Europe, due to Brexit.

5.1.14 Those with limited English have little means to check out what they have been told and will find themselves living in a bubble created by their partner.

5.1.15 **Access to services and support**

5.1.16 In Eastern European countries, very few services for victims of domestic abuse exist, so there will be little expectation or understanding about what support might be available.

5.1.17 They will not understand that many services are independent and confidential. Those seeking to offer support, must make it very clear if the service is independent and/or confidential. For example, if an IDVA (Independent Domestic Violence Advocate) tries to contact a victim, their job title alone will lead to misunderstanding and distrust. The word advocate is problematic and will be perceived to mean that the person is a solicitor.

5.1.18 As discussed earlier, victims of domestic abuse may be judged harshly by their family and friends. When it then comes to speaking to agencies, such as Children's Social Care, they will expect them to judge them too. There is a strong misconception that CSC will be assessing the family with a view to removing the children. This fear leads to a reluctance to engage with any statutory agency, including the children's school. Not only are they reluctant to disclose domestic abuse but will avoid discussing the normal developmental issues that children face. This leads to them not receiving the support that they need.

5.1.19 The issue of alcohol consumption is viewed differently by those from Eastern Europe and is seen as much more acceptable. Those affected may be reluctant to access services as they may not see that there is a problem, or they may fear being seen as 'crazy'.

5.1.20 We know that Antoni and Alicja consumed alcohol to the extent that they were described as 'in drink'. This may not have been seen as a problem by the couple because, like with many families, the husband/father may be a 'functioning alcoholic', in that they go to work and are able to maintain relationships outside the family home, but they are then drinking excessively every night. As they are working and bringing money into the home, this is not seen as a problem.

## 5.2 THE IMPACT OF COVID-19 LOCKDOWN

5.2.1 During the first COVID-19 lockdown, Alicja had a virtual appointment with the breast clinic. The impact of COVID-19 on the delivery of this service, has been discussed earlier in the report.

5.2.2 The couple were not impacted by COVID-19 in any other interactions with services.

5.2.3 As the review has not been able to speak with Antoni or Alicja's family, it is not clear the extent to which the couple's relationship was impacted by the enforced lockdown and the additional pressures that this would have placed on the family.

5.2.4 That said, we know from a witness account, that early in lockdown, there was an altercation between Antoni and Alicja on the doorstep of their home that resulted in Alicja being assaulted. Another witness told the homicide investigation that the arguments between Alicja and Antoni had become more frequent in 2020.

5.2.5 In November 2021, Alicja's mother was concerned enough about the situation in the home that she went to the police station to seek advice, despite not speaking English. This suggests that, as she told the police, she was significantly concerned for her daughter and grandchildren.

5.2.6 Although it would be wrong to speculate how this relationship might have been impacted by lockdown, research does cast some light on the potential impacts that might have existed. Women's Aid's survey[22] found that 66.7% of those surveyed said that their abuser had started using lockdown restriction, or the virus and its consequences, as part of the abuse. More than half said that they had experienced deteriorating mental health, which left them feeling less able to cope with the abuse. 61.3% of women reported that the abuse that they

[22] A Perfect Storm: The Impact of the Covid-19 Pandemic on Domestic Abuse Survivors and the Services Supporting Them, Bristol, Women's Aid. 2020

experienced got worse during lockdown. This finding was especially true for those living with their abuser.

5.2.7 As has previously been discussed, the review has noted that all the reports of abuse occurred when one or both were in drink. We cannot know if the couple increased the amount of alcohol that they consumed during lockdown, but research[23] has identified that 36% of people increased their alcohol consumption and 42% reported no change. Only 22% decreased the level of alcohol consumption in lockdown. The research also found that a quarter of adults increased their drinking frequency.

## 5.3 OPERATION ENCOMPASS[24]

5.3.1 Operation Encompass is a police and school early intervention safeguarding information sharing partnership that supports children experiencing domestic violence and abuse. The scheme ensures that when the police attend crimes/incidents and there are school age children in the home/family, the information is shared with the school **prior** to the start of the next school day. (Incidents over the weekend are shared on a Monday morning, and all incidents in school holidays are also shared).

5.3.2 Incidents are reported through Operation Encompass, regardless of the risk level.

5.3.3 Notifications are received via an email inbox that is managed by the education team within NE Lincolnshire Council. They are then sent to the Designated Safeguarding Lead within the relevant schools.

5.3.4 This information is shared in order that the children can be appropriately supported without putting anyone at risk. Operation Encompass began in NE Lincolnshire in 2017.

> Records indicate that there was no Operation Encompass referral to the children's school after the incident in February 2020. Had they been notified in February 2020; support could have been provided to the children.

5.3.5 The school notes that they received an Operation Encompass notification in November 2020. It is also noted that this was the first indication that the school had of domestic abuse in the family.

5.3.6 The review has been advised that Humberside Police are now implementing a Vulnerability Hub. Furthermore, as part of its implementation, PiT Stop (Partner Information Triage) meetings have been introduced. These daily, multi-agency triage meetings are held to look at incidents where lower/earlier intervention can be provided to families to prevent escalation to complex services. Police incidents are triaged by the partner agencies to identify the most appropriate support.

5.3.7 As part of this implementation, it has been identified that Operation Encompass notifications are not shared with the Integrated Front Door (CSC), as many will not meet the threshold for

[23] Winstock et al. (2020) cited in The effect of COVID-19 on alcohol consumption, and policy responses to prevent harmful alcohol consumption, OECD, May 2021

[24] https://www.operationencompass.org/

partner agencies' referrals (level 3). Operation Encompass notifications are not, therefore, routinely shared with an allocated social worker if there is one.

5.3.8 To ensure that all incidents that may not have precipitated a partner referral to complex services, are considered alongside information held by partner agencies.

5.3.9 The daily triage of domestic abuse incidents at PiT Stop, for those who are not open to services or who are open to lower-level services, may ensure that patterns of domestic abuse are recognised, which could have a cumulative impact over the longer term.

5.3.10 The perceived risk assessment made by police can then be reassessed alongside other information. This may lead to a requirement for the family to receive specific support to prevent escalation to complex/safeguarding services being identified and implemented.

5.3.11 Operation Encompass notifications for families open to the CSC Safeguarding team, are shared with the allocated social worker.

**The review recognises this good practice but notes that this enhanced approach to using information gathered through Operation Encompass, will only be effective if notifications are raised appropriately and consistently.**

# Section Six – Lessons Identified

6.1 **Humberside Police**

6.1.1 There was, on occasions, a lack of professional curiosity demonstrated by officers when speaking to Alicja and reviewing previous incidents.

6.1.2 When Alicja was offered a referral to domestic abuse services, and she declined, it would have been good practice to leave her the details of support available.

6.1.3 Despite both Antoni and Alicja being in drink when seen by the police, no details were provided of support services.

6.2 **Northern Lincolnshire and Goole NHS Foundation Trust (NLaG)**

6.2.1 Professionals need to be more inquisitive and professionally curious about how injuries are sustained, and to document the explanations.

6.2.2 There were times when the use of an interpreter would possibly have led to a better understanding (by practitioners) of the situation. An interpreter should be used when a language barrier is identified, to enable a better understanding of the situation.

6.2.3 The lack of recognition of the extent of the injuries and causative factors not explored, highlights the need to seek advice and support from the safeguarding team to support signposting and referral.

6.3 **North East Lincolnshire Council – Children's Social Care**

6.3.1 When carrying out assessments in cases of domestic abuse, both parties should be seen separately to allow for more open disclosure.

6.3.2 That there is a need to improve the information that is available for those for whom English is not their first language.

# Section Seven – Recommendations

7.1 **Humberside Police**

7.1.1 That children are visible in domestic abuse cases, that any children are fully documented, and referrals are then gmade.

7.1.2 That when a third-party attends to report domestic abuse, that consideration is given to whether an officer should attend and obtain the details.

7.1.3 That all officers are reminded of the importance of not only offering a referral to domestic abuse services but also leaving details with a victim who declines a referral.

7.1.4 That officers are reminded to provide details of alcohol support services.

7.2 **Northern Lincolnshire and Goole NHS Foundation Trust (NLaG)**

7.2.1 That, via training and supervision, staff are reminded that when an adult presents to ED with injuries and concerns/behaviours that could impact on the care of dependents, a discussion is to be held with the safeguarding team to support with appropriate signposting and referral.

7.2.2 That the Trust implements a Quality Improvement Project designed to encompass and discuss selective/routine enquiry for both male and female patients across the Trust.

7.2.3 That training is provided by the Independent Sexual Abuse Advocate and Humberside Sexual Assault Centre to gynaecological and A&E staff, to increase awareness of the service

7.2.4 That a supply of literature in key languages is made available to staff to use within the Trust, together with promotion of the use of interpreting services.

7.3 **North East Lincolnshire Council**

7.3.1 That in cases of domestic abuse, partners are always seen separately as part of Children's Social Care assessments.

7.3.2 That the visibility of support available to male victims is increased.

7.3.3 That, as part of the Family Hub Transformation Project, printed and online materials are generated in Polish and other languages.

7.3.4 That in future, domestic abuse commissioning specifications include a requirement for key messages to be provided in common languages, and the use of translation services to be incorporated.

7.3.5 That the requirement to use professional interpreters is added to training.

7.3.6 That information is provided, in commonly spoken languages, on what domestic abuse is (including controlling behaviours), navigating services, and myth busting.

7.3.7 That a multi-lingual awareness raising poster is designed, which uses the commonly spoken languages on one page.

7.4 **Home Office**

7.4.1 That the Home Office revisits the positioning of domestic abuse and coercive control experienced by men, in order that it is understood in its own context and not in conflict with abuse experienced by women.

7.5 **Women's Aid NEL**

7.5.1 That Women's Aid NEL considers making it clearer on their website, particularly on the home page, that support is also provided to male victims.

7.5.2 That the visibility of support available to male victims is increased.

7.6 **All Agencies**

7.6.1 That all agencies provide a briefing for their staff – clearly explaining the need to bear in mind the misunderstandings that can occur because of the lack of translation for 'isolation' and 'coercive control'.

# Section Eight – Conclusions

8.1 This review has been unable to engage with the families of those involved. As such, it has had to rely largely upon the information contained within agency records. It has, however, been helped enormously by the inclusion of a panel member able to advise specifically upon the challenges faced by people for whom this is not their country of origin.

8.2 The facts of the case are simple. Following an argument at a family barbecue, Antoni was followed out into the street by Alicja, who stabbed him to death. It is accepted that earlier in the day, Antoni had assaulted Alicja. The couple's relationship was littered with violence, and Antoni had been previously arrested for assaults upon her. He seems to have been identified as the aggressor in most of the previous incidents.

8.3 There had been a number of opportunities to better understand the level of violence and abuse within the household. In particular, when Alicja's mother sought help.

8.4 The welfare of the couple's two children does seem to have been prioritised, and referrals were made to schools and Children's Social Care when necessary.

8.5 The language barrier does appear to have resulted in a lack of professional curiosity in some of the incidents, and the services available to staff to help translate and thus obtain a clearer picture of what was going on, were not always utilised.

8.6 The issue of explaining that domestic abuse is not only about physical assault, is something that all agencies need to continually educate staff upon. This is particularly relevant when the person they are engaging with does not originate within the UK, as similar behaviours are not always considered criminal offences in other countries.

8.7 We make a number of recommendations within this review that we feel will make the future safer for others.

# Appendix One – Terms of Reference

**NORTH EAST LINCOLNSHIRE COMMUNITY SAFETY PARTNERSHIP**

**Terms of Reference for the Domestic Homicide Review into the death of Antoni**

1 **Introduction**

1.1 This Domestic Homicide Review (DHR) is commissioned by North East Lincolnshire Community Safety Partnership in response to the death of Antoni, which occurred in April 2021.

1.2 The review is commissioned in accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.3 The Chair of the Partnership has appointed Gary Goose MBE and Christine Graham to undertake the role of Independent Chair and Independent Report Author, respectively, for the purpose of this review. Neither Christine Graham or Gary Goose is employed by, nor is otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

2 **Purpose of the Review**

The purpose of the review is to:

2.1 Establish the facts that led to the death of Antoni, and whether there are any lessons to be learned from the case about the way that professionals and agencies worked together to safeguard him.

2.2 Identify what those lessons are, how they will be acted upon, and what is expected to change as a result.

2.3 Apply these lessons to service responses, including changes to inform national and local policies and procedures, as appropriate.

2.4 Establish whether agencies have appropriate policies and procedures to respond to domestic abuse, and to recommend any changes as a result of the review process.

2.5 Contribute to the understanding of the nature of domestic abuse.

3 **The Review Process**

3.1 The review will have regard to the Statutory Guidance for Domestic Homicide Reviews, under the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

3.2 This review will be cognisant of, and consult with, the criminal investigation into Antoni's death and the process of inquest held by HM Coroner.

3.3 This review will identify and liaise with other parallel processes that are ongoing or imminent, in relation to the homicide, in order that there is appropriate sharing of learning.

3.4 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable: that is a matter for the criminal and coroner's courts.

## 4 Scope of the Review

The review will:

4.1 Draw up a chronology of the involvement of agencies involved in the life of Antoni, to determine where further information is necessary. Where this is the case, Individual Management Reviews will be required by relevant agencies, defined in Section 9 of the Act.

4.2 Produce IMRs for the time period from 1st January 2012 to the date of the homicide.

4.3 Invite responses from other relevant agencies, groups or individuals identified through the process of the review.

4.4 Consider the impact of COVID-19 on service delivery.

4.5 Consider the impact of COVID-19 lockdown on the relationship.

4.6 Consider the ethnicity of the couple and how this might have impacted on their access of services.

## 5 Family Involvement

5.1 The review will seek to involve Antoni's family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

5.2 We will seek to agree a communication strategy that keeps families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support, and any existing arrangements that are in place to do this.

5.3 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews, thereby avoiding duplication of effort and minimising their levels of stress and anxiety.

## 6 The Overview Report

6.1 The review will produce a report that summarises the chronology of events, including the actions of involved agencies, analyses, and comments on the actions taken. The report will make any required recommendations regarding safeguarding of individuals where domestic abuse is a feature.

6.2 Aim to produce a report within the timescales suggested in the Statutory Guidance, subject to:

- guidance from the police as to any sub-judice issues,
- sensitivity in relation to concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

## 7 Legal Advice and Costs

7.1 Each statutory agency will be expected to inform their legal departments that the review is taking place. The costs of legal advice and involvement of their legal teams are at their discretion.

7.2 Should the Independent Chair, Chair of the CSP, or the Review Panel require legal advice, then North East Lincolnshire CSP will be the first point of contact.

## 8 Media and Communications

8.1 The management of all media and communications matters will be through the Review Panel, escalating to the CSP chair as necessary.

Gary Goose and Christine Graham
Independent Chair and Overview Report Author

# Appendix Two – Ongoing Professional Development of Chair and Report Author

1. Christine has attended:
   - AAFDA Information and Networking Event (November 2019)
   - Webinar by Dr Jane Monckton-Smith on the Homicide Timeline (June 2020)
   - Ensuring the Family Remains Integral to Your Reviews – Review Consulting (June 2020)
   - Domestic Abuse: Mental health, Trauma and Selfcare, Standing Together (July 2020)
   - Hidden Homicides, Dr Jane Monckton-Smith, AAFDA (November 2020)
   - Suicide and domestic abuse, Buckinghamshire DHR Learning Event (December 2020)
   - Attended Hearing Hidden Voices: Older victims of domestic abuse, University of Edinburgh (February 2021)
   - Domestic Abuse Related Suicide and Best Practice in Suicide DHRs, AAFDA (April 2021)
   - Post-separation Abuse, Lundy Bancroft, SUTDA (April 2021)
   - Ensuring family and friends are integral to DHRs, AAFDA (May 2021)
   - Learning the Lessons: Non-Homicide Domestic Abuse Related Deaths, Standing Together (June 2021)
   - Suspicious Deaths and Stalking, Professor Jane Monckton-Smith, Alice Ruggles Trust Lecture (April 2021)
   - Reviewing domestic abuse related suicides and unexplained deaths, AAFDA (May 2021)
   - Young people and stalking: Reflections and Focus, Dr Rachel Wheatley, Alice Ruggles Trust Lecture (May 2021)
   - Giving children a voice in DHRs – AAFDA (November 2021)
   - Cross Cultural Training Webinar – Incels and Online Hate – HOPE Training (November 2021)
   - Male victims of domestic abuse, Buckinghamshire DHR Learning Event (January 2022)
   - Older victims of domestic abuse, Dr H Bows, DHR Network (February 2022)
   - Enhancing the cancer workforce response to domestic abuse – Standing Together and Macmillan (April 2022)

2. Christine has completed the Homicide Timeline Online Training (Five Modules), led by Professor Jane Monckton-Smith of University of Gloucester.

3. Gary and Christine have:
   - Attended training on the statutory guidance update (May 2016)
   - Undertaken Home Office approved training (April/May 2017)
   - Attended Conference on Coercion and Control (Bristol, June 2018)
   - Attended AAFDA Learning Event (Bradford, September 2018)
   - Attended AAFDA Annual Conference (March 2017, 2018 and 2019)
   - Attended Mental Health and Domestic Homicides: A Qualitative Analysis, Standing Together (May 2021)
   - Attended AAFDA DHR Chair Refresher Training (August 2021)
   - Commissioned bespoke training on DHRs and Suicide, Harmless (March 2022)
   - Attended Strangulation and Suffocation: Introduction to the new offence for England and Wales, Training Institute of Strangulation Prevention (July 2022)