Watford Community Safety Partnership

Domestic Homicide Executive Summary into the death of Anna, December 2019

Official

Chair and author: Elizabeth Hanlon

Review completed: February 2022

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Anna

“Anna was born in Poland and moved to England in 2006. She was a wonderful mum, wife, daughter, and sister. She was family-orientated, and loved her family greatly, always providing food for daily meals. She particularly loved to eat nuts and waffles.

Anna had a bubbly personality, was very friendly and hardworking - laughing and smiling often with family and work colleagues.

We all miss her terribly and think of her often.”

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1. The Review Process

This summary outlines the process undertaken by Watford Community Safety Partnership's Domestic Homicide Review panel in reviewing the homicide of Anna, who was a resident in their area, by her son, Tomasz.

The death of any person in circumstances such as those examined herein is a tragedy. The panel therefore send their sincere condolences to the family and friends of Anna and thank them for the time they have dedicated to ensuring Anna's voice can be heard in this report.

1.1 Pseudonyms

1.1.1 Pseudonyms for both the victim and the perpetrator have been used throughout this report to maintain anonymity. These pseudonyms were discussed with the family through their Victim Support case worker and were agreed. These are shown in the table below, which also provides an overview of the composition of the victim's family.

Pseudonym	Age (at time of homicide)	Relationship to victim	Ethnicity
Anna	49	Victim	White Polish
Tomasz	17	Victim's son and alleged perpetrator	White Polish
Jakub	52	Husband	White Polish
Piotr	29	Son	White Polish

1.2 Criminal proceedings

1.2.1 Tomasz was found guilty of the murder of his mother and was given a life sentence in November 2020. The verdict of the inquest was open and closed due to Anna's death being recorded as murder.

1.3 The review process

1.3.1 On 19 December 2019, Watford Community Safety Partnership and the Hertfordshire Domestic Abuse Partnership were notified of Anna's death by Hertfordshire Constabulary. On 15 January 2020, it was determined that the criteria had been met for a DHR to be undertaken.

2. Contributors to the review

2.1 All agencies that potentially had contact with the victim and perpetrator prior to the point of death were contacted and asked to confirm whether they were involved with them. Scoping letters were sent out to:

- GP services
- Hertfordshire Constabulary
- Hertfordshire County Council's Children's Services and Adult Care Services
- Watford Borough Council
- Refuge (who provide the Hertfordshire IDVA service)

- Hertfordshire Partnership Foundation Trust (the county's provider of mental health services)
- National Probation Services
- Bedfordshire, Northamptonshire, Cambridgeshire & Hertfordshire (BeNCH) Community Rehabilitation Company
- Citizens Advice Bureau

2.2 As a result of the information received, these agencies were asked secure their files and to submit chronologies.

2.3 Individual Management Reviews (IMRs) were then requested from Community Housing and Youth Connections Hertfordshire. Both IMR writers identified that they were independent of the case and did not line manage any individual who had contact with the family.

3. The Review Panel Members

3.1 The names of the DHR panel members and their role, job title and the agency they represent are detailed in the table below.

Name	Position and Organisation
Elizabeth Hanlon	Independent Chair and Report Writer
Danielle Davis	Senior Development Manager, Adult Care Services, Hertfordshire County Council
Tracey Cooper	Associate Director Adult Safeguarding, East and North Herts and Herts Valleys Clinical Commissioning Groups
Alan Gough	Group Head of Community and Environmental Services, Borough Council
Saira Awan	General Practitioner
Graeme Walsingham	Detective Chief Inspector, Hertfordshire Constabulary
Janet Jones	Head of Assessments, Children's Services
Maria Sharples	Community Housing Trust
Amy Willcox-Smith	Head of Customer Relationships, Watford Community Housing Trust
Karen Hastings	Consultant Social Worker (Adult Safeguarding)/AMHP, Hertfordshire Partnership Foundation NHS Trust
Jonathan Jack	Services for Young Persons, SfYP, Strategy and Development Manager, Children's Services
Julia Dwyer	Senior Operations Manager, Refuge
Julia Kulak	Service Manager -Refuge, Eastern European Independent Gender Violence Advocacy Service (EE IGVA)

Louise Coulson	Senior Operations Manager, Refuge
Vicky Boxer	Senior Social Worker and Safeguarding Lead, Spectrum Change, Grow, Live (CGL)

3.2 The panel met on four occasions between August 2020 and April 2021.

3.3 All panel members were independent of any line management of staff involved in the case.

4. Author of the overview report

4.1 The independent chair and report writer appointed by the Watford Community Safety Partnership was Elizabeth Hanlon, who is independent of the Community Safety Partnership and all agencies associated with this overview report.

4.2 Elizabeth Hanlon is the current independent chair for the Hertfordshire Safeguarding Adults Board. This is an independent role and as such, she has no affiliation to any of the agencies involved in the review. The role of the chair of the Safeguarding Adults Board is to gain assurance that agencies are safeguarding adults with care and support needs within Hertfordshire and to hold these agencies to account. As such, the chair must remain independent on all occasions and must act as an independent scrutineer.

4.3 Elizabeth Hanlon is also a retired senior police detective from Hertfordshire Constabulary, having retired in 2015. She has several years' experience of partnership working and involvement with several previous Domestic Homicide Reviews, Partnership Reviews and Serious Case Reviews in Hertfordshire. She has also completed several DHRs for Cambridge and Essex County Councils.

5. Terms of reference for the review

In conducting the Domestic Homicide Review into the death of Anna, the Panel had regard to the following terms of reference.

5.1 Scope

5.1.1 This review was commissioned by Hertfordshire Domestic Abuse Partnership (HDAP) in partnership with Watford Community Safety Partnership because of the death of Anna in 2019.

5.1.2 The review focused on events from January 2017 until Anna's death. This date was chosen by the review panel because in January 2017, concerns were raised by Tomasz's school regarding his learning ability and a referral was made to an Educational Psychiatrist.

5.2 Purpose

5.2.1 Community Safety Partnerships have a statutory duty to enquire about the death of a person in accordance with the provisions of the Domestic Violence, Crime and Victims Act 2004, Section 9(3)(a). The Act states that a DHR should 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 person to whom he/she was related or with whom he/she was or had been in an intimate relationship with, or a member of the same household as themselves, held with a view to identifying the lessons learnt from the death.

5.2.2 The overall purpose of any 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 upon, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

5.2.3 The purpose of this specific DHR is to:

- Gain an understanding of what pre-domestic abuse Anna suffered, if any.
- Establish the appropriateness of agency responses to Anna and her wider family, both historically and immediately prior to Anna's death.
- If and how agencies assessed risks within the family household.
- If and how agencies assessed needs for care and support within the household and care settings.
- Establish whether single agency and inter-agency responses to any concerns about Anna and Tomasz were appropriate.
- Identify any system issues and learnings within agencies.
- Identify good practice that was in place.
- Establish how well agencies worked together.
- Identify how inter-agency practice could be strengthened to improve the identification, and safeguarding, of vulnerable adults where domestic abuse is a feature.

5.3 Key Lines of Enquiry

5.3.1 **Information:**

- Did agencies comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?

- Did agencies have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators, and were these assessments correctly used?

5.3.2 **Contact and support from agencies**

The Panel wish to determine:

- What disclosures were made to agencies and what were the circumstances behind them meeting them?
- If and how did agencies assess risks to Anna?
- Were agencies' responses proportionate in relation to their knowledge?
- Did relevant agencies discharge their duties properly?
- What lessons are to be learned for the future?
- Was there any good practice demonstrated in agencies' interactions with Anna?
- Are agencies equipped to identify and respond to cases of domestic abuse where a child is abusing a parent? If so, was appropriate signposting and support available?
- How effective was inter-agency communication, including that between Children's Services and Adult Care Services?
- Did agencies encounter any difficulties when working with Anna and her family that had an impact on the case?
- Were the records kept by agencies accurate and up to date?
- Could any agency have acted differently during their involvement with Anna and other family members in a way that would have made a difference to the outcome?
- Did family members need support for possible substance misuse and mental health issues? If so, were these needs identified by agencies and were family members offered the appropriate support?
- Are Polish victims of domestic abuse less likely to be identified, and supported, by professionals?
- Are specialist domestic abuse services equally accessible to victims of domestic abuse whose first language is not English?
- Were there any other barriers to support in relation to communicating with professionals, including language and culture, religion?

5.3.3 The Panel shall seek information on the background and any previous convictions of Tomasz and whether they had ever been subject to Multi Agency Public Protection (MAPPA) arrangements or perpetrator programs for perpetrators of domestic abuse

5.3.4 The overview report shall be written by the Chair, who will submit drafts to the review panel for their consideration. The report shall set out whether there are improvements that could be made in the way in which relevant agencies and organisations work individually or together to safeguard future potential victims.

5.3.5 The panel shall also consider whether further information should be made available in the public domain for the benefit of family or friends who have concerns relating to potential abusive relationships.

5.3.6 Subject to the point above, the panel will:

- Identify any changes in policies and procedures arising from the lessons learnt
- Make recommendations and identify actions
- Establish timescales for the implementation of an agreed action plan

6 Background information (the facts)

6.1 Police were called by the ambulance service to an address in December 2019 following a 999 call to them by Tomasz, who was identified as being aged 17 years.

6.2 He reported to ambulance control that his mother, Anna, had stabbed herself at their home address. Upon arrival of the ambulance service, he disclosed that he had returned from a job interview at 3pm that afternoon and that his mother had returned home some 20 minutes later. He said that she called him down from upstairs and proceeded to stab herself with a kitchen knife.

6.3 There were indications that Anna had been dragged from one room to another, and that efforts had been made to clean blood from the floor. Anna appeared to be suffering from multiple stab wounds. A large kitchen knife was close by, which appeared to belong to a block set from the kitchen of the premises. There was no apparent forced entry.

6.4 Paramedics confirmed the presence of rigor mortis, casting further doubt on Tomasz's account. He was arrested on suspicion of the murder of his mother.

6.5 Tomasz was subject to a mental health assessment in custody but was deemed fit and well for detention and interview. Tomasz was charged and remanded for the murder of Anna.

6.6 A post-mortem examination revealed the cause of death to be multiple stab wounds to the neck, abdomen, and chest areas.

6.7 At this time, the family did not know the motive for the murder. Tomasz proceeded to give a no comment interview.

6.8 The police spoke to Anna's husband, Jakub, who explained that Anna was a heavy drinker and often slept in a different room to him. The family identified to the police that Anna had had drink related problems in Poland and that she had spent money set aside for Christmas on alcohol. It appears that a family member had taken Anna to an Alcohol Anonymous (AA) meeting at one point, but that she hadn't wanted to go back. The fact that she used to drink apparently caused arguments within the family, although there was no explicit mention of domestic abuse. There was no indication from the family of any previous mental health or behavioural issues surrounding Tomasz. Jakub stated that he had never identified any domestic abuse taking place between Anna and Tomasz and that if he had he would have sought help.

6.9 Tomasz was found guilty of the murder of his mother and was given a life sentence in November 2020. The verdict of the inquest was open and closed due to Anna's death being recorded as murder. Anna's death is recorded as resulting from numerous stab wounds

7.0 Overview- This section of the report provides background detail of Anna and Tomasz taken from information provided by professionals.

7.1 The Community Housing Provider (CHP)

7.1.1 The CHP identified that they currently have 84 Polish tenants within their area, and they also have several Polish staff working for them. They identified that they did not have a disproportionate level of involvement with the Polish community in any way and had good established links with the local Polish school and a local Polish radio station, who they had worked with previously.

7.1.2 It seems the family were consistently in rental arrears, and there were multiple letters of intended eviction and threatened court cases in the several years leading to Anna's death. During that time, there is no mention of any additional support being given to the family.

7.1.3 The CHP have identified a single agency recommendation surrounding the support available to their tenants and how this support is available and accessible:

- The CHP is to have sessions with their income team to discuss ways to offer support.
- The CHP is to carry out an investigation of cases of concern and to look at arrear's methodology.

7.1.4 The CHP had no direct contact with Anna, as she was not on the tenancy agreement. They had one interaction with Tomasz, who acted as an interpreter for his father following a visit to the property. They have identified in their IMR that communications could have been better with Jakob. However, they stated that he appeared happy to use his son as a translator on the one occasion that they spoke to him. The CHP have identified that translation services should be more widely encouraged, even if family members offer to translate. They are currently creating a bespoke communication that can be handed out to customers during visits. This will be in the form of a card that can be posted offering support and help. They are also looking at ways to better promote and understand the amount of people using their website and the Google translate function.

7.1.5 The CHP have also identified the following recommendation following their review:

- To review the offer of their translation services, including the creating of a calling card for NOSP letters and for officers to use whilst 'on patch'.

7.1.6 In October 2019, when housing officers attended the home address, family members were asked about the damage to the kitchen window and how it had happened. It was identified that the damage had been caused during a storm. This was an opportunity to identify the dynamics within the family and to identify whether there were any causes for concern or the need for intervention.

7.1.7 The CHP were not aware of any instances of domestic abuse within the household. Since Anna's death, they have reviewed their policies and procedures relating to the way they manage tenancies and support vulnerable people, including victims of domestic abuse. These policies were identified as being up to date and fit for purpose. Staff receive the appropriate training.

7.1.8 Since the death of Anna, CHP have conducted an in-depth review of several their cases of concern, who are in rent arrears, to see if there is anything that can be done differently in terms of communication. They are also working with Watford Borough Council to examine at groups most at risk of domestic abuse in their properties. They will also conduct a joint communication campaign and educate staff of the signs of domestic abuse and risk factors. More visits will also be completed to homes where there is no contact with the tenant.

7.1.9 The following recommendation has therefore also been made by CHP:

- To explore and implement community projects which support victims of domestic abuse following the outcome of the review.

7.2 YC Hertfordshire Services for Young People (SfYP)

7.2.1 YC Hertfordshire SfYP provides targeted youth work, information, advice, careers guidance and work-related learning to young people aged 11-17 (up to 24 for those with special educational needs and disabilities). It helps young people to develop personal and social skills and resilience, supporting progression and economic independence. The service delivers targeted prevention and early intervention work using the professional practice of informal education, addressing emerging needs, improving life chances, and reducing escalation to more expensive and intensive services.

7.2.2 At school, Tomasz was referred to a SfYP Personal Adviser (PA), as part of a paid for contract, when the school had determined he would be unlikely to achieve 5 GCSEs. The PA was contracted to provide advice about potential education, training, and career opportunities.

7.2.3 The very first involvement with Tomasz occurred in school. There are no records of any information that may have been passed from the school to the SfYP PA. It does appear that both conversations at school were based solely on determining Tomasz's needs for education, training, and career support. There does not appear to have been any probing conversations with Tomasz regarding his family background or looking into the possible reasons behind his low educational attainment. Had these conversations taken place, the support worker may have deemed Tomasz as being suitable for additional support. SfYP have reviewed their policies because of this review.

7.2.4 Once Tomasz had left school, routine follow-ups (by phone) took place as part of the 'September Guarantee' process, confirming that he had been offered a place at college. This is the usual process SfYP follows, in which all young people not known to be in education are contacted for information, per the County Council's statutory duty.

7.2.5 A year passed between confirmation of Tomasz's college place and the next attempted contact by SfYP, at which point Tomasz was counted as a 'lost contact.' Lost contacts are passed to the Keeping in Touch team (KIT), who attempt to ascertain the young person's status as part of the County Council's statutory duty to decrease the rate of NEETs (Not in Education, Employment or Training).

7.2.6 It appears that the KIT team made every endeavor to re-engage with Tomasz by phone and text, even calling a second mobile number thought to belong to his father and ensured that his address was provided to the outreach team for further action.

7.2.7 Tomasz was caught, by chance, at his home address during a second outreach visit. It is at this point that Tomasz confirmed that he did not start the second year of college. There was no

engagement with the college by SfYP as it is not considered within general practice guidelines to do so, with interactions being between the SfYP practitioner and young person only.

7.2.8 It is not clear how much of the college course Tomasz completed or why he left, but this information could have helped SfYP understand Tomasz's reasons for dropping out. It may have also prompted a Contextual Safeguarding approach. Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhood, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts, and young people's experiences of extra-familial abuse can undermine parent-child relationships.[1]

7.2.9 SfYP have identified a single agency recommendation in relation to staff training. The recommendation seeks to ensure that all SfYP practitioners have direct interactions with young people, use their professional curiosity to identify and understand indicators of abuse and the impact that these could have on the young person's behaviour, education, and aspirations. The recommendation is as follows:

- Training to understand the concept of contextual safeguarding and relevant support mechanisms.

7.2.10 Tomasz's reasons for leaving college were not probed by the practitioners dealing with Tomasz from this point onwards. The main reason cited for not contacting the college was that the service focuses solely on the young person's needs in the context of careers and education advice. Data protection, and a lack of information sharing agreements, were also cited as inhibitors to seeking (and providing) information from third party organisations.

7.2.11 The practitioner, when interviewed as part of this review, said that with hindsight, Tomasz did appear to be 'drifting' and was not highly motivated to engage. During the interviews with Tomasz, he presented as a nice, polite young man who was a little shy. Tomasz told the support worker that he enjoyed cooking and cleaning in the family home and would like to develop a career in catering, a 'simple' job that was close to his home.

7.2.12 Both practitioners interviewed felt that language was not a barrier for Tomasz, who had a very good command of spoken English. The practitioners noted that Tomasz had changed his mind several times about the direction of his future but felt this to be quite normal in this cohort of young people struggling to achieve the Government's educational standard. The agency's IMR identified the number of missed and unreturned calls made to Tomasz as concerning and something that might have raised questions with professionals.

7.2.13 SfYP identified a further recommendation for their agency regarding lack of contact with Tomasz. The recommendations below seek to ensure that processes are developed that will help to identify potential young people (lost contacts) who may fall through the gaps for support.

- Development of a 'flag' system for the KIT team, for when a young person has been particularly difficult to contact.

- Process to be developed for follow up with school, parent, college, or workplace when a young person reaches the 'flagged' stage.

[1] Contextual Safeguarding.org.uk

7.3 Family and friends

7.3.1 The family described Anna as being a wonderful mum, wife, daughter, and sister. She was family-orientated, and loved her family greatly, always providing food for daily meals. She particularly loved to eat nuts and waffles. Anna had a bubbly personality, was very friendly and hardworking - laughing and smiling often with family and work colleagues. The report writer tried to contact the family through the Victim Support Officer upon receiving feedback from the Home Officer however, sadly they were unable to make any further contact. Anna's husband has returned to live in Poland and the eldest son has moved.

7.3.2 The Chair spoke to a work colleague of Anna's, who stated that although they were friends at work, they did not socialise outside work. She described Anna as being a lovely person who was very hard working. They worked together as cleaners and Anna always appeared to be happy. She stated that Anna didn't speak about her family much, but that she knew she was married with children. She did state that she would often be able to smell alcohol on Anna's breath but that she never appeared to be drunk or to drink whilst she was at work.

7.3.3 A friend of Tomasz's was also spoken to. He described Tomasz and himself as being friends from school and college. He stated that they first met when Tomasz started school, and that they then used to eat lunch and walk home together. Tomasz's friend stated that he was being bullied at school and that Tomasz had stepped in and helped him out, which is how they had become friends. He said that Tomasz was a good friend to him.

7.3.4 He described Tomasz as being quiet and shy at school, and that he didn't have many friends there. However, he did have Polish friends outside of school. He believed that Tomasz had a close relationship with his mother and that she used to meet him halfway when they were walking home, and she would walk with them.

7.3.5 Tomasz had told him that he didn't have a good relationship with his father and that his father would often shout and swear at him. On one occasion, Tomasz had asked him if he could come and live with him as he wanted to move out of the family home. He said that Tomasz had told him that his dad was going to kick him out. He believed that there was friction in the house due to Tomasz not working.

7.3.6 The friend said that Tomasz would often come to his house but that he didn't often go to Tomasz's. He said on one occasion when he did go to Tomasz's home, Tomasz made him stand on the doorstep and wouldn't invite him in. He stated that the main form of communication outside school was via text message, as Tomasz didn't like to answer the phone.

7.3.7 Tomasz's friend described how Tomasz had a fascination with guns and that when they were at school, Tomasz would talk about guns all the time. He knew a great deal about them and studied them and could tell people different facts about different guns. He described how Tomasz had gotten into trouble at school as he had printed off pictures of guns which he had found on the internet. He believed that Tomasz's parents were contacted about it. The family identified that as a hobby they have an interest in military memorabilia and they have an air weapon and deactivated firearm within the household. The air weapon was used by the father in the garden for target practice and this sort of activity is not unusual in Poland.

7.3.8 Tomasz's friend stated that he last saw him in October 2019, but that he didn't have any concerns about him because Tomasz's behaviour hadn't changed in any way. He knew that he was looking for a job. He did state, however, that Tomasz's personal hygiene wasn't very good and that he smelt when he met him as if he hadn't had a shower for a while. He described being very shocked at the death of Tomasz's mother and that Tomasz had been responsible.

8. Key issues arising from the review - In its analysis, the review identified the following key issues.

8.1 Experiences of domestic abuse for European nationals in Hertfordshire

8.1.1 Data supplied from the Annual Population Survey 2019-2020, which is comprised of the Labour Force Survey and sample boosts in England, Wales and Scotland shows that the two greatest foreign nationalities registered as living in Hertfordshire are those of Polish or Romanian nationality.[2] The panel therefore wanted to gain a fuller understanding of Polish communities in Hertfordshire, how best they can work with them and how to offer the most appropriate help and support.

8.1.2 As such, the DHR panel were lucky to have two members of Refuge, one of whom is the service manager for Refuge's Eastern European Independent Gender Violence Advocacy Service and is herself a Polish national. The Refuge Eastern European service manager kindly presented to the panel her thoughts and views in supporting Polish nationals who are survivors of domestic abuse, including the barriers to support that they experience.

8.1.3 The EE IGVA Service Manager has extensive experience in supporting Eastern European survivors, having joined the Eastern European Advocacy Service as a Polish speaking worker in October 2015. In March 2016, she became the manager of the service. Working as an IDVA and manager of the Eastern European Advocacy Service has allowed the panel to make use of her understanding of Eastern European cultures, religion, and language.

8.1.4 The EE IGVA Service Manager described to the panel how Polish women often feel that they have to be the perfect wife, housewife and mother and that women in the family are often blamed for any challenges that might occur, including problems with children, mental health issues and alcohol or drug abuse.

8.1.5 The EE IGVA Service Manager also described language as being one of the main barriers for nationals who have moved to live in England from other countries. She stated that a large majority of people do not speak or understand English enough to be able to fully comprehend what is being explained to them, or to be able to answer specific questions.

8.1.6 They also heavily rely on younger family members to interpret for them, as they have often been through the English educational system and are therefore more able to understand and communicate. This, in turn, can mean that parents wishing to disclose domestic abuse feel they cannot do so, as they do not want their children or other members of their family to be made aware. Anna attended her GP surgery for a health check with a nurse. It is recorded that she attended with her son, who acted as an interpreter. It is not recorded which son attended with her, but it is believed to be Piotr. During the heath check Anna's alcohol intake was discussed and it was during this consultation that she requested help to stop smoking. Anna did not disclose to the nurse any alcohol intake problems but stated that she would like to

[2] Population of the UK by country of birth and nationality: individual country data

receive help in stopping smoking. Anna does not appear to have been asked any questions regarding her home life or domestic abuse within the household although there were no tiggers identified during the health check that would have warranted further exploitation.

8.1.7 This raises a question as to whether Anna would have disclosed domestic abuse if her son were present and acting as an interpreter. Having a family member act as an interpreter severely restricts someone's opportunity to disclose abuse or to ask for help and support.

8.1.8 The panel discussed how open Anna would have been with professionals if she was having to discuss personal things in front of her son. This might be why Anna did not make a follow up appointment.

8.1.9 A representative from the GP surgery stated, during panel meetings, that they do have access to an interpreter service and that they would arrange an interpreter if the appointment were booked in advance, and they were aware of a patient needing one. The representative stated that family members and friends are often used as interpreters if appointments are made at the last minute and there is no time to arrange the service. In these cases, consent is always gained by the person having the appointment to use their family member as an interpreter.

8.1.10 It is important to note, at this point, non-English speakers living in the UK do not always have the support from other family members, meaning they are more reliant on professionals for support.

8.1.11 NHS England published guidance in September 2018 on commissioning interpretation and translation services in primary care.[3] The guidance states that the NHS is committed to providing high quality, equitable, effective healthcare services that are responsive to all patients' needs.

8.1.12 It was also identified that there are often significant delays in accessing services due to a lack of translators and therefore parents rely very heavily on their children to translate for them. This can be the cause of confusion as children do not always understand what is happening or appreciate the importance of what is being said to them.

8.1.13 The EE IGVA Service Manager stated that in Poland, the police are often very 'dismissive' of domestic abuse, seeing it more as a family or personal matter that they won't get involved with. Many Eastern Europeans in the UK believe that police in the UK will respond to domestic abuse in the same way, and therefore will be reluctant to report domestic abuse. A common belief amongst Polish people in the UK is that it is their individual responsibility to push cases of domestic abuse through the court system, including paying for a solicitor. It was identified that Anna was unlikely to have access to information about domestic abuse or other support agencies for mental health or substance abuse.

8.1.14 The EE IGVA Service Manager also identified barriers surrounding agencies involvement with families who had children. She stated that many Eastern European nationals believe that if agencies become involved with a family, then the children will be taken away. She highlighted

[3] Guidance for commissioners: Interpreting and Translation Services in Primary Care 2018

the fact that there are still newspaper articles in Eastern European countries reiterating how children will be removed if agencies became involved.

8.1.15 The EE IGVA also spoke of how the Polish community often like to keep to themselves, and do not like others to know there are problems within their family. It can be rare for them to access support due to concerns about shame and stigma.

8.2 The impact of Brexit

8.2.1 The impact of Brexit on Eastern Europeans in the UK was also identified. Many Eastern Europeans now believe they are no longer entitled to the support that was available to them before Brexit. They are also sometimes fearful that their need for additional support, especially in terms of finding and accessing services, will be held against them and that they would somehow be punished.

8.2.2 Information regarding Brexit in the public domain was identified as being very misleading and has raised several concerns within the Eastern European community. Some nationals believe that since Brexit, they are now unable to access certain stores, such as Tesco, due to them being British.

8.2.3 Concerns were also raised regarding information available about recourse to public funds and the impact that Brexit would have on access to benefits. There is still uncertainty around what services and support foreign nationals can access, which has only been intensified by Brexit. The panel felt this would further isolate victims of domestic abuse.

8.3 Additional needs

8.3.1 Anna's use of alcohol and any barriers to obtaining support she may have encountered were also discussed during this review. The EE IGVA Service Manager described substance misuse in Eastern European countries as being more acceptable than in Britain. Drinking alcohol is much more accepted and is embedded in Polish life and community. Alcohol addiction is much less recognised, and there is a social belief that as long as you can function, excess alcohol consumption is acceptable.

8.3.2 Anna's family told the police during their investigation into her death, that the family had taken Anna to one AA meeting but that she had not returned for any more meetings. They believed that this was because Anna did not feel that she had a problem with alcohol and that she did not need any additional help. Again, the barriers of attending AA meetings with a family member was discussed by the panel however, the panel were unable to identify whether a family member went into the meeting with her or just took her. The AA do hold 'open meetings' where members are allowed to attend with family members. The AA provide contact details for Polish nationals who live in England and wish to attend Polish speaking meetings. Access to these meetings is through their website and there are Polish speaking AA meetings in several locations in Hertfordshire. The panel were able to identify that Anna attended a Polish speaking AA meeting.

8.3.3 Possible stigma around mental health issues were also discussed. The EE IGVA stated that mental health problems are often minimised in Poland due to stigma. Polish families often worry that they will be judged it is identified that either the parents or children within a family had any mental health issues. There is also stigma around accessing support services, unless it is considered there is no alternative.

8.4 Parricide: children who murder their parents

8.4.1 Parricide is the term used to describe to the killing of one's own parents. Matricide refers to the killing of one's mother. In the UK, it is thought that there are around nine cases of parricide per year. Research carried out indicates that most offenders are adults and are over the age of 18 years at the time of the murder. However, one in five parricides are carried out by offenders under the age of 18 years, with 30% of those being under the age of 20 years.[4]

8.4.2 Recent research by Dr Heide has highlighted the key differences between adolescents who commit parricide and adults. Adolescents are more likely to commit parricide when their home life is problematic. The reasons cited for this are:

- They cannot simply leave as they have nowhere to go
- They have no money
- They have not completed education, meaning it is difficult to get a job and provide for themselves.

8.4.3 Adolescents are also still developing. They have less life experience and less understanding of their own emotions compared to adults, and therefore are less able to deal with difficult situations and conflict. Adolescents are, according to this research, less likely to think about the consequences of their actions or to consider alternative options available to them. They often cannot weigh up decisions in the same way that adults can.[5]

8.4.4 Another study conducted by Dr Heide found that adolescences who commit parricide often have parents who have not been available to help them. In fact, they are most often assuming the responsibility of an adult within their families.[6]

8.4.5 During this review, it was identified that Tomasz was:

- Under pressure from his family to get a job
- Not getting on with his father
- Seeking to move out of the family home

8.4.6 During the investigation into Anna's death, the police forensically examined Tomasz's phone and computer. During this examination, they found that Tomasz had conducted extensive internet searches a month before Anna's death about:

- Ways to buy a gun
- How to poison someone
- How to kill someone instantly with poison
- How long a prison sentence you would receive for murdering three family members

8.4.7 There were also searches regarding child protection and where to go if you have family problems.

8.4.8 The use of technology to perpetrate domestic abuse, referred to as tech abuse, has become increasingly common. Domestic abuse charity Refuge reported that in 2019, 72% of women

[3] Fiona Guy, *Family Violence and Homicide* July 2018.
[5] Kathleen M. Heide, '*Understanding Parricide: When Sons and Daughters Kill Parents*', 2013
[6] Kathleen M. Heide '*Tragedy in the family: When kids murder parents',* 2016

said that they had been subjected to technology-facilitated abuse. Common devices such as smartphones and tablets can be misused to stalk, harass, impersonate, and threaten victims. Some groups have raised concerns that the growing use of internet-related home devises may provide perpetrators with a wider and more sophisticated range of tools to harm victims[7].

8.4.9 The Home Office Department for Digital, Culture, Media and Sport published their Online Harms White Paper in 2020. The paper highlights the real harm which people face online every day. It identifies that in the wrong hands there is a link between internet usage and the spread of terrorism and other illegal or harmful content which could undermine civil discourse and be used to be abusive or bully other people. Online harms are widespread and can have serious consequences. The White Paper puts forward plans for a new system of accountability and oversight for tec companies which will mean that companies have the responsibility to keep UK users, particularly children, safer online with the most robust action to counter illegal content and activity. No date has yet been confirmed for the Bill's remaining stages.

8.5 Previous Domestic Homicide Review from 2013

8.5.1 A DHR took place in Hertfordshire in 2013 following the sad death of a Polish woman murdered by her husband. This review resulted in similar findings and learnings regarding the impact and awareness of domestic abuse throughout the Polish community living in England. The learnings and recommendations are below and unfortunately show a stark alignment to the learnings from this review. The panel were concerned that it appeared that the same barriers for Eastern Europeans living in Hertfordshire were still there.

9. Conclusions and lessons to be learned

9.1 The cross-government definition of domestic abuse is:

> *Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality, there is very limited data or unavailable data available regarding violence against parents perpetrated by their off springs.*

9.2 It has been identified that it is difficult to obtain information where domestic abuse is being perpetrated by a child to a parent. This means that this is a subject that agencies are not always aware of, and therefore they do not provide the specific help and support required.

9.3 Most guidance on domestic abuse available to professionals is reflective of intimate partner abuse. In turn, domestic abuse tools and assessments used by agencies are geared toward this and may not be suitable to other forms of domestic abuse

9.4 The DASH risk assessment tool is specific to intimate relationships and is not particularly relevant to instances of familial domestic abuse[8].

9.5 Standing Together Against Domestic Violence (STADV) recently produced a briefing sheet in relation to Adult Family Violence (AFV).[9] Within the briefing sheet, it is identified that there

[7] Lorna Christe and Susie Wright, Post Parliament Rapid Response, '*Technology and domestic abuse' 2020*
[8] T. Phan, *Fatal Adult Child to Parent Abuse Webinar, 2021.*
[9] Standing Together against domestic violence "*Adult Family Violence (AFV) Briefing Sheet.*

was a dearth of research into AFV (Sharp-Jeffs and Kelly, 2016). The lack of research means that the majority of current guidance and tools for responding to domestic abuse are geared towards intimate partner violence and are therefore potentially unsuitable for dealing with AFV.

9.6 Westmarland (2015) emphasises that whilst current practice guidance and tools are geared towards intimate partner violence, this has 'almost certainly contributed to its invisibility and the relative lack of research attention and therefore theoretical development' around domestic abuse occurring in non-intimate partner contexts.

9.7 The review panel also identified that the Hertfordshire Police's Domestic Abuse Safeguarding Unit (known as the DAISU) only deal with instances of domestic abuse perpetrated by a current or former intimate partner.

9.8 Other research has shown that 26% of all domestic homicides involved adult family members, most of which involved adult children killing their parents. Between April 2014 and March 2017, the Home Office Domestic Homicide Index recorded 400 domestic homicides, of which 114 were adult family homicides (28% of all domestic homicides).[10] This is an outstanding number.

9.9 Research has shown that many minority ethnic women experiencing domestic abuse prefer to access support services from a specialist service targeted at their community, and that women from Eastern communities find it difficult to access mainstream services due to the lack of awareness of support services and language barriers.[11]

9.10 Research carried out during the Refuge Eastern European Outreach Project identified that majority of women in the project required language support. While 16 were able to communicate in some English, 207 women (93%) either needed an interpreter or needed project staff to provide interpretation and language support.[12]

9.11 Agencies should consider various methods to provide outreach in their communities and to provide the information, help and support needed in the appropriate format.

9.12 There were no recorded instances of domestic abuse within Anna's household and very limited agency involvement. This might, however, be due to the family not wishing for agencies to be involved and the feeling that accessing services would result in stigma being attached to the family.

9.13 The family identified that when they had first arrived in England their eldest son, Piotr, struggled at school as he was unable to speak English. As a result of this the family stated that they really wanted Tomasz to do well in school and to get a good job. During the Police investigation it was identified by the family that they were a hard working family and it was expected that all family members worked hard and contributed to the household. Tensions appeared to exist within the household because Tomasz, in their opinion, had not applied himself to school/college and as such had been unable to get a good job. They stated that on the day of the murder Tomasz had gone to a job interview as a waiter but that he had turned up looking scruffy which is why he did not get the job. They were disappointed in this. The

[10] Office for National Statistics, 2018b)

[11] In a survey of BAME women accessing services, found that 89% preferred a specialist BAME worker. Thiara, R & R, S. (2012) Vital statistics 2: Key findings on black, minority ethnic and refugee women's and children's experiences of gender-based violence.

[12] Refuge independent evaluation report: Eastern European Community Outreach Project Dr. Ravi K. Thiara 2011

panel felt that the level of support that Tomasz had received from the SfYP was limited and that workers should have delved deeper into Tomasz and his families background to try and understand what was happening and whether there were any family barriers that were blocking Tomasz. The workers appeared to take everything at face value, and either were not aware of any identified issues with Tomasz, i.e., additional educational needs, family background or didn't ask any delving, follow up questions.

9.14 Relevant information was not able to be obtained from the school due to there being very limited records surrounding Tomasz's time there. There were records that the school had made a referral around Tomasz's learning ability in year 6 which had been a cause for concern for some time. He had been given support, but this had had little impact. The educational psychologist had been asked to determine why Tomasz was finding learning so difficult so that the curriculum could be made easier for him. Nothing specific was identified by the school records apart from a referral being made to SfYP for additional support. It is recorded that Tomasz was given additional support in lessons and exams to help him but again the panel were unable to identify which support was made available to him. The school did identify that Tomasz's parents would attend parents' evenings and appeared to be very supportive of Tomasz.

9.15 It is not clear how much of the college course Tomasz completed or why he left, but this information could have helped SfYP understand Tomasz's reasons for dropping out. It may have also prompted a Contextual Safeguarding approach. Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhood, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts, and young people's experiences of extra-familial abuse can undermine parent-child relationships.[13]

9.16 Tomasz left college after one year of his two-year course. It appears that he also struggled getting a job. This was around the same time Anna attended an AA meeting and when the family were also in rent arears, suggesting they may have been struggling financially. Tomasz's friend also identified that the last time he had seen him, which was close to the date of the murder, he noticed that Tomasz appeared to be unkempt and had smelt unclean.

9.17 Following Anna's murder, police reviewed Tomasz's internet history and found a substantial amount of internet searches in relation to ways to kill your family, including how to buy a gun and using poison. There was also evidence to suggest that Tomasz was very unhappy and was looking for support, as he had also searched ways to contact child protection and where to go if you had family problems. These searched had taken place one month prior to the murder.

9.18 Although a previous DHR has identified learnings to this review, agencies have identified that a considerable amount of work has taken place regarding signposting and offering support to non-English speaking nationals. The Hertfordshire Sunflower Partnership offers help and support for victims of abuse including sexual abuse and physical abuse. The Sunflower Partnership is easily accessible on the internet and can be translated into numerous languages. The Sunflower Partnership also links into the Herts Domestic Abuse Helpline which offers a confidential and free support and signposting service for anyone affected by domestic abuse.

[13] https://www.contextualsafeguarding.org.uk/

9.19 Hertfordshire Independent Domestic Violence Advocacy (IDVA) service offers support to survivors of domestic abuse from all backgrounds and interpreting services are always used to support those who need language support. The service has also recruited IDVAs who speak a number of difference languages, including Polish.

9.20 In 2008, Refuge identified a need for additional support for Eastern Europeans who were living in England and set up a service to offer that additional help and support. This support has had a significant impact on the help and support available and is something that should be considered as a priority within Hertfordshire.

10. Recommendations from the review

1. Hertfordshire County Council Domestic Abuse Strategic Partnership Board, when recommissioning their domestic abuse services, to ensure the specification requires providers to demonstrate how they will ensure their service is accessible and removes barriers to access for Eastern European's and other marginalised communities within Hertfordshire. This will include their literature/website etc.

2. When the Hertfordshire County Council Domestic Abuse Strategic Partnership Board develop the new Domestic Abuse strategy a partnership communications strategy will also need to be developed to sit alongside it and be 'owned' by the practice network subgroup.

3. The Hertfordshire County Council Domestic Abuse Strategic Partnership Board to strengthen their existing J9 project[14] to invite more community based organisations (e.g. religious institutions etc.) to become J9 centers. To work with the practice network and providers to scope existing community groups initially within the Eastern European communities and then to expand to other hard to reach communities within Hertfordshire.

4. For individual agencies to review the access to resources to meet the needs of Eastern European communities and other marginalised communities within Hertfordshire, including access to translation and interpreting services where and when required.

5. The Hertfordshire County Council Domestic Abuse Strategic Partnership Board to carry out some deep dives from pathways for minority ethnic and marginalised communities to include a survey of all services in Hertfordshire to identify how they access translation services for victims that might need them.

6. The Chair of the Watford Community Safety Partnership to write to the Brexit lead within the Government to highlight the impact of being a foreign national living in the United Kingdom, as a result of Brexit, to raise awareness of the 'myths' that now exist within the community.

7. Agencies to review and amend their data collection set to make sure that acts of Adult Family Violence (AFV) are captured and monitored. This recommendation leads into recommendation 8 below.

[14] The J9 initiative raises awareness of domestic abuse amongst local nosiness and services. It was developed in the memory of Janine Mundy, a mother of two killed by her estranged husband in 2003.

8. Hertfordshire Community Safety Partnership to work with the local partners to develop and share a greater understanding of the nature and risk factors relating to familial abuse. This includes understanding the dynamics of these cases and the best practice responses to them. This learning should be shared widely throughout Hertfordshire.

Appendix A: Family's comments on the Overview Report

The family's comments in Polish

W Lutym zapytałem się Tomasz, czy złożył już aplikacje na nowy rok do College Tomasz odpowiedział, że nie, bo jakiś nauczyciel powiedział, że nowa aplikacje na następny rok szkola ma składać dopiero od połowy Sierpnia. Próbowaliśmy mu przemówić do rozsądku kilkukrotnie razem z mamą, ale nie stety Tomasz nie przyjmował tego do wiadomości zeby applikacje na nowy rok w szkole złożyć już w Lutym /Marcu. Potem nie pamiętam dokładnie, w jakim miesiącu Tomasz przyszedł do domu i powiedzail nam rodzinie, że nauczyciele w szkole twierdza, że nieradzi Sabie z nauką na kursie Turystycznym i proponują mu zmianę kierunku kursu na coś innego. Wiec powiedzieliśmy Tomaszowi zeby poszedł i podpytał się, jaki nowy kierunek nauczyciele proponują mu i nauczyciele zaprononowali mu przejście na kurs Biznesu, który w naszej opinie wydawał się jeszcze trudniejszy, a i sam Tomasz nie za bardzo był zadowolony z tej propozycji. Więc wspólnie podpowiedzieliśmy Tomaszowi zeby poszedł na kurs Gastronomiczny, gdyż ja miałem doświadcznie i znajomości w branży gastronomicznej, więc łatwiej, by było załatwić Tomaszowi jakieś ewentualne praktyki, czy nawet etat pracy, a i nawet mama jako gospodyni domowa od wielu lat mogłaby pomc Tomaszowi z podstawami gotowania. Po wielukrotnych namowach Tomasz dał się namówić na aplikowanie do szkoły wcześniej, niż w Sierpniu i Tomasz wyslal aplikajce do szkoły. Która wypełnił niepoprawnie i potem mama poprosiła zeby pomógł Tomaszowi z tą aplikacją i złożyliśmy wspólnie kolejna aplikacje do szkoły na nowy rok w sumie Tomasz wysłał 3 aplikacje do szkoły jedna sam i dwie zemną niestety mijał czas i nie było żadnej odpowiedzi ze strony szkoły, a był już Wrzesień i Tomasz próbował się skontaktować kilkukrotnie z collegem telefonicznie parę razy został poproszony o przyjście osobiście do szkoły, gdzie paru krotnie czekał na nauczycieli wiele godzin proszony, aby poczekać na nich, a potem mówiono mu zeby przyszedł znowu następnym razem. Tomasz był bardzo zdenerwowany tym faktem, że musi chodzić do szkoły czeka po parę godzin i jest odsyłane do domu bez załatwienia sprawy. Po jakimś czasie po rozmowach z Tomaszem i usłyszeniu od niego na czym sprawa stanęła zacząłem osobiście kontaktować się z collegem w sprawie Tomasza. Sprawa była notorycznie przedłużana, a to ktoś miał przekazać, że ja dzwoniłem w spawie Tomasz głównemu nauczycielowi, który miał do mnie oddzwonić, lecz nigdy tak się nie stało i po kolejnym telefonie do szkoły dowiadywałem się, że nikt nie przekzal nic głównemy nauczycielowi i dlatego do mnie nie odzwonil. Po wielu telefona rozmowach z dyrektorem college usłyszałem, że niestety Tomasz złożył aplikacje za późno i już nie ma dla niego miejsca i nie da się już nic dla niego zrobić musi wrócić do edukacji za rok.

The family's comments translated into English

Please note that the follow translation has been checked by the family and they are happy with the wording

In February, I asked Tomasz if he had already submitted applications for the New Year to the College. Tomasz replied that he had not, because some teacher said that the new application for the next year the school is to submit only from mid-August.

We tried to talk him to reason several times together with my mother, Tomasz did not accept it in order to submit apps for the New Year at school in February / March. Then I don't remember exactly what month Tomasz came home and told our family that the teachers at school said that he would not advise Tomasz to study at the Tourist course and offered him to change the direction of the course to something else.

So we told Tomasz to go and ask what new direction the teachers were proposing to him and the teachers had prevented him from switching to the Business course, which in our opinion seemed even more difficult, and Tomasz himself was not very happy with this proposal.

So together we suggested to Tomasz to go to the Catering course, because I had experience and acquaintances in the catering industry, so it would be easier to arrange for Tomasz to get some possible internships, or even a full-time job, and even his mother as a housewife for many years could help Tomasz with the basics of cooking.

After many persuasions, Tomasz was persuaded to apply to school earlier than in August and Tomasz sent an application to the school. Who filled in incorrectly and then mom asked him to help Tomasz with this application and we submitted together another application to the school for the new year in total Tomasz sent 3 applications to the school one on his own and two with help from his family unfortunately time passed and there was no response from the school, and it was already September and Tomasz tried to contact the college several times by phone, several times he was asked to come to the school in person, where several times he waited for the teachers for many hours asked to wait for them, and then he was told to come again the next time.

Tomasz was very upset by the fact that he had to go to school waiting for a few hours and was sent home without settling the matter.

After some time, after talking to Tomasz and hearing from him what the matter was about, I began to personally contact the college about Tomasz. The case was notoriously prolonged, and it was someone who was supposed to convey that I was calling Thomas to the main teacher, who was supposed to call me back, but it never happened and after another phone call to the school I found out that no one had transferred anything to the main teacher and therefore he did not call me back. After many phone calls with the headmaster of the college, I heard that unfortunately Tomasz submitted applications too late and there is no place for him and nothing can be done for him he must return to education in a year.

The family feel that the above mistakes and lack of care by the school, lead to Tomasz leaving the Education system, without a job, and with no ongoing education, and pressure from the family to get a job: the family believe this had a part to play in the actions that followed by Tomasz.

The family believed Tomasz was a shy teenager, and they are sorry they didn't recognise that Tomasz was struggling.