NORTH EAST LINCOLNSHIRE
Community Safety Partnership

Domestic Homicide Review
Executive Summary

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

Review into the death of Antoni
in April 2021

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

Preface

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

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

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

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1 The Review Process

1.1 This summary outlines the process undertaken by the North East Lincolnshire Community Safety Partnership (CSP) Domestic Homicide Review Panel in reviewing the homicide of Antoni, a resident in their area prior to the point of his death in April 2021.

1.2 The following pseudonyms have been used in this review for the victim and the perpetrator, to protect their identities and those of family members:

- The victim is known as Antoni. He was a 32-year-old man of Polish nationality. He had moved to the UK in around 2013.
- The perpetrator in this review will be known as Alicja. She was Antoni's wife and was 27 years old at the time of Antoni's death. She was also a Polish national. She had moved to the UK with Antoni in around 2013.
- The couple had two young children. No further information will be provided about their identities within this review.
- Alicja's mother lived with the couple in the UK.

1.3 Alicja was arrested and charged with Antoni's murder. At a subsequent trial, her plea of guilty to manslaughter on the grounds of diminished responsibility was accepted. Criminal proceedings were concluded in December 2021 when Alicja was sentenced to 6 years' imprisonment: with half to be served in custody and the remainder on licence. She was sentenced to a six-month concurrent sentence of imprisonment for the offence of possession of an offensive weapon.

1.4 The process of review began with the police notifying the CSP of the circumstances of Antoni's death. On 12th May 2021, the CSP's Domestic Homicide Core Group met: this was chaired by the area's Domestic Abuse Co-ordinator. All agencies that potentially had contact with the victim and/or perpetrator prior to the point of his death, were contacted and asked whether they had records of prior involvement. As a result of the information shared at that meeting, there was a unanimous decision from the panel to recommend that a full Domestic Homicide Review (DHR) needed to be completed. The Chair of the CSP thus took the decision to conduct a DHR based upon these recommendations. The Home Office was notified on 14th June 2021

2 Contributors to the Review

2.1 As a result of the information received, the review requested Individual Management Reports (IMRs) from four agencies:

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

2.2 In addition, the review received a report from an expert in the cultural impact of domestic abuse within Eastern European communities, to assist its understanding of the issues in this case.

2.3 Through the process of review, the Chair established the independence of each of the IMR authors.

3 The Review Panel Members

3.1 The DHR Panel comprised the following members:

Gary Goose MBE	Independent Chair	
Christine Graham	Independent Report Author	
Julia Kulak	Specialist Advisor	
Catherine Ainsworth*	Senior District Crown Prosecutor	Crown Prosecution Service
Susan Bunn	Head of Safeguarding	Focus Adult Social Care
DCI Emma Heatley Replaced by DCI Mark Skelton	Tactical Lead for domestic abuse and Lead for the safeguarding governance unit	Humberside Police
Ellie Walsh*	Assistant Director – Adult Acute Mental Health Services	Navigo – Acute Mental Health Services
Emma Kosakowska	Lead Practitioner, Safeguarding	Navigo – Acute Mental Health Services
Lynn Benefer	Deputy Head of Safeguarding	Northern Lincolnshire and Goole NHS Foundation Trust
Julie Wilburn	Designated Nurse for Safeguarding Adults and Children	North East Lincolnshire Clinical Commissioning Group
Rebecca Freeman	Community Safety Partnership Manager	North East Lincolnshire Community Safety Partnership
Spencer Hunt	Assistant Director, Safer and Partnerships	North East Lincolnshire Council
Dawn Alaszewski	Children's Social Care	North East Lincolnshire Council
Beverley Compton	Director, Adult Services	North East Lincolnshire Council
Helen Cordell	Domestic Abuse Co-ordinator	North East Lincolnshire Council
Helen Willis	Safeguarding Children's Board Manager	North East Lincolnshire Council
Stewart Watson	Assistant Director of Safer and Partnerships	North East Lincolnshire Council
Jennifer Steel	Head of Pupil Support (Wellbeing and Safeguarding)	North East Lincolnshire Council
Nick Hamilton-Rudd	Head of the North & North East Lincolnshire Probation Delivery Unit	Probation Service
Steph Price	Chief Executive Officer	The Blue Door Support Service
Lisa Pidd	Contracts Manager	We are With You
Denise Farman	Chief Officer	Women's Aid
Kate Ransom	Support Manager	Women's Aid NE Lincs
Nicola Harrison	Outreach Support Worker	Women's Aid NE Lincs

*Corresponding members

3.2 The review panel met five times, and the review concluded in April 2023.

4 Terms of Reference

4.1 The review panel set out to:

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

4.2 The full Terms of Reference can be found in Appendix One of the DHR overview report.

5 Domestic Homicide Review Chair and Overview Report Author

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

5.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years, managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. As well as delivering training in relation to tackling anti-social behaviour, Christine has worked with several organisations to review their approach to community safety. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA, which involved her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews. Christine chairs her local Safer off the Streets Partnership.

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

5.4 Neither Gary Goose nor Christine Graham is associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[1] Details of ongoing professional development can be found within the overview report.

6 Summary Chronology

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

6.2 A chronology of information known to agencies follows[2]. This is purely that which was known by agencies, as the review has been unable to supplement this with information from family and friends. Little has been established about their lives prior to arriving in the UK.

6.3 On the day of Antoni's death, he and Alicja were hosting a barbecue to celebrate Alicja's birthday. The event was attended by friends and family.

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

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

6.6 When sentencing on 1st December 2021, the judge referred to several factors that must be considered when passing sentence:

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

6.7 The judge cited several mitigating factors:

- She had no previous convictions.

[1] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016
[2] A full chronology is available in the Overview Report

- She had showed genuine and significant remorse.
- She had suffered significant previous violence from Antoni.
- She was, or would be, the sole carer of the surviving children.
- There was an intention to cause very serious harm rather than to kill.

6.8 This review sought to identify any trail of abuse that existed within the relationship and sought to identify what information was known about the couple – not only since their arrival in the UK but also any relevant information that may exist within Poland. Unfortunately, despite efforts, the review was not able to secure the assistance of the couple's family, nor indeed the assistance of Alicja, in helping us understand some of that background. Whilst the review respects their decision, it does mean that we rely upon what is recorded within agency notes to assist our understanding of the case.

6.9 What we do know is that Antoni and Alicja had contact with the police six times over eight years. The first two incidents took place over a seven-year period: the first in 2013, then 2016, and then nothing until 2020. Antoni was arrested and cautioned on one occasion. None of the incidents resulted in court appearances for either Antoni or Alicja.

6.10 What is also clear is that the levels of abuse increased from the beginning of 2020 onwards, with reports to police in February and November of that year. Alicja's mother also became so concerned about the impact of the relationship on her daughter and the children that she attended the police station to raise her concerns. Whilst there is evidence of elements of good practice by the police, it is a fact that the children were not visible in the police reports: this led to a lack of referral, and thus support, for the children and family in coping with the effects of domestic abuse.

6.11 In August 2020, Alicja also attended hospital with a significant tear to her vaginal area. She gave an explanation that it had been caused by regular sexual intercourse; however, the medical staff doubted this explanation because of the presentation of the injury itself. No onward referrals were made to explore this issue further.

6.12 From the information available to this review, it does appear that Alicja was the primary victim of domestic abuse at the hands of Antoni. However, evidence exists that shows a level of bi-directional abuse. In one incident, at least, it appears that Alicja perhaps should have been cautioned rather than Antoni. It appears, however, that abuse contributed to Alicja's struggles with mental ill health and increased the level of her complex PTSD (from which she suffered, following earlier life events).

7 Key Issues Arising from the Review

7.1 This review has sought to identify any trail of abuse. It has looked at the abuse that is known and the evidence that exists of who was primarily responsible for that abuse.

7.2 The lack of visibility of the children in several of the reports is concerning; however, the review is heartened by the work evidenced within the overview report to ensure greater professional curiosity is utilised when attending reports of abuse – to ensure that children and families are properly supported. We make recommendations in relation to this area.

7.3 The lack of professional curiosity, around what may have been evidence of a serious sexual assault revealed when Alicja attended hospital, is also concerning. But again, the work being

done by the Trust to ensure appropriate specialist support is recognised, is something that is a positive reaction to this review. We make recommendations in relation to this area.

7.4 The issue of how the couple's heritage, culture, and beliefs influenced their lifestyle and agencies' engagement with them, has been subject of this review. Also, their likely understanding of domestic abuse within the UK, particularly regarding the legislation around controlling and coercive behaviour and whether language may have provided a barrier to engagement. We make a number of recommendations in relation to this area and also in relation to signposting for alcohol support. It is clear that alcohol was a factor when incidents occurred between them, and there is no evidence of signposting to services.

7.5 We have looked specifically at the issue of support offered to the couple at the time of the reports that were made. Particularly, the support offered to male victims of domestic abuse because, as has been said previously, there is evidence that Alicja may have been the aggressor on at least one of the occasions.

7.6 We have also looked at any of the unintended consequences of COVID-19 lockdown legislation upon the relationship and services that were involved with them.

8 Lessons Identified

8.1 **Humberside Police**

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

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

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

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

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

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

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

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

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

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

9 Recommendations

9.1 **Humberside Police**

9.1.1 That children are visible in domestic abuse cases and that any children are fully documented, and referrals are made.

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

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

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

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

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

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

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

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

9.3 **North East Lincolnshire Council**

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

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

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

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

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

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

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

9.4 **Home Office**

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

9.5 **Women's Aid NEL**

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

9.6 **All Agencies**

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

10 Conclusions

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

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

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

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

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

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

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