Safer Hull
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Domestic Homicide Review

Amelia

March 2021

Overview Report

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Commissioned by: Hull City Council Community Safety Partnership

Review completed: February 2023

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1 Introduction

1.1. The key purpose of a Domestic Homicide Review (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.

e) Contribute to a better understanding of the nature of domestic violence and abuse.

f) Highlight good practice.

1.2 Scope

This DHR examines the circumstances leading to the murder of Amelia by her partner Marek. Both were Polish Nationals living and working in the UK. Early requests made to the agency representatives of the DHR panel identified that neither Amelia or Marek had ever been in contact with or came to the attention of agencies in the UK. The only interaction was an online housing application. The scope of this Review was therefore adapted to reflect this and set out to explore whether services in Hull were accessible to people living and working in the Hull area who were not originally from the UK and/or were working there on a temporary basis.

1.3. Terms of Reference

The terms of reference for the DHR are set out in *Appendix A* to this report.

1.4 Timescales

Formal notification of Amelia's murder was made by Humberside police to the Community Safety Partnership on 20th April 2021. On the 13th May 2021 the Core DHR panel met, and a recommendation was made for a DHR to be completed which the chair of the Community Safety Partnership endorsed. Following appointment of independent chair, the DHR review commenced on the 8th of September 2021 and concluded on the 16th of February 2023. Subsequently, the review was ratified by the Chair of the Hull Community Safety Partnership before being submitted to the Home Office. The timescales for the completion of this review were compromised in several ways. The court process and sentencing were not completed until January 2022, and tracing and speaking to friends and employees was slower due to a response rate requiring multiple contacts. A reliance on information from the Police investigation was the only way to gain details of friends and background information, and due to friends' involvement in a trial relating to Amelia's death, needed to be sensitively managed and led to apprehension in further discussions about Amelia. These factors together with a requirement for information to be gleaned through investigation (due to a lack of IMRs from agencies) slowed the completion of this DHR and led to a longer than expected completion timescales.

On 27th March 2021 Police Officers attended an address in the city. There they found Amelia the victim, she had been stabbed repeatedly and was dead.

Marek, Amelia's partner was arrested for murder and was subsequently charged and remanded in custody. On the 23rd of December 2021 following a guilty plea Marek was sentenced to seventeen and a half years imprisonment for the murder of Amelia.

2 The Review Process

2.1. Confidentiality

Each review and its findings are confidential. Information is available to those engaged with the review panels and their line managers. Pseudonyms are used to protect the identity of individuals involved and are usually agreed with family members of the victim. In this case the family decided they did not wish to engage in the review process and as a result the pseudonyms were decided upon and agreed by the panel and were chosen as a reflection of the culture and upbringing of the victim.

2.2 Methodology

2.2.1 In most DHR's the overview report is an anthology of information gathered from Independent Management reports (IMRs) prepared by representatives of the organisations that had contact and involvement with the victim and the perpetrator within a specific timescale. In the case of this review this would relate to Amelia and Marek between 1st January 2018 and Amelia's death on the 27th of March 2021. However, this was not possible as neither Amelia or Marek had contact with, nor were they known to agencies in the area. Consideration therefore had to be given as to whether conducting a DHR was either possible or relevant. Representatives from the Hull Community Safety Partnership discussed this and determined that a DHR would be of benefit. It was felt that undertaking a review would facilitate an examination of Hull's Domestic Abuse services with the aim of exploring whether the provision and support offered was available to, and cognisant of the needs of people living and working temporarily in the UK whose first language was not English.

2.2.2 This approach created the opportunity not just to explore the set up and delivery of established services, but to give focused reflection on whether they were visible to this specific group within the community and whether what they offered was relevant and accessible to them. It was anticipated that the following specific questions, as outlined within the terms of reference, were potentially the most relevant.

a. Were there any specific considerations around equality and diversity such as ethnicity, age or disability that required special consideration?

b. Did anyone in contact with the victim know whether the victim was aware of Domestic Abuse Services locally? If they did were there barriers to the victim accessing those services?

c. What were the key relevant points/opportunities for assessment and decision making in this case in relation to victim and perpetrator?

d. Was the impact of Domestic Abuse on the victim recognised?

e. Was there learning in this case that would improve safeguarding practice in relation to Domestic Abuse experienced by European Nationals, overseas workers in

the UK or persons, asylum seekers or people with an undetermined immigration status?

f. Did Amelia's place of work have a Domestic Abuse policy to support staff who may be the subject of Domestic Abuse or to those who may know a friend or colleague was experiencing Domestic Abuse?

2.3. Family and Friends Involvement

2.3.1 The review panel considered which family members, friends, and members of the community should be consulted and involved in the review process. Amelia's family all lived in Poland and following advice and guidance from AAFDA (Advocacy After Fatal Domestic Abuse) the independent chair wrote to them providing information about the review and inviting them to contribute. All correspondence was translated into Polish, including the AAFTA leaflet include in the correspondence. However, the family declined to engage stating they would find the process too painful. The panel were also made aware of friends Amelia worked with. Four were written to and one of these decided to contribute. The information provided by this friend was invaluable in providing context and gaining some understanding of the relationship between Amelia and Marek in the last months of her life. The Panel were extremely grateful to her and recognise how difficult this was for her.

2.3.2 In March 2023 the Independent chair again wrote to Amelia's family. This was to inform them that the review had been concluded and offered a copy of the report for them to read and comment upon.

2.4 Contributors to the Review

2.4.1. The review panel consisted of an Independent Chair and senior representatives of the relevant organisations that could have had contact with Amelia and/or Marek. The DHR Review Panel members have not had any direct involvement with Amelia or Marek and were not the immediate line manager of any staff involved with them. The panel included a representative of the Hull Community Safety Partnership. In addition, independent advisor was commissioned from a National Polish Domestic Abuse Charity to offer expert advice to the panel. Representatives of community organisations were invited to contribute and share their own specific knowledge of different community groups in the city and access to services. This included victims/survivors of Domestic Abuse and a perpetrator program. Their support to this review was invaluable in understanding the different communities and their use of services in the city.

2.4.2 The review panel members were:

Mark Skelton / Emma Heatley /	Detective Inspector, Humberside Police
Vicki Paddison	Strategic DA Services Manager, Hull Community Safety Partnership
Andrew Rabey	Independent Chair
Ewa Wilcock	Chief Executive Officer VESTA Independent Specialist Polish DA Advisor
Tanya Ferguson	Senior DA Practitioner, City Council Housing Access and wellbeing
Deborah Wainwright / Mags Shakesby	Safeguarding lead, City Health Care Partnership
Sonja Harrison / Caroline James / Selina Johnson	Senior Probation Officer, National Probation Service
Vicki Macklin	Team Leader Domestic Abuse Partnership Support Service, City Council
Laura Pickering / Rachel Sharp	Safeguarding Lead, Health Integrated Care System

Jayne Wilson	Safeguarding Lead, University Teaching Hospital Trust
Carolyn Taylor	Adult Safeguarding, City Council
Kerry Boughen	Safeguarding, Teaching NHS Foundation Trust
Sophie Lee	Safeguarding Lead, RENEW – Substance Misuse Service

2.4.3 The Independent Chair of the review panel is a retired senior Police Officer having retired in 2014. He is currently the chair of Kent & Medway Safeguarding Adult Board and Bexley Safeguarding Adult Board. He has experience and knowledge of domestic abuse issues and legislation, along with a clear understanding of the roles and responsibilities of those involved in the multi-agency approach to dealing with domestic abuse and Safeguarding Adults. He has a background in serious crime investigation, reviews, multi-agency panel working groups and the chairing of strategic and multi-agency meetings. He has been an Independent Chair for Domestic Homicide Reviews since 2015. The Independent Chair has no connection with the Community Safety Partnership other than being commissioned to undertake this Domestic Homicide Review.

2.4.4 It was reported that Amelia had lived and worked around the city for approximately two years before her death. She had settled well, rented her own home and was enjoying life in the UK. Amelia had worked in two locations at the time of her death. The review hoped to add further context to this from Amelia's employers. However, no information was provided by her previous employer despite requests to contribute, and the employer where she worked at the time of her death was only able to provide limited information. This lack of information was in part due to Amelia's employment status of being employed at the packing factory through an agency. It appears that during the first 6 months of working at the factory there is no Human Resource services available to employees. At the time of her death, Amelia had not reached this six-month timeframe. Subsequently only scant information of Amelia's time at this place of work was available from the

employer but some insightful detail was provided by her friend which added valuable context.

2.4.5. The nature of the relationship between Amelia and Marek was discussed at length by the panel. It was known that they had both grown up in Poland. Amelia had moved to the UK, and she had met Marek through a gaming website. The panel were provided with very little information about Marek and gathered only minimal details of his relationship with Amelia. In a bid to gain a greater understanding of the relationship, and the factors leading up to the tragic murder of Amelia, the panel carefully considered whether it would be appropriate to invite a contribution to the review from Marek. It was acknowledged by the panel this was a sensitive decision, but on balance it was felt that it could potentially provide much needed information to support reflection and learning following Amelia's death. The panel were clear that in inviting Marek to contribute, this did not in any way deflect from the horror of Amelia's death, nor would it be a main focus of the review. To progress this aspect of the review advice was sought from the Probation Services and it was agreed that Marek's Prison Probation Officer would initially speak to him to explain the review process. Marek subsequently agreed for a letter of approach to be sent. The Independent Chair wrote to Marek in January 2022, the letter contained information about the review process and invited him to contribute. On receiving the letter Marek discussed it with his Prison Probation Officer. Probation Services confirmed that Marek had agreed to contribute to the review and a date of 22nd April 2022 was arranged for an online meeting. The meeting commenced but during the introductions Marek declined to answer any questions and the meeting was ended.

2.5 <u>Review Meetings</u>

2.5.1 The review panel initially met on 8th September 2021 to discuss the terms of reference, which were then agreed by correspondence. The Crown Court trial into

Amelia's death took place November 2021 at which Marek made a guilty plea. Sentencing followed in January 2022. A further Review meeting was arranged for 31st January 2022. In the absence of any IMRs, this meeting established what would be the focus of the review and agreed actions. The review panel then met in September 2022 and December 2022 to consider this information and the draft Overview Report was considered, and amendments made. The final report was completed February 2023.

3. Parallel reviews

A Domestic Homicide Review of a similar nature is taking place in Northeast Lincolnshire and because of this the two DHR Panels have worked together to identify key themes and explore combined learning and activities going forward. Key panel members have agreed to continue to meet to drive this work.

4. Dissemination

The overview report will be shared with the following:

Hull Community Safety Partnership
Hull Safeguarding Adults Partnership Board
Hull Safeguarding Children Partnership
Hull Strategic Domestic Abuse Board
Office of the Humberside Police and Crime Commissioner

5. The Death of Amelia

5.1 Events surrounding the Death of Amelia

5.1.1 In March 2021 Marek knocked on a random door in the street, it was answered by a female. When she answered the door Marek informed her that he had killed his partner, Amelia. The female rang the Police emergency number and Marek

spoke to the call handler. He told them that he had stabbed his girlfriend with a knife and told them the location where this had occurred.

5.1.2 Police Officers attended Amelia's home address. There they discovered the body of Amelia lying on the lounge floor. There was a large wound to the centre of her throat, and she had bruising to her forehead, eyes, and nose. Amelia had died as the result of a ferocious attack.

5.1.3 Marek was subsequently arrested, charged, and detained in custody. In November 2021, at Crown Court, Marek pleaded guilty to the murder of Amelia. He offered no evidence but in mitigation said that he had been bought up in a family where domestic abuse was common and this had affected his behaviour. He was sentenced to seventeen and half year's imprisonment.

6. Equality and Diversity

6.1 The review addressed the nine protected characteristics (age, disability including learning disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, ethnicity, sex, and sexual orientation) as prescribed in the public sector Equalities Act duties and considered if they were relevant to any aspect of this review.

The review considers whether access to services or the delivery of services were impacted upon by such issues, and if any adverse inference could be drawn from the negligence of services towards persons to whom the characteristics were relevant.

6.2. At the initial Terms of Reference meeting the Chair discussed with the panel the cultural make-up of the members in relation to Amelia, her family, and Marek. It was agreed, in a bid to reflect and ensure a better understanding of the specific

cultural issues relating to Amelia and Marek's Polish heritage, that representation from a person with a Polish background should be sought to join the panel. As a result, a person with a professional background and understanding of domestic abuse within the Polish community were commissioned to join the panel. They brought context and knowledge of how Polish people have experienced living in the UK, and how Polish culture and relationships can differ from those in the UK.

6.3 It was acknowledged during the initial discussions within the panel that culture, upbringing, and customs may form an important part of this review. In preparation for this, and to increase awareness, the Independent Chair arranged for Panel members to be provided with a briefing, which offered valuable insights and background information into the culture that Amelia and Marek would have experienced in Poland. The panel felt that these cultural differences may be relevant and therefore should be considered as part of this review, whilst appreciating that individual circumstances and experiences can also vary greatly, this may have impacted upon the dynamics of the relationship between Amelia and Marek.

6.4 The panel agreed that a wider understanding of the Domestic Abuse services available within the area of Hull would be helpful. In particularly whether these services were flexible, had adapted and were cognisant of the diverse ethnic make-up of the city. As a result of this the panel agreed and commissioned the following work to be undertaken. The panel agreed to the undertaking of a survey which would be directed at self-defined females from an ethnic background other than that of the UK. This work was conducted through the City's Local Authority's Customer Insights and engagement team with the support of partnership community and diversity engagements groups. The responses failed to deliver any specific information relating to the target group and as a result the data collected has not been used in this review. However, the lack of response was discussed by the panel who felt this was indicative of the problem in engaging victims of differing ethnic groups who are victims of domestic abuse.

6.5 The Panel also agreed that the independent chair would meet with community groups and charities working in the city who support and represent victim/survivor and perpetrators of Domestic Abuse. These meetings were mainly held online and provided the independent chair with a useful insight into the different types of services and level of availability of services throughout the city.

6.6 In June 2022 Panel members also attended a national conference relating to the experiences of Polish women suffering domestic abuse in the UK. The conference also presented a report focused upon this. The report is entitled *"Polish women's experiences of domestic violence and abuse in the United Kingdom".* The report draws on data from 28 life history interviews with Polish survivors of domestic abuse and 18 semi structured interviews with statutory and voluntary services across the UK. I have, with the authors permission and where relevant, used and referenced information from that report within this review.

7 Background Information

7.1 Amelia

7.1.1 It is known that Amelia had lived in the UK for approximately 2 years, although exact details of the date she arrived and started work was not available for this review. Amelia had lived most of her life in Poland, where her family remain. The panel had scant information about Amelia's life and her family were so traumatized by the events of her death, and subsequent trial, that they did not feel able to engage in this review. In domestic homicide reviews the life and history of the victim is an important element. It allows the review to be balanced and respectful, ensuring that practice issues alone are not the focus of the report and that the individual at the centre of this report is visible and remembered. Whilst the panel would have liked to have heard more about Amelia as an individual and been able to have reflected this in this report, it fully understands why this was not possible. What the panel was able to learn is that when Amelia came to the UK, she initially worked for a local pizza delivery

company until August 2021. Amelia met Marek through an online gaming app and their relationship begun in 2020. In August 2020 Marek moved to the UK to live with Amelia. At the time of her death Amelia was working in a large packing factory outside of the city. Initially both Amelia and Marek worked there together, but it is understood that Marek later left his job and remained at their home.

7.1.2. Julia, one of Amelia's friends was identified and invited to contribute to the review and was contacted by the Independent Chair and a meeting was convened online.

Julia met Amelia whilst working in the packing factory. She only knew Amelia for about three months but during this time they had become more friendly and had arranged to go out after work together. This however never happened, and so their friendship was purely within the workplace. Julia described Amelia as a chatty, smiley, and a friendly young woman. As they became closer friends Amelia had shared that she had come to the UK to make a fresh start. Julia describes Amelia as a kind and lovely person. Amelia always said how much she loved working in the UK, doing different jobs and having a go at different roles. She had enjoyed travelling with her ex-boyfriend and that having come to the UK had worked hard to make a new life for herself. Whilst in the UK she had met Marek online and quite quickly he had moved from Poland to live with her. Julia shared a picture of Amelia's life at this time as a period of unhappiness and distress. She said that Amelia had told her that Marek, when left at home, would drink alcohol and smoke weed all day, and that sometimes she was frightened to go home.

7.1.3 Julia describes Marek as a controlling character who appeared to be jealous of Amelia's interaction with other work colleagues, particularly if they were male. Julia said that Amelia had told her that Marek had locked her in their flat when he went out. She said that she was very frightened of Marek and that he controlled everything that she did. Julia said that when at work Marek would come to where Amelia was working and watch her, talking to her in Polish,

despite the fact that this was contrary to a rule at the factory which stipulated that only English could be spoken in the workplace. Julia said it was apparent to her, and to other people in her team, that Marek was aggressive and controlling of Amelia. Julia said that on one occasion she recalls one concerned colleague, one of the cleaners, approaching Marek and asking him to give Amelia some space. Marek is said to have become very angry at this. Julia remembers on another occasion Marek approached her and Amelia when they were speaking and demanded she tell him what they were talking about. Julia confronted him back and as a result he stormed off. Julia describes later seeing Amelia and Marek talking together in the canteen and following this Amelia approached Julia and told her that everything she had said about Marek she had made up. It is Julia's belief that at the time of Amelia's death she was preparing to leave Marek and that somehow, he had become aware of this.

7.2. <u>Marek</u>

7.2.1. Marek moved from Poland in August 2020. Before this he had spent his entire life living in Poland. In pre-sentence reports provided to the court by the National Probation Service, Marek said that he had been bought up in a home where domestic abuse was frequent and persistent. He said that he was subject to emotional abuse from his Father. A psychiatric report provided to assist in sentencing, reported that the experiences and behaviours Marek was subjected to and witnessed by his father, as he was growing up, may have been a contributory factor of his own behaviour towards and attack upon Amelia.

7.2.2 The pre-sentence reports also make statements which can be described as 'victim blaming' and states that Marek had blamed some of his actions upon Amelia. He claimed that she was taking money from him and blamed her for their relationship difficulties.

8. Chronology (Research and Practice Evaluation)

This section considers in detail the information generated from the activity undertaken in response to the terms of reference (set out in section 2 of this report). This was obtained from a variety of sources and individual groups engaged in Domestic Abuse services from across the city, including surveys relating to the experiences of persons using Domestic Abuse services and migration reports relating to working population. Out of this emerged 3 distinctive questions.

1. What services are available in the city, and were those services adapted to support persons from different ethnic groups and backgrounds?
2. Did Amelia's place of work have processes in place to support victims of Domestic Abuse, and what support was available to her?
3. Was Amelia's status as a Polish national a hinderance to her obtaining support or escape from her dangerously escalating situation with Marek?

8.1 <u>What services are available in the city, and were those services adapted to support persons from different ethnic groups and backgrounds?</u>

8.1.1 A fundamental question in the provision of Domestic Abuse services in any town or city is whether they are accessible and available to all people experiencing Domestic Abuse. Amelia had not reached out for support. In an interview with Amelia's friend Julia, it became clear that Amelia was a victim of domestic abuse from Marek and that he was controlling of her movements and friends she kept. (4.1.3) however, no information was identified locally that at any time did she approach services within the city to seek help or advice. It is also clear that it was evident to others in the workplace that she was experiencing domestic abuse from Marek, but to the panels knowledge no one stepped in to offer her advice about services who could help her. It is evident that there are extensive services provided within the city and as part of standard contractual agreements all commissioned services must provide Domestic Abuse support within minimum standards. Two commissioned services provide accommodation-based support and outreach

support. In addition, this also includes online support and chat facility. The local authority also provides domestic abuse services to all victims of domestic abuse.

8.1.2 A variety of meetings were held during May 2022 with different voluntary agencies and organisations.

- BAME focus group
- Area Manager for Refugee council
- Perpetrator Programme
- Humber All Nations Alliance (Hanna)
- City's Polish Community Group
- Commissioned domestic abuse services – Women's Aid Refuge and Preston Road Womens Centre.
- City Council Domestic Abuse Partnership

8.1.3 A Domestic Abuse Partnership (DAP) team in the city provides a structure and platform for access to services. It is co located in a Police station and has representatives from Domestic Abuse Support Service (includes Independent Domestic Violence Advisor service [IDVA]), City Council Housing, Police, and substance misuse service. The team also has Reach in satellites situated within the following agencies:

Internal Council Departments

Children's Social care, Adult Social care, Housing Services, Targeted Young Support, Children's Centres x 8

External council departments

Department for Work and Pensions, renew – substance misuse service, Adult Education, Hull College, Wyke College, Lighthouse – Sex workers, Complex needs young people housing provider, Humber Mental Health Service, Humber All National Alliance (HAHA), Polish Community Service.

At each reach in location a Domestic Abuse Practitioner is available to offer support and advice to any person who reports that they are experiencing Domestic Abuse.

8.1.4 An Early Help and Safeguarding Hub (EHaSH) is located within Children's services. The DAP service rota a practitioner into the Hub daily. The practitioner takes part in discussions on referrals made to Childrens social care and attends children and adult strategy meetings, and more latterly the daily police Pit Stop meetings. The meetings focus on victims with children.

8.1.5 Escaping from Domestic Abuse is a fundamental challenge for victims and the city provides a variety of options in such cases. A DAP Practitioner linked to the City's housing Hub provides fast track Domestic Abuse support and advice and works alongside housing officers to identify appropriate emergency accommodation and housing options available within the city with support provided to realize any transition. The DAP service manages and facilitates the Sanctuary Scheme which provides additional security (target hardening) to enable a victim and their children to remain at home if they choose to do so. This also extends to other practical support such as digital door viewers, life alarms, mobile phones, SIM cards, additional fencing, lighting, CCTV, and smart phones. A Womens Aid refuge provided accommodation for victims fleeing Domestic Abuse together with ongoing out of hours support 24 hours a day. An additional and separate women's service offers an additional six properties all set up to provide safe accommodation. The City Council Housing hub also offer accommodation-based support for all victims of Domestic Abuse ensuring all those seeking support can access accommodation-based support tailored to their needs.

8.1.6. As previously described the DAP service provides a wide range of services and adapts the approach of agencies to meet the population make-up of the city. Data taken from the DAP case management system shows that between January 2019 to March 2021 965 contacts with people who identified as from a nationality other than British were offered support and interpretation services was provided. The breakdown of nationalities evidenced that 587 of the 965 contacts were with people identifying as Polish.

8.1.7. A Multi-Agency Risk Assessment Conference (MARAC) is a meeting where information is shared on the highest risk domestic abuse cases between representatives from police, health, child protection, housing practitioners, DAP Independent Domestic Abuse Advisors (IDVA), probation and other specialists from the statutory and voluntary sectors. National data relating to MARACs is provided on regional and local levels. This review examined the National data relating to the City and region, focusing upon the timescales set for this review and the number of cases considered where the victim was from a BME background. The data compared most similar police force areas and provided a guide to the number of cases expected to be considered. The city showed that it dealt with 125 cases per 10,000 population, compared with 63 per 10,000 population in similar locations, and that 12.1% of those cases where their ethnicity was not white British, compared to 9.4% in similar areas, and a national target of 7%. This highlights that the city is engaging with victims above the Safe lives recommended number. Matched with the DAP data evidences that the service is engaging with different ethnicities and nationalities.

8.1.8 The city has a strong and active link with the National "White Ribbon" charity. White Ribbon is a UK charity engaging men and boys to end violence against women and girls. (https://www.whiteribbon.org.uk). In 2015 the city obtained White Ribbon accreditation. This then led to many public and voluntary sector organisations becoming accredited and committing to the aims and objectives of the charity. This includes: Police, Fire and Rescue, Mental Health Services, Primary Health an secondary health, local schools and they use the key massages to raise awareness of Domestic Abuse and act to prevent it. Each year the city, led by the Children and Young People Living with Domestic Abuse Workstream to mark White Ribbon undertake the international 16 days of action whereby agencies engage with children and young people through local schools and community groups to raise awareness about Domestic Abuse and provide opportunities to discuss the role men play in preventing DA.

8.1.9 **The City Migration Profile 2020** provides an overview of the migration trends for the city. (Further details of which can be obtained at

www.migrationyorkshire.org.uk/statistics) I have reference in the paragraphs below data that I feel is most relevant or interesting to this review.

8.1.10 This report evidences the local population was estimated at 259,800 people. Different measures of immigration suggested between 2,400 and 3,600 new long-term immigrants (expected to stay more than 1 year) arrived in the city. The non-British population comprises of 10% of the community, above the regional average of 7%.

8.1.11 The overall number of new migrant workers arriving in 2019 was around 3,400, an increase of around 440 compared to 2018. There was an increase in arrivals from most regions of the world. The changes to European union (EU) membership led to an increase in Migration from those countries in comparison to non-European Union countries. By comparison and as example in 2019 2,400 arrivals came from European countries as compared to 1000 from non-European countries. From EU countries Romania was the top country of origin at 1,598 documented, Poland second with 450 and Lithuania third with 111 arrivals.

8.1.12 Information provided through the **city newcomers evaluation**, provided some interesting analysis from the above migration data (5.3.7). Migrant workers from non-EU countries tended to move into specific areas of the city with people from a similar background and culture, however people from EU countries moved into all areas throughout the city and concentration areas did not occur.

8.1.13 Information taken from the **National census data for 2021** showed that there were 1959 pupils in schools across the city who identified as polish, this equated to 5.1% of the total pupil population in the city. Around 6,600 pupils in Hull have a first language which is not English, this equates to 17% in primary schools and 14% in secondary schools, this is on par with the regional levels which are 18% and 14% respectively (source of data as 5.3.7 above)

8.1.14 Information taken from the **European Union Settlement Quarterly Statistics** provided more specific information relating to persons coming from Poland and demonstrated that an above average number of settlement applications were

received, between 28th October 2018 and 30th September 2022, 12,230 applications were made from a total number of 38,480 applications from all countries across the world. Although the data falls outside of the time scales set for this review is demonstrates the strong link between the city and settlement applications from Poland.

8.1.15 14 in every 1000 new GP registrations in the city are made by people who previously lived abroad, compared with a regional average of 10 per 1000 population. (Source of data as 5.3.7 above)

8.1.16 The fertility rate in the city has fallen in recent years but remains on par with the regional average. 23% of births were to mothers who were themselves born outside the UK, slightly above the regional average of 21% (source of data as 5.3.7 above)

8.2. Did Amelia's place of work have processes in place to support victims of DA, and what support was available to her?

8.2.1 In 4.1 above, background information is provided about Amelia's place of work together with information from her friend Julia (appendix B contains a transcript of the interview with Julia) Further information has been provided by a representative from the packing factory where Amelia was employed.

8.2.2 Information provided to this review by a management employee from Amelia's workplace described that the workforce at the factory was estimated to be made up of 50% EU nationals and 50% British workers. Staff were provided to the factory via a recruitment agency, who would retain responsibility for them for a period of 3 months, following this the employee would be fully employed by the factory. Following a total period of six months Human Resources support would be provided to staff by an independent company. At the time of her death Amelia had

not been employed for the requisite time to be entitled to Human Resource support.

8.2.3 The factory did not provide any details of reporting mechanisms for Domestic Abuse. The recruitment company who provides the staff to the factory stated that once the person had started work, they had no further contact with them.

8.2.4 Information provided to this report from Julia demonstrates that Marek was openly aggressive and controlling towards Amelia while at work. Marek asked supervisors to allow him to work closer to Amelia because of his bad knee, Julia felt that this was because he wanted to control her. Julia described how she could see a physical change in Amelia's body language when Marek was close by. She told Julia how Marek would lock her in their flat if he went out, he told her what to wear and became aggressive if she spoke to other men. Julia said that it became obvious to other workers how controlling Marek was of Amelia, and some tried to intervene by speaking to Marek and Amelia. Julia described that Marek would only ever speak to Amelia in Polish, this was against the terms of conditions for workers employed at the factory. Julia said that following an incident where Marek was challenged by a co-worker about his behaviour towards Amelia, he left the job at the factory, but Amelia continued. Julia said she was pleased this happened as she felt that now Amelia could move on from Marek. However, from that day on Julia said that she and other work colleagues could see that Amelia was upset daily, and frequently would be crying at work. Julia and other work colleagues tried to discuss this with Amelia in a bid to support her, but she refused to speak about the reasons, she did say to Julia that while she was working Marek would remain at home drinking alcohol and smoking weed.

8.2.5 In the days before Amelia died, she had told Julia that Marek had said to her that if she left him, he would kill himself, and that she was afraid to go home. Julia gave Amelia her phone number and told her to call if she needed anything at all. Julia said she felt frightened for Amelia wellbeing.

8.2.6 Julia described the on-floor workforce at the factory they worked at was mostly female but most of the managers and supervisors were male. It was Julia's view that the supervisors clearly knew what was happening between Amelia and Marek but did nothing to intervene. To Julia and her colleagues, it was clear Amelia's situation was not good, and it was Julia's view that the supervisors or managers did nothing to help her. Julia said there were a few people working with Amelia who tried to help but it was also the case that many did nothing. Describing a situation of people possibly seeing her circumstances as something to accept, of turning a blind eye, or simply not wanting to get involved. Julia's own self-reflection was that she was saddened that she had not done more, often wonder if she could have, and blamed herself for not intervening more forcefully.

8.3 <u>Was Amelia's status as a Polish national a hinderance to her obtaining support or escape from her dangerously escalating situation with Marek?</u>

8.3.1 People who come from different cultures, ethnic origins and nationalities can lead to them having different values and cultural norms. In this review it was important to understand if this was a relevant factor in Amelia accessing Domestic Abuse services and whether services were structured and cognisant of such differing values and experiences.

8.3.2 VESTA is an organisation dedicated to supporting Polish victims of Domestic Abuse living in the UK. It was established in 2018 and built upon the work carried out by a Polish Domestic abuse helpline established in 2014. A representative from VESTA was invited to be an independent consultant to the panel. A briefing to the panel was provided about Domestic Abuse within Poland, highlighting attitudes and different views that can be prevalent within the Polish community.

8.3.3 In June 2022 a conference focusing upon Domestic Abuse within the Polish community was held in Manchester. The conference presented the findings of a significant report entitled ***"Polish Women's experience of domestic violence and***

abuse in the UK". The research was undertaken, and a report was written by Iwona Zielinska, Sundari Anitha, Michael Rasell and Ros Kane.

The report provides very interesting reading, and, in my view, the summary gives a backdrop and context to Amelia's situation that is helpful to reflect upon within this review. The report presents the findings of the first research project to investigate Polish women's experiences of domestic violence and abuse, and services responses in the UK. It seeks to understand why Domestic Abuse services receive few referrals from Polish women despite the Polish community constituting the second largest foreign-born group in the UK with over 700,000 residents.

8.3.4 The following is a summary of key points and information taken from the Report's executive summary.

The research identified that domestic abuse was poorly recognised in Poland with the Polish government sited as critical of domestic abuse and women's rights campaigns as undermining traditional values, the sanctity of marriage and Polish identity. It also found that non-physical forms of abuse were poorly reflected in Polish law and state policy, as well as funding cuts to services and the threat to withdraw from the Istanbul Convention on combating violence against women. It concluded that it was not possible to provide an accurate picture of the prevalence of domestic abuse amongst Polish women in the UK due to crime data not identifying victims by country of birth, however Polish women are over- represented in femicide statistics in the UK.

The research found that women experienced multiple forms of abuse, with coercive and controlling behaviour being most common, but always with other forms, i.e., physical, psychological, economic, sexual. It concluded that women's understandings of abuse and their view on possible options were shaped by their experience of migration, their personal circumstances, how settled or isolated they may have been, as well as conflicting values from Poland around the family and alcohol.

The research highlighted the complexities for women around personal recognition that they were experiencing, and it recognised that this was a gradual process that often required outside intervention from friends, family, or services. Strong influences were traditional Polish cultural and religious values and norms about women's roles within family, as well as shame and stigma attached to divorce and failed relationships, which impacted on women's disclosures of violence. Fear of repercussions by the perpetrator and intervention by formal services was evident, as well as an undercurrent sense of worry about their children being taken into care. Another significant barrier reported by practitioners related to benefit entitlements, housing, and no recourse to public funds.

The role family, friends, and social networks, including those made through work, was recognised in enabling women to recognise abuse and in giving emotional and practical support. However, these networks were not always supportive, could side with the perpetrator and engender shame on women for 'breaking up' the family and ignore the abuse, which resulted in women being trapped in the relationship for longer.

The research also concluded that Polish women are often unfamiliar with what services there were available to support them, lacked knowledge of the legislative frameworks and practice processes in the UK, such as Legal Aid, social housing, child protection and police injunctions.

It also very confidently concluded that domestic abuse services were good at recognising and understanding women's background, migration patterns and specific barriers they experienced which impacted on their decisions to take action.

9. Analysis

9.1 During this review the city provided the opportunity for the panel to engage with and review services dedicated to the delivery of domestic abuse services, and this was

offered and facilitated with openness and transparency. It is clearly evident that systems and processes within the city are well established, and a true sense of collaboration exists. The Domestic Abuse Partnership (DAP) provides strong guidance to all statutory services which is backed up by practical support through the provision of specialist Domestic Abuse Practitioners or IDVA's, and a Coordinated Community Approach is delivered by statutory, charity and voluntary sector organisations. The City Council demonstrates their commitment to ending Domestic Abuse by ensuring all commissioned services must evidence that they have policies in place to support victims/survivors and staff who become victims/survivors of Domestic Abuse before contracts are granted. The City is also a dedicated White Ribbon organisation and takes an impressive and proactive approach to expanding this network within the area. White Ribbon website data evidences that Hull visits falls number 3 after much larger population areas of London and Manchester. It undertakes direct work to increase awareness in local schools and across the community, including professional sports teams. Most Statutory services are signed up to the White Ribbon principals and each year 16 days of action provide a focus in schools across the city.

9.2 This review only focused on one local business, the packing factory that Amelia and Marek worked in. It considered the delivery of support services available to people working within this setting. The information provided to this review was limited and due to ongoing COVID restrictions meetings were held via online processes. At the time of her death, Amelia had worked within the factory for less than 6 months and was therefore not entitled to any supportive policy or Human Resource processes. A manager with responsibility for Human Resources from the factory met with the independent chair. The information they provided confirmed that access to support services within the organisation was limited generally, and did not include any support or guidance around Domestic Abuse. Because Amelia fell below the 6-month period required, she had no rights or access to support from them as an organisation. The established process of supplying staff to the factory was managed through an independent recruitment agency and although information provided to the review stated that the recruitment agency retained responsibility for staff for the first 2 months, the reality was that there was no involvement once they had begun work.

Human Resource support was only available to staff once six months continuous employment at the factory had been achieved, and this was outsourced to a private Human Resource service. The factory representative was able to confirm some details about Amelia and Marek and stated that Amelia was a good worker with good attendance. Marek was said to have had a lot of time off and it was noted that there was a rumour that he was jealous of Amelia. It was also known that Marek had a specific disagreement with Amelia, and he was angry. This confirms that that there was evidence of a concern and some knowledge regarding the relationship between Amelia and Marek, and that this had reached senior manager level within the organisation. Despite this nothing was done to reach out to Amelia to check she was ok, offer advice and information regarding available services in the area, or support as an employee. This was an opportunity missed.

9.3 Information provided by Amelia's friend, Julia, said that supervisors and managers were aware of the problems between Marek and Amelia, but they did not intervene or offer support to Amelia. This supports the view that no information or intervention was provided to Amelia relating to accessing local Domestic Abuse services which might have assisted her in dealing with her situation. It also describes the position that managers and supervisors, although aware that Amelia was experiencing difficulties within the workplace from Marek's aggressive and controlling behaviour, did nothing to intervene to offer support or protect her by implementing measures within the structured day. This was a missed opportunity.

9.4 The information provided by the City's DAP service showed that they have extensive and effectively support available to a person in Amelia's position. It is however a tragic fact that Amelia appeared to not have information, or was unable to, or was prevented from seek support. Evidence provided to this panel strongly suggests that information about such support services was not readily available to Amelia. We know it was not available to her through her work, no one directly offered her information about services even though there was a concern for her wellbeing. There did not appear to be a welfare culture within the factory and not even a poster on a notice board was there to offer an opportunity to seek help. We know very little of

Amelia's life, but it is not too big a leap for us to conclude that potentially valuable information alluded her. Whilst registered with a GP in the area she never attended the surgery and to our knowledge no one outside of her work knew of her situation. Her place of work was outside of the city, and she travelled daily to the factory with Marek, so she wasn't exposed to community notices and information about support services. It is fair to conclude that Marek's control of Amelia made it impossible for her to seek help. Amelia's work colleagues, although concerned and keen to help, were not supported by their supervisors or by relevant supportive information as it was not available within the workplace. There were missed opportunities, that is clear, but it is impossible to say that if supportive information had been offered or available to Amelia that she would have taken action to move away from Marek in a supported and safe way.

9.5 Amelia had moved to the UK to work and build a new life, she had enjoyed traveling across Europe with a previous partner and told friends that she was keen to establish a home in the UK. She enjoyed work and was described by her friend Julia as fun and very smiley. Amelia met Marek on a gaming website and at the time of their meeting he lived in Poland. Following a short online relationship, she went to meet him in Poland, and he came to the UK to live with Amelia. Both Amelia and Marek had lived in Poland for all their childhood and early adulthood. This review considered why, when Domestic Abuse became a feature of her relationship, she did not seek support from the services available within the city. We have concluded that potentially she did not know about such services, but also it is possible because she had come from Poland and was working on a temporary basis in the UK, made services seem unavailable to her. Information provided to this review (5.1.9) highlights that migration from Poland for work made up the second largest population increase across the city. In the report entitled *'Polish women's experience of domestic violence and abuse in the UK'* (referenced in section 5.3 of this report) Domestic Abuse in Poland is poorly recognised, and it is particularly noted that non-violent abuse was not generally considered as abuse, as was the case in the UK until relatively recently. This lack of recognition leads to a lack of reporting, and this may have been relevant for Amelia. In the UK coercive control is defined under the Serious Crime Act 2015 as,

A person (A) commits an offence if —

- (a) A repeatedly or continuously engages in behaviour towards another person (B) that is controlling or coercive
- (b) at the time of the behaviour, A and B are personally connected
- (c) the behaviour has a serious effect on B, and
- (d) A knows or ought to know that the behaviour will have a serious effect on B

Coercive control is a course of conduct – not a single action but a continuous set of actions - which pervade all areas of a victim's life, and which subordinates the victim to the will of the abuser. Ultimately, the victim becomes unable to think or act for themselves. Coercive control is invisible in plain sight, making it difficult for those outside of a relationship to recognise the abuser's behaviours as coercive.

From the information about Amelia's relationship with Marek she was clearly a victim of coercive control, as defined above. Information provided to this panel suggests that Marek locked her in the flat when he went out, he didn't allow her to speak to other people at work, he controlled her interactions with other men and threatening to kill himself if she left him. All are examples of coercion and control as is her fear of him. Information provided to this review also shows that Amelia was distressed and upset by her situation, her persona and presentation changed from a happy smiley young woman to someone frightened and crying at work, she also expressed fear about going home. There is also a suggestion that she may have been preparing to leave Marek.

There is extensive evidence from research and studies that shows a victim of Domestic Abuse is at greater risk when their intent to leave becomes known to the perpetrator, and in many cases, this has sadly led to death. We do not know if this is true in Amelia's case, but it is one theory as to what led Marek's violent attack and murder of Amelia. An Eight Stages of Homicide framework has been developed by Professor Monckton-Smith which has spanned many years. The homicide timeline lays out identifiable stages in which intimate relationships, where one partner is coercive, can escalate to

murder. The timeline aims to support a better understanding of coercive control and domestic homicide amongst professionals responding to domestic abuse. (Monckton-Smith J ***In Control: Dangerous Relationships and How They End in Murder*** **(2021)**

Further academic research is available on this subject and the following studies relate to the effects and impact of the coercive control. Not all the examples below relate to what we know about Amelia's situation, but this is largely due to the lack of information available to this review, however there are clear parallels to be made from what we do know about Amelia and Marek's relationship.

The following quotes from research, taken from a variety of studies, outline not just the prevalence but the significant impact it has on the victim's life and wellbeing.

Evan Stark suggests the experience of living with a coercively controlling partner is like living in an invisible cage. He describes how '[the] barrage of assaults, locked doors, missing money, rules for cleaning, text messages...[are] recognised as bars. He goes on to describe coercive control as:

"A course of conduct that subordinates (the victim) to an alien will by violating their physical integrity (violence), denying them respect and autonomy (intimidation), depriving them of connectedness (isolation) and appropriating or denying them access to resources required for personhood and citizenship (control). (*E Stark Coercive control:* ***How men entrap women in personal life.*** *Oxford University Press, 2007)*.

Marianne Hester describes coercive control as a 'long thin offence', explaining that abusers often do not stand around with blood on their hands waiting to be arrested and victims do not always present to professionals with visible injuries. (*M Hester, Domestic Abuse Masterclass: Thames Valley Police October 2013, cited in J Monckton Smith, A Williams, & F Mullane,* ***Domestic abuse, Homicide, and gender: Strategies for policy and practice*** *Palgrave Macmillan 2014)*

Emma Williamson describes the abuser's world as an 'unreality' that their partner must negotiate to survive. The rules of this world change without notice and the

abused partner must keep up with the new rules or suffer the consequences. (*E Williamson* ***'Living in a world of the Domestic Violence Perpetrator:*** *Negotiating the unreality of coercive control 2010.)*

Coercive control is often described as invisible in plain sight because the behaviours of the abuser are nuanced and private, and the attached meaning only known to them and their partner. Once a victim has been conditioned by their partner, it only takes a look, a gesture, as single word, or comment, for the victim to understand what is expected of them. They also know that if they do not comply there will be consequences. This is usually not obvious to others outside of the relationship as they do not understand the meaning behind the abuser's gesture, look, word or comment. Living in reality where the goal posts change, and the victim has to second guess situations regularly inevitably impacts on an individual's mental wellbeing. This is often further used by the perpetrator as a means of control and derision, which can lead to victims losing all sense of themselves.

Coercive and controlling behaviours are often very subtle, nuanced and are completely individual to the person on the receiving end, therefore the identification of changes in personality and character can be central to beginning to understand a person's lived experience of Domestic Abuse. We saw this reflected in the statements made by Julia about Amelia and her recognition of how much she had changed in a short period of time. It was however evident to others that Marek was a controlling factor, and that Amelia was suffering consequently. Even with this understanding there was a passive engagement, and possibly an accepting response to her situation from the majority of people around her.

9.6 Information provided to this report and referenced in section 5.1 demonstrates the changing demographics of the city. Changes in EU membership had led to an influx of people entering the UK for the purpose of finding work. The industries in the city, dependent on large work forces, became a destination of choice and work was plentiful. It was evident to the panel that Statutory services do try to keep pace with such changes and differing voluntary groups and individuals work hard to ensure needs of new residents and citizens of the city are met. As previously highlighted

Settlement applications from Poland are well above national averages and workers from Poland made up the second largest group migrating to the UK, School data taken from the 2021 census demonstrates that 5.1% of the school population in the city identify as Polish, and at the same time 23% of all births were from mothers who were not born in the UK. As highlighted in the report '*Polish women's experience of domestic violence and abuse in the UK'*, Polish women were not familiar with what services were available in their new communities and how they could help them. They also didn't know about formal structures such as legislation or the supportive practice to assist them if faced with the terrible reality of feeling trapped within an abusive relationship. So, the structured safety net that we know is well established within our society, somehow seems to evade them. It does feel after analysing the information provided to this panel that this resonates with Amelia's circumstances. She was powerless herself to act, worn down by the undermining coercion and control, and didn't have information about pathways to avenues of support.

Although this review rightly focuses on Amelia, and endeavours to give greater understanding to her individual circumstances, it would not be a huge leap to conclude that other women from other ethnic backgrounds coming to the UK for work, or fleeing persecution in other parts of the world, may find that access to Domestic Abuse services difficult, or they believe are unavailable to them. Whilst there is evidence provided to this review that the city demonstrated a higher-than-average response to persons from a BME background (5.1.6 & 5.1.7 refers) services continually have to adapted their support to meet the changing demographics and subsequent risk to specific groups. This requires long term planning involving education, careful monitoring of population changes and a flexible approach from all agencies whether private of public sector, as well as from the community which must include employers. Information and support are there but making it accessible to all requires a collective understanding and commitment.

10. Conclusions

10.1 This review has determined that Amelia was a victim of domestic abuse and was subjected to coercion and control by her partner Marek. This persisted and ultimately

led to her tragic death on the 27th of March 2021. The panel was presented with evidence that both colleagues, supervisors and managers at her workplace knew she was unhappy, and that Marek exerted control over her. No support was available to her from the workplace, and although it was widely known that she was experiencing difficulties no offer of support, or even check in, was done by her employer. It appears the only outlet Amelia had to confide in and get support was with her friend Julia. We know Amelia was invisible to Domestic Abuse services and we have concluded that it is highly likely that she did not have access to, or knowledge of, any of the services locally that could have given her practical support and advice.

10.2 The provision of Domestic Abuse services within the city is of a high standard and supported by all statutory agencies through the Domestic Abuse Partnership (DAP). The Commissioned Domestic Abuse Services are also flexible in terms of the support they offer. However, when overlaying the changing demographics of the city through work force recruitment a more complex environment emerges. Different life experiences, views surrounding relationships, empowerment, and Domestic Abuse, create challenges for all agencies. There is no evidence that Amelia sought support or help to escape her situation, but we do know she was registered with a GP surgery and applied to the City's local authority housing provider via an online system for housing provision for herself and Marek. However, she did not raise concerns about her situation with any of these agencies. This supports the narrative that Domestic Abuse services may have been invisible to her, or that she did not identify with being a victim of Domestic Abuse. The data analysis provided to this review and reflected upon in 5.1.6 & 5.1.7 shows a good response to that changing demographic awareness of the changing population, and the different cultural values and norms. However, this is a complex issue so gaining further understanding and considering what services need to do and how they need to change to ensure that are not just available, but accessible to all nationalities within the community, is essential for the city 's Domestic Abuse services to remain truly inclusive.

10.3 Amelia like many other migrants to the city arrived intending to work hard and finding a new life. The transition from a life in another country can be difficult. The UK

economy benefits and is dependent upon the support of workers from other countries and continues to seek ways to encourage people to come to the UK for work. It was therefore disappointing that the level of support provided to Amelia when at work was so limited. Setting aside the lack of intervention from supervisors when Marek was openly intimidating and controlling of Amelia at work, but the fact that no Human Resources support is available for new employees until six months continuous employment is completed seems totally unfair. This, in my view, demonstrates a lack of basic care and places no consideration or value on the contributions or welfare of the workers. It clearly does not provide for or is conducive of a supportive working environment.

10.4 In seeking to end Domestic Abuse, setting out what is unacceptable behaviour and challenging it when evident remains a critical approach for statutory services, community groups and employers. The '*White Ribbon'* charity provides a solid platform for this, and it is evident that the City's statutory agencies engage well and support its principals. Understanding the signs of Domestic Abuse or the behaviours of a perpetrator engaged in coercive behaviour is complex and can be difficult. Amelia was the victim of controlling behaviour by Marek while at work. Her work colleagues were aware and tried to help, offering support, and showing kindness towards her. However, although aware of the issues supervisors and managers did not intervene. Had information been provided within the workplace through briefings or availability of literature, offering information to those experiencing Domestic Abuse, Amelia may have sought support, if not through work but via community services. No training or information for supervisors and managers on what they should do if they were concerned a staff member was experiencing Domestic Abuse was available at the factory, leaving individuals to find their own responses to what we know is a very complex situation. In reality this led to no action and no support for Amelia. Amelia may have been able to escape her situation if afforded support. Sensitive reflection of the tragic circumstances of Amelia's death does provide an opportunity for the employer to consider its approach and response to staff regarding all welfare matters. It also makes a clear case for providing training for supervisors and managers to equip them to respond to such situations where staff wellbeing is identified.

11. Lessons Learned

Information should be made available in a variety of languages relevant to the city and in different formats. The accessibility of information in a person's first language is important in building inclusivity as it not only increases awareness provides information and signposting support services available to all.

Through the already established engagement with schools, further development work to engage families and community groups should be used to support and improve awareness and understanding of what healthy relationships look like, and the different level of support available across the city.

Information and support regarding DA is limited or even non-existent in some workplaces, leaving individuals unsupported and unaware of pathways to support.

Reaching out with information, advice and potentially training to employers should be considered to work towards developing a culture within the wider City and community that recognises and wants to combat violence against women and girls. Engendering an increased awareness and supportive response for all employees experiencing Domestic Abuse in the area, to include migrant groups and temporary workers.

We know that Domestic Abuse and particularly the elements of coercive control were features of the relationship between Amelia and Marek. This has been and may continue to be accepted as within social norms by some communities. However, it is important not to conflate the two and ensure information, awareness and training about coercion and control clearly defines it as Domestic Abuse as per legislation and national guidelines

12. Recommendations

12.1 The review panel made 6 recommendations from this DHR:

	Recommendation	Organisation
1	That a campaign of action driven by the Community Safety Partnership and High Sheriff of the East Riding of Yorkshire 2022/23 to be undertaken to influence community groups and	

	local businesses to provide support and information to people suffering domestic abuse	
2.	Literature and information be available to community groups provided in languages reflective of the demographics within the city	
3.	Awareness be raised around the signs and impact of coercive control within all agencies, through a series of quick learning processes	
4.	White Ribbon campaigning be promoted beyond public sector.	
5.	Greater support for schools in promoting healthy relationships in particularly a focus upon coercive control.	
6.	Consider developing out-reach opportunities to engage and raise awareness within hard-to-reach communities.	
7.	Hull and North East Lincolnshire DHR Panel member representatives continue to meet to share key learning.	

Appendix A

TERMS OF REFERENCE

On 27th March 2021, police officers attended an address in the city. They found that Amelia the victim had been stabbed repeatedly and was dead.

Andrew Rabey February 2023

1.2 Marek was arrested for murder and was subsequently charged and remanded in custody. On the 23rd of December 2021 following a guilty plea, Marek was sentenced to 17 ½ years in prison for the Murder of Amelia

1.3 Following a discussion with the Community Safety Partnership representative and Humberside Police on the 20th of April, Humberside Police sent a formal notification of Amelia's death. In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Domestic Homicide Review (DHR) Core Panel meeting was held on 13th May 2021. It was confirmed that the criteria for a DHR have been met.

1.4 That agreement has been ratified by the Chair of the Community Safety Partnership (under a CSP agreement to conduct DHRs jointly) and the Home Office has been informed.

2. The Purpose of a DHR

2.1 The purpose of this review is to:

i. Establish what lessons are to be learned from the death of Amelia in terms of the way in which professionals and organisations work individually and together to safeguard victims.

ii. Identify what those lessons are both within and between agencies, how and within what timescales that they will be acted on, and what is expected to change as a result.

iii. Apply these lessons to service responses for all domestic abuse victims and their children through intra and inter-agency working.

iv. Prevent domestic abuse homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

3. The Focus of this DHR

3.1 This review will establish whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Amelia.

3.2 If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.

3.3 If domestic abuse was identified, this review will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols, and

procedures in existence at the time. If domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also consider current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

In line with the statutory guidance, these terms of reference are subject to review and updating as the DHR progresses.

This Domestic Homicide Review will cover the time Amelia was in the UK from 1st January 2018 Until her death on 27th March 2021.

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.
e) Contribute to a better understanding of the nature of domestic violence and abuse; and
f) Highlight good practice.

Specific Terms of Reference

In addition, the following areas will be addressed in the Individual Management Reviews and the Overview Report:

1. If the adult had no known contact with any specialist domestic abuse agencies or services. The review will address whether the incident in which they died was a 'one off' or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic abuse.

2. Whether family, friends or colleagues want to participate in the review and if so whether they were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide.

3. Whether there were any barriers experienced by adult or family/ friends/colleagues in reporting any abuse, including whether they knew how to report domestic abuse should they have wanted to.

4. Whether the adult had experienced abuse in previous relationships, and whether this experience impacted on their likelihood of seeking support in the months before they died.

5. Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by the victim that were missed.

6. Whether the alleged perpetrator had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies.

7. Whether there were opportunities for agency intervention in relation to domestic abuse regarding adult, the alleged perpetrator or any dependent children that were missed.

8. The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the city.

9. The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator, and dependent children e.g., age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

10. The review will examine issues of forced marriage and honour-based violence to assess agency's responses at relevant times.

The review will consider any other information that is found to be relevant.

TERMS OF REFERENCE PART B – QUESTIONS TO BE COVERED IN THE IMR

The review should consider the events that occurred, the decisions made, and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened but why. Each homicide may have specific issues that need to be explored and each review should carefully consider the individual case and how best to structure the review in light of the particular circumstances. The following are examples of the areas that will need to be considered:

- Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

- When, and in what way, were the victim 's wishes, and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options / choices to make informed decisions? Were they signposted to other agencies?

- Had the victim disclosed to anyone and if so, was the response appropriate? Was this information recorded and shared, where appropriate?

- Are there ways of working effectively that could be passed on to other organisations or individuals?

- How accessible were the services for the victim and perpetrator?

Appendix B

Meeting with Julia

This meeting relates to the DHR about Amelia who was murdered by Marek on 27th March 2021. The meeting was held over the phone on 25/05/2022 and these notes are a summary of the conversation that took place, no other persons were present.

I first met Julia in the break room at the factory where we both worked. This was approximately 3 months before Amelia died. Amelia was always with Marek, and she was a chatty, smiley, and friendly. I noticed that Marek hardly ever spoke to anyone else. I became aware that Marek did not like working in his section and asked to work directly with Amelia, He told the supervisors that he had a bad knee and needed to be close to Amelia because of this. This move was driven by Marek and not Amelia this I soon realised was because he wanted to control Amelia. I was aware that Amelia was friends with another worker whom she had previously worked with in another team. Over a period, Amelia and I became friends. Amelia told me that she had come to the UK for a fresh start and a new life and that she had met Marek on a gaming website. We had arranged to meet outside of work together, but this did not ever happen.
When at work I noticed that often Marek would come over to where Amelia was working and stand behind her watching what she was doing, he would speak to her in Polish. As we became more friendly Amelia would tell me about her relationship with Marek and it quickly became obvious to me and other workers on our section that Marek was very controlling of Amelia. Marek came across as aggressive and did not get on with other people at the factory his eyes were always cold, and everyone felt uncomfortable around him.
As Amelia became more friendly she spoke more openly about her relationship with Marek I could see that when he was around she would look unhappy and in her body language, her shoulders would hunch and she would look withdrawn, I have seen people affected by domestic abuse in the past and feel you can recognise the signs and see the impact through their stance and body language, and I could see this in Amelia. She told me and others that she was unhappy but would not talk to men as she was aware how angry this made Marek. She told me that Marek lived with her at her flat, and when they were there if he went out, he would lock her in the flat and take the keys with him so that she could not leave. She also told me that they had other jobs in the past where they worked together but when Marek was not working directly with her they would leave the job and go on to another one.
It began to become more and more obvious to other workers how controlling Marek was over Amelia, and some other workers spoke to him, I remember there was a cleaner who worked at the factory, and she spoke to Marek telling him to give Amelia more space, he did not like this and when people spoke to him, he said he did not understand what was being said to him. One of the rules

where we worked was that all workers had to be able to speak read and write English and when at work, they were meant to speak English all the time. Marek did not do this with Amelia.
On one occasion I was speaking to Amelia when Marek came over and demanded to know what we were speaking about, this made me angry, and I told him to fuck off and leave us alone. Due to this Marek got angry and stormed out of the work room and said he was going to quit. At this Amelia began to cry and said that she was frightened of Marek, and she told me that he controlled everything she did. Later in the canteen I saw that Marek was there, and she went over to him, and they began to talk in Polish. Following this Amelia came over to me and said that everything she had previously said was not true.
I was then not in work for three days and I was really worried and scared for Amelia. The next time I was at work I saw Amelia, but Marek was no longer there. I was so relieved I went over and gave her a big hug and she hugged me back. I really wanted to help Amelia and when Marek was not there I really felt I could do something. From then onwards each day I and my work colleagues could see that Amelia was really upset, her eyes were always puffy, and she was frequently crying but Amelia refused to speak to anyone about why she was so upset. When she was asked, she said that everything was fine, but it was clear to me that it was not. She did tell me that when she was at work, and since he had left the job at the factory, Marek would sit at home drinking alcohol and smoking weed all day. This was the week before Amelia was killed.
Later in the same week, on Thursday, before the weekend she was killed, she told me that Marek had said that if she left him, he would kill himself. She also said that she was afraid to go home. I gave Amelia my phone number and told her to call me if she needed anything at all and I said that I would speak to her again on Monday.
At 3 am on Monday morning I received a message with a link to a report telling me that Amelia had been killed by Marek. I went to work that day, and everyone was shocked but spoke about it like it was a bit of gossip, which made me sad and angry.
A person from HR came down to the where we worked and said that the door to HR was always open if anyone wanted to talk.
Where we work at the factory the main work force is female but most of the managers and supervisors were male. The supervisors clearly knew what was happening between Amelia and Marek but did nothing to intervene. Amelia made it clear that her situation was not good, and I am concerned that nothing was done. It was always the people working around Amelia who tried to help but many did nothing. I am sad I did not do more and often wonder if I should and at times blame myself for not doing more. Amelia was a kind and lovely person; she was always smiling when she was with me. She told me that she loved working in the UK and doing different jobs and having a go at all the different roles. She had enjoyed travelling with her ex-boyfriend and that having come to the UK had worked hard to make a new life for herself.
Soon after this I left for maternity leave and have not returned to work at the factory. It is not the job for me.

GLOSSARY

Abbreviation/Acronym	Explanation
DHR	Domestic Homicide Review

IMR	Independent Management Review
DA	Domestic Abuse
GP	General Medical Practitioner
EU	European Union
CSP	Community Safety Partnership
MARAC	Multi Agency Risk Assessment Conference
DAP	Domestic Abuse Partnership
CHCP	City Health Care Partnership
AAFDA	Advocacy After Fatal Domestic Abuse
BAME	Black Asian & Minority Ethnic
UK	United Kingdom
CCTV	Closed Circuit Television