



minute briefing:

Domestic Homicide Review into the death of ‘Antoni’, 2021

Antoni’s life

Antoni and his wife, Alicja, were Polish nationals who settled in the UK in around 2013. They had two children.

There had been examples of situational violence within Antoni and Alicja’s relationship, whereby conflict led to violence. A small number of incidents had been reported to the police, although the review was not able to identify a clear victim and perpetrator as both acted as the primary aggressor at different times. There were no identified reports of sustained coercive control. Neither party had received support from domestic abuse services. Violent episodes were linked to the consumption of alcohol.

On the day of his death Antoni and Alicja were hosting a barbecue. It is accepted that earlier in the day Antoni assaulted Alicja. During the party a significant amount of alcohol was consumed by all. The couple argued and Antoni left the home. Alicja picked up a knife and followed him shouting verbal abuse. She stabbed him to his chest and Antoni died from the injuries.

Alicja pleaded guilty to manslaughter on the grounds of diminished responsibility. It was acknowledged by the judge that Alicja was suffering a form of PTSD caused by incidents in her childhood, and that abusing alcohol both exacerbated and was a symptom of her mental disorder.

Purpose of the review

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

The Community Safety Partnership has a legal duty to conduct a multi-agency review to understand where public services may improve their responses to individuals and families in similar situations. The review does not consider who is to blame but seeks to support the prevention of similar incidents from happening in the future.

Good practice identified

Good positive action was taken when a domestic abuse incident was reported to the police in 2020. An arrest was made and case for an evidence-led prosecution prepared for the CPS.

Routine questioning is well established within maternity services. Alicja was asked questions about domestic abuse during her pregnancy which were recorded within her electronic maternity record (CMIS).

Following a referral by the police, child social work assessments were completed within the required timescales and included the grandmother in the children’s safety plan.

Operation Encompass works well with information on all incidents shared with the school the next school regardless of risk level. Domestic abuse incidents are now triaged daily at PiT Stop meetings to ensure patterns of domestic abuse are identified and lower / earlier intervention is provided to prevent escalation of complex services.

Key learning points

- There was, on occasion, a lack of professional curiosity into facts as presented. There was further scope for police to review relevant previous incidents, and for health to explore the extent and causative factors behind how injuries had been sustained. Practitioners should seek the advice and expertise of their safeguarding teams to ensure a sense of completeness in how cases are addressed.
- Signposting to support services could have been improved. There is one recorded offer to refer Alicja to domestic abuse services, which she declined and no details were left with her. No such offer of support was made to Antoni. Similarly, no details of alcohol support services were provided to Antoni or Alicja despite both parties being in drink when seen by police.
- Alicja, Antoni and Alicja's mother (who attended Grimsby Police station to report a concerns) experienced blockages in accessing services due to English not being their first language. There were times when the use of an interpreter could have led to practitioners understanding the situation better. In addition information needs to be provided not only on the support available but on the context of this support – explaining how domestic abuse law and services in the UK may be different to the provision within other countries.
- Further work is required to promote the availability of support for male victims of domestic abuse.

Next steps

- Training has been provided by the Independent Sexual Abuse Advocate and Humberside Sexual Assault Centre to A&E and gynaecological staff to increase awareness of sexual assault and raise confidence in signposting / referring victims to appropriate support.
- All children are documented on the DASH risk assessment as being present at the address to ensure their visibility as victims of domestic abuse. A&E staff have received training and are now confident in exploring dependents when patients attend A&E. Partners are seen separately in Children's Social Care assessments to afford victims the opportunity to disclose any domestic abuse.
- Police officers are reminded of the importance of leaving details of domestic abuse services and alcohol support services with victims and offenders who decline an immediate referral.
- The use of professional interpretation services is to be adopted by all agencies so that family members are never used, thus removing this as a method for limiting victims' communications. A supply of printed and online literature in key languages is to be made available through the domestic abuse operational group, including information on controlling behaviours, how to navigate services, and myth busting. This will be distributed through all partner agencies including health and children's services to allow non-English speaking victims of domestic abuse to easily and discretely access information and support. Resources relating to drug and alcohol use will also be developed in additional languages and work is planned to proactively reach out to non-English speaking members of our communities by drug and alcohol services.
- The newly commissioned domestic abuse services will develop communications plan targeted at male victims in order to raise awareness of the signs of domestic abuse and controlling behaviour, and increase the visibility of support available to them, leading to earlier and increased disclosures.

The full report, action plan for this review, and a copy of the quality assurance letter from the Home Office can be found at:

<https://www.safernel.co.uk/crime-and-staying-safe/domestic-homicide-review/>



NORTH EAST LINCOLNSHIRE
Community Safety Partnership