Domestic Homicide Review (DHR)

Amelia

March 2021

Executive Summary

Author: Andrew Rabey

Commissioned by:
Hull Community Safety Partnership
Review completed February 2023

OFFICIAL SENSITIVE

EXECUTIVE SUMMARY

The Review Process

This summary outlines the process undertaken by the Multi-Agency Review panel in reviewing the death of Amelia who lived in the city of Hull.

To protect the identities of the deceased and her family members, the deceased is referred to in this DHR as Amelia.

Amelia was a white Polish female, who was thirty when she died.
In March 2021, Amelia was killed by her partner Marek and in December 2021 he was found guilty of her murder.

The DHR Core Panel met on the 8th of September 2021 following an agreement that the criteria for a DHR were met. Agencies that potentially had contact with Amelia and/or Marek prior to Amelia's death were contacted and asked to confirm whether they had contact with them. This highlighted that neither Amelia nor Marek were known to agencies.

Although Amelia did not have contact with agencies or services, 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.

Contributors to the Review

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.

Review Panel Members

The members of the panel were:

Name	Role
Mark Skelton / Emma Heatley / Vicki Paddison	Detective Inspector, Humberside Police 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

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.

Author of the Overview Report

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.
The Independent Chair has no connection with the Community Safety Partnership and agencies involved in this review.

Terms of reference for the review

The terms of reference were agreed by the core panel for this review following their meeting in September 2021

Background

Amelia

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.

Events surrounding the Death of Amelia

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.

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.

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.

Summary Chronology

This review focused upon the information generated from the activity undertaken in response to the terms of reference. 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?

Findings from the Review

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 evidence 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.

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.

Several Amelia's friends from work were contacted and invited to contribute to the review. 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.

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.

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 must 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 many people around her.

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 must adapt 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.

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.

Recommendations

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 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 Northeast Lincolnshire DHR Panel member representatives continue to meet to share key learning.	