DOMESTIC ABUSE FATALITY REVIEW

Community Safety Partnership

Report into the death of Aneta
October 2020

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Glossary

AAFDA: Advocacy After Fatal Domestic Abuse
ICB: Integrated Care Board
CSP: Community Safety Partnership
DASH: Domestic Abuse, Stalking and Honour-based violence risk identification check list
DHR: Domestic Homicide Review
EMAS: East Midlands Ambulance Service
FreeVA: Free from Violence and Abuse
GP: General Practice / General Practitioner
IDVA: Independent Domestic Violence Adviser
IMR: Individual Management Review
IPV: Intimate Partner Violence
IRIS: Identification and Referral to Improve Safety
MARAC: Multi Agency Risk Assessment Conference
NGH: Northampton General Hospital
UAVA: United Against Violence & Abuse

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OVERVIEW REPORT INTO THE DEATH OF ANETA, OCTOBER 2020

Preface

The Independent Chair and the Panel members offer their deepest sympathy to all who have been affected by the death of Aneta[1], and thank them, together with the others who have contributed to the deliberations of the Review, for their participation, generosity of spirit and patience.

The Review Chair thanks the Panel for the professional manner in which they have conducted the Review and the report authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies. Particular thanks are due to the Domestic and Sexual Violence Team for their impeccable administrative support.

1. Introduction

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

(a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or

(b) A member of the same household as herself;

with a view to identifying the lessons to be learnt from the death.

This report uses the statutory definition of domestic abuse introduced in the Domestic Abuse Act 2021.

1.2 The purpose of a DHR is to:

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

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

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

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

[1] Not her real name

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

f) highlight good practice.

1.3. Since 2016, the statutory guidance has been clear that DHRs should also be undertaken when there is a domestic abuse related suicide. In recognition of the fact that this report concerns a suicide and not a homicide, the term 'Domestic Abuse Fatality Review' has been used in place of DHR.

This report examines the circumstances leading up to the death of Aneta, a Polish national, aged 54, who took her life in October 2020. Aneta died in Leicester but had previously been sleeping rough in Northamptonshire. After she died, there was a period of discussion between the two relevant Community Safety Partnerships as to who would undertake the Review with the Home Office eventually determining that it should be Leicester.

Timescales

1.4 In May 2021, the Chair of the Community Safety Partnership (CSP) agreed with a recommendation put to him by the CSP's Domestic Homicide Review subgroup that a Review should be undertaken. This subgroup consists of safeguarding leads from partner agencies as well as the Team Manager of the Domestic & Sexual Violence Team at Leicester City Council. The Home Office was duly informed on 21st May. Family members of the victim were informed in June 2021. An independent Chair was appointed in July 2021 and the Panel met for the first time in August where Independent Management Reviews (IMRs) were commissioned, and agencies advised to implement any early learning without delay. Four further meetings of the Panel were subsequently held in October, November, February and April. Subsequent to that, drafts of the report were circulated electronically for comment with this being concluded in early July.

Local context

1.5. Domestic abuse is currently a priority for the Community Safety Partnership which ensures that a range of services are available locally. These include:

- Family and outreach services – 1-2-1, group work and support - aimed at children and their families as well as services for both men and women without children.
- Safe home and refuge services covering both advice and support to victims about housing options as well as safe refuge accommodation and support to live safely in their own homes
- The Jenkins Centre, an accredited behaviour change perpetrator programme for those using abusive behaviours towards an intimate (ex)partner as well as an intervention programme for young people aged 13-18 who are using abusive behaviours towards a partner, parent or carer
- An IDVA service who offer short term, intensive support and advocacy and who work closely with the local Multi-Agency Risk Assessment Conference (MARAC) and Specialist Domestic Violence Court.
- A local freephone helpline.

1.6. Local domestic abuse services in Northampton include:

- Northampton Domestic Abuse Service: Amongst other services, provides advice and guidance for individuals (aged 18+) who are subject to domestic abuse. Their helpline is open 24 hours.

- There is refuge provision across the county, including a male refuge and a drug and alcohol refuge.
- Voice (incorporating the Sunflower Centre) which provides free, confidential advice and support across crisis intervention, risk assessment and individual safety planning as well as advice and support on civil and criminal court proceedings.

2. Overview

2.1. Background and summary of the incident

Aneta, a Polish national was aged 54, when she took her own life in October 2020. At the time of her death, she was living alone in a refuge flat[2] in Leicester. Until relatively recently, however, she had been sleeping rough in Northamptonshire and had been in an on-off relationship with her partner, also a rough sleeping Polish national, since 2016. Aneta had two adult children but was largely estranged from them and had been for some time. Reports of domestic abuse had been made to authorities in both Northamptonshire and Leicestershire and Aneta had been in the company of her ex-partner the day before she died.

In late October 2020, Aneta took an overdose and left a farewell note. The police investigation found no suspicious circumstances.

3. Parallel reviews

3.1. An inquest was opened by Her Majesty's Coroner which concluded with a verdict of suicide caused by ingesting a combination of alcohol, codeine, sertraline[3] and other medications. The coroner was informed of the Review on 21st May 2021.

3.2 There were no other reviews or investigations.

4. Domestic Abuse Fatality Review Panel

4.1 The Panel was comprised of the following**:**

Organisation	Role	Name of Panel Member
-	Independent DHR Chair and report author	Davina James-Hanman
Accommodation Concern (Northants)	Chief Executive Officer	Jo
East Midlands Ambulance Service	Children and Young Person Safeguarding Lead	Liz
FreeVA- Free from Violence and Abuse	Head of Victim Services Member of the UAVA Consortium, Leicester	Claire

[2] Rather than the communal model, this refuge consisted of self-contained units with a staff presence and female security overnight on site.
[3] An anti-depression medication that Aneta had been prescribed.

Hope Centre (Northants)	Head of Service Delivery	Lee
Leicester City Council Housing Services	Service Manager Homelessness Prevention	Nicola
Leicester Integrated Care Board	Deputy Designated Nurse	Carol
Leicester City Council	Manager of the Domestic & Sexual Violence Team	Stephanie
Leicester City Council	Programme Manager, Mental Health, Public Health Co-Chair, Suicide Audit and Prevention Group, Leicestershire and Rutland	Mark
Leicestershire Police	Detective Inspector, Serious Case Review Partnership Manager	Chris / Ross
North Northants Council (Kettering)	Homelessness Manager	Claire
Northamptonshire Police	Detective Inspector Domestic Abuse Team (DAT), North Local Policing Area	Mark
Probation Service	Head of Probation Service in Leicestershire	Kaye
Project Polska	Chair, Project Polska	Barbara
Sunflower Centre (Northants)	Senior IDVA & Independent Stalking Advocacy Caseworker	Fiona
Turning Point (Substance Misuse)	Partnership Manager	Caroline
West Northants Council Safeguarding Adults	Safeguarding Adults Team Manager	Patricia
Women's Aid Leicestershire Ltd (WALL)	Chief Executive Officer Member of the UAVA Consortium, Leicester	Pamela

4.2 The Review Panel included the following agencies as expert/advisory panel members to ensure appropriate consideration to the identified characteristics and to help understand crucial aspects of the death:

- United Against Violence and Abuse (UAVA) and WALL as domestic abuse specialists
- Project Polska, a community organisation working towards improving the wellbeing of the Polish community in Leicestershire as the deceased and her ex-partner were both of Polish origin, and
- Turning Point, a charity supporting people who have complex needs including drug and alcohol misuse, mental health conditions, offending behaviour, primary care needs, housing and unemployment issues and people with a learning disability which are reflective of the issues faced by the subjects of this Review.

5. Independence

5.1. The author of this report, Davina James-Hanman, is independent of all agencies involved and had no prior contact with any family members. She is an experienced DHR Chair and is also nationally recognised as an expert in domestic violence having been active in this area of work for over three decades. Further details are provided in appendix B.

5.2. All Panel members and report authors were independent of any direct contact with the subjects of this Review and nor were they the immediate line managers of anyone who had had direct contact.

6. Terms of Reference and Scope

6.1. The full terms of reference can be found at appendix A. Following an initial scoping exercise, the Review Panel (and by extension, IMR authors) determined that the following issues would be considered:

6.2. In relation to this case, the specific lines of inquiry are:

a) To review the involvement of each individual agency, statutory and non-statutory, with:

- Aneta (the deceased) aged 54, a Polish national
- Kronos aged 46 (ex-partner of the deceased), a Polish national

between the dates of October 2017 (3 years prior to the date of the death) and October 2020 inclusive and to summarise agency involvement prior this time where relevant.

b) Analyse the communication, procedures, and discussions, which took place within and between agencies.
c) Analyse the co-operation between different agencies involved with any of the above named
d) Analyse the opportunity for agencies to identify and assess domestic abuse risk of death or serious injury.
e) Analyse agency responses to any identification of domestic abuse issues especially within the context of multiple needs.
f) Analyse organisations' access to specialist domestic abuse agencies.
g) Analyse the policies, procedures, and training available to the agencies involved on domestic abuse issues.
h) Analyse any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

i) Determine if organisational capacity had any impact on the services offered
j) Consider if there are any lessons to be learned about managing clients who move between different local authority areas
k) If there are any lessons arising from the process of undertaking this Review (e.g. a suicide rather than a murder, the cross-authority nature etc) which ought to be usefully highlighted to the Home Office.

6.3. Agencies were asked to search their records from October 2017 as this covered the period when most agency contact occurred. Events falling outside of this timeframe were summarised and appear in the narrative chronology below.

7. Confidentiality

7.1. At the time of writing, the findings of this Overview Report are restricted. Information is available only to participating officers/professionals and their line managers, until after the Review has been approved for publication by the Home Office Quality Assurance Panel. Aneta's adult children were invited to view a copy of the report, but only her daughter responded (see 8.6 below).

7.2 As recommended within the 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identities of those involved, pseudonyms have been used and precise dates obscured.

7.3 The Executive Summary of this report has also been anonymised.

7.4 This has not prevented agencies taking action on the findings of this Review in advance of publication.

7.5 Details of persons involved in this Review

Name	Sex	Age at the time of the incident	Relationship with victim	Ethnicity
Aneta	F	54	Victim	Polish
Kronos[4]	M	46	Ex-partner	Polish

Aneta had two children who were both adults when their mother died. Both live in Leicester but were largely estranged from her at the point of her death.

Dissemination

7.5 Subsequent to permission being granted by the Home Office to publish, this report will be widely disseminated including, but not limited to:

- Members of the Community Safety Partnership
- Police & Crime Commissioner for Leicestershire
- Ivan Cartwright, Coroner
- The Domestic Abuse Commissioner

[4] Not his real name. The pseudonym was chosen by the ex-partner.

- Kent and Medway Suicide Prevention Network
- Museum of Homelessness[5]
- Northants CSP
- The victim's family

7.6 Community Safety Partnership has adopted a DHR Learning and Improvement Framework which guides the implementation of learning from this - and other - DHRs. All recommendations are categorised, and early implementation is encouraged. A DHR subgroup of the Community Safety Partnership monitors the progress, on a quarterly basis, of implementing any recommendations which remain post-publication. The sub-group can also commission specific work to test the effectiveness of completed actions.

This subgroup also works to ensure the learning is disseminated and embedded. Amongst other activities, this includes:

- The production of a double-sided A4 Learning Summary Sheet of the key messages arising from each DHR
- The provision of free, half day 'Learning from DHRs' workshop sessions as part of the multi-agency Domestic & Sexual Violence Training Programme, administered by the Domestic and Sexual Violence Team.
- The production of a 'Briefing Presentation' for Safeguarding Leads, the Leicester, Leicestershire & Rutland Domestic and Sexual Violence Operational Group and other key stakeholders, to assist in the sharing of key messages within their own agencies/organisations.
- The incorporation of findings into the development and content of training on domestic violence and abuse.
- Using collated learning in campaign and promotional material developed by the Domestic and Sexual Violence Team, where appropriate.

7.7. All DHRs are published on a permanent hyperlink on Leicester's website: https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/public-safety/safer-leicester-partnership/domestic-homicide-reviews-dhrs/

8. Methodology

8.1. The table below sets out the written contributions made by each participating agency.

Organisation	Chronology	IMR	Summary report	Report not required
Police (Leicestershire & Northamptonshire)				
Women's Aid Leicestershire Ltd				
East Midlands Ambulance Service				
Leicester City ICB/GP				
Turning Point				
Accommodation Concern				
West Northants Council				
Leicestershire Partnership NHS Trust				
Leicester City Council Housing				

[5] This organisation maintains an online memorial to people who have died whilst homeless. This includes those in temporary accommodation at the time of their death.

FreeVA				
North Northamptonshire Council				
Northampton General Hospital				
Probation Service				
Hope Centre				
Sunflower Centre				
Project Polska				
Harborough District Council Housing Team				
UAVA				
Crown Prosecution Service				

8.2. All agencies providing a chronology had their interactions with Aneta and / or Kronos scrutinised even if they did not provide an IMR.

8.3. A further 46 agencies advised they had not had any contact with Aneta or Kronos. This included the UK Border Agency which would be indicative of them both entering the UK after 2004 (see also paragraphs 8.7.5 and 8.7.6).

8.4. This report is an anthology of information and facts gathered from:

- The reports detailed above
- Review Panel discussions
- Presentations made at the Review Panel meetings which included one on domestic abuse in the Polish community and one on suicide prevention.
- Relevant research (referenced in the text)
- Information provided by Kronos (see below) and Aneta's daughter

8.5. Community Safety Partnership is responsible for monitoring the implementation of the action plan (appendix C).

8.6. Involvement of family and friends

8.6.1. Aneta's two adult children were informed by the Community Safety Partnership of the decision to undertake a Review in June 2021. The relevant Home Office leaflet and information about AAFDA was also provided.

8.6.2. In August 2021, the newly appointed Chair wrote to both adult children setting out a variety of ways in which they may wish to participate in the Review. No response was received.

8.6.3. In March 2022, further contact was made to inform them that a draft copy of the final report was available should they wish to see it and to check if the chosen pseudonyms met with their approval. In April, Aneta's daughter made contact and asked a number of questions. She was offered, and accepted, a copy of the draft final report but did not wish to engage further.

8.6.4. Contact was also made with Kronos to which he responded, agreeing to have a telephone conversation. This took place in November 2021 with the assistance of an interpreter.

8.6.5. In this conversation, he shared the following:

- He said he had two children aged 26 and 24 and was now also a grandfather.
- He also said he had a house back in Poland and he had tried to get Aneta to return with him, but she had always said '*Not yet'*.
- Kronos said he arrived in the UK six years previously; Aneta came nine years ago after her marriage had broken down. She wanted to be closer to her son.
- He had moved to different areas of the UK (Northampton, Manchester and Birmingham before going back to Northampton), in various jobs including packing, cleaning and washing up.
- He stated he and Aneta met in Northamptonshire and for a time were living in Lutterworth on a caravan site.
- He claimed to have been in a continuous relationship with Aneta and to have never abused her – indeed to have never even argued *'I used to leave the room or walk away'.*
- Kronos said he did not know why she left and moved to Leicester but later said she had done so to gain a passport and to claim Universal Credit.
- He last saw Aneta the day before she died. They met in a park and spoke of normal things. He did not notice anything unusual in her presentation and could not think of a reason as to why she may have taken her own life.
- He finished by saying "*I miss her terribly – I miss her face".*

8.6.6. It should be noted that it has not been possible to verify much of the above, but where it has been possible, other evidence often contradicts Kronos's accounts. For example, records by various agencies recording Aneta's views contradict his assessment of their relationship. Her views were that she saw their relationship as on-off – at points describing herself as separated. There was also a period when Kronos was in prison for assaulting her (see paragraph 10.15) and Aneta was also seen with injuries at other times which she stated had been caused by Kronos, something he denies.

8.6.7. Efforts were also made to identify any friends of Aneta, but none were located.

9. Equality and Diversity

9.1. All nine protected characteristics[6] in the 2010 Equality Act were considered by the Review Panel along with consideration of other vulnerabilities which may have impacted on their circumstances. There were no grounds for assuming that age; gender reassignment; marriage; pregnancy or sexual orientation played a role in this case. There is no record of any formal religious affiliation or faith for either of them although in June 2020, Aneta did tell Northamptonshire police officers that she had previously thought about taking her own life but wouldn't because of her religious beliefs.

9.2. Three protected characteristics were found to have relevance. These were race, sex and disability.

9.3. Aneta was, and Kronos is, a Polish national. Both required interpreters although Kronos's English was slightly more advanced than Aneta's. As will be explored in the next section, this significantly impacted on their ability to access services and would not have helped in building trust to disclose personal matters. In one instance, information in English was left in Aneta's tent (see paragraph 10.3) with the hope that 'a friend' would translate it for her. Given that this was as a consequence of her being referred to MARAC, this was a substandard response. There were also several occasions when an interpreter was not

[6] These are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation

available immediately and a separate second appointment had to be made or Kronos was used. When Aneta was due to appear in court, reassurance that an interpreter would be available was not forthcoming. It has not proven possible to resolve where responsibility for this lies: Northampton Voice are adamant that an interpreter was booked within a week of receiving the case (early July) and the day before this, had called the refuge three times to no avail. The refuge is equally adamant that all voice mails were responded to. Voice has pointed out that an interpreter would always be booked for those requiring one; refuge staff were not aware of this – hence them seeking reassurance. Navigating systems when you do not speak the language is bewildering and confusing even when not in a state of trauma. Whilst there were some examples of good practice in response to Aneta not speaking English there were also occasions when she was badly let down.

9.4. In 2011, the most frequently reported country of birth of non-UK born Leicester residents was India (11 per cent, 37,224). Four per cent (12,392) were born in South and Eastern Africa (primarily Uganda) and 2 per cent (just over 7,000) in Kenya. In addition, almost 6,500 Leicester residents were born in Poland. This changing face of migration is due in part to the accession of 10 countries, including Poland, into the EU in 2004.

9.5. Leicestershire Police recorded 10,734 domestic abuse crimes in 2021. Data shows incidents are generally under-reported in those concerning people from minority communities and those in older age groups. Both issues apply to Aneta, in that English was not her first language and she was 54 at the time of her death.

9.6. The Review Panel is grateful to Project Polska for its presentation on domestic abuse within the Polish community during which the following key points were made:

- There are many challenges and cultural elements around domestic violence and the Polish community, with a particular stigma and fear around social services involvement.
- There is a high value on family privacy, rather than seeking outside support for any problems.
- Women are pressured to sacrifice their own ambitions for the family and may not even know what domestic violence is. Physical, sexual and financial abuse may be seen as the norm in a relationship.
- The Catholic Church plus the Polish right-wing government / culture drives this rhetoric of women's role in society.
- The unrealistic expectations of family back in Poland can lead to victims of domestic violence fearing being rejected by their children.
- Some women feel disheartened that records of domestic abuse in Poland are not easily accessible by UK agencies.
- Often church attendance is more about belonging to a community, rather than a spiritual commitment. Nevertheless, it is likely that Aneta grew up in a culture where suicide was stigmatised as a mortal sin and indeed, she did once reference this (see paragraph 9.1).

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9.7. In her article '*Making Domestic Violence Visible in Poland*',[7] Magdalena Grzyb, states '*Although laws counteracting domestic abuse have existed since 2005, domestic violence is implicitly legitimized within the prevailing discourse on the protection of family values. The Law and Justice Party does not legitimize domestic violence itself, but it does enforce, via the legal system and official discourse, the traditional patriarchal family structure and women's confinement to the private sphere".* She goes on to say that "*Despite the gender equality of the communist era of 1945-1989, when women were granted access to labour, education, and reproductive rights, traditional gender roles – particularly within family*

[7] https://globaldialogue.isa-sociology.org/articles/making-domestic-violence-visible-in-poland

relations and intimate relations – have persisted and women continue to occupy an inferior position vis- à-vis men'.

9.8 Sex was also found to be relevant as it is a significant risk factor for being a victim of domestic abuse; women are more likely than men to be subjected to abuse. Before Aneta's death, she was known to the police as a victim of domestic abuse and Kronos was known as a perpetrator. In 2020, she fled Northamptonshire to Leicester to escape his abuse despite being financially dependent on him. Women are around twice as likely to experience domestic abuse and men are far more likely to be perpetrators. The majority of domestic homicide victims are women, killed by men[8]. On average, two women are killed each week by their current or former partner in the UK, a figure that has changed relatively little in recent years. It impacts women's health and independence, reduces their ability to work and creates a cycle of economic dependence. Poverty or lack of access to financial or social resources contributes to dependency on a violent partner as a risk factor.[9] Women's inequality limits their ability to escape from abusive relationships; it can make it more difficult for them to enforce their rights and more likely to experience sexual harassment and violence. Women who report that they are in poor health experience more than twice the rate of domestic abuse than women who report that they are in good health.[10] The single most dangerous thing for a woman to do is to enter into an intimate relationship with a man and women remain more likely to be threatened, raped, assaulted and murdered by men they know and, in particular, by men with whom they are having or have had a romantic relationship.[11]

9.9. Disability was also considered as being potentially relevant. Aneta was in poor health, and this had an adverse impact on her day-to-day activities. She had arthritis, chronic back pain which impeded her ability to walk any distance and she also had eye injuries and sight impairment. It is highly likely that these physical ailments contributed to her low mood even without the ongoing trauma of the domestic abuse.

9.10 Other vulnerabilities included mental health issues, homelessness, and alcohol consumption. These are discussed further in the analysis section.

10. Key events

Summary of relevant events outside the temporal scope of the Review

10.1. In August 2016 Aneta jumped in a river as she was stressed about having lost her job (albeit that in 2017, it was recorded that she was not eligible for housing assistance as she had not worked since 2013). She was seen by the acute liaison team - a service delivered in Northampton General Hospital by Northamptonshire Healthcare NHS Foundation - and discharged.

10.2. In 2016, Northampton Hope Centre was a drop-in Centre for Rough Sleepers and other vulnerable adults. Average daily attendance was between 80-100 per day, most of whom were using the facility to obtain food or clothing or to shelter from the elements. All service users completed a registration when first using the service, which was 2013 for Aneta and 2015 for Kronos. Upon registration, a support needs assessment was carried out and questions asked about relationship status. There are no notes on the system to suggest

[8] Office for National Statistics. 'Homicide in England and Wales 2021.
[9] Walby, S. and Allen, J. (2004). Domestic violence, sexual assault and stalking: findings from the British Crime Survey. London: Home Office.
[10] Ibid
[11] *'Long-term partners – Reflections on the shifts in partnership responses to domestic violence'* Kirsty Welsh, International Review of Victimology March 2022

any interventions with either of them other than accessing the service for basic essential support with access to things like showers, clothing and hot meals. Detailed examination of the records reveals that Aneta and Kronos attended the Day Centre on the same day on 13 occasions, but there are no records at any point of them having any association with each other, let alone being in a relationship. Separate individual next of kin details were provided by them both.

10.3. Aneta was first known to the IDVA service at the Sunflower Centre in March 2017 when she was referred after being assaulted by Kronos. She was living in a tent at the time, location unknown, and had previously been issued with a Domestic Violence Protection Order (DVPO). Attempts to contact her were unsuccessful so the case was referred back to the police. The case was heard at MARAC two weeks later. It was agreed that the Police would undertake a welfare visit with a view to making a referral to housing. Aneta's tent was located but no-one was present so a card was left in the hope that it could be translated by a friend.

10.4. Aneta was re-referred to the Sunflower Centre in August 2017. Aneta had contacted the police following an assault by Kronos, who had turned up at her tent, shouting and attacking her, as he was not happy that their relationship was over. The assault included hits and scratches to her face, eye and chin area with cuts and grazes, as well as twisting her left leg causing a bad limp and twisting the fingers on her right hand. Aneta had to walk to a local pub to use their phone to contact the police as she didn't have one of her own. Despite contacting several agencies to see if anyone had current contact with Aneta, the Sunflower Centre was unable to establish contact, and so once again, they referred the case back to the police.

October 2017

10.5. The case was heard at MARAC In October with the resulting action being that the Complex Needs IDVA would be asked to try and engage Aneta, with advice to link in with the Domestic Abuse Police Officer to explore the possibility of undertaking a joint visit.

December 2017

10.6. Due to staff sickness, this was not actioned until December. The police officer deemed it unsafe for the IDVA to visit, stating the site where Aneta had her tent was both muddy and unhygienic. The police officer said that she would visit, but these attempts were unsuccessful.

10.7. Towards the end of December, a member of staff from KFC, St James Retail Park, Northampton called Northamptonshire Police to report that Aneta had walked into the restaurant in a distressed state. She had a black eye with a bloody wound above and below. Due to the language barrier, it was initially believed that she had been the victim of a robbery. Officers attended and through a member of staff who spoke Polish, they ascertained Aneta had been assaulted by Kronos. Aneta was taken to Northampton General Hospital (NGH) for medical treatment. Officers assured her they would return to take a statement from her after they had arrested Kronos.

10.8 Later that evening, Kronos was arrested from his tent at the campsite and taken into custody. When officers returned to NGH in the early hours of the morning, Aneta had left without receiving treatment or notifying staff and a search of the vicinity failed to locate her. The attending officer completed a DASH risk assessment based on his observations and interactions with Aneta and classified her as being at medium risk. This was reviewed by a supervisor who agreed with the risk rating.

2018

January

10.9. Police officers conducted a search of the canal and campsite to trace Aneta, eventually locating her in a tent. In her subsequent statement, she told officers she had been drinking with Kronos and felt unwell, so went to bed. She recalled rolling over and seeing Kronos beside her before he punched her in the face. She fled the tent and sought help at KFC. Aneta also detailed the level of sustained abuse she had suffered over the previous 18 months which included death threats and coercive and controlling behaviour. She stated she had been in a relationship with Kronos since 2016. A subsequent DASH risk assessment was completed which identified a high risk. Aneta was once again referred to MARAC. The Sunflower Centre was unable to progress this referral as they still did not have a phone number on which to contact her. A file was submitted to the CPS and a charge of Assault by Beating was authorised. An application for remand was not backed by the CPS and bail conditions were imposed.

10.10. Later that day, officers conducted a welfare check on Aneta and found her in a tent with Kronos; Kronos was arrested for breaching the bail conditions.

10.11. The following morning, Aneta attended the Police counter at the Guildhall and said she wanted to retract her statement. The officer requested another officer attend to assist with this but, unfortunately, due to commitments, officers were unable to attend until 5:30pm. The officer at the Guildhall persuaded Aneta to remain until then.

10.12. Kronos was arrested for a second time for breach of bail towards the end of the month and held on remand.

February

10.13. In trying to establish contact with Aneta, a worker made contact with the Street Outreach Worker from the Housing Options & Advice Team. They replied that they had not had any previous contact with Aneta, which is of concern, given how long she had been sleeping rough in the area. Eventually the police located Aneta and provided her with a phone, which enabled the Sunflower Centre to make successful contact with her.

10.14 Aneta declined any support from the Sunflower Centre although they were able to discuss a safety plan with her. Her case was heard again at MARAC at the end of the month. The minutes record that Kronos had previously been in prison in Poland for attempted murder, but it does not say against whom. The action from the MARAC was for the Police to carry out a further welfare check on Aneta and for her to be updated on the MARAC.

March

10.15. Kronos was found guilty of battery at Northampton Crown Court and sentenced to 12 weeks imprisonment at HMP Woodhill, given a Restraining Order (Protection from Harassment) to last until March 2020 and ordered to pay £115 (£85 costs and £20 victim surcharge). He was also found guilty of threatening to damage or destroy property and sentenced to four weeks imprisonment to run concurrently. He was further found guilty of wasting police time[12] and sentenced to 12 months conditional discharge.

[12] Kronos had falsely claimed to have illicit drugs in his anus

10.16. Aneta was referred to Voice (Witness Care). Multiple attempts were made to engage Aneta. One direct contact with Aneta was successful, but the call was terminated. Liaison took place with Adult Social Care due to her unsanitary living conditions. Adult Social Care made three attempts to contact Aneta, but all were unsuccessful, and they closed the case.

10.17. Towards the end of March, HMP Woodhill initiated contact with Probation to determine arrangements for Kronos being released. Due to time served on remand, this was imminent. Additional licence conditions were requested to include engagement with a substance misuse agency and to not contact Aneta. Reporting instructions were given for Kronos to attend Probation for an appointment at 4 pm on the day of his release. In practice, Kronos was not released for another six weeks due to enquiries being made about his immigration status and checks on the address he had given as the place he would live at on release. Ultimately, these address checks were not completed before the release date.

June

10.18. In early June Kronos was released from prison late in the day with instructions to report to Probation the following morning. He did not attend. Immediate breach action was instigated, but when the release address was checked, Kronos was not there and nor was anyone resident at that address with the name he had provided. An application was made to issue a warrant for his arrest, and this was granted in August.

July

10.19. Before the arrest warrant was issued for breach of Probation, Kronos was arrested for breaching the Restraining Order. The Crown Prosecution Service (CPS) determined no further action was to be taken. One aspect of this decision was due to the police asserting that Aneta would become homeless if action were taken against Kronos (they were living in a caravan at the time).

August

10.20. A warrant was issued for Kronos's arrest for breaching the terms of his probation. Attempts to locate him were initially unsuccessful, but he was eventually located at a caravan park and Aneta was outside the caravan. A referral to Northants Adult Social Care was made due to concerns about Aneta's well-being.

November

10.21. Kronos reported a dispute between himself and persons he had been working for to the police; he was accompanied by Aneta. No offences were identified, but Kronos was arrested for breach of a court order and breach of the Restraining Order. No further action was taken based on a lack of support from Aneta.

10.22. At the end of the month, Kronos was found guilty at Northamptonshire Magistrates Court of breaching his supervisory order and fined £130 plus £60 costs. He subsequently missed his next three appointments with Probation. A warning letter was issued for the first missed appointment, but an administrative error meant the second warning letter was not issued and action was thus not taken over the breach until early January.

2019

January

10.23. In early January, an arrest warrant was issued for Kronos, but this was not implemented until the end of March.

10.24. Three weeks later, Aneta reported being assaulted by Kronos before he told her to leave the accommodation they had rented together. Aneta then changed her story, stating that her bruised eye was a result of her surgery. No further action was taken due to a lack of evidence.

10.25 Aneta also approached Housing Options stating that she had been sleeping rough in a tent for a few days since being physically assaulted by Kronos. She had a visible injury to her eye. She said that Kronos had formed a new relationship with a landlady, and he had asked Aneta to leave. The address that she gave was of a caravan park. At this point, the Housing Options Officer was unsure of Aneta's eligibility for housing assistance as a non-UK citizen, so whilst this was investigated, Aneta was referred to the night shelter. As English was not her first language, Aneta was invited back the following day with an interpreter to complete the triage assessment and gather further information.

February

10.26. Kronos failed to attend a court summons regarding his breach of Post Sentence Supervision (PSS). No bail warrant was issued and three weeks later, the case was terminated as the PSS licence period had expired. Nevertheless, the breach remained outstanding at that stage.

10.27. Aneta was seen at the Emergency Department of NGH at the end of the month following an overdose of paracetamol opiate and alcohol. She had been found in a park and smelled of alcohol, with empty paracetamol packets found next to her. A Mental Capacity Assessment undertaken deemed that Aneta did not hold capacity to refuse treatment for the overdose and metabolic acidosis. A clinical record note was made that Aneta was not to leave the hospital. Capacity for other purposes was not assessed.

10.28. Aneta was cared for in the Critical Care Unit and the Intensive Therapy Unit. Records identified that she had intended to take her own life, that she was homeless due to a relationship problem, did not have contact details for her adult children in Leicester, had back pain, felt depressed, was unemployed and that she wanted to get off 'living on the streets'.

10.29. A safeguarding referral was made to Northampton Council Adult Social Care and the Hospital Discharge Team tried to manage Aneta's discharge. They confirmed she was in contact with Kettering Council Housing who were seeking to confirm her eligibility for support. The Discharge Team verified that Aneta had a National Insurance Number, was registered with a GP, and had an NHS registration number – all of which made her eligible for support. This information was passed to Kettering Council Housing, and it was agreed that upon discharge, Aneta would be seen by them on the same day.

March

10.30. At the end of March, Northants police completed an intelligence report stating that a police officer had gone to a hedgerow opposite an Asda Garage in Kettering where he had seen Kronos living in a tent. Kronos told the officer he was awaiting money before he could get a place to live. The Officer advised him to seek help with accommodation at the Council offices. Kronos was compliant and seemed well. He was advised about the amount of litter and empty alcohol bottles outside his tent. The following day a member of the public lodged a complaint with Northamptonshire Police about people in a nearby park, drinking and scaring the children who were playing football. Officers attended and arrested Kronos for

breaching a court order as this was still showing on PNC and had not been removed. There was no further action taken, but the intelligence report was updated to add that Kronos should be considered for deportation if he was arrested again.

10.31. The following day, Kronos appeared at Northampton Magistrates Court on the breach Warrant. He admitted to the breach and was sentenced to a £135 fine.

10.32. Aneta was discharged from NGH but did not attend her pre-arranged appointment with Kettering Housing Options.

July

10.33. An ambulance attended a local park in response to a 999 call from a member of the public who had found Aneta intoxicated. Ambulance crew thought the chief complaint was hypothermia, but unfortunately Aneta left the hospital before a clinical assessment could be undertaken.

August

10.34. Aneta approached Accommodation Concern and received a food parcel and a blanket. A follow up appointment was made to see the Rough Sleeper Outreach Worker, but Aneta did not attend.

10.35. At the end of the month, Northants Police created an intelligence report suggesting that Aneta was homeless in Kettering, sleeping in a tent in a wooded area.

September

10.36. Aneta reported to Northamptonshire police that she had been assaulted by Kronos. She had no visible injuries but stated that he had slapped her face six times. Officers attended the location where she said this had occurred and arrested Kronos. Aneta was asked to meet with officers the following day to provide a statement with an interpreter. They left her at her tent and noted that she was intoxicated. Aneta did not attend the appointment to provide a statement and when the location was attended, officers found no trace of Aneta or the tent. Kronos was interviewed and denied the offence of assault and breach of the Restraining Order; he told officers Aneta had turned up at his tent that day intoxicated, and he had told her to go away. He stated the tent he had been arrested in was his tent. As there was no evidence offered and no realistic prospect of a conviction, this incident was filed for no further action.

10.37. Two weeks later, Accommodation Concern contacted Kronos to let him know they had found a flat for him and Aneta to rent. An appointment was made for them to view it. The day after this appointment, Kronos called Accommodation Concern to inform them they no longer required their support as both of them were now in Leicester. Kronos appeared angry and ended the call abruptly. As they had moved out of area, the case was closed.

December

10.38. Aneta was arrested for being extremely drunk and disorderly in a supermarket in Leicestershire on Christmas eve. The arrest was a ‘last resort’ option as no accommodation could be located for her and officers recognised that she was in too vulnerable a state at that point to be simply let go. She was released the following day and no further action was taken.

2020

March

10.39. In the middle of March, a member of staff at The Unicorn Inn public house, Lutterworth, Leicestershire called Leicestershire Police to report a female had attended the pub and had told them she had fled from a friend; she was in a distressed state. Unfortunately, when officers arrived, Aneta was being cared for by the people within the pub who had been buying her alcoholic drinks and she was intoxicated and emotional. A translation service was used, and despite difficulties faced by the attending officer (including arguments with the translator), Aneta's identity was established along with her domestic abuse history and the fact there was a Restraining Order that Kronos should not contact her. Aneta was given emergency accommodation at the Travelodge in Market Harborough and arrangements were made for her to be collected the following morning to provide a statement with an interpreter.

10.40. The next morning, Aneta was taken to Market Harborough Police Station where she told them that Kronos had been drinking and they had argued. He had pushed the side of her face and left in a taxi. Aneta declined to make a statement, but a DASH risk assessment was completed with the outcome of being assigned as at standard risk. Contact was made with Aneta's daughter, who did not wish to make contact with Aneta, saying she was aggressive when intoxicated. Officers took Aneta to the Market Harborough Council Offices to seek emergency accommodation.

10.41. Officers attempted to locate Kronos but were unable to do so. With no victim engagement, no corroborating witnesses nor evidence to prove contact, the incident was filed 'no further action'.

10.42. NB By now, the onset of the Covid 19 pandemic meant that the UK was subject to lockdown restrictions.

April

10.43. Towards the end of April, Aneta became a client of the Leicester Hope Project[13], initially due to contact by Aneta's estranged daughter. Over the next couple of months, interpreters were arranged, temporary accommodation and food parcels provided and a trip to Manchester was arranged and paid for so that Aneta could obtain a new passport and thus have some identification. This was an essential step towards many changes including - for example – being able to open a bank account. Mental health support was offered, but Aneta declined, saying she did not need it.

May

10.44. Harborough District Council's Housing Team investigated suspicions that Kronos might be a victim of modern slavery. He had been evicted from a Traveller Site and approached housing for assistance. Kronos would not confirm their suspicions, but from the description of how he had been treated, they were concerned that he had been a victim. Kronos did not consent to his details being passed via the National Referral Mechanism[14] to enable him to access support.

[13] The Hope Project was a partnership project between, WALL, Panahghar Safehouse (both DA specialist refuge providers), New Dawn New Day, Turning Point and the local authorities across Leicester, Leicestershire & Rutland, funded through MHCLG, to support and accommodate women with additional needs such as alcohol use, high mental health related need, immigration or language barriers. Aneta was initially accommodated by WALL in their 'complex needs' refuge which was funded through this initiative.

[14] This is the support system for victims of modern slavery

10.45. Due to the Covid-19 regulations, Kronos was housed in a local Travelodge whilst his homelessness application was being processed. He was asked for proof of ID, which was not forthcoming. As such, the temporary accommodation was ended on 29th May 2020

June

10.46. By mid-June, Aneta was confirmed as an EU passport holder and therefore eligible for benefits. Arrangements were made for her to leave the hotel where she had been staying and move into the local complex needs refuge[15]. However, a couple of days later, an East Midlands Ambulance Service crew attended Aneta in relation to an assault perpetrated by Kronos. Aneta was assessed by the crew, and had visible facial injuries, but she declined the offer to be taken to hospital. Police officers escorted Aneta to a tent in the local area that she was sleeping in.

10.47. The following day, Hope Project received a call from Aneta's daughter. Aneta had rung her to let her know she had moved out of the hotel and was now with Kronos in Northampton. Aneta was quite abusive during this call, accusing her daughter of interfering in her life. The Hope Project, using Language Line, called Aneta. She was crying and very distressed. She said she would not be returning to Leicester, that she had gone to Northampton to end her life and there was nothing left for her to go on for. She was so distressed that the Hope Project worker raised concerns for her safety and mental health state. She told Aneta that she was going to contact the police and Aneta agreed. This was duly done.

10.48. The Hope Project then spoke to the police. Police officers informed the Hope Project that Aneta had been beaten up by Kronos, who had not been seen since. They interviewed her and she declined to go to the complex needs refuge or stay at the police station, so she went back to the tent. She did not want to make a statement. Police were concerned for her safety given that Kronos was still at large.

10.49. Arrangements were made to pay for Aneta's transport to the refuge and after some reassurance that she would not be judged by anyone, Aneta agreed to go to there. Before she left, she agreed to support a prosecution and attended the Northamptonshire Police Northern Access Building at Kettering to provide a statement.

10.50. On arrival she was duly inducted into the complex needs refuge and – via an interpreter - a conversation was had with her about her suicidal ideation. Aneta disclosed that she was having those sorts of suicidal thoughts all the time as she couldn't see a light at the end of the tunnel. However, she also stated that she wasn't thinking about acting on these thoughts and did not have a plan. She stated that her suicidal thoughts were a consequence of her domestic abuse experiences and that she needed a few days to mentally recover from the traumatic events that she had been through. Additional sources of mental health support were provided to Aneta should she need them.

10.51. The following day, Kronos was arrested and charged. He was remanded in HMP Peterborough, and the Sunflower Centre made contact with Aneta to update her of this. Northampton MARAC made a referral to Leicester MARAC. This stated that Aneta was alcohol dependent, and this information was passed on to the refuge.

[15] Not all refuges are equipped to accommodate women with high support needs. Those that can, are referred to as complex needs refuges.

10.52. Aneta was provided with food parcels, some money, some clothes and efforts were made to try and open a bank account although this proved complicated due to the pandemic restrictions. Receipts from her shopping did not show any expenditure on alcohol.

July

10.53. Efforts continued to establish a bank account for Aneta and to also get her registered with a GP so that her eye injury and dental needs could be addressed. She was offered mental health support again but declined, stating that she wasn't ready yet. Initial steps were also taken to address her longer-term housing needs. A few days later, Aneta attended the local hospital where, under a local anaesthetic, she received stitches for her mouth injury. Measures to address her other health needs were also progressed. Refuge records note that Aneta was still very fragile and declining support with her mental health.

10.54. Aneta was asked about her alcohol dependency based on the information in the MARAC referral. Aneta denied this was the case and pointed out that since she had been in the refuge, no-one had smelled alcohol on her, and her spending did not show any evidence of alcohol purchases. She was angry about the allegation and felt that Northamptonshire police were slandering her. Staff explained they were concerned that if she became desperate, she might return to Kronos. Aneta replied that she had been in a hell hole for the past three years with this guy and had finally escaped and was receiving help. Why on earth would she go back to a hell hole? When asked what might make her feel desperate, she said she was fearful and scared of another court case and did not want to go through that again. Special measures[16] were discussed.

10.55. Meanwhile, Northants Police liaised with the Hope Project to confirm court dates and to explore if Aneta wanted to make a victim impact statement and / or apply for a Restraining Order. Aneta's fears of attending court were discussed and special measures explored including the possibility of giving evidence via a video link. This information was relayed to Aneta, who became very distressed and declined the offer of both a Restraining Order and a victim impact statement.

August

10.56. In early August, the Witness Care Unit (WCU) in Northampton made contact with the refuge to discuss Aneta's upcoming court appearance. It is acknowledged that communication between the WCU and the Refuge could have been better so that Aneta's fears were more effectively managed. Arrangements were discussed for the Witness Care Unit to speak directly to Aneta – via an interpreter.

10.57. Before this meeting could take place, Aneta told her key worker in the refuge that she wanted to retract her statement and emphatically did not want to attend court. She stated that she had received so much help from the refuge and had got more things done in her life in the past few months than she had for the past four years with that man. Despite gentle challenging from the key worker, she was adamant that the assault was her fault.

10.58. Aneta had a number of health appointments during August to address her ongoing issues with back pain, her eyes and depression.

10.59. Due to the impact of covid restrictions, efforts to convey the information about Aneta wanting to retract her statement were frustrated for a few days until it was the day before the scheduled court case. Aneta was informed that she may be summonsed to appear even if

[16] These are steps that can be taken in court to allow someone to give their best evidence such as having a screen.

she retracted. It is now known that an interpreter would always be made available, and that travel is always booked once the victim has confirmed attendance, but this was not known to the refuge worker at the time who was, in turn, unable to reassure Aneta. Aneta was very distressed and said she felt as if she had been forgotten. It also appears as if there may have been some confusion over terminology: a retraction statement and a withdrawal statement are not the same thing albeit that many people use the terms interchangeably[17].

10.60. Aneta did eventually attend court and was sworn in by a Polish interpreter before refusing to give evidence. As a consequence, the case collapsed, and the charges were withdrawn. Two days later, Aneta was seen drinking with another refuge resident outside a supermarket. On return to refuge both residents appeared to be under the influence of alcohol.

September

10.61. In early September, Aneta signed out of the refuge and was out of contact for four days. Other residents disclosed that Aneta had been in touch with Kronos, who had been calling nearly every day. They said that Aneta was getting annoyed with him calling all the time. The Hope Project reported Aneta as a missing person to the Police, who visited the refuge and searched her room.

10.62. Another resident disclosed that when she went into the bank with Aneta another day, Aneta had recognised two Polish men that she knew and hugged them both. Aneta had told her that Kronos was promising to give her money if she dropped the charges against him and had told her to meet him at Leicester train station when he was released. The same day, Northants police logged an intelligence report that Aneta had been seen walking hand-in-hand with Kronos at Kettering train station.

10.63. Two days later, Aneta called one of the refuge residents. She was very distressed, so the police were contacted who traced her location. After much negotiation between housing departments and the police as to who could assist, Aneta was returned to the refuge in Leicester.

10.64. Texts from Aneta to the Hope Project worker:

1. I am very sorry for my behaviour. I got back home. I'm in peace. I'm not ready to talk in the morning. I am very ashamed.
2. Let's talk please. I know I did wrong. I'm back and it will never happen again. I understood my mistake. I should, however, testify in court.
3. Kronos threatens me with his friend Mr X [who] lives in Kettering [He] said that I am a whore and will bury me alive. I do not know what to do

10.65. Aneta told her key worker that Kronos had been continually calling and texting her promising that he had changed. She had fallen for it but when she arrived, he had once again become aggressive, and she had realised that he was just the same. She was very apologetic and said she was embarrassed and ashamed for not exercising common sense.

[17] There is no specific definition of either but in general the difference is understood as follows: When a victim (after providing evidence) says they no longer wish to attend court or support a prosecution this is generally called a withdrawal statement. When a victim states that the crime never occurred, this is generally referred to as a retraction statement and it immediately calls into question the victim's credibility. As such, it is far more likely that a victim would be summonsed to appear in court if they made a withdrawal statement rather than a retraction statement. An expressed desire by a victim to make a withdrawal statement usually triggers an in-person visit from a police officer both to take the statement and also to undertake a risk assessment to judge if a summons would raise the risk for the victim.

10.66. Meanwhile, health appointments continued to address Aneta's physical health problems.

October

10.67. At the start of October, the refuge worker started to progress a housing application for Aneta. This was not straightforward as Aneta was not currently in possession of a permanent passport (only a temporary one). Nevertheless, the application was progressed and in the middle of the month, three attempts were made by housing to contact Aneta but there was no reply. The application was terminated as Aneta was deemed to have abandoned her claim.

10.68. There were more health-related appointments in this month; Aneta's back pain was worsening, and her hair was now starting to fall out. She was on anti-depressants and refuge staff checked with her regularly to see if she needed extra support.

10.69. In the middle of October, a discussion was initiated with Aneta about her moving to an alternative refuge as the complex needs refuge was for women with high support needs and Aneta was not making use of any of the support on offer. Aneta was delighted that the alternative accommodation would take the form of a self-contained flat, near the shops and her GP. She moved the following day.

10.70. Ten days later, Aneta was seen in a local park, hand in hand with a man. When she returned to the refuge, she smelled slightly of alcohol and was evasive when questioned about the man. Kronos later confirmed that this was him.

10.71. The following day, refuge staff were unable to make contact with Aneta. A worker went to her flat where she found Aneta deceased. The police later found a suicide note in Polish which read:

I don't want my children by my coffin… or their father.
Only [Kronos] has got the right to bury me.
[Kronos] I am sorry.
[mobile number for Kronos]
Take care Kronos and remember about me.
Krasnoludek,
Pampusia,
Mufinka (nick names)
This is my last will. Kronos don't tell my children what I have done

11. Analysis

11.1 Actions taken by agencies have been carefully considered through the viewpoint of Aneta to ascertain if each of the agencies' contacts was appropriate and whether they acted in accordance with their set procedures and guidelines. Where they have not done so, the Panel has deliberated if all of the lessons have been identified and are being properly addressed. The Review Panel is satisfied that all agencies have engaged fully and openly with the Review and that lessons learned and recommendations to address them are appropriate.

11.2 Some changes have already been made since the start of this Review and thus no additional recommendations have been made. This has included a review of the domestic

abuse materials for North Northamptonshire homelessness service, Leicester City Council Homelessness Service introducing a robust policy and training on DASH and the Sunflower Centre reviewing their case management process. It should further be noted that to reduce unnecessary repetition, events have been analysed under the most pertinent key line of inquiry even where more than one might apply.

11.3 Review the involvement of each individual agency, statutory and non-statutory, with:

- **Aneta (the deceased) aged 54, a Polish national**
- **Kronos aged 46 (ex-partner of the deceased), a Polish national**

between the dates of October 2017 (3 years prior to the date of the death) and October 2020 inclusive, summarising agency involvement prior this time where relevant

11.3.1. This is set out in detail in the section above.

11.4 Analyse the communication, procedures, and discussions, which took place within and between agencies.

11.4.1. There were a number of instances where communication was sub-optimal both within and between agencies. For example, the Sunflower Centre could have initiated a more proactive approach to escalate the lack of a face-to-face visit with Aneta from the Police (there was gap of nearly two months). Within Probation, there was insufficient urgency in conducting address checks so that in practice, they remained incomplete when Kronos was released. Nor was a welfare check initiated for Aneta ahead of his release. When the Probation Officer for Kronos changed in November 2018, there was no evidence of a handover taking place as would have been expected practice.

11.4.2. There was poor communication with Aneta by both Northamptonshire Police and the Witness Care Unit around court attendance and poor handover when officers went on annual leave. Aneta had made requests around an interpreter and a screen video link which – whilst processed - do not appear to have been effectively communicated to Aneta. Aneta felt that she was being discriminated against because she was not a British citizen. With one day to go, she was still unclear about the court arrangements, and everything seemed very last minute which only added to her anxiety. It is accepted that Aneta did not always respond to letters or telephone calls but there could have been more empathy and understanding of her and the fact that she was terrified of attending court and giving evidence. More effort could have been made to ensure that the victim was aware that an interpreter had been booked.

11.4.3. With respect to communication within agencies, there were also instances where practice could have been better. For example, at Accommodation Concern, there was a missed opportunity for Aneta to engage with the service as she was not assessed as an individual so there was no case opened for her as a rough sleeper. This resulted in the case not being reviewed in supervision.

11.4.4. The incident in December 2019 when Aneta was arrested when highly intoxicated could have been handled better by Leicestershire Police. It is acknowledged that this was a challenging situation and that efforts were made to safeguard her. However, retrospective assessments when she was sober were not undertaken.

11.4.5. Northampton General Hospital found limited evidence of professionals' being curious about the holistic circumstances for Aneta. There was a discrepancy in information given regarding the circumstances of the injury to her left eye in that the first time she claimed it

had been due to an accident and then subsequently disclosed it was as a consequence of being assaulted by Kronos. This did not appear to be noted by staff and hence appropriate procedures around risk and safeguarding were not followed.

11.5 Analyse the co-operation between different agencies involved with any of the above named.

11.5.1. More robust attempts to undertake joint visits to see Aneta by Northamptonshire police and the Sunflower Centre could have been attempted. It is acknowledged that the police deemed a sole visit by the Sunflower Centre to be unsanitary and muddy, but violence was not recorded as a reason which could have put the IDVA at risk. The visit which ultimately took place was wholly unsatisfactory: a 'calling card' in English was left in Aneta's tent in the 'hope' that 'a friend' would translate.

11.5.2. Probation has a clear information sharing protocol with Northamptonshire Police, but the timeliness of its operation could have been improved.

11.5.3. Accommodation Concern felt their responses would have been enhanced with better Information sharing with other involved organisations and increased professional curiosity. If they had treated Aneta as a client in her own right, then her other needs may have been identified and better support offered.

11.5.4. Leicester Homelessness Prevention & Support could have provided a better service to Aneta had they liaised with staff at the refuge. Having been unable to make direct contact with Aneta on two occasions, it would have been more effective if, on the final attempt, contact had been made with staff at the refuge before closing the case.

11.6 Analyse the opportunity for agencies to identify and assess domestic abuse risk of death or serious injury.

11.6.1. Accommodation Concern recognised that they need to do more in this area. Previously their domestic violence policy was included within a wider safeguarding policy. However, there is now a separate domestic abuse policy which has been issued to all staff and additional training is now being rolled out, including on the use of DASH.

11.6.2. Similarly, North Northamptonshire Council Housing Options Team did not undertake DASH risk assessments at the time Aneta approached them. However, following the introduction of the Domestic Abuse Act 2021 and the new responsibilities placed on the local authority, North Northamptonshire Council are in the process of sourcing additional training for the Housing Options Team to ensure all staff are confident in completing DASH risk assessments.

11.6.3. Within criminal justice system agencies, the CPS acknowledged that their decision in July 2018 to no further action the breach of the Restraining Order was probably premature and incorrect. Evidence that could have been sought included clarification of the basis on which the officer was able to assert Aneta and Kronos had been staying in the caravan and to whom the caravan belonged. Probation also recognised that more could have been done to manage the risks posed by Kronos. After he failed to attend for his initial appointment on release and following breach, an OASys risk assessment and associated specialist risk assessment tools such as the Spousal Assault Risk Assessment (SARA) should have been completed. It is also noted that the assessments undertaken while Kronos was in custody, failed to identify him as a domestic abuse perpetrator. Finally, efforts should have been made to check or get a copy of Kronos's previous convictions from Poland.

11.6.4. On the positive side, a number of Northamptonshire Police officers completed DASH risk assessments and identified a standard or medium risk before using their professional judgement to upgrade the risk to high. This demonstrates a victim focussed approach and an understanding of Aneta's propensity to minimise the abuse she suffered due to her vulnerabilities, mental health or language barrier.

11.6.5. Aneta made a domestic abuse disclosure to Northampton General Hospital, the effects of which were seen in the serious damage to her eye. There was also evidence of an old fracture which may or may not be related to domestic abuse in the past. Whilst the medial treatment was of a good standard, the disclosure was all but ignored. There was no evidence of any further questions being asked post disclosure, no evidence that anyone present during the contact sought a case discussion with the Safeguarding Consultation and Advice Team within NGH, nor of anyone seeking further information from the range of domestic abuse resources available to NGH staff. This was a serious omission.

11.6.6. On reflection, WALL thought that a risk assessment could have been done when Aneta was relocated out of the complex needs refuge although this was somewhat mitigated by the numerous offers of mental health support. However, staff at the refuge were informed by other residents that Aneta was in touch with Kronos. More work could perhaps have been done with Aneta in identifying and understanding her feelings and the characteristics of perpetrators, including coercive control with a possible counselling referral.

11.7. Analyse agency responses to any identification of domestic abuse issues especially within the context of multiple needs.

11.7.1. Northampton General Hospital (NGH) found that suicide risk and potential alcohol dependency were not clarified in any communications with primary care who would assume responsibility once Aneta was discharged. There appeared to be a reluctance to discuss alcohol and drug use with her, particularly opioid use, and to consider more fully alcohol use and potential support from drug and alcohol services. With respect to suicide risk, the fact that she had taken an overdose previously should have triggered a risk assessment and communications with partners, particularly primary care, due to the potential for this to occur again.

11.7.2. At her GP surgery, Aneta was prescribed medication for stress and anxiety but there is no evidence in the records of any conversations being initiated about domestic abuse. Indeed, other than on her initial registration with the surgery, there was no documentation of asking about drug or alcohol use or if the patient was in a current relationship. This meant that Aneta was not coded or flagged as a vulnerable adult.

11.8. Analyse organisations' access to specialist domestic abuse agencies.

11.8.1. Most agencies felt confident in their knowledge of specialist services and knew how to access these. However, there were two exceptions: Probation and the East Midlands Ambulance Service (EMAS).

11.8.2. Probation noted an absence of consideration on the case record that liaison with or re-referral to MARAC was considered.

11.8.3. EMAS noted that when a crew attended in June 2020 following the assault on Aneta by Kronos, their domestic abuse policy was not followed. This policy states that: '*Staff should be able to recognise and respond to safeguarding and domestic violence concerns.'* When Aneta disclosed that she had been assaulted by her partner and had incurred facial injuries

as a result, it would have been best practice and adherence to EMAS domestic abuse policy for the crew to have discussed domestic abuse support services with Aneta.

11.8.4. This failure to adhere to policy is slightly mitigated by the fact that the police were on scene supporting Aneta and had called for ambulance support in relation to the injuries sustained. The lesson to be learned here is that staff should not deviate from policies and protocols based on assumptions that tasks have been / will be completed by others. The individual staff members involved in this event have undertaken reflective discussions with the divisional management team and have taken on board the learning.

11.9. Analyse the policies, procedures, and training available to the agencies involved on domestic abuse issues.

11.9.1. Except where noted below, all participating agencies have a domestic abuse policy in place that has been reviewed within the last two years or is currently in the process of being reviewed. Robust inter-agency procedures and protocols are in place and training is made widely available to relevant staff. However, very few participating agencies were able to confirm that their domestic abuse training covered identifying and responding to perpetrators. This is of particular concern in health settings where we know that perpetrators may be presenting for help.

11.9.2. Northants ICB currently subsumes its domestic abuse training under general safeguarding training and has no specific response in place to domestic abuse such as IRIS[18].

11.9.3. With respect to procedures, a gap was identified concerning MARAC to MARAC referrals. At the time of the events in question, a referral was only made when a victim left the area if she had been discussed at MARAC in the previous two years. This has since been reviewed and changed.

11.9.4. A member of staff at Accommodation Concern made assumptions based on Aneta and Kronos's nationality. She said that although she had observed hostility between the couple, this was incorrectly dismissed by her as being the result of cultural gender roles. This was in breach of policy and has since been addressed.

11.9.5. Leicester Homelessness Prevention & Support did not undertake a DASH assessment in contravention of policy and nor were adequate records made for case closure rationale.

11.10. Analyse any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

11.10.1. Aneta's access to help and support was hampered by two almost insurmountable factors: she did not speak English and she was sleeping rough with little access to money. The impact of these factors is discussed in sections 9 and 13 and is not repeated here.

11.10.2. The Sunflower Centre did have a Complex Needs IDVA for 12 months during this time period, but there was limited input made from this role on this case. However, the role of the Complex IDVA has since changed and now works proactively in the community with survivors with complex needs. Included within this role is a strong partnership focus to look at how survivor engagement can be increased and to ensure joint approaches are sought.

[18] IRIS – Identification and referral to Increase Safety is a primary care model for responding to domestic abuse.

11.10.3. Consistent and persistent support that involved a high degree of reassurance seemed to be most successful with Aneta. This strengths based, or trauma informed, approach taken by staff at the Hope Project in Leicester succeeded in maintaining positive engagement with Aneta more than most agencies.

11.11. Determine if organisational capacity had any impact on the services offered

11.11.1. All MARAC administration and IDVA service staff in Northampton were Tupe'd to Voice Ltd in October 2019 having previously been managed through Northants Police Service and the Office of the Police Fire and Crime Commissioner. All Sunflower Centre and MARAC employees are Voice Ltd employees, managed by Voice Ltd and governed by the Voice Directors Board. Since October 2019 the service has grown in size, work has been undertaken to develop the skills in the team and a new case management system was introduced in December 2020 enabling the service to be much more transparent, and to increase its accurate reporting of the number of cases each IDVA is working on and also to easily identify the progress made with each case.

11.11.2. Between September to October 2019, Accommodation Concern moved out of their main office for it to undertake a refit and redecoration to a temporary office in the shopping centre. From March 2020 some staff were placed on furlough, whilst the Rough Sleeper Outreach Service had to change dramatically when the government announced its '*Everyone In'* policy. Rough Sleepers were given a temporary, self-contained one bedroomed property in Kettering. The Outreach Team were required to provide in-reach tenancy support instead. They were also tasked with furnishing the properties and coordinating the provision of food for this cohort. Instead of rough sleepers coming to the office, the staff had to travel across the town to their properties and provide 1:1 support. The staff team were all remote working, being home based where possible. As they were designated key workers, they were still required to undertake home visits with full PPE being issued. Many of the 'housed rough sleepers' did not want to be isolated in their own property and did not understand the pandemic so the team had to manage difficult behaviours along with people being unable to access their alcohol and drugs.

11.11.3. The onset of the pandemic also inevitably affected how other services were delivered. For example, before lockdown, specialist staff from Turning Point would come into the complex needs refuge and this was an opportunity for clients to have face to face appointments, for Turning Point staff to informally engage with residents and build trust and for refuge staff to be supported. During COVID, this stopped, and refuge workers were left with specialist support only being provided over the phone or via email.

11.11.4. Probation also experienced difficulties in being able to implement a timely response to Kronos missing his appointments. There was a delay in them being able to list the breach at Court for application of the warrant as there were court restrictions on the number of cases that could be listed.

11.12. Consider if there are any lessons to be learned about managing clients who move between different local authority areas

11.12.1. There were some difficulties experienced with respect to housing over different local authority areas with some 'buck passing' as to who held responsibility. When Aneta travelled to Kettering and had nowhere to stay, the focus of emergency accommodation services appeared to be on eligibility and last place of residence prior to refuge as opposed to vulnerability, risk to the individual and their safety.

11.12.2. There were also some difficulties with cross authority working when it came to Aneta's court case in the summer of 2020. However, there were other factors influencing events not least of which was the covid restrictions.

11.13. If there are any lessons arising from the process of undertaking this Review (e.g., a suicide rather than a murder) which ought to be usefully highlighted to the Home Office.

11.13.1. The Panel wished to note the following:

- Current research on domestic abuse and suicide suggests that proximity to criminal justice processes can act as a trigger. For Aneta, the insistence that even though she wished to retract her statement, she was still required to attend court significantly impacted on her mental health. This knowledge should be embedded into the practice of criminal justice system staff working with victims and consideration given to it being a supplementary question in risk assessments.

- Fortunately, homicide is a relatively rare event but suicide – including attempted suicides – are not. Whilst direct personal experience is not necessary to be impacted by someone's suicide, it is far more likely that professionals participating in a Review will have some direct experience that may negatively impact on their ability to fully participate. Additional care is needed when undertaking suicide Reviews to ensure that professionals involved in a Review are cared for and supported.

- The statutory guidance is not wholly appropriate for undertaking Reviews involving a suicide and the Panel recommends that separate statutory guidance be developed to assist in this regard.

11.14 Whether practices by all agencies were sensitive to the nine protected characteristics[19] of the respective family members and whether any special needs on the part of either Aneta or Kronos were explored, shared appropriately, and recorded.

11.14.1. This is set out in detail in section 9 above. See also 11.9.

12. Good practice

12.1. *Kettering Borough Council:* The out of hours service demonstrated good practice in their response by securing immediate transport back to a place of safety for Aneta.

12.2. *Northamptonshire Police*: When Aneta arrived at the Guildhall in January 2018, the police officer showed exemplary resoluteness and commitment to ensuring Aneta remained at the Guildhall until officers arrived and took her to the CJC. She logged her concerns regarding the fact that Aneta was a high-risk domestic violence victim and required full engagement and safeguarding.

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12.3. A number of Northamptonshire Police officers completed DASH risk assessments and identified a standard or medium risk before using their professional judgement to upgrade the risk to high. This demonstrates a positive victim focussed approach.

[19] These are: age; disability; gender reassignment; marriage or civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation

12.4. Northamptonshire Police are also to be commended for providing Aneta with a phone to enable her to access support.
12.5. *Probation:* There was good evidence of a positive and appropriate enforcement decision taken by the first allocated Probation Officer following Kronos's failure to report to his appointment following his release from prison. This utilised the measures available to Probation to manage the risks posed.

12.6. *The Hope Project:* Refuge staff are commended on their support to Aneta and their tenacity in liaising with other agencies and getting answers.

12.7. *Northampton General Hospital:* The expectation that NGH would confirm for primary care services (GPs) any care or services delivered at secondary care level for their patients was met. Positively, these were within good timeframes, something that past national reviews have found not to be the case and which resulted in drift and delay for the patient.

12.8. *WALL:* Staff are to be commended for their tenacity in seeking support and information for Aneta. In addition, after Aneta's death, counselling arrangements were put in place for both staff and residents and were easily accessible. This included both group and individual counselling arrangements.

13 Key findings and lessons learned

Mental health

13.1. The full extent of domestic abuse related suicide is unknown but in 2004, it was estimated[20] that one in eight of all female suicides and suicide attempts in the UK were due to domestic violence and abuse. This is equivalent to nearly 200 women taking their own lives each year: more than double the domestic homicide rate. More recently, a Home Office and police study of the first year of the pandemic[21], recorded 38 domestic abuse related suicides. This is an underestimate as the paper only included those with a reported history of abuse to police. 90% were female. Female victims with a chronic illness or disability who experience intimate partner violence have an increased risk of threatening or attempting suicide.[22]

13.2. Aneta made attempts to take her life before the fatal event and was on anti-depressants at the time of her death. Domestic abuse has a significant impact on mental health with some research studies putting the number of female mental health patients being subjected to domestic abuse as high as 69%[23]. Depression and self-harm are therefore significant health risks for women in abusive relationships. In research studies, the experience of domestic abuse is strongly and consistently associated with both depressive disorders and self-harm. In 2013 researchers published a systematic review of longitudinal studies to explore intimate partner violence (IPV), incident depressive symptoms and attempted suicide[24]. They identified 16 longitudinal studies involving a total of 36,163 participants almost all of which were undertaken only on samples of women[25] and completed

[20] '*The Cost of Domestic Violence'* 2004, Women & Equality Unit
[21] '*Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021*' VKPP
[22] '*Prevalence and Correlates of Suicidal Behavior Among Adult Female Victims of Intimate Partner Violence'* Courtenay E et al, *Suicide and Life-Threatening Behavior* 41, no. 4 (August 2011)
[23] Khalifeh. H, Moran. P, Borschmann R, Dean. K. (2014) Domestic and sexual violence against patients with severe mental illness, Psychological Medicine, Volume 45, Issue 4 March 2015, pp. 875-886
[24] Devries KM, Mak JY, Bacchus LJ, Child JC, Falder G, Petzold M, et al. (2013) Intimate Partner Violence and Incident Depressive Symptoms and Suicide Attempts: A Systematic Review of Longitudinal Studies. PLoS Med 10(5): e1001439. https://doi.org/10.1371/journal.pmed.1001439
[25] Only four out of the sixteen studies also included men.

in high and middle-income countries. For women, eleven studies showed a statistically significant association between intimate partner violence (IPV) and subsequent depressive symptoms. In a meta-analysis of six studies, the experience of IPV nearly doubled the risk of women subsequently reporting depressive symptoms. There was also evidence of a reverse association, that is, the occurrence of depressive symptoms nearly doubled the risk of women subsequently experiencing IPV.

Homelessness / rough sleeping

13.3. Whilst rough sleeping is dangerous for anyone, it poses particular risks for rough sleeping women due to the extremely high rates of sexual violence. Research by Crisis found that a quarter of rough sleeping women were sexually assaulted each year, and this is in addition to being physically assaulted, including being urinated on, demeaned and verbally abused. This means that many rough sleeping women hide away from public view to protect themselves which has the unfortunate side effect of also making it more difficult for street teams to find them. Alternatively, they may bed down with a partner who is more than likely abusive. As one domestic abuse specialist said: '*There are cases where they're having to choose between being potentially abused by everybody on the streets or by getting abused by one person and using them as protection for everybody else. It's a really difficult choice.*'[26] Even when rough sleeping women are aware of services, they often avoid those which are not single sex.[27]

13.4. Getting and staying clean is a constant struggle for most rough sleepers; even accessing a toilet may be difficult, let alone a sink or a shower. This can be especially distressing during menstruation.

13.5. Intense loneliness and an almost constant state of fear characterise women's experiences of homelessness. Analysis by St Mungo's[28] of their data showed that on average, rough sleeping women present at their services with an average of 9-12 entrenched issues compared with an average of 4-6 entrenched issues for rough sleeping men. In part, this is due to women experiencing additional trauma as a consequence of their efforts to avoid becoming a rough sleeper (e.g., staying in unsafe or exploitative arrangements).

13.6 In 2020, 976 people were identified as having died whilst homeless[29]; 14% of these died from suicide and 41% were in temporary accommodation at the time of their death. This is highly likely to be an underestimate. This compares poorly with 710 people identified in 2019. Due to the onset of pandemic restrictions and the launch of the '*everybody in*'[30] initiative in March 2020, the data suggests that a significant and increasing number of people were dying when they came off the streets.

13.7 Agency records show that Aneta first registered as a rough sleeper in 2013 with Kronos registering two years later. There were periods of staying in a caravan, but these didn't last long so most of the time they were sleeping in a tent.

13.8. At the time of her death, Aneta was in temporary accommodation (a refuge).

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[26] Rhiannon Barrow, Housing First Team Manager, Solace Women's Aid
[27] https://www.mungos.org/app/uploads/2018/10/Women-and-Rough-Sleeping-Report-2018.pdf
[28] St Mungo's is a homelessness charity specialising in working with rough sleepers https://www.mungos.org/
[29] https://museumofhomelessness.org/wp-content/uploads/2021/02/Museum-of-Homelessness-report-of-findings-on-homeless-deaths-in-2020-FINAL-2.pdf
[30] More detail on this scheme can be found here: https://commonslibrary.parliament.uk/research-briefings/cbp-9057/

Alcohol consumption

13.9 Both Aneta and Kronos consumed alcohol. Kronos consistently appears in agency records as an alcoholic. The Panel wishes to make it clear that although the consumption of alcohol generally leads to more severe injuries, it is not a cause of domestic abuse and nor does it relieve a perpetrator of any responsibility for their choices.

13.10. However, the evidence is not consistent with respect to Aneta's consumption. Medical records show that from 2015 she was recorded as having problems with alcohol and alcohol-related seizures. However, in April 2018, an alcohol harm reduction audit was carried out at Northampton General Hospital which gave a score of 0. This means that Aneta had not consumed any alcohol in the previous month.

13.11 Once she was in the refuge, Aneta was adamant that she didn't have any issues with alcohol asserting that she didn't ever drink spirits and didn't need to drink alcohol. She did not present as being alcohol dependant and nor did her spending receipts show expenditure on alcohol. However, it should be noted that when Aneta was arrested in December 2019, she had a bottle of vodka in her possession that was only a third full. Aneta's daughter was also clear that her mother was an alcoholic. What seems beyond dispute, however, is that when Aneta came into contact with individuals who did enjoy or abuse alcohol, she appeared unable to retain self-control. This also seemed to happen when she was feeling suicidal.

13.12. This would suggest that Aneta's alcohol dependency was historical and although she was intoxicated on subsequent occasions, she was no longer alcohol dependent. Nevertheless, alcohol is a depressant, and any consumption is likely to have negatively contributed to Aneta's low mood. It was noted that there may have been some carelessness about the terms being used: unless professionals have the necessary expertise to make a diagnosis, the terms 'alcoholic' and 'alcohol dependent' should not be used as they both have a very specific meaning. It was also noted by the panel that few agencies seemed to consider a referral or signposting to substance use agencies.

Risk

13.13. There is a tendency when someone is experiencing domestic abuse for interventions to focus solely on managing the risk of that person experiencing serious injury or death. Indeed, this is the risk that DASH[31] is assessing and which MARACs[32] are designed to address. But what if this is too narrow a focus? What if *professionals* are minimising risk by taking this somewhat limited approach to the risks that victims are facing? Research[33] has shown that survivors are usually juggling multiple risks of which physical safety is but one.

13.14. From Aneta's perspective, it is likely that the risk of being permanently homeless and / or destitute, of never repairing her relationship with her children, of never being in a relationship where she was loved and cherished, the risk of always being depressed and in poor physical health, of slipping back into alcohol dependency, of never being truly free of the past and in control of her own life – all of these risks are likely to have weighed heavily on her. Within this landscape, whilst it is true that Kronos was physically violent to her, he also represented a way for her to manage or offset some of her other risks. Interventions which focused on her separating from him may not have seemed as helpful to her as professionals may have assumed.

[31] Domestic Abuse, Stalking and 'Honour' based violence risk identification checklist
[32] Multi-Agency Risk Assessment Conference
[33] *Finding the costs of freedom'* Kelly et al 2014, Solace Women's Aid

13.15 It is also worth noting that risk assessments all seemed to focus on Aneta and not on the risk that Kronos may be posing to others. Only Probation – whose efforts were incomplete – seemed to consider this (see paragraph 11.4.1). Accommodation Concern were disquieted to learn that although they directly worked with Kronos – and other agencies knew he had been accused of domestic abuse on more than one occasion – this information was never shared with them.

The relationship between domestic abuse and suicide

13.16. The work of the Kent and Medway Suicide Prevention Network has identified a lack of evidence and wider understanding about the relationship between suicide and domestic abuse and sought to address it locally. Their work[34] has generated the following data:

- Real Time Suicide Surveillance which highlighted that between 20% and 25% of all deaths by suicide have been impacted by domestic abuse. (60 out of 240 in Kent and Medway during 2020 and the first eight months of 2021).
- Exploration of the levels of suicidality by analysing local domestic abuse providers DASH risk assessments, which found that 63% of victims had felt suicidal and 61% of perpetrators had attempted or threatened suicide (threatening suicide is a known tactic for maintaining power and control in cases of domestic abuse, and a key risk factor of further harm to victim/ survivors).
- Further analysis is showing that victims are split into two cohorts: 1. Victims that are dying by suicide in the middle of the abuse 2. Victims that are dying by suicide months after the abuse has ended (with significant implications for framing risk solely in terms of the risk of serious injury or death at the hands of another).
- Review of 93 nationally published Domestic Homicide Reviews (DHRs), which found that 26% of DHRs contained a suicide, either being that of the victim or the perpetrator (most domestic abuse related suicides do not result in a DHR).
- Proximity to criminal justice processes is linked to suicide.

13.17. It should be noted that whilst Leicester is the same as, Leicestershire is below the national average for suicide in England[35] and that support around mental health was offered on a number of occasions but declined by Aneta.

Economic abuse

13.18. Very limited information was available to the Panel to more fully understand the part that economic abuse played in the relationship between Aneta and Kronos. It was established that Aneta had no money of her own and was dependent on Kronos for economic support. Aneta's near destitution meant that she was often difficult to contact due to having no phone or no credit. In some instances, this led to her case being closed. Kronos was able to exploit Aneta's lack of money by offering to pay her if she made a withdrawal statement. Having little money of her own also made some tasks very difficult – travelling to a place of safety, travelling to Manchester to sort out a new passport or even being able to access 999 in an emergency.

13.18.1. Research has established that people who have recently experienced severe financial strain may have up to a 20-fold higher risk of attempting suicide than those who have not encountered financial hardship.[36]

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[34] https://nspa.org.uk/wp-content/uploads/2021/04/Highlighting-the-link-between-domestic-abuse-and-suicide-1.pdf
[35] https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/0/gid/1938132828/pat/6/par/E12000004/ati/102/are/E06000016/cid/4/page-options/ovw-do-0
[36] https://doi.org/10.1093/aje/kwaa146

Equality considerations

13.19. As detailed in section 9, the language barrier and the availability of interpreters impacted on Aneta's ability to find and receive help. In some instances, the lack of understanding of Polish culture also negatively impacted on the support that was offered. This was undoubtedly further complicated by Aneta being a foreign national and thus lacking familiarity with UK systems and services. Lack of knowledge among some professionals as to what support could be offered to someone who was a foreign national also led to some delays in support being provided to Aneta. and there also appeared to be a lack of knowledge about where to go to clarify such information. This uncertainty is also mirrored among Polish nationals. Research in Watford[37] suggests that Brexit has led many Eastern Europeans to believe they are no longer entitled to the support that was available to them before Brexit and wide uncertainty about their access to benefits.

13.19.1. The links between mental health, domestic abuse and suicide and the experiences of marginalised communities are currently poorly understood. What research has been done has largely been carried out on South Asian women and cultural differences do not permit easy comparisons. A study in Scotland on suicide in the Polish community found that the suicide rates of Polish and non-Polish women in Scotland [were] very similar[38] whereas it was significantly elevated for Polish men. There is currently very limited research into or information about Polish women's experiences of domestic abuse and suicide is not mentioned.[39] There is clearly a need for more intersectional research to aid greater understanding and clarity of how the experience of domestic abuse can impact on those with different protected characteristics and its links to suicide.

Fear of CJS processes

13.20. Closely related to the issues above, was Aneta's fear of attending court to give evidence. It is recognised that covid restrictions and the need to have an interpreter were significant contributory factors to the communications breakdown. There remains some disagreement between the relevant agencies as to where the fault lies / what actually happened or did not happen but in the final analysis, Aneta seems to have been let down and to have not received the support and reassurance to which she was entitled.

A lack of client centred approaches

13.21. Until Aneta arrived at the complex needs refuge, most of her agency interactions involved a focus on one or more of her presenting needs. It is ironic that it is often the case that the more needs a victim has, the less likely they are to have them met, due to the often-siloed nature of services. This failure to take a more holistic approach, viewing Aneta as a whole person, meant that on occasion she was treated as if *she* was a problem instead of someone *with* a problem. There were – of course – some exceptions to this - but in tracing Aneta's experiences over the past three years of her life, what stands out is just how rare it was for her to be engaged with long-term. She experienced care and concern on occasion – including from staff at KFC and the Unicorn Inn who went above and beyond to access help for her – but such kindness seemed sporadic and inconsistent.

Lack of professional curiosity

[37] Watford Community Safety Partnership DHR into the death of Anna, December 2019.
[38] *'A review of suicides in Polish people living in Scotland (2012-2016)'* D.Gorman et al, ScotPHN October 2018
[39] Eg https://eprints.lincoln.ac.uk/id/eprint/49945/1/Polish-women-and-DVA_project-report_June2022.pdf and https://www.vestasfs.org/domesticviolenceinpolishfamilies

13.22 The shame that Aneta expressed in being labelled as an alcoholic should have been further explored as should her inconsistent explanations for injuries at the hospital.

Deportation

13.23 During the scoping phase of this Review, enquiries were made of UKBA who submitted a 'no contact' response. During the Review process, it emerged that UKBA had been updated by Northampton Police on several occasions when Kronos was arrested for criminal offences. Indeed, he was arrested by UKBA themselves in 2016 as an over-stayer. In March 2019 Northamptonshire police sought advice from UKBA regarding possible deportation of Kronos. At the time they were informed that after three criminal convictions within a three-year period, deportation would be considered upon any subsequent conviction.

13.24 Kronos did in fact have three convictions in 2018. Thereafter, however, although he was arrested on numerous occasions, these did not result in conviction. Therefore the opportunity to deport him based on these criteria was not met. Interestingly, if the trial had gone ahead and resulted in a conviction for the assault against Aneta then this may have led to deportation. It is possible that Aneta was aware of this possibility, and this may have affected her decision not to give evidence.

MARACs

13.25 MARACs were established to manage the risk of those at high risk of serious injury or death. As such, it follows that any actions arising from a case heard at MARAC should be completed as a matter of some urgency. It also follows that any actions should clearly demonstrate that they are making an appreciable difference to the safety of the client. This was not always the case for the three MARAC meetings which considered Aneta.

Impact of Covid

13.26 Once the pandemic began and restrictions were put in place, face-to-face support was not as available and impacted on individuals building up relationships with specialist workers. People became harder to contact with enquiries sometimes going unanswered for days at a time and limitations on trying other methods to engage clients.

14. Recommendations

14.1. Single agency recommendations

Sunflower Centre

- It is recommended that a MARAC-to-MARAC referral is always held between different areas when the victim has moved from one to another, regardless of the last time the victim was discussed at MARAC. To ensure all the information surrounding the victim is passed over.
- More outreach attempts could have been made or attempts to proactively engage with homeless support organisations who might have been able to assist.
- The outcomes and benefits of the Complex Needs IDVA post to be thoroughly evaluated to demonstrate the impact. With the hope of achieving more sustainable funding in the future to support complex cases.

- A timescale should be agreed for when and how to escalate a lack of contact from Northamptonshire police when visits need to be undertaken to victims or upon waiting for actions to be updated. IDVAs should be more proactive in questioning the reasoning why a joint visit cannot be undertaken.
- Further methods of communication should be sought when engaging with non-English speaking victims, including translating text messages and written materials.

Accommodation Concern

- Individual assessments for all clients – not as couples/family groups
- Domestic Abuse policy and training to be implemented and accessed by all staff
- Language Line to be used with everyone where English is not a first language.
- Training records to be reviewed in supervision and non-attendance followed up
- Dash Training to be sourced and implemented

North Northants Homelessness

- Check details of corporate contract for interpretation services in terms of services provided and ability to access translators immediately via a variety of methods. Ensure that staff at all levels have easy and quick access to interpretation services when dealing with a customer whose first language is not English. This is to ensure that appointments are able to be undertaken then and there, and there is no need to send the customer away to return at a later date. Establish the services provided by the new corporate contracted interpretation provider for NNC and disseminate information to all frontline Housing staff.
- Ensure that staff have a good understanding of risk assessments, and the ability to competently complete DASH assessment. Explore the possibility for a domestic abuse 'specialist' within the team. Ensure a skills audit of Housing Options staff is completed and a training programme devised in response to findings.
- Ensure that staff are reminded of the importance of always adding contemporaneous and detailed notes of all customer interactions and enquiries / actions.
- Create a factsheet for housing staff outlining the entitlements for foreign nationals and with details of where to obtain further information for inclusion on the council intranet.

Leicestershire Police

- Leicestershire Police officers to be reminded, where there is a requirement for a PPN, it is the duty of the attending officer to ensure that submission.

Northamptonshire Police

- Northamptonshire Police to remind investigating officers and supervising officers of the need to ensure a holistic approach to evidence gathering and preparation when submitting files to the CPS for advice on charging for Breach of Bail.

- Northamptonshire Police to encourage supervising officers to appeal CPS charging decisions where further evidence could be gathered to strengthen a case against an individual who has breached bail.

- Northants to work with Voice to develop a protocol with respect to welfare checks.

Probation

- Address checks to be completed with the Police using information sharing protocols in place within 24 hours of a change of address being provided.
- Quicker information sharing between Police and Probation when requests are made.
- All subsequent failures to engage with a probation sentence following sentence/release or breach action to result in further immediate breach action – unless reasons are clearly recorded and reviewed with a Senior Probation Officer as to why this is not appropriate.
- Where the whereabouts of a domestic abuse perpetrator are unknown and there is no allocated Victim Liaison Officer the Probation Practitioner, to liaise with the Police in the absence of any other identified professionals or personal contact of identified victims to ascertain their safety or any concerns.
- For all foreign national cases or where there is information that the person on Probation reports to have spent a period of time overseas attempts to be made to gain information regarding previous convictions.
- Probation to produce a learning document for training purposes using this Review as a case study

East Midlands Ambulance Service

- Training around perpetrators of domestic abuse will be included when the next review of the EMAS safeguarding training takes place. Perpetrators will also be included in the EMAS Domestic Abuse policy at its next review.

WALL

- Review of Suicide Protocol after each suicide or at least annually.
- Staff refresher training on suicide prevention annually
- Regular mental health safety planning training for all staff.
- Welfare calls to be made to refuge residents before 12 noon each morning.
- Posters to be displayed on support available, with crisis numbers and other useful contacts.

Leicester Homelessness Prevention & Support

- All Domestic Abuse cases whether in refuge or not will not be closed until the team leader for that officer has agreed that the casework is complete and in the instances of “lost contact” that there are recorded and documented records demonstrating that all attempts to contact the applicant and the refuge in which they reside have been exhausted.
- All presentations where domestic abuse is the reason for the approach will receive a DASH assessment regardless of whether they are currently in refuge or not.
- Create a factsheet for housing staff outlining the entitlements for foreign nationals and with details of where to obtain further information for inclusion on the council intranet.

Northampton ICB

- Explore a more focused response to domestic abuse through the development of domestic abuse specific training and policies and explore the potential for implementing IRIS or similar.

Northampton Hope Centre

- Seek to attend the Part 4 Domestic Abuse Partnership Board

Northampton General Hospital

- That relevant staff at NGH receive training related to professional curiosity, respectful uncertainty, and professional courage to enable and empower them to formulate judgements that translate into effective actions for those receiving care and services from the organisation.
- Any domestic abuse training delivered should take an intersectional approach, it should include information on the dynamics of domestic abuse, how to appropriately identify, support and risk assess victims, survivors, and perpetrators. This stand-alone training must be mandatory considering the requirements of the Serious Crime Act 2015, and implications to anyone over the age of 16 (Children Act 1989/2004)
- For any training to be effective it needs to be complimented with an organisation wide domestic abuse policy which responds to the needs of staff as well as patients experiencing domestic abuse and should include clear and established referral pathways. This should be separate from the adult safeguarding policy within the organisation.
- There must be consistent and comprehensive record keeping as this is crucial in ensuring appropriate continuity of care across health disciplines and organisations and an integrated response for victims and survivors of domestic abuse. Record keeping should be included in internal audits to ensure compliance with the domestic abuse policy.
- Undertake a root and branch review of the safeguarding service, the safeguarding governance and accountability arrangements across NGH and safeguarding organisational culture to ensure compliance with all statutory legislative, national and local policy arrangements

14.2. Multi-agency recommendations

- All health agencies to review their domestic abuse training content to ensure that information on identifying and responding to perpetrators is included. 'Health agencies' should be broadly interpreted to cover drug and alcohol services and voluntary sector mental health services.
- All domestic abuse, health and social care staff undertaking frontline work to complete mental health and suicide prevention training[40]. This should include a focus understanding both risks and protective factors with additional support put in place for those at high risk.
- All mental health staff undertaking frontline work to complete specific domestic abuse training, rather than it being subsumed under general safeguarding training
- All Northants MARAC victims to be signposted to specialist domestic abuse informed counselling
- All participating agencies to provide reassurance to their respective CSP that language needs of service users are considered and to explore the potential for simple messages (e.g., '*we need to speak to you – please call this number*') are translated into locally spoken languages for use on business cards or as text messages.

- All participating agencies to review their DNA policy to include a more flexible application for service users with multiple vulnerabilities, to consider checking contact

[40] Some free training resources can be located here: https://www.zerosuicidealliance.com/training

details are accurate at each successful contact and to attempt more assertive outreach on the third attempt before closing a case.

- All participating agencies to receive training on economic abuse and understand how to provide better support. For example, ensuring that all staff are aware of the option of applying for a no-fixed-abode bank account such as through services like HSBC's no fixed abode bank accounts for people experiencing homelessness.

- CSP to produce a briefing note for distribution to all participating agencies outlining the differences between:
  - alcohol dependent, alcoholic and someone with alcohol issues
  - the difference between a retraction and a withdrawal statement.

14.3 National recommendations

- The Home Office to consider clearer parameters in its next iteration of the statutory guidance for undertaking DHRs in the context of suicides.
- The Home Office to satisfy itself that UKBA's responses to requests for information by DHRs are robust and accurate.
- The Home Office to commission research into the links between mental health, domestic abuse and suicide and the experiences of marginalised communities. The methodology chosen should allow for the experiences of those from different cultures to be separated out. Upon completion, guidance for professionals should be developed and widely distributed.

Appendix A: Terms of Reference

1. Principles of the Review

- Objective, independent & evidence-based
- Guided by humanity, compassion and empathy with the victim's voice at the heart of the process.
- Asking questions, to prevent future harm, learn lessons and not blame individuals or organisations
- Respecting equality and diversity
- Openness and transparency whilst safeguarding confidential information where possible

2. Introduction

2.1 Leicester's Community Safety Partnership, known locally as the Community Safety Partnership (CSP), uses Domestic Homicide Reviews (DHRs) as a management tool to identity opportunities for learning that reduce the risk to potential victims of such homicides.

2.2 The purpose of a DHR is not to assign blame or responsibility, but to learn lessons and improve policies and practice at a local and national level. This undertaking should allow a free flow of information, cooperation, and improved outcomes for potential victims.

2.3 The legal requirement for DHRs is set out under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004).

2.4 DHRs will use the cross-government definition (Part 1 of the Domestic Abuse Act 2021) of domestic abuse as a framework for understanding domestic violence and abuse.

2.5 Each DHR, its' process and the resulting report products are the responsibility of the Community Safety Partnership (CSP). This partnership fulfils the statutory duties under the 1998 Crime and Disorder Act and subsequent legislation.

2.6 The nominated agencies will share all information in accordance with section 115 of the Crime and Disorder Act 1998 and do so without prejudice.

3. Terms of Reference

3.1 The Panel will examine how effectively Leicester City's statutory agencies and non-Government Organisations worked together in their dealings with the deceased and the alleged perpetrator in this case.

4. Purpose

4.1 The Panel aims to:

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

b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
e) Contribute to a better understanding of the nature of domestic violence and abuse; and
f) Highlight good practice
g) Ensure that the review is completed in a timely manner and highlight potential slippage to the CSP DHR sub-group.

4.2 In relation to this case, the specific lines of inquiry are:

a) To review the involvement of each individual agency, statutory and non-statutory, with:

- Aneta (the deceased) aged 54, a Polish national
- Kronos aged 46 (ex-partner of the deceased), a Polish national

between the dates of October 2017 (3 years prior to the date of the death) and October 2020 inclusive and to summarise agency involvement prior this time where relevant

b) Analyse the communication, procedures, and discussions, which took place within and between agencies.
c) Analyse the co-operation between different agencies involved with any of the above named
d) Analyse the opportunity for agencies to identify and assess domestic abuse risk of death or serious injury.
e) Analyse agency responses to any identification of domestic abuse issues especially within the context of multiple needs.
f) Analyse organisations' access to specialist domestic abuse agencies.
g) Analyse the policies, procedures, and training available to the agencies involved on domestic abuse issues.
h) Analyse any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.
i) Determine if organisational capacity had any impact on the services offered
j) Consider if there are any lessons to be learned about managing clients who move between different local authority areas
k) If there are any lessons arising from the process of undertaking this Review (e.g., a suicide rather than a murder, the cross-authority nature etc) which ought to be usefully highlighted to the Home Office

4.3 The Panel will consider all protected characteristics (as defined by the Equality Act 2010) of the above-named individuals (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any additional vulnerabilities as necessary.

5. Confidentiality, disclosure and information sharing

5.1 All parties will be bound by a confidentiality and information sharing agreement as defined in the Crime and Disorder Act 1998 (as amended by the Police and Justice Act 2006), which each Panel member will be required to sign.

6. Principal responsibilities of the Panel

- Establish chronological order of events
- Analyse organisational links within the partnership
- Assess the quality and quantity of available information from across the partnership
- Examine the effectiveness and suitability of relevant protocols
- Critically evaluate partnership working practice

7. Process

7.1 The DHR process will be determined by national statutory guidance and the local DHR Protocol (to open, click on link below).

Adobe Acrobat Document

8. Chairing

8.1 The independent chair for this review is to be appointed, who will drive the DHR process, lead the panel and draft the final reports and recommendations to the CSP.

8.2 In brief[41], the independent chair will:

- Chair the Panel.
- Oversee the DHR process, liaising with the DHR Officer and an administrator as necessary
- Ensure that family members are offered the opportunity to take part in the review process initially, and then updated at regular intervals on progress throughout the process.
- Quality assure the approach and challenge agencies where necessary.
- Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

8.3 It will be the responsibility of the independent chair to ensure contact is made with any other parallel process if these are identified during the DHR process.

[41] For full specification see terms and conditions of contract

9. Panel membership

9.1 Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting

9.2 Proposed membership of Panel:

Organisation	Role	Name of Panel Member
Accommodation Concern (Northants)	Chief Executive Officer	Jo
Leicester City Integrated Care Board	Deputy Designated Nurse, Safeguarding Adults and Children	Carol
East Midlands Ambulance Service	Children and Young Person Safeguarding Lead	Liz
FreeVA- Free from Violence and Abuse	Head of Victim Services Member of the UAVA Consortium, Leicester	Claire
Hope Centre (Northants)	Head of Service Delivery	Lee
Leicester City Council Housing Services	Service Manager Homelessness Prevention	Nicola
Leicestershire Police	Detective Inspector, Serious Case Review Partnership Manager	Chris
North Northants Council (Kettering)	Homelessness Manager	Claire
Northamptonshire Police	Detective Inspector Domestic Abuse Team (DAT) (North Local Policing Area)	Mark
Probation Service	Head of Probation Service in Leicestershire	Kaye
Project Polska	Chair, Project Polska	Barbara
Sunflower Centre (Northants)	Senior IDVA & Independent Stalking Advocacy Caseworker	Stephanie

Turning Point (Substance Misuse)	Partnership Manager	Caroline
West Northants Council Safeguarding Adults	Safeguarding Adults Team Manager	Patricia
Women's Aid Leicestershire Ltd (WALL)	Chief Executive Officer Member of the UAVA Consortium, Leicester	Pamela
Leicester City Council	Manager of the Domestic & Sexual Violence Team	Stephanie

9.3 Deputies to the agreed panel members are not preferred, to ensure continuity.

9.4 The Review Panel will include the following service as an expert/advisory panel member to ensure appropriate consideration to the identified characteristics and to help understand crucial aspects of the death:

- United Against Violence and Abuse (UAVA) as standard,
- Project Polska, as the deceased and the alleged perpetrator are of Polish origin, and
- Turning Point, a charity supporting people who have complex needs including drug and alcohol misuse, mental health conditions, offending behaviour, primary care needs, housing and unemployment issues and people with a learning disability

10. Roles of panel members

- Ensure their agency's case records are secured immediately
- Appoint a person to produce the Individual Management Review (IMR) report and / or other reports requested. This person must not be anyone involved in the case, or the line manager of a staff member involved.
- Quality-assure the IMR report
- Feedback and debrief staff on completion of the IMR report
- Ensure timely and comprehensive response from organisations
- Offer constructive challenges
- Further feedback and debrief on completion of overview report, prior to publication
- Agree and implement relevant parts of action plan

11. Roles of Agency IMR authors

- Draw up a chronology
- Interview staff involved with case. Make written record and share back.
- Forward relevant evidence to the disclosure officer for the criminal case.
- Draw together and analyse information and produce IMR report.
- Attend a panel meeting to discuss findings.

IMR authors must be independent of any line management of staff involved in the case. To streamline the process, IMR authors are expected to attend the meeting where their report will be discussed.

12. Family involvement

12.1 The DHR will:

- seek to involve the family of both the victim and the perpetrator in the DHR process
- take account of who the family wishes to have involved as lead representative
- identify other people they think relevant to the DHR process
- keep family members informed, if they so wish, throughout the DHR process
- be sensitive to family members' wishes and their need for support.
- Invite them to attend a Panel meeting should they so wish

13. Governance

13.1 The CSP's DHR subgroup will monitor the process via its' monthly progress reporting system and will sign off the final report before it goes to the Chair of the CSP for permission for submission to the Home Office.

14. Support

14.1 Support to the Chairperson and the review process will be provided by the DHR Officer and an administrator, who will arrange meeting spaces, and a minute taking.

14.2 The Manager of the Domestic & Sexual Violence Team will support the Panel with information on local specialist commissioned services and partnership arrangements.

15. Frequency

15.1. Statutory guidance sets out a six-month timetable for DHRs to be completed. Which takes us to the end of January 2022.

Appendix B: Further information about the chair and report author

Davina James-Hanman is an independent Violence Against Women Consultant. She was formerly the Director of AVA (Against Violence & Abuse) for 17 years (1997-20014), which she took up following five years at L.B. Islington as the first local authority Domestic Violence Co-ordinator in the UK (1992-97). From 2000-08, she had responsibility for developing and implementing the first London Domestic Violence Strategy for the Mayor of London. A key outcome of this was a reduction in domestic violence homicides of 57%.

She has worked in the field of violence against women for over three decades in a variety of capacities including advocate, campaigner, conference organiser, crisis counsellor, policy officer, project manager, refuge worker, researcher, trainer, and writer. She has published innumerable articles and three book chapters and formerly acted as the Department of Health policy lead on domestic violence (2002-03). She was also a Lay Inspector for HM Crown Prosecution Service Inspectorate (2005-10). Davina has authored a wide variety of original resources for survivors and is particularly known for pioneering work on the intersections of domestic violence and alcohol/drugs, domestic violence and mental health, child to parent violence, developing the response from faith communities and primary prevention work.

She acted as the Specialist Adviser to the Home Affairs Select Committee Inquiry into domestic violence, forced marriage and 'honour' based violence (2007-08) and Chairs the Accreditation Panel for Respect, the national body for domestic violence perpetrator programmes. From 2008-09 she was seconded to the Home Office to assist with the development of the first national Violence Against Women and Girls Strategy. Davina was also a member of the National Institute of Health & Care Excellence group which developed the domestic violence recommendations and subsequent Quality Standards. She remains an Expert Adviser to NICE.

Davina is a Special Adviser to Women in Prison and a Trustee of the Centre for Women's Justice.

Appendix C: Action Plan (see separate document)