Domestic Homicide Review Report

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

Review into the death of Katarzyna
in December 2021

Independent Chair: Gary Goose MBE

Report Author: Christine Graham
April 2023

Preface

The Bassetlaw, Newark and Sherwood Community Safety Partnership and the Review Panel wish at the outset, to express their deepest sympathy to Katarzyna's family and friends. This review has been undertaken in order that lessons can be learned.

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

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

This Overview Report has been compiled as follows:

Section 1 will begin with an **introduction to the circumstances** that led to the commission of this review, and the process and timescales of the review.

Section 2 will **set out the facts** in this case, **including a chronology** to assist the reader in understanding how events unfolded that led to Katarzyna's death.

Section 3 will provide **a detailed analysis of agency involvement** with Katarzyna and Konrad.

Section 4 will set out the **domestic abuse** known to the review and barriers that Katarzyna may have faced in seeking support.

Section 5 will consider **suicide and domestic abuse.**

Section 6 will bring together **the lessons identified,** and **Section 7** will collate the **recommendations that arise.**

Section 8 will bring together **the conclusions** of the Review Panel.

Appendix One provides the **terms of reference** against which the panel operated.

Appendix Two sets out the **ongoing professional development** of the Chair and Report Author.

Where the review has identified that an opportunity to intervene has been missed, this has been noted in a text box. Examples of good practice are highlighted in italics.

Contents

Section One – Introduction

1.1 Summary of Circumstances Leading to the Review

1.1.1 This report of a Domestic Homicide Review examines agency responses and support given to Katarzyna, a resident of Newark, prior to her death in December 2021. On a day over Christmas a call was made to the ambulance service reporting that Katarzyna had hanged herself. When they attended, they found her in the kitchen at the address with a belt loosely wrapped around her neck. There were suspicions that she had been moved to the location where she was found, and the death was investigated by the police as a suspicious death.

1.1.2 The following day, Katarzyna's boyfriend was arrested on suspicion of her murder. He was further arrested for the cultivation of cannabis, as two rooms at the property had been converted to grow cannabis. Following an investigation, the police came to the conclusion that the evidence suggests that Katarzyna took her own life. A note was found that indicated that she had taken her life because of her boyfriend's abuse towards her.

1.1.3 An inquest was subsequently held in March 2023, which came to the conclusion that Katarzyna had formed the necessary intention to take her own life. The inquest did not attribute any contributing factors.

1.1.4 Katarzyna was a 49-year-old Polish woman who, at the time of her death, was living with her boyfriend: he was also a Polish national. Both had been living in the UK for some time. It is thought that they had known each other for five years and had been living together for 2 – 3 months.

1.1.5 When she was spoken to by the police in July 2020, following a previous incident at the address, Katarzyna said that she had two adult children, but the review has been unable to find any further information.

1.1.5 It is within this context that the review is set.

1.1.6 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of domestic abuse before Katarzyna's death, whether support was accessed within the community, and whether there were any barriers to her accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.1.7 The review considered agency contact and involvement with Katarzyna and her boyfriend for the period from 1st January 2021.

1.1.8 The key purpose for undertaking a DHR is to enable lessons to be learned from homicides or other deaths where the person dies. Furthermore, whether domestic abuse may have been a contributory factor or a key factor in the person's life. For these lessons to be learned as widely and thoroughly as possible, professionals need to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening again in the future.

1.2 Reasons for Conducting the Review

1.2.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.2.2 The review must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by:

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

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.2.3 In this case, Katarzyna died in circumstances that suggest that she took her own life, and she had been a victim of domestic abuse; therefore, the criteria have been met.

1.2.4 The purpose of the DHR is to:

- 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
- 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
- Apply these lessons to service responses, including changes to policies and procedures as appropriate
- Prevent domestic violence and homicide and improve service responses to 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 possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice.

1.3 Methodology and Timescales for the Review

1.3.1 Bassetlaw, Newark and Sherwood Community Safety Partnership was notified by Nottinghamshire Police of Katarzyna's death on 22nd February 2022. It was immediately identified that the death met the criteria for a Domestic Homicide Review, and the Home Office was notified on 26th April 2022. The Chair and Report Author were appointed in May 2022.

1.3.2 After time had been taken for the partners to identify the information that they held about Katarzyna, the Community Safety Partnership met on 8th June 2022 and was chaired by the Community Safety Partnership Chair. At this meeting, agencies briefly shared the information that they held, and it was agreed that the DHR should now proceed.

1.3.3 The first panel meeting was held on 16th September 2022, and the following agencies were represented at the meeting:

- East Midlands Ambulance Service
- Newark and Sherwood District Council
- Nottingham and Nottinghamshire ICB
- Nottinghamshire County Council
- Nottinghamshire Police
- Sherwood Forest Hospitals NHS Foundation Trust

1.3.4 Apologies were received from Nottinghamshire Women's Aid and Probation Service.

1.3.5 At the first meeting, the panel considered its composition and was happy with the representation. It was noted that, at the recommendation of the Chair and Report Author, a specialist in working with Eastern European women who have experienced domestic abuse, had been included on the panel. The Terms of Reference were reviewed and accepted: subject to Katarzyna's family having a view on these.

1.3.6 A chronology was compiled in advance of the first panel meeting; therefore, Individual Management Reviews (IMRs) and summary reports were commissioned at the first meeting. Reports were requested from:

- Nottinghamshire Police – IMR
- Nottinghamshire Women's Aid (as providers of IDVA service) – IMR
- Sherwood Forest Hospitals NHS Trust – Summary report for Katarzyna
- Nottinghamshire County Council – Summary of Konrad's domestic abuse against his previous partner that had led to their children being taken into care
- Ambulance Service – clinical records of calls to the address.

1.3.7 All report authors were independent and had no direct involvement with Katarzyna or Konrad.

1.3.8 The panel met on two further occasions, and the review was completed in September 2023. The review was not completed within six months due to the time taken to seek involvement of the family.

1.4 Terms of Reference

1.4.1 The Domestic Homicide Review will set out to explore the following areas:

- The immigration status of both Katarzyna and her partner, and the impact this may have had on their decision-making.
- The part that Katarzyna's lack of English had on her ability and confidence to report the abuse that she was experiencing.
- Whether Katarzyna knew how to navigate services in the UK, and whether she understood what was happening when she was referred to MARAC[1].
- The part that her previous experience of domestic abuse had on Katarzyna's confidence to report the abuse.

[1] Multi-Agency Risk Assessment Conference

- The part that the domestic abuse played in her decision to take her life.

1.4.2 The full Terms of Reference can be found in Appendix One.

1.5 Confidentiality

1.5.1 The content and findings of this review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the review has been approved for publication by the Home Office Quality Assurance Panel.

1.5.2 To protect the anonymity of the deceased, and her family and friends, the subject of the review will be known as Katarzyna. Her partner will be known as Konrad.

1.5.3 The following pseudonyms were also used:

Krzysztof for Katarzyna's ex-husband
Bartosz for Katarzyna's ex-partner

1.5.4 These pseudonyms were selected by the specialist advisor to the panel, to ensure that they were culturally appropriate.

1.6 Engagement with Katarzyna's Family

1.6.1 The Chair and Report Author were provided with the details of Katarzyna's mother in Poland and her two sisters and her niece in the UK. All letters and leaflets to Katarzyna's family were translated into Polish.

1.6.2 In October 2022, a letter was sent from the Community Safety Partnership explaining that the review was to be undertaken and introducing the Chair and Report Author. These were followed up, a couple of weeks later, by a letter from the Chair and Report Author. Katarzyna's sisters were provided with a leaflet about AAFDA[2].

1.6.3 Unfortunately, there was no contact from the family, and the Review Panel respects their decision not to be involved.

1.6.4 This review has carefully considered attempts to contact Konrad. The review is aware of information that makes such contact both practically and sensitively inappropriate.

1.6.5 The review did not have details of any friends or employers who might have assisted the review.

1.7 Contributors to the Review

1.7.1 Those contributing to the review, do so under Section 2(4) of the statutory guidance for the conduct of DHRs, and it is the duty of any person or body participating in the review to have regard for the guidance.

[2] Advocacy After Fatal Domestic Abuse

1.7.2 All panel meetings included specific reference to the statutory guidance as the overriding source of reference for the review. Any individuals interviewed by the Chair or Report Author, or other body with whom they sought to consult, were made aware of the aims of the Domestic Homicide Review, and were referenced to the statutory guidance.

1.7.3 However, it should be noted that whilst a person or body can be directed to participate, the Chair and the DHR Review Panel do not have the power or legal sanction to compel their co-operation, either by attendance at the panel or meeting for an interview.

1.7.4 The following agencies contributed to the review:

- Nottinghamshire Police – Panel member and IMR
- Nottinghamshire Women's Aid (as providers of IDVA service) – Panel member and IMR
- Sherwood Forest Hospitals NHS Trust – Panel member and summary report for Katarzyna
- Nottinghamshire County Council – Panel member and summary of Konrad's domestic abuse against his previous partner that had led to their children being taken into care
- Ambulance Service – Panel member and provided clinical records of calls to the address.

1.7.5 In view of the very limited contact with Katarzyna's GP, no IMR was requested from them.

1.7.6 The DHR Panel is grateful to Julia Kulak for her expertise in supporting women from Eastern Europe who have experienced domestic abuse.

1.8 Review Panel

1.8.1 The members of the Review Panel were:

Gary Goose MBE	Independent Chair	
Christine Graham	Independent Report Author	
Julia Kulak	Independent Eastern European Gender-based Violence Consultant	
David Hinds	Quality Lead	Change Grow Live
Emma Wilson	Adult Safeguarding Lead	East Midlands Ambulance Service
Paul Cottee	Regional Reviewer	EMSOU
Stephanie West	Partnership Officer – Bassetlaw Newark & Sherwood Community Safety Partnership	Newark and Sherwood District Council
Yvonne Swinton	Community Protection Manager	Newark and Sherwood District Council
Matthew Finch	Director NSDC and Chair of the BNS CSP	Newark and Sherwood District Council
Nicolette Richards	Domestic Violence Co-ordinator	Newark and Sherwood District Council

Alan Batty[3]	Public Protection Business Unit Manager	Newark and Sherwood District Council
Jenny Walker[4]	Public Protection Business Unit Manager	Newark and Sherwood District Council
Clare Galley	Children's Service Manager – Mansfield District Child Protection Team	Nottinghamshire County Council
Ishbel Macleod	Designated Professional for Safeguarding Adults	Nottingham and Nottinghamshire ICB
Mark Dickson	Detective Chief Inspector, Public Protection	Nottinghamshire Police
Luke Waller	Detective Inspector	Nottinghamshire Police
Richard Idle	Named Nurse, Safeguarding Adults	Sherwood Forest Hospitals NHS Foundation Trust
Mandy Green	Head of Services	Nottinghamshire Women's Aid
Lisa Adkins-Young	Deputy Head for Nottingham City and County Probation Delivery Units	Probation Service

1.8.2 All the panel members were independent of any direct involvement with Katarzyna.

1.9 Domestic Homicide Review Chair and Report Author

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

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

1.9.3 Gary and Christine have completed, or are currently engaged upon, a number of Domestic Homicide Reviews across the country, in the capacity of Chair and Overview Author. Previous domestic homicide reviews have included a variety of different scenarios: male

[3] Retired during the review.
[4] Replaced Alan Batty.

victims; suicide; murder/suicide; familial domestic homicide; a number which involve mental ill health on the part of the offender and/or victim; and reviews involving foreign nationals. In several reviews, they have developed good working relationships with parallel investigations/inquiries, such as those undertaken by the IOPC, NHS England, and Adult Care Reviews.

1.9.4 Neither Gary Goose nor Christine Graham is associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[5]

1.9.5 Full details of the ongoing professional development of the Chair and Report Author are included in Appendix Two.

1.10 Parallel Reviews

1.10.1 Inquest held in March 2023 as per 1.1.3 of this report.

1.10.2 There were no other reviews undertaken.

1.11 Equality and Diversity

1.11.1 Throughout this review process, the panel has considered the issues of equality. In particular, the nine protected characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

1.11.2 Both Katarzyna and Konrad were Polish nationals. The impact of their ethnicity is discussed in detail within the report. It is recognised that this may have presented barriers for Katarzyna, and this is discussed at 4.2.

1.11.3 Women's Aid state: '*domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family*'.[6]

1.12 Dissemination

1.12.1 The following individuals/organisations will receive a copy of this report:

- Nottinghamshire Police and Crime Commissioner
- Domestic Abuse Commissioner

[5] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016
[6] (Women's Aid Domestic abuse is a gendered crime, n.d.)

- The Chief Officer of all organisations represented on the DHR Panel
- The Chief Officer of all organisations represented on the Community Safety Partnership.

Section Two – The Facts

2.1 Outside the scope of the review

2.1.1 **KATARZYNA**

2.1.2 Katarzyna was a Polish national who had settled in the UK with her then husband. It remains unclear when they first came to the UK, but organisations became aware of her from 2014 onwards, when issues relating to her relationship came to light. What is known about her before she met Konrad is set out below.

2.1.3 **2014**

2.1.4 On 31st May 2014, a crime of assault against Katarzyna was recorded when she alleged that her then husband, Krzysztof, had kicked her about the body three times during a domestic argument at their home address. An ambulance was called because the police suspected she had a broken wrist. She was treated by paramedics but was afraid to attend hospital. She went to the ED at Kings Mill Hospital later that evening, having been taken by a neighbour. She said that her husband was now in custody. She had swelling to her right hand and wrist, and she said that she had been kicked in the rib area. There was no fracture; however, bruising to the top of her legs and shins was seen. Her neighbour reported that her husband had said that he hits in the kidneys, abdomen, and ribs to minimise the bruising.

2.1.5 Katarzyna reported that the violence was occurring three times a week for the previous nine years. She said that she had lost her job because she had to take time off due to her injuries. A DASH was completed, and as Katarzyna was identified as high risk, a referral was made to MARAC. She was made aware of support available from other agencies but declined any support, saying she knew where to go if need be. Katarzyna said that she did not wish to continue the relationship with her husband but was financially dependent upon him, as she was unable to claim benefits and could not work due to her injuries. She made a witness statement via an interpreter. Her husband was arrested, charged, and remanded in custody. He was convicted of battery on 4th August.

2.1.6 On 6th June 2014, Nottinghamshire Women's Aid contacted Katarzyna via Language Line. Despite efforts to engage with Katarzyna, she was keen to end the call and said that she did not want to go to court and just wanted to get on with her life. Nottinghamshire Women's Aid noted that Krzysztof had pleaded guilty and there was to be a Newton hearing on 4th August 2014. It was noted that Katarzyna had reluctantly agreed to attend court and accept support. Her friends were also attending with her.

2.1.7 On 19th June 2014, Katarzyna was discussed at MARAC. The perpetrator on this occasion was Krzysztof. Nottinghamshire Women's Aid reported that Katarzyna was financially dependent upon Krzysztof and that he was breaching court bail by contacting her. She had said that she needed time to think if she wanted to be with him, and she had declined court support. There was a Place of Interest Marker (POIM) on the property, and safety checks were done. She had told the IDVA that she had been experiencing domestic abuse for some time but had not reported it previously. She described how he would hit her on her torso so there were no visible injuries, he would harass her if she went out, he would ring her all the time, and that there had been in an escalation in his abuse. He was, she said, jealous and controlling.

2.1.8 The IDVA tried to contact Katarzyna to advise her of the outcome of the MARAC meeting and explore other interventions that may be appropriate; however, the IDVA was not able to contact her.

2.1.9 On 4th August, the court IDVA spoke to Katarzyna at court. Through the court interpreter, she said that she did not want to give evidence because they wanted to resume their relationship, and she wanted to give him one more chance. Safety planning was carried out with Katarzyna, and she was advised to keep the IDVA's number. Krzysztof was found guilty of criminal damage and received a fine.

2.1.10 At 11.56 pm on 15th August, a 999 call was made by a friend of Katarzyna reporting a domestic disturbance at her address. The caller said that a female was hitting a male, and she had also pushed the caller. The police attended and found Katarzyna with torn clothing and a scratch mark on her breast. There were two other Polish nationals present. The caller was Krzysztof, who had minor facial injuries. All were intoxicated. As only the caller spoke English, the officers used Language Line to obtain accounts from each person. Katarzyna said that the caller had grabbed her and caused her injury because she would not roll him a cigarette. Her husband said that he had tripped and banged his head, causing his injury.

2.1.11 The caller was uncooperative and, based on Katarzyna's account, a crime of assault was recorded: the caller was subsequently arrested. He gave No Comment replies during interview. Katarzyna was revisited the next morning, and she still declined to provide a statement, so the arrested person was released without charge.

2.1.12 **2015**

2.1.13 Katarzyna presented at ED at Kings Mill Hospital at 7.25 pm on 21st November. She said that she had fallen down a flight of 3 – 13 stairs and was unable to weight bear. She was complaining of an injury to her left knee. No fracture was noted. She smelled strongly of alcohol and said that she had been drinking strong beer. She had a poor command of English and so her husband translated. There was no indication that any domestic abuse had occurred.

2.1.14 The first record of Katarzyna being registered with a GP is 24th November 2015.

2.1.15 **2016**

2.1.16 On 10th September, a crime of assault was recorded on Katarzyna by a male (not Krzysztof), who she said had been visiting her address and had pushed her over a garden fence. The male was arrested, and he said that it was she who had assaulted him whilst drunk, and she fell over the garden fence. No further action was taken.

2.1.17 Katarzyna presented at ED at Kings Mill Hospital at 12.01 am on 11th September, complaining of an injury to her left shoulder and back. She said that this had been caused when she was pushed by a neighbour during an argument. It was noted that she was intoxicated. Katarzyna left the department before having an X-ray. Her presentation was identified as not being related to domestic abuse or to have any safeguarding concerns.

2.1.18 **2017**

2.1.19 Katarzyna presented to ED at Kings Mill Hospital at 3.40 pm on 3rd October, complaining of an injury to her left hand – caused when getting out of the shower the previous day. No

concerns were identified on X-ray. No further treatment was required, and she was discharged. Her presentation was identified as not being related to domestic abuse or having any safeguarding concerns.

2.1.20 There is no further contact recorded in relation to Katarzyna until 2021. During this intervening period, it is believed that she began her relationship with Konrad.

2.1.21 **KONRAD**

2.1.22 The victim's boyfriend, 'Konrad', is a Polish national who has been living (for the majority of his time) in the UK for several years. He was initially living in the UK with his wife and their two children. As a result of several incidents between them, set out below, they separated, and he ultimately became involved in a relationship with Katarzyna. What is known about his time in the UK before he was involved with Katarzyna, is set out below.

2.1.23 In July 2012, he was circulated as being wanted for fraud offences in Poland.

2.1.24 At the end of December 2014, he was arrested and cautioned for the offence of battery, after he had punched his ex-wife on the arm. He was detained on a European Arrest Warrant (issued in Poland on 18th September 2009) for offences of deception. He was placed before Westminster Magistrates Court, who remanded him into police custody. It is believed that he was taken back to Poland.

2.1.25 In 2016, Nottinghamshire Police had intelligence to suggest that he was still in Poland, but that he was planning to return to the UK.

2.1.26 In October 2019, he was forensically linked to a burglary at a residential address in Mansfield. He was not arrested because the victim did not co-operate with the investigation.

2.1.27 On 21st December 2019, he was arrested on a European Arrest Warrant (on behalf of the police in Poland) for burglary/fraud offences committed in Poland. He was placed before Westminster Magistrates Court for extradition; however, the application for extradition was declined due to issues with the Polish paperwork, and he was released.

2.2 Chronology from 1st January 2021

2.2.1 At 1.40 pm on 15th January, a 999 call to Nottinghamshire Police was made by an officer who was visiting Katarzyna's address. The caller had heard shouting and found Katarzyna lying on the floor injured and bleeding, with a male stood next to her. The male had left the flat complex, and Katarzyna had said that he had hit her with some wood. She named her ex-partner, Bartosz, as the man who had assaulted her.

2.2.2 An ambulance was initially called and then cancelled, and a description of the male was circulated to other police officers. At 1.57 pm, a police officer detained a male in the area who fitted the description and had blood on his hands. The male did not comply with the officer's request, so they used the Taser ('Red Dotting' him) to make him comply, and he was placed in handcuffs. He said that he knew Bartosz was a lodger at Katarzyna's address but that he had not been in a relationship with her. He denied assaulting Katarzyna.

2.2.3 When the police officer spoke to Katarzyna, she was intoxicated and said that Bartosz had arrived to collect some of his property and had hit her with wood, from a broken picture

frame, causing her injuries. She was shown a photograph of the detained male, Konrad, and she maintained that it was Bartosz who had assaulted her, not Konrad.

2.2.4 The photograph of Konrad was also shown to the ~~warrant~~ officer; however, as he was unable to identify him, Konrad was released. A crime of assault was recorded on Katarzyna, and a DAPPN (Domestic Abuse Public Protection Notification) was submitted: it identified her as standard risk.

2.2.5 At 7.10 pm on 20th July, a neighbour called the police (via 999) reporting a disturbance at Katarzyna's address. The caller reported seeing a female banging on the windows and shouting for help, from inside the property, and she was being dragged around.

2.2.6 When the police arrived, the male suspect had left. Katarzyna informed them that she lived alone at the address, that her ex-partner had visited, and that they had been drinking together. She said that they had started to argue about money, and he had grabbed her by the throat, called her a 'whore', and hit her. Katarzyna named Konrad as the suspect for this offence. She declined to make a complaint and signed the officer's notebook confirming this. A crime of assault was recorded. A DAPPN was submitted, as medium risk, and shared with the DASU.

2.2.7 On 23rd July, Juno Women's Aid Referral Hub received a medium risk referral from the police, following an incident that had occurred on 20th July. Konrad was recorded as the perpetrator. The Support Worker tried to contact Katarzyna twice without success. When they tried to call an alternative number that they had been given, an incorrect number message was received.

2.2.8 The Juno Women's Aid Support Worker tried to call Katarzyna again on 30th July, but the phone rang to voicemail. A message was left asking her to return their call if she required their support. The message advised that if no contact was made by the end of the week, the referral would be closed.

2.2.9 At 11.18 am on 24th December, a call was made to EMAS reporting that Katarzyna had hanged herself. She had been found by Konrad who had then phoned her sister, and it was she who reported this to EMAS. She was found in the kitchen at the address with a belt loosely wrapped around her neck. There were suspicions that she had been moved to the location where she was found, and the death was investigated as a suspicious death.

2.2.10 On 25th December, Konrad was arrested on suspicion of murder and the cultivation of cannabis, as two rooms at the property had been converted to grow cannabis. Following a police investigation, the police believe that Katarzyna took her own life, and Konrad has been released under investigation.

2.2.11 A note left by Katarzyna suggested that she had taken her own life because of domestic abuse from Konrad. When he was interviewed, he said that he had been in a relationship with Katarzyna for five years, and he described their relationship as being, 'sometimes good, sometimes bad'. He agreed that there had been occasions in the past when they had both pushed each other and that he had hit Katarzyna in the past with the flat of his hand. He said that Katarzyna had spoken, in 2020, about wanting to end her life; however, as far as he knew, she had not seen a doctor or sought advice about this.

Section Three – Detailed Analysis of Agency Involvement

3.1 NOTTINGHAMSHIRE COUNTY COUNCIL – CHILDREN'S SOCIAL CARE

3.1.1 Children's Social Care's only involvement was with Konrad and his ex-wife. There was significant involvement from February 2007 to August 2017, when the children were taken into care. Two referrals related to domestic abuse.

3.1.2 **April 2014**

3.1.3 The police reported that they had been called after a neighbour had reported screaming coming from the property. It was alleged that Konrad and his ex-wife were arguing, and she had run out of the house with a knife and had threatened to end her own life.

3.1.4 Konrad's ex-wife was spoken to, and she confirmed that the couple were separated, and she had discovered that he had a new partner.

There are no specific recommendations for this organisation.

3.2 NOTTINGHAMSHIRE POLICE

3.2.1 **15th January 2021**

3.2.2 At 1.40 pm, an officer attending Katarzyna's address made a 999 call to the police after they heard shouting and had found Katarzyna lying on the floor injured and bleeding, with a male standing over her. The male fled, and Katarzyna said that he had hit her with some wood. She named the man as her ex-partner, Bartosz.

3.2.3 At 1.57 pm, a man who fitted the description, with blood on his hands, was detained in the area. This man was Konrad, and he said that he had been at her house doing DIY for her. He said that Bartosz was Katarzyna's lodger but had not been in a relationship her. He denied having assaulted her.

3.2.4 The police spoke to Katarzyna, who was intoxicated, and she said that Bartosz had arrived to collect some property and had hit her with wood, from a broken picture frame, causing her injuries. When she was shown a photograph of Konrad, she maintained that it was Bartosz who had assaulted her.

3.2.5 As the ~~warrant~~ officer was unable to identify Konrad, he was released. A crime of assault was recorded, and a DAPPN was submitted: it identified Katarzyna as standard risk.

3.2.6 Following Katarzyna's death, a review of this incident was commissioned by the police and was undertaken by a Detective Sergeant from the Public Protection Unit. This review identified several procedural and investigative issues in the response by the police to this incident.

The police did not record their rationale for decisions that were made. For example, the DAPPN was identified as standard risk but the rationale for this was not recorded.

Any safeguarding measures or advice given were not recorded.

Officers attending the incident did not comply with force policy, in respect of Body Worn Video (BWV) for recording witness evidence, the victim's injuries, and her decision not to make a complaint.

Nottinghamshire Police have a robust domestic abuse policy that requires officers to use BWV in all cases of domestic abuse with the expectation that the victim's disclosures, and any injuries, are captured and retained. Communications messages have been sent by senior officers to reiterate this policy.

Recommendation One
It is recommended that Nottinghamshire Police take measures to improve the use of BWV by officers attending domestic abuse incidents and ensure those images are retained for future use.

Officers did not take positive action with the arrest of Konrad. This would have enabled Katarzyna to be spoken with (supported by an interpreter) when she was no longer under the influence of alcohol and allow the recovery of forensic evidence, the blood on her hands, from Konrad.

3.2.7 After Katarzyna's death, a note written by her, and an audio recording, indicate that she had been subjected to domestic abuse by Konrad.

3.2.8 The IMR author has highlighted that the possibility of exploring a prosecution against Konrad for this offence may be possible with the use of 'hearsay' evidence from the friend and the materials recovered after Katarzyna's death, namely the suicide note and audio recordings from her phone. Although there is a six-month limitation on prosecutions for these offences, advice could be sought from a specialist domestic abuse lawyer at the Crown Prosecution Service.

Recommendation Two
It is recommended that Nottinghamshire Police consider seeking legal advice from a specialist lawyer at CPS.

3.2.9 **20th July 2021**

3.2.10 At 7.10 pm, a neighbour called the police (via 999) to report a disturbance at Katarzyna's address. The caller reported seeing a feBartoszanging on the windows and shouting for help, from inside the property, and she was being dragged around.

3.2.11 The officer who attended the incident was Polish speaking and spoke with Katarzyna in Polish. She activated her BWV and later had this translated by a Polish interpreter. ***This is an example of good practice.***

3.2.12 Prior to leaving the address, the officer provided Katarzyna with contact numbers for Women's Aid and other charities. She was given an advice leaflet in Polish and was informed that there were Polish speaking women at Women's Aid. ***This is an example of good practice.***

3.2.13 A friend of Katarzyna's arrived at the flat and said that she would stay with her.

3.2.14 Two weeks after the incident, Katarzyna was spoken to again, and she said that she was no longer in a relationship with the suspect, who she maintained was Bartosz, and reiterated that she did not wish to make a complaint.

3.2.15 A supervisory review considered an evidence-led prosecution, and evidence was gathered to support this. During this evidence gathering, the friend who had arrived at the property, informed officers that the person responsible was, in fact, Konrad.

3.2.16 Following the supervisory review, attempts were made to arrest Bartosz; however, when the police were advised that he was not the person responsible, no further attempts were made.

3.2.17 When interviewed on 25th December 2021, following Katarzyna's death, Konrad was asked about this incident and accepted that he was there but that it was a verbal argument.

3.2.18 Following Katarzyna's death, a review of this incident was commissioned. Several investigative and administrative issues were identified. The investigative issues related to the arrest attempts of Bartosz.

The NICHE record for this system states that there was no trace of Konrad on Niche when the officer conducted the search. He is, and was, recorded on NICHE.

During the translated conversation, Katarzyna disclosed that she had two adult children, but she did not name them.

It was also noted that she understood the English language very well. The officer said that she had signed their notebook that was written in English.

3.2.19 During this conversation, Katarzyna said that she was having some difficulty with her landlord due to her partner, Bartosz, stealing electricity. She had informed the council and had been speaking to a solicitor through Citizens' Advice. She said that the police were also aware, but there is no record on the police systems.

3.2.20 It is noted that Katarzyna had been engaging with the police in the early stages of the investigation, supported by her friend, but she stopped answering the door and taking calls after her friend had said that Bartosz was not the offender.

3.3 NOTTINGHAMSHIRE WOMEN'S AID

3.3.1 There was no contact with Katarzyna whilst she was with Konrad. Katarzyna had been involved with the IDVA service in 2014, when she was in a relationship with Krzysztof.

3.3.2 Nottinghamshire Women's Aid was involved with Konrad's previous partner (and the mother of his children) in December 2014.

The review notes that in both cases, the workers explored all the options available for support, and safety planning advice was given. Neither survivor felt able to accept the support offered. The reasons for this may have been due to the perceived consequences to their immigration status: this will be explored later in the report.

The review is advised that Nottinghamshire Women's Aid has a Polish language safety booklet that is accessible via the centre/services, and once a newly revised website is up and running, will be on the website for individuals to download.

3.3.3 Nottinghamshire Women's Aid recognised that language may have been a barrier, as both engagements were from referrals from the police and were not self-referrals. On both occasions, interpreters were used to facilitate the engagement.

3.3.4 It is recognised by the organisation that more could be done to aid engagement, and a review is being undertaken of the website that will provide a 'Recite Me'[7], enabled to improve accessibility and language options. This is due to go live in April 2023.

3.3.5 Since the review commenced, Nottinghamshire Women's Aid ltd staff have completed an online suicide awareness course by Zero Suicide Alliance, alongside commissioning Papyrus to deliver SP-OT, SP-EAK, and ASIST (Applied intervention suicide skills training).

3.3.6 In order to improve responses following incidents of domestic abuse and increase opportunities for referrals, new partnerships and co-location have been developed with those organisations where barriers were identified. The organisations involved are:

- A hospital IDVA based at Sherwood Forest Hospitals Trust
- An IDVA based at Mansfield Police Station
- Children's and Young People Domestic Abuse Support Worker based in the Multidisciplinary Team at Newark Child Protection Team
- Maternity IDVAs based with the Family Nurse Partnership
- Medium Risk Intervention Team based within the Partnership Hub
- Domestic Abuse Housing Liaison workers based within each district council Homeless team.

There are no specific recommendations for this organisation.

[7] https://reciteme.com/

3.4 SHERWOOD FOREST HOSPITALS NHS TRUST

3.4.1 Impact of language on interactions with Katarzyna

3.4.2 It was clearly documented in 2014 that a translator was requested to assist with the MARAC referral. When the translator was not available, she asked that her friend translate on her behalf.

3.4.3 When Katarzyna attended hospital in 2015, having fallen down a flight of stairs, her husband translated for her.

The review believes that not being able to match a patient's first or preferred language can impact on patient experience and health outcomes, the frequency of missed appointments, and the effectiveness of consultations. It may have serious implications, such as misdiagnosis and treatment, ineffective interventions and, in extreme circumstances, preventable deaths. The use of an inadequately trained (or no) interpreter, poses risks for both the patient and healthcare provider. The error rate of untrained interpreters (including family and friends) may make their use a greater risk than having no interpreter at all. The General Medical Council (GMC) recommends that practitioners should 'use an interpreter or translation service if (a patient has) difficulty understanding spoken English' (Decision Making and Consent, November 2020[8]).

Recommendation

It is recommended that Sherwood Forest Hospitals NHS Foundation Trust reviews its use of translators and reassures itself that all practicable steps are taken to ensure that translators are available whenever possible.

3.4.4 Professional curiosity about domestic abuse

3.4.5 When Katarzyna attended ED in 2014, she consented to a DASH risk assessment and a referral to MARAC. This suggests that she was, in the right environment, willing to disclose domestic abuse.

3.4.6 However, when Katarzyna attended in 2015, she was accompanied by her partner who translated for her. Clearly, it would have been impossible for Katarzyna to disclose any domestic abuse in those circumstances. The review has explored with the hospital if as much as possible was done to give Katarzyna the opportunity to disclose. For example, in response to a question, the hospital has advised that at the time of this incident, the hospital did not have a system to alert ED staff to the fact that Katarzyna had disclosed domestic abuse a year earlier, and there was nothing in the notes to give the clinician an indication that this had been the case.

The review was assured by Sherwood Forest Hospitals Trust that extensive work has been undertaken with practitioners in the ED, and they are now more professionally curious. This is supported by there now being an Independent Domestic Abuse Advocate (IDVA) within the department and an alert on the system to prompt staff to ask about domestic abuse.

[8] https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors---decision-making-and-consent-english_pdf-84191055.pdf

3.5 KATARZYNA'S GP

3.5.1 Katarzyna was registered with a local GP that has a good number of patients from Eastern Europe. Consequently, the surgery provides many leaflets and posters in Polish and other languages of Eastern Europe.

3.5.2 Katarzyna attended her GP on a number of occasions, as recorded in the chronology, but none of these visits were in connection with matters that one would expect to have led the GP to ask about domestic abuse.

Katarzyna's attendance at the GP demonstrates that she knew where to go for assistance with medical matters. There are no specific recommendations for this organisation.

Section Four – Domestic Abuse

4.1 **EVIDENCE OF DOMESTIC ABUSE**

4.1.1 Every Domestic Homicide Review is tasked with seeking out the history of domestic abuse within the relationship. Given how little is known about Katarzyna, this is a rather limited picture, but that which is known, paints a picture of a woman who had experienced domestic abuse in more than one relationship and was identified, through DASH, as high risk.

4.1.2 We can hear Katarzyna's voice through the note that she left and text messages between herself and Konrad.

4.1.3 Katarzyna had experienced domestic abuse in her marriage from Krzysztof and had been abused by Konrad during their relationship. Given the lack of clarity in some reports, it is possible that Katarzyna was also subject to abuse by other men.

4.1.4 **Physical abuse**

4.1.5 In May 2014, she had attended hospital after having been kicked about her body during an argument at home. Her neighbour, who accompanied Katarzyna to hospital, said that her husband had said that he hits her in the kidneys, abdomen, and ribs to minimise the bruising. She said that this had been happening three times a week for the previous nine years.

4.1.6 The police were called to Katarzyna's home in August 2014, and she was found with torn clothing and bruising to her breast. She said that he had done this because she would not roll him a cigarette.

4.1.7 Katarzyna attended hospital on 21st November 2015, when she said that she had fallen down the stairs and was unable to weight bear. This incident is discussed elsewhere in the report, and the review cannot be certain that this was not a result of domestic abuse.

4.1.8 In 2017, Katarzyna presented at hospital and reported an injury to her hand after falling whilst getting out of the shower. Again, the review cannot be certain that this was not a domestic assault.

4.1.9 The police were called to Katarzyna's address in January 2021 after an officer attending the address, heard shouting and saw Katarzyna lying on the floor injured and bleeding, with a man standing over her. She said that she had been hit with some wood.

4.1.10 In July 2021, the police attended Katarzyna's address because a caller had seen her banging on the windows and shouting for help, from inside the property, and being dragged around. When the police arrived, she said it was Konrad who was responsible for this attack.

4.1.11 **Verbal abuse**

4.1.12 Katarzyna said that Konrad had called her a 'whore'. A transcript of some voice calls provided to the review, indicate that this was an example of extensive verbal abuse used by Konrad when speaking to Katarzyna.

4.1.13 **Strangulation**

4.1.14 Katarzyna said that, during the assault in July 2021, Konrad had grabbed her by the throat.

4.1.15 **Economic abuse**

4.1.16 In May 2014, Katarzyna reported that she had lost her job after having to take time off because of the injuries she had sustained. She said that she did not wish to continue the relationship but could not leave because she was financially dependent on him, as she could not claim benefits.

4.1.17 In July 2021 Katarzyna told the police that she and her partner had been arguing about money and, on another occasion, that she was having difficulty with her landlord as he had been stealing electricity.

4.1.18 **Coercion and control**

4.1.19 When contacted by Women's Aid in June 2014, following the referral to MARAC, Katarzyna said that the assault had been her fault, as she had gone to a nightclub dressed in the way she had.

4.1.20 Following the incident, Krzysztof was arrested and charged. He continually breached his bail conditions by contacting Katarzyna.

4.1.21 In her brief conversations with Women's Aid, Katarzyna said that Krzysztof would harass her all the time if she went out and would ring her all the time.

4.1.22 She said that he was jealous and controlling and that there had been an escalation in the abuse.

4.1.23 When the criminal case came to court, Katarzyna said that she did not wish to give evidence because they were going to resume their relationship.

4.1.24 When the police were called in August 2014, Katarzyna's husband, Krzysztof, was arrested: he gave No Comment replies in interview. The next day, when the police visited Katarzyna, she declined to make a statement, and he was released without charge.

4.1.25 Katarzyna left a note when she died. This allows us to hear first-hand her desperation.

> I don't do it in the house. You know why. Do not look where …..
> You won't find where I'll be…..
>
> There will be a struggle for survival. Taking your own life is probably my only chance to walk away from you. To be precise without bruises or broken ribs or other things. I will not suffer anymore but I hope, and I know that you will live with it. You've never kept your word, so you're not a guy. You are like a PARASITE, and I have always said that. I never said anything unless I was 100% sure. In the end, I lost, and I no longer have the strength to fight. I don't understand this. Love someone with all your heart and give them everything that's a battlefield in your opinion? Watching the other person die. You took everything away from me – dignity, faith in another human being and, above all, humanity without it you are nobody. For the first and only time I really fell in love. I've never lied

to you or deceived you. I loved you as I knew you until the end. Even though you brought me to the extreme, that is, I couldn't live forever in fear every time you didn't like something. I know you will destroy this letter, my phone and anything that can harm you. SURPRISE – letter, phone, memory card (everything!!!). Now it depends on how you behave because each copy has a different purpose. To be honest – I feel sorry for you, but it doesn't matter to me anymore. I loved you to the end. (I doubt that after death this will change). By the way - I really want you to suffer, just like me
It is a pity that I will not find out what it is like to live with the knowledge that you have destroyed someone's life. And you destroyed mine. You abused me physically and mentally. You have brought me to a state, it is not even possible to imagine, that the only way out will be to TAKE my own life. You hit me once too many times and after so many times it is impossible to live normally. I will not end up like a PLANT. How can you say that you LOVE and at this time I am the so-called 'punching bag' on which you shake your hands. I will no longer live in fear. My Shame, I will not be able to see it.
I love you
I love you
I love you
(but I have to finish it now and not when you make me a plant)
Goodbye!
Katarzyna
I gave you everything

4.2 THE BARRIERS THAT KATARZYNA FACED IN REPORTING DOMESTIC ABUSE AND ACCESSING SUPPORT

4.2.1 Katarzyna's previous experiences of domestic abuse

4.2.2 Katarzyna had experienced domestic abuse for many years, from at least two men – her ex-husband and Konrad. This repeated victimisation will have impacted on her mental health and self-esteem. Having experienced abuse previously and escaped, when Katarzyna began to be abused by Konrad, this may have increased her feeling of guilt, shame, and lack of confidence. She may have felt that she had to accept her 'fate' because she did not know how she could escape. Her previous experience may have impacted on her trust of professionals.

4.2.3 Fear

4.2.4 We can see that, on more than one occasion, Katarzyna pointed to other men as being responsible for her abuse to deflect attention away from Konrad. She was obviously fearful of him.

4.2.5 The language barrier

4.2.6 It is clear from the reports provided to the review, that Katarzyna had limited understanding of English.

4.2.7 The review is aware that Nottinghamshire Women's Aid has produced a Polish Safety Book that is available at their premises and sessions. It is also available on their website.

4.2.8 The website now has the Recite Me function that allows visitors to access the website in their own language.

4.2.9 In 2025, Newark and Sherwood District Council will be seeking DAHA[9] accreditation.

Recommendation
It is recommended that, as part of the preparation for DAHA accreditation, Newark and Sherwood District Council considers adding the Recite Me function to the council website.

4.2.10 The review noted the good practice of agencies in using interpreters, in the main, to communicate with Katarzyna.

The review does not consider that Katarzyna's limited English impacted on her ability to access primary services, such as attending hospital, but may have played a more significant part in her ability to accept support that was offered by specialist agencies and her inability to report the full extent of the abuse that she was experiencing.

4.2.11 There are some keywords that we would use in the context of domestic abuse do not translate well and can have a different meaning. These words do not capture the complexity of the words in English, for example, the concepts of coercive control can be challenging to translate.

4.2.12 Similarly, when we ask about 'isolation', in some Polish translations it can sound like the responsibility for 'being isolated' is being placed on the victim rather than emphasising that the perpetrator is actively isolating their victim, and what it means in terms of ongoing abuse.

It is therefore important that any interpreters are adequately briefed to ensure that the correct meaning of the questions asked, is understood by the interpreter

Recommendation
It is recommended that all organisations involved in this review, consider how they can provide guidance on the use of interpreters to practitioners.

4.2.13 **Cultural understanding of domestic abuse**

4.2.14 It is important that we remember that whatever is said to women like Katarzyna about services in the UK, they are immensely influenced from their experiences in Poland and the understanding of domestic abuse that they have grown up with.

4.2.15 The understanding in Poland of domestic abuse is different to the UK. For example, marital rape and financial abuse are not considered abusive. Some abusive behaviours that, in the UK would be considered a crime, are not investigated by, or even recorded by, the police in Poland.

4.2.16 In Poland, the provision of domestic abuse support services is very limited; therefore, promotion and accessibility to these services is very limited. Many victims from Poland who have accessed services, have commented that they did not know about the services available in the UK and were in disbelief that they may be able to access such services in Poland.

[9] https://www.dahalliance.org.uk/

4.2.17 Women in Poland can apply to the police for the 'Blue Card' (Niebieska Karta). This is a file that gathers disclosures of domestic abuse, records the home address of the victims and perpetrators, holds safety information, and so on. However, there is criticism that the Blue Card is not used appropriately by the police in Poland: very often the information is not recorded accurately; the police do not consider it a priority to act on disclosure of abuse; and information is not shared with statutory agencies. Responsibility to 'keep the case going' lays with the victim. There are also many reports that the police in Poland actively discourage women from applying for a Blue Card or closing their files without the victims' consent or knowledge.

Therefore, it is fair to assume that Katarzyna may not have known, or fully understood, what support, assistance, and protection the police could offer to her. It is not easy for many women for whom English is not their first language, to understand the role of MARAC; consequently, it is highly likely that Katarzyna did not understand the impact that it could have on her safety.

Recommendation

It is recommended that resources are produced in minority languages, Polish in this case, that clearly explain what domestic abuse is, and the support that is available to victims.

4.2.18 **Her immigration status**

4.2.19 We do not know for certain about Katarzyna's immigration status; however, as she had lived in the UK for several years, she would have been eligible for EU Settled Status. The first incident known to the review occurred before the EU Settlement Status application deadline (30th June 2021), and we believe, from information provided by the police, that she had applied and was waiting on the outcome. She would have received one of two outcomes to her application, as she was already a UK resident – Settled or Pre-Settled Status. As she had submitted her application within the deadline, she was able to live and work legally in the UK.

4.2.20 If Katarzyna had been granted Settled Status, she would have been eligible for assistance from the state. She would have been able, for example, to make a homeless application to the council or access refuge. It is unlikely that Katarzyna would have had a full understanding of how each status impacted her ability to claim means-tested welfare benefits.

The review feels that Katarzyna's immigration status did not play a major part in her ability to call the police when she needed help.

4.2.21 **Konrad's criminal history**

4.2.22 Konrad's criminal history may have impacted on Katarzyna's ability to support the police investigations. The official police website in Poland allows members of the public to freely access details of all those wanted people in Poland, including their personal details, their description along with a photograph, and details of the alleged crimes that they have committed. It is therefore very likely that, even if he had not disclosed to Katarzyna, she would have been aware of his wanted status.

4.2.23 From the reports to the police, we can see that, on more than one occasion, Katarzyna sought to protect Konrad by claiming that the assaults had been committed by other males.

The review believes that it is very possible that Katarzyna was worried that, if Konrad came to the attention of the police, she would be blamed for his subsequent deportation.

Section Five – Suicide and Domestic Abuse

5.1 Prevalence

5.1.1 The number of Intimate Partner Abuse Related Suicides (IPS) are not formally counted in England and Wales. The ONS (2019) reported that on average, 30 women took their own lives each week in the UK in 2018. It has been estimated that one third of female suicides may be related to IPA[10], which would equate to nine or ten suicides per week. This number is thought to have increased in the first period of COVID-19, with 38 suspected suicides of victims of domestic abuse reported from 1st April 2020 to 31st March 2021[11]. Women who have experienced interpersonal violence are more likely than those who have not to have experienced suicidality[12].

5.1.2 Analysis undertaken by Kent and Medway Suicide Prevention Team[13] of the 93 nationally published DHRs, found that 26% contained suicide of either the victim or the perpetrator.

5.1.3 The most recent report from the National Confidential Inquiry into Suicide and Safety in Mental Health[14], found that between 2015 and 2019, there were 532 patients who were known to have experienced domestic violence – 9% of all patients during this time, 104 deaths per year. The average number in 2016 – 17 was 101 per year, but in 2018 – 19, this had increased to 149 per year. The majority (73%) were female, an average of 76 per year.

5.1.4 Women with a history of domestic violence were more likely to be younger than other women, and be single or divorced, living alone and unemployed. The majority (81%) had a history of self-harm, and previous alcohol (61%) and/or drug (47%) misuse was common. Nearly a third (29%) had been diagnosed with personality disorder.

5.1.5 More women with a history of domestic violence had experienced adverse life events in the previous 3 months (115, 50% v. 351, 32%) – the most common relating to family issues (21% v. 6%), serious financial problems (22% v. 11%), and loss of job, benefits, or housing (19% v. 12%).

5.2 From research into suicide, what can we learn about Katarzyna's decision?

5.2.1 **THE INTEGRATED MOTIVATIONAL-VOLITIONAL (IMV) MODEL**[15]

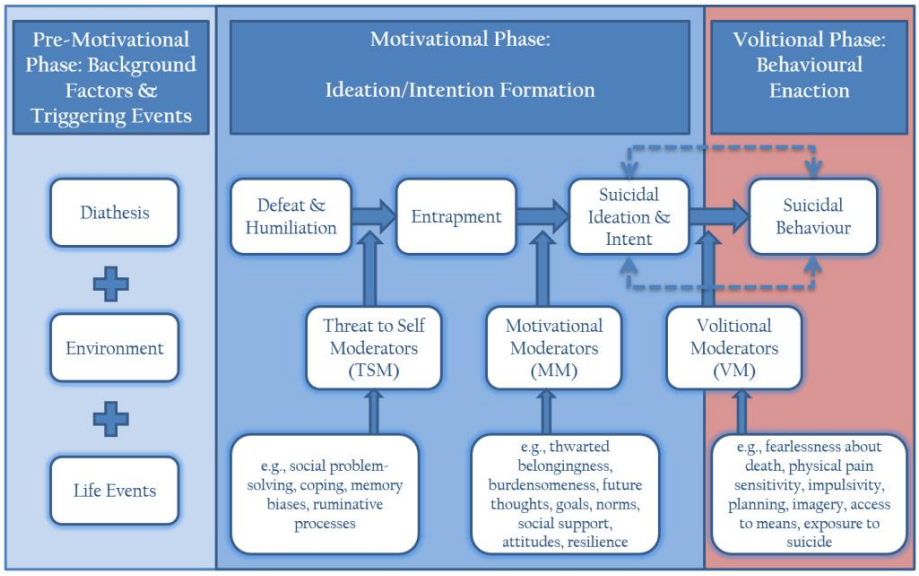
5.2.2 Suicide is complex, and the journey of suicidal ideation to suicidal behaviours is not static but fluid and can be seen as being cyclical in nature. The Integrated Motivational-Volitional (IMV) model aims to synthesise, distil, and extend our knowledge and understanding of why people die by suicide, with a particular focus on the psychology of the suicidal mind. It proposes that defeat and entrapment drive the emergence of suicidal ideation and that a group of factors (volitional moderators) govern the transition from suicidal ideation to suicidal behaviour.

[10] Walby, 2004, Stark and Flitcraft, 1996 cited in ibid.
[11] Bates et al., 2021, cited in ibid.
[12] Agenda Alliance, Underexamined and underreported, 2023
[13] Highlighting the relationship between domestic abuse and suicide, Transforming health and social care in Kent and Medway, 2020
[14] The National Confidential Inquiry into Suicide and Safety in Mental Health, Annual Report 2022: UK patient and general population data 2009-2019, and real-time surveillance data, University of Manchester, 2022
[15] The integrated motivational-volitional model of suicidal behaviour, O'Connor RC and Kirtley OJ, Royal Society PUblishing, 2018

5.2.3 This model includes:

5.2.4 The pre-motivational phase – background factors and triggering events:

- The motivational phase – ideation and intention formation, and the factors that govern the transition from suicidal ideation to suicide attempts
- The volitional phase – suicide attempts or death by suicide.



5.2.5 The IMV model of suicidal behaviour is based on seven key premises:

(1) Vulnerability factors combined with stressful life events (including early life adversity) provide the backdrop for the development of suicidal ideation
(2) The presence of pre-motivational vulnerability factors (e.g., socially prescribed perfectionism) increases the sensitivity to signals of defeat
(3) Defeat/humiliation and entrapment are the key drivers for the emergence of suicidal ideation
(4) Entrapment is the bridge between defeat and suicidal ideation
(5) Volitional-phase factors govern the transition from ideation/intent to suicidal behaviour
(6) Individuals with a suicide attempt or self-harm history will exhibit higher levels of motivational and volitional-phase variables than those without a history
(7) Distress is higher in those who engage in repeated suicidal behaviour and over time, and intention is translated into behaviour with increased rapidity.

5.2.6 This model can be an effective tool to help map a story of suicide and highlight specific points or factors of which the review should take note. The Report Author has used this model to explore what is known about Katarzyna.

5.2.7 **Pre-motivational phase: Background factors and triggering events**

5.2.8 The first phase sets the context for suicidal ideation and factors that are often present in those who take their own life. As we know so little about Katarzyna, it is very difficult to identify, with any certainty, those that were present.

5.2.9 From what we do know, we can see the following factors:

- Relationship difficulties (partner, ex-husband)
- Domestic abuse – emotional, sexual, physical (ongoing)
- Unemployment (Katarzyna said she had to leave her job because she had to take time off due to her injuries)
- Alcohol use (a number of times when services interacted with Katarzyna, she was described as 'intoxicated', but we do not know if she had an ongoing issue with alcohol abuse).

5.2.10 From the information that we have, there are a number of other potential factors that we are not able to identify in Katarzyna's life:

- Previous suicide attempts
- A family history of suicide
- Adverse Childhood Experiences
- Homelessness
- Long-term physical health concerns
- Bereavement
- Suicide bereavement or exposure to suicide
- Bullying
- Self-harm.

5.2.11 **Motivational phase: Emergence of suicidal ideation**

5.2.12 The centre column of the table highlights the key drivers: defeat, humiliation, and unbearable entrapment for the emergence of suicidal ideation.

5.2.13 Connor and Kirtley[16] say that entrapment can be internal or external in nature:

- Internal – concerned with being trapped by pain triggered by internal thoughts and feelings
- External – relates to the motivation to escape from events or experiences in the outside world.

5.2.14 Feelings of entrapment are likely to give rise to agitation. Whilst this phase is consistent with Williams' cry of pain hypothesis that is discussed later in the report, feelings of entrapment are distinct from hopelessness, which is a pervasive sense of pessimism for the future.

5.2.15 According to the IMV model, the presence or absence of threat to self-moderators, renders it more or less likely that defeat leads to entrapment. We can see from Katarzyna's note that she felt trapped. She says: 'taking my own life is probably my only chance to walk away from you' and 'you brought me to a state, it is not even possible to imagine, that the only way out was to TAKE my own life'.

5.2.16 The final part of the motivational phase is the transition from entrapment to suicidal ideation. It is suggested that the presence of motivational moderators will increase or decrease the likelihood of entrapment being translated into suicidal ideation. Whilst the

[16] The integrated motivational-volitional model of suicidal behaviour, O'Connor RC and Kirtley OJ, Royal Society Publishing, 2018

motivational moderators, such as belongingness, connectedness, or attainable positive future thinking, may provide a person with reasons for living conversely, other motivational moderators, such as feeling a burden and depleted resilience, can lead to an increase in the likelihood of entrapment.

5.2.17 **Volitional phase: Behavioural enaction**

5.2.18 This third phase considers the transition from ideation to intent. It has been identified that there are eight volitional factors from suicidal ideation to suicidal behaviour.

5.2.19 Unfortunately, as so little is known about Katarzyna and her thinking in the time leading up to her death, it is not possible to identify the volitional factors that may have moved her from suicidal ideation to suicidal behaviour.

5.2.20 It is important to acknowledge the potential importance of the day on which Katarzyna took her life – Christmas Eve. Christmas Eve is the most important day of Christmas in the Polish tradition. The Christmas Eve supper includes many traditional dishes and desserts and will last for over two hours. It is the time when family will come together and is followed with the exchanging of gifts.

5.2.21 We cannot be certain, but it is possible that Katarzyna felt trapped in her abusive relationship and isolated from her family and friends. This may have come to a head for her on Christmas Eve. She might have been facing an evening alone or an evening with her family, putting on a front to hide her distress. We do not know.

5.3 Hope

5.3.1 Research undertaken by Refuge[17], states that: 'those trapped by domestic abuse can feel so hopeless that they believe the only way out is suicide'.

5.3.2 The power of hope has been studied by The Hope Research Centre at the University of Oklahoma. Domestic abuse victims can often only see the present – day-to-day survival – but are unable to see a future outside of the current situation. It has been argued that hopelessness can focus individuals on the short term, with little vision for the long term (Hellman 2021)[18].

5.3.3 Hope is defined as the ability to see beyond the immediate situation, and plan or visualise a future. Saleebey (2000) contends that hope is a cognitive set, essential to resilience and recovery. He said: 'Hope is about imagining the possible, the 'untested feasible' as Frieire would have it. But more specifically, it is about thinking of oneself as an *agent*, able to effect some change in one's life, having *goals* that not only have the promise but also *pathways* to their accomplishment – pathways that may be short of long, full of ruts or smooth, well-lit or darkened[19]'.

5.3.4 Friere, a pioneer in the study of individuals facing oppression, points to the importance of hope to resilience. He says: 'There is no change without the dream, as there is no dream without hope'.[20] Research undertaken by Aitken and Munro (2018)[21], identified that 96% of victims of Interpersonal Abuse (IPA) who were identified as suicidal, suffered from feelings of hopelessness and despair, and that these feelings are a key determinant for suicidality.

5.3.5 We can see from her note that Katarzyna had given up hope of being able to escape from her abusive relationship.

5.4 Local Suicide Prevention Strategy

5.4.1 The national suicide prevention strategy[22] was first published in 2012. Its key aims were to reduce the suicide rate in the general population in England and to better support those bereaved or affected by suicide.

5.4.2 To support this strategy, the NHS asked all Clinical Commissioning Groups to deliver local multi-agency suicide prevention plans.

[17] Domestic abuse and suicide, Refuge and Warwick Law School, 2018.
[18] Hellman C, The Science of Rape, St Mary's Centre SARC Annual Conference Virtual 16-17 March 2021, cited in cited in Monckton Smith et al., University of Gloucestershire, Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing and intimate partner homicide, 2021
[19] The Relationship between Hope and Life Satisfaction among Survivors of Intimate Partner Violence: the Enhancing Effect of Self Efficacy, Munoz, Hellman and Brunk, Applied Research Quality of Life, 2017
[20] The Psychology of Resilience: A Model of the Relationship of Locus of Control to Hope Among Survivors of Intimate Partner Violence, Munoz RT, Brady S and Brown V, Traumatology, 2016
[21] Aitken R and Munro V, Domestic Abuse and Suicide: Exploring the Links with Refuge's Client Base and Work Force, Refuge, 2018 cited in Monckton Smith et al, University of Gloucestershire, Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing and intimate partner homicide, 2021
[22] https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england

5.4.3 Nottingham City and Nottinghamshire has a Suicide Prevention Strategy 2019 – 2023[23]. The overall aim of this strategy is to *reduce the rate of suicide and self-harm in the Nottingham City and Nottinghamshire population, by proactively improving the population's mental health and wellbeing, and by responding to known risks for suicide in the population.*

5.4.4 The strategy has the following key areas for local action:

- Priority 1 – At-risk groups
- Priority 2 – Use of data
- Priority 3 – Bereavement support
- Priority 4 – Staff training
- Priority 5 – Media

The review notes that this strategy recognises that suicide prevention goes hand in hand with addressing the well-recognised risk factors and at-risk groups for suicide.

5.4.5 Suicide and self-harm are often precipitated by recent adverse events across the life course. These include relationship breakdowns, conflicts, legal problems, financial concerns, interpersonal losses, and traumatic events.

5.4.6 Research has shown that, in terms of suicide prevention, it is important to note that the experience of sexual or domestic violence in adulthood is associated with the onset and persistence of depression, anxiety and eating disorders, substance misuse, psychotic disorders, and suicide attempts[24].

5.4.7 The governance structures have been strengthened and the Nottinghamshire and Nottingham City Suicide Prevention Strategic Steering Group now reports to the Health and Wellbeing Boards (for both Nottingham City and Nottinghamshire) and the Nottingham and Nottinghamshire Integrated Care System (ICS), Mental Health and Social Care Partnership Board. Membership of this Group includes strategic representatives from local authorities, Clinical Commissioning Groups, health providers, Office of the Police and Crime Commissioner, universities, community, and voluntary sector.

5.4.8 The Steering Group has established the Nottinghamshire and Nottingham City Suicide Prevention Stakeholder Network. This provides a forum to engage, work with, and support stakeholders to implement the Nottingham and Nottinghamshire Suicide Prevention action plans and to deliver the required outcomes

5.4.9 The review is advised that more than 60 organisations have signed up to this network. It is noted that there are organisations represented on the DHR panel that have not signed up to the network.

Recommendation

It is recommended that all agencies represented on the DHR panel commit to the Suicide Prevention Stakeholder Network

[23] https://committee.nottinghamcity.gov.uk/documents/s94904/Enc.%202%20for%20Nottingham%20City%20and%20Nottinghamshire%20Suicide%20Prevention%20Strategy%202019-2023.pdf

[24] Hawton K, Van Heeringen K. The International Handbook of Suicide and Attempted Suicide. The International Handbook of Suicide and Attempted Suicide. 2008 cited in ibid.

5.4.10 A guide has been produced for frontline workers and has been shared with all services in the city, as well as a poster for staff in primary care services. A suicide prevention and self-harm awareness and prevention pack is also being produced for primary care and pharmacies.

5.4.11 With funding from the NHSE Suicide Prevention Transformation Programme, the area will be using its three-year funding for:

5.4.12 **Communication** – Campaigns will raise awareness in the public about suicide. Through extensive consultation with partners, stakeholders, and people with lived experience, new suicide prevention branding and communications materials have been developed and widely disseminated, including to services working with people experiencing domestic abuse. The new branding and communications will be used for both population level and targeted communications campaigns over the coming year. Communications direct people to an updated suicide awareness webpage, to support access to the right help at the right time.

5.4.13 **Training** – A training needs' assessment has been completed, and a training provider has been appointed following a procurement exercise. The programme of training is being finalised and will be rolled out before the end of 2022. Services supporting people experiencing domestic abuse and the community and voluntary sector, are included as target groups for training. Options for bespoke training for Nottinghamshire Police and East Midlands Ambulance Service, as 'first responders', are being explored.

5.4.14 **Real Time Surveillance System** – This area of work, being led by Nottinghamshire Police, will strengthen this system and will be exploring domestic abuse as a factor in suicide. The Terms of Reference have been revised and now include an objective to 'review learning from any Domestic Homicide Reviews shared by local Domestic Abuse Commissioning Leads where a suicide death is suspected or confirmed to identify any recommendations for action within the suicide prevention partnership'.

5.4.15 **DOMESTIC ABUSE AND SUICIDE**

5.4.16 Learning from Domestic Homicide Reviews in the area will be reviewed by the Real Time Surveillance Group and will report to the Steering Group.

5.4.17 Work is underway, with the Domestic Abuse Commissioner (led by the county council and across the Nottingham and Nottinghamshire footprint), to understand the issues for those experiencing domestic abuse and suicidal ideation. There is an intention to explore the feasibility of commissioning suicide prevention work in the domestic abuse services locally. This will be in addition to the worker from Nottinghamshire Healthcare Trust (mental health service), who already works within the domestic abuse service.

Section Six – Lessons Identified

6.1 **NOTTINGHAMSHIRE POLICE**

6.1.1 When attending the incident in January 2021, the force policy on the use of Body Worn Video was not followed.

6.2 **SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST**

6.2.1 That relatives were used as a translator in the ED department: this can inhibit disclosures.

6.3 **ALL AGENCIES**

6.3.1 It is important that any interpreters are adequately briefed to ensure that the correct meaning of the questions asked, is understood by the interpreter.

6.3.2 For women for whom English is not their first language, it can be difficult for them to understand the role of MARAC in safeguarding them.

Section Seven – Recommendations

7.1 **NEWARK AND SHERWOOD DISTRICT COUNCIL**

7.1.1 It is recommended that, as part of the preparation for DAHA accreditation, Newark and Sherwood District Council considers adding the Recite Me function to the council website.

7.2 **NOTTINGHAMSHIRE POLICE**

7.2.1 It is recommended that Nottinghamshire Police take measures to improve the use of BWV by officers attending domestic abuse incidents and ensure those images are retained for future use.

7.2.2 It is recommended that Nottinghamshire Police consider seeking legal advice from a specialist lawyer at CPS.

7.3 **SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST**

7.3.1 It is recommended that Sherwood Forest Hospitals NHS Foundation Trust reviews its use of translators and reassures itself that all practicable steps are taken to ensure that translators are available whenever possible.

7.4 **ALL AGENCIES**

7.4.1 It is recommended that all organisations involved in this review, consider how they can provide guidance on the use of interpreters to practitioners.

7.4.2 It is recommended that resources are produced in minority languages, Polish in this case, that clearly explain what domestic abuse is, and the support that is available to victims.

7.4.3 It is recommended that all agencies represented on the DHR panel commit to the Suicide Prevention Stakeholder Network.

Section Eight – Conclusions

8.1 This review concerns the tragic death of a 49-year-old Polish woman, Katarzyna. At the time of her death, she was living with her boyfriend, Konrad, also a Polish national. Both had been living in the UK for some time. It is thought that they had known each other for five years and had been living together for 2 – 3 months.

8.2 It is believed that she took her own life by hanging, at the address they shared.

8.3 Records show that both had been involved with previous partners in issues of reported domestic abuse within the UK. Katarzyna as a victim; Konrad as a suspected perpetrator. Coincidentally, both reports were in 2014.

8.4 Knowledge of their relationship only came to light in 2021, when two calls were made to the police indicating that Katarzyna had been assaulted. On both occasions, she told the police that Konrad was not responsible; however, there is a strong view that this was done to deliberately divert the police away from Konrad. This review has looked carefully at why that may have been the case and what barriers may have existed in helping her report any abuse to others.

8.5 There is strong evidence of domestic abuse from Konrad towards her, not least because of the nature of the messages recorded between them before her death.

8.6 The review has sought assistance from an expert, of the barriers to seeking support by migrants: this has helped us to understand the pressures that she may have been facing.

8.7 We make a number of recommendations that we believe will help make the future safer for others.

Appendix One – Terms of Reference

Terms of Reference for the Domestic Homicide Review into the death of Katarzyna

1 INTRODUCTION

1.1 This Domestic Homicide Review (DHR) is commissioned by Bassetlaw, Newark and Sherwood Community Safety Partnership in response to the death of Katarzyna, which occurred at the end of 2021.

1.2 The review is commissioned in accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.3 The Chair of the partnership has appointed Gary Goose MBE and Christine Graham to undertake the role of Independent Chair and Independent Report Author, respectively, for the purpose of this review. Neither Christine Graham or Gary Goose is employed by, nor is otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

2 PURPOSE OF THE REVIEW

The purpose of the review is to:

2.1 Establish the facts that led to the incident, and whether there are any lessons to be learned from the case about the way in which professionals and agencies worked together to safeguard Katarzyna.

2.2 Identify what those lessons are, how they will be acted upon, and what is expected to change as a result.

2.3 Apply these lessons to service responses, including changes to inform national and local policies and procedures, as appropriate.

2.4 Establish whether agencies have appropriate policies and procedures to respond to domestic abuse, and to recommend any changes as a result of the review process.

2.5 Contribute to the understanding of the nature of domestic abuse.

3 THE REVIEW PROCESS

3.1 The review will follow the statutory guidance for Domestic Homicide Reviews, under the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

3.2 This review will be cognisant of, and consult with, the criminal investigation into Katarzyna's death and the process of inquest held by HM Coroner.

3.3 This review will liaise with other parallel processes that are ongoing or imminent, in relation to the incident, in order that there is appropriate sharing of learning.

3.4 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable: that is a matter for the criminal and coroners' courts.

4 SCOPE OF THE REVIEW

The review will:

4.1 Draw up a chronology of the involvement of agencies involved in the life of Katarzyna, to determine where further information is necessary. Where this is the case, Individual Management Reviews will be required by relevant agencies, defined in Section 9 of the Act.

4.2 Produce IMRs for the time period from 1st January 2021 to the date of her death.

4.3 The review will pay particular attention to:

4.3.1 The immigration status of both Katarzyna and her partner, and the impact this may have had on their decision-making.

4.3.2 The part that Katarzyna's lack of English had on her ability and confidence to report the abuse that she was experiencing.

4.3.3 Whether Katarzyna knew how to navigate services in the UK, and whether she understood what was happening when she was referred to MARAC.

4.3.4 The part that her previous experience of domestic abuse had on Katarzyna's confidence to report the abuse.

4.3.5 The part that the domestic abuse played in her decision to take her life.

5 FAMILY INVOLVEMENT

5.1 The review will seek to involve Katarzyna's family in the review process, taking account of who the family may wish to have involved as lead members, and to identify other people they think relevant to the review process.

5.2 We will seek to agree a communication strategy that keeps families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support, and any existing arrangements that are in place to do this.

5.3 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews; thereby avoiding duplication of effort and minimising their levels of stress and anxiety.

6 THE OVERVIEW REPORT

6.1 The review will produce a report that summarises the chronology of events, including the actions of involved agencies, analyses and comment on the actions taken. The report will make any required recommendations regarding safeguarding of individuals where domestic abuse is a feature.

6.2 Aim to produce a report within the timescales suggested in the statutory guidance, subject to:

- Guidance from the police as to any sub-judice issues,
- Sensitivity in relation to concerns of the family, particularly in relation to parallel enquiries, the inquest process, and emerging issues.

7 LEGAL ADVICE AND COSTS

7.1 Each statutory agency will be expected to inform their legal departments that the review is taking place. The costs of legal advice and involvement of their legal teams are at their discretion.

7.2 Should the Independent Chair, Chair of the CSP, or the Review Panel require legal advice, then Bassetlaw, Newark and Sherwood Community Safety Partnership will be the first point of contact.

8 MEDIA AND COMMUNICATIONS

8.1 The management of all media and communications matters will be through the Review Panel, escalating to the CSP Chair as necessary.

Gary Goose and Christine Graham
Independent Chair and Overview Report Author

Appendix Two – Ongoing Professional Development of Chair and Report Author

2.1 Christine has attended:

- AAFDA Information and Networking Event (November 2019)
- Webinar by Dr Jane Monckton-Smith on the Homicide Timeline (June 2020)
- Ensuring the Family Remains Integral to Your Reviews - Review Consulting (June 2020)
- Domestic Abuse: Mental health, Trauma and Selfcare, Standing Together (July 2020)
- Hidden Homicides, Dr Jane Monckton-Smith, AAFDA (November 2020)
- Suicide and domestic abuse, Buckinghamshire DHR Learning Event (December 2020)
- Attended Hearing Hidden Voices: Older victims of domestic abuse, University of Edinburgh (February 2021)
- Domestic Abuse Related Suicide and Best Practice in Suicide DHRs, AAFDA (April 2021)
- Post-separation Abuse, Lundy Bancroft, SUTDA (April 2021)
- Ensuring family and friends are integral to DHRs, AAFDA (May 2021)
- Learning the Lessons: Non-Homicide Domestic Abuse Related Deaths, Standing Together (June 2021)
- Suspicious Deaths and Stalking, Professor Jane Monckton-Smith, Alice Ruggles Trust Lecture (April 2021)
- Reviewing domestic abuse related suicides and unexplained deaths, AAFDA (May 2021)
- Young people and stalking: Reflections and Focus, Dr Rachel Wheatley, Alice Ruggles Trust Lecture (May 2021)
- Giving children a voice in DHRs – AAFDA (November 2021)
- Cross Cultural Training Webinar – Incels and Online Hate – HOPE Training (November 2021)
- Male victims of domestic abuse, Buckinghamshire DHR Learning Event (January 2022)
- Older victims of domestic abuse, Dr Hannah Bows, DHR Network (February 2022)
- Enhancing the cancer workforce response to domestic abuse – Standing Together and Macmillan (April 2022)
- Understanding Trauma – Delivered by Nikki Dhillon Keane (September 2022)
- Understanding How Coercive Control Harms Children – Delivered by Dr Emma Katz (November 2022).

2.2 Christine has completed the Homicide Timeline Online Training (Five Modules), led by Professor Jane Monckton-Smith of University of Gloucester.

2.3 Gary and Christine have:

- Attended training on the statutory guidance update (May 2016)
- Undertaken Home Office approved training (April/May 2017)
- Attended Conference on Coercion and Control (Bristol, June 2018)
- Attended AAFDA Learning Event (Bradford, September 2018)
- Attended AAFDA Annual Conference (March 2017, 2018 and 2019)
- Attended Mental Health and Domestic Homicides: A Qualitative Analysis, Standing Together (May 2021)
- Attended AAFDA DHR Chair Refresher Training (August 2021)
- Commissioned bespoke training on DHRs and Suicide, Harmless (March 2022)
- Attended Strangulation and Suffocation: Introduction to the new offence for England and Wales, Training Institute of Strangulation Prevention (July 2022).