Domestic Abuse Related Death Review (DARDR)
Kamila/August 2023
Overview Report

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Commissioned by: Safer Lincolnshire Partnership

Review completed: October 2025

The Safer Lincolnshire Partnership, all panel members, and the Independent Chair extend their deepest condolences to Kamila’s family and friends.

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1. Introduction

1.1. This Domestic Abuse Related Death Review (DARDR) examines agency responses and support given to Kamila, a resident of Town A, prior to her death in August 2023.

1.2. Kamila died by suicide just over one week after her partner Sean had taken his own life. Both had died by hanging, in the home which they had shared since the commencement of their relationship in late 2019.

1.3. The key reasons for conducting a Domestic Abuse Related Death Review (DARDR) are to:

a) establish what lessons are to be learned from the death, about the way in which local professionals and organisations work individually and together to safeguard victims.
b) identify clearly what those lessons are both within and between organisations, how and within what timescales will be acted on, and what is expected to change;
c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
d) prevent domestic violence and abuse, and improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-organisation working;
e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

2. Confidentiality

2.1. The findings of this DARDR remained confidential throughout the process, and information was only made available to participating officers/professionals and their line managers, until after the DARDR was approved by the Home Office Quality Assurance Panel and published.

2.2. Dissemination is addressed in section 11 below. As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved. In the absence of involvement from the family, pseudonyms were chosen by the panel, who were mindful of the ages and nationalities of the parties.

2.3. Details of the deceased and perpetrator:

Name (Pseudonym)	Gender	Age at time	Relationship to deceased	Ethnicity/Nationality

		of death		
Kamila	Female	35	*Deceased*	White Polish
Sean	Male	40	*Partner and perpetrator - Also deceased*	White British

2.4. The following individuals/family members were known to the Review Panel and have been given the following pseudonyms to protect their identity:

Pseudonym	**Relation to deceased:**	**Relation to perpetrator:**
Child A	Child	None
Leon	Ex-husband	None

3. Methodology

3.1. The detailed information on which this report is based was provided in Individual Management Reports (IMRs) completed by each organisation that had significant involvement with Kamila and Sean. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

3.2. Each IMR was written by a member of staff from the organisation to which it relates. Each was signed off by a Senior Manager of that organisation before being submitted to the DARDR Panel. Neither the IMR Authors nor the Senior Managers had any involvement with Kamila or Sean during the period covered by the review.

3.3. In addition to IMRs, two organisations provided summary reports due to the small amount of information they held. Also, West Yorkshire based organisations who had limited contact with Kamila in January 2023 completed Summary of Involvement forms, which were sourced via the Leeds and Bradford Community Safety Partnerships.

3.4. The IMR and summary reports were also quality assured by the panel's legal advisor.

4. Timescales

4.1. Lincolnshire Partnership Foundation NHS Trust (LPFT) submitted a DARDR notification form to Safer Lincolnshire Partnership on 11th October 2023 for Kamila. Following receipt of the notification, and in accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a DARDR Decision Panel was held on 14th November 2023. The panel agreed that the criteria for a DARDR had

been met. That agreement was ratified by the Chair of the Safer Lincolnshire Partnership, and the Home Office were informed.

4.2. The Independent Chair was recruited in June 2024, and an initial meeting was held with the DARDR panel on 4th July 2024. Following receipt of chronologies in October 2024, the Terms of Reference were agreed, and IMRs/Summary Reports were requested. These were received throughout January and February 2025 and reviewed by the full panel at an in-person IMR review day in March 2025.

4.3. The first overview report draft was presented to the panel in May 2025, and following panel discussions, the final draft was signed off by the Safer Lincolnshire Partnership in November 2025 and submitted to the Home Office.

5. Terms of Reference

5.1. Following a review of a collated chronology of agency contacts with Kamila and Sean, the Review Panel agreed the Terms of Reference at a meeting in October 2024.

5.2. The scoping period for the review was agreed as January 2019, to the date of Kamila's death in August 2023. The rationale for this period being that Kamila and Sean commenced their relationship in 2019.

5.3. Relevant issues for agencies to consider within their IMRs, and subsequently for the panel to consider throughout the process, are detailed in the Home Office Statutory Guidance.[1]

5.4. In addition, the following bespoke terms of reference were agreed by the panel:

a) Identification of coercive and controlling behaviour

i) In what ways was isolation of Kamila identified and understood by professionals who were involved with supporting Kamila? What can agencies learn from this case regarding the impact of the isolation; both on Kamila as an individual but also how this impacted her access to services, and professionals' ability to engage with Kamila?
ii) What did professionals know about Sean's use of surveillance? If this form of control was known to professionals, what was their understanding of the impact of this on Kamila? How did professionals respond to Sean's use of surveillance as form of control?
iii) What did professionals know about the impact of Sean's behaviour on Kamila's relationship with her ex-husband and Son, and how was it addressed?
iv) What did professionals know about pregnancies and was this recognised as a potential area of CCB?

[1] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews | Page 13

b) How were the available disclosures schemes utilised? If there were barriers to fully utilising the available resources, what were these barriers, and what will your agency learn from this review in terms of reducing these barriers to make the future safer for potential victims?

c) What was known about Kamila prior to her relationship with Sean? Namely:

    i) What was known about her mental health? What services was she offered, and which did she engage with prior to her relationship with Sean?
    ii) What do we know about her relationship with Leon?
    iii) What do we know about how Sean and Kamila met – and the early part of their relationship?

d) What was known about Sean prior to his relationship with Kamila? Namely:

    i) What was known about his mental health? What services was he offered, and which did he engage with prior to his relationship with Kamila?
    ii) Was Sean identified as a perpetrator of domestic abuse prior to his relationship with Kamila? If so, how successfully was the risk he posed to others identified, monitored and managed during this time?

e) What can agencies learn from this review, about children and young people as direct victims of domestic abuse?

    i) In what ways was Child A identified as a victim in their own right?
    ii) What measures are available for children who are identified as victims of domestic abuse, were these measures utilised, and if not, what were the barriers to utilising these measures?
    iii) What measures may have been of benefit in supporting Child A as a victim of domestic abuse – and if they are not available, how can the learning from this review support the provision of effective measures for the future?

f) Information sharing:

    i) In what ways were information sharing processes followed; including where risks were identified to any of the parties, including Child A.
    ii) Were any barriers, difficulties or gaps encountered in terms of information sharing, within agencies, and across different agencies, in respect of all parties, including Child A.
    iii) Do practitioners in your organisation understand children's safeguarding thresholds, and when these would require information to be shared. Is your organisation's safeguarding policy, and are information sharing protocols clear?

g) In what ways did agencies work together in responding to Kamila and/or Child A? Namely:

   i) Were available mechanisms utilised fully and if not, what barriers can be identified regarding the lack of multiagency working?
   ii) Does this review highlight gaps in current multiagency mechanisms and provisions - including referral pathways into specialist services?
   iii) What can agencies learn from any identified gaps in multiagency working?

h) In what ways did housing provision have an impact on Kamila? Did housing provision, or lack of, affect her choices, and if so was this recognised by professionals who were involved with supporting Kamila.

6. Involvement of Family Members and Friends

6.1. At the commencement of the review process, the Safer Lincolnshire Partnership wrote to Kamila's family in Poland, advising them of the process and inviting them to speak with the Independent Chair.

6.2. The Independent Chair followed up with a further letter and also wrote to Leon. There was no response from these letters.

6.3. In May 2025, the social worker who had been working with the family met with Leon and his sister. They provided some background information about Kamila, and also shared insights into the family dynamics, before and after the relationship between Kamila and Sean began.

6.4. The Safer Lincolnshire Partnership, the Independent Chair and all agencies involved in the review extend their sincere condolences to Kamila's family and friends.

7. Contributing Organisations

7.1. Each IMR was written by a member of staff from the organisation to which it relates and signed off by a senior manager of that organisation, before being submitted to the DARDR Panel.

7.2. Each of the following organisations contributed to the review:

Agency/ Contributor	**Nature of Contribution**	**Source**
GP Practice A	IMR Chronology	SystmOne

Lincolnshire Partnership NHS Foundation Trust (LPFT)	IMR Chronology	- RIO - IAPTUS - MOSAIC Interviews with key staff
Lincolnshire Police	IMR Chronology	- Police National Computer (PNC) - Police National Database (PND) - NICHE - the crime recording and intelligence system - NSPIS - the Command and Control and Custody system - Guardian Command - CAD - view incident recording system - GENIE - an intelligence search engine Liaison with British Transport Police
Lincolnshire Domestic Abuse Specialist Service (LDASS)	IMR Chronology	Modus Interview with IDVA
Lincolnshire Probation Service	IMR Chronology	Delius
East Midlands Ambulance Service NHS Trust (EMAS)	IMR Chronology	- Siren - SystmOne - CAD
United Lincolnshire Teaching Hospitals NHS Trust (ULTH) - Hospital A	Summary Report Chronology	CareFlow Paper Medical Records
Lincolnshire County Council – Adult Social Care	IMR Chronology	MOSAIC
Town Council A	Summary Report Chronology	- E-Cins - Making Time Counts Tomorrow - CIVICA Xpress - CIVICA APP - Academy - Northgate (NEC) - MRI- Housing Jigsaw - Assure - Agile PLACIS - Xpress Register - Xpress Management - MOSAIC

		- Idox - Uniform - Acolaid - LA Support Tasking Portal - V-TAS (Viewscape) - CRM System – Collective - MRI
Children's Social Care (CSC)	IMR Chronology	Mosaic Interviews with allocated social worker and Team Manager
Primary School A	IMR Chronology	MyConcern Interviews with key staff
Secondary School B	IMR Chronology	MyConcern Interviews with key staff

7.3. The following organisations provided a Summary of Information:

West Yorkshire Police	Pre-scoping period January 2023	Non-recent involvement with Sean and Ms Y (Sean's ex-partner). Investigation following Kamila attempted suicide
Yorkshire Ambulance Service (YAS)	January 2023	Responded to incident and conveyed Kamila to hospital
Leeds Community Healthcare NHS Trust	January 2023	Assessed Sean in Custody
Leeds Teaching Hospitals NHS Trust	January 2023	Emergency Department and Intensive Care Unit
Leeds and York Partnership NHS Foundation Trust	January 2023	Mental Health Liaison Service
Leeds Children's Social Care	Pre-scoping period	Historic information - Sean

8. Review Panel Members

8.1. The Review Panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Kamila and/or Sean. It also included a senior member of the Lincolnshire Safer Partnership.

The panel were supported by an Assistant Chief Legal Officer from Legal Services Lincolnshire.

8.2. The panel met on five occasions during the DARDR process.

8.3. The members of the panel were:

Agency	Advisor	Job Title
ViMar Solutions	Liza Thompson	Independent Chair
Lincolnshire Partnership Foundation Trust	Tony Mansfield	Head of Safeguarding, Public Protection and Mental Capacity
United Lincolnshire Teaching Hospitals NHS Trust	Elaine Todd	Named Nurse Safeguarding Children and Young People
NHS Integrated Care Board	Claire Tozer	Head of Safeguarding Adults and Primary Care
EMAS	Charlotte Salt	Named Professional for Safeguarding Adults
Lincolnshire Police	Rachael Cox / Emma Coleman	DCI Safeguarding Hub and DA lead for the force
DA Specialist Services	Sharon Walker	IDVA Manager
Providers of Probation Services	Rachel Crook	Deputy Head East and West Lincolnshire PDU
Adult Social Care (ACCW)	Angela Copestick	Area Manager for Safeguarding
Children's Services	Paula Bexon	Head of Service
Children's Health	Dawn Waring	Locality Health Manager
Town Council A	Peter Hunn	Community Safety Manager
Public Health Suicide Prevention	Kate Cooper	Public Health Officer
Lincs Recovery Partnership	Lisa Brooks	Operations Manager
Lincolnshire Community Health Services NHS Trust	Jennifer Parker	Named Nurse for Safeguarding

Lincolnshire Education Support	Debbie Barkes	Pathfinder Education Lead

Panel Supported by:

Agency	**Name**	**Job Title**
Legal Services Lincolnshire	Toni Geraghty	Assistant Chief Legal Officer
Lincolnshire Domestic Abuse Partnership	Lara Iggulden	Domestic Abuse Operational Lead

9. Independent Chair and Author

9.1. The Independent Chair, who is also the Author of this Overview Report, is Dr Liza Thompson.

9.2. Dr Thompson has experience of working directly with high-risk victims of domestic abuse, and of leading a specialist domestic abuse charity. She is an accredited Independent Domestic Violence Advisor (IDVA), and an accredited Service Manager. Dr Thompson's PhD thesis examined the experiences of abused mothers within the child protection system. In addition to chairing and authoring DARDRs, Safeguarding Adult Reviews (SARs) and Offensive Weapon Homicide Reviews (OWHRs), Dr Thompson delivers training around domestic abuse and coercive control and is the Independent Chair for Rochester Dioceses' Safeguarding Advisory Panel.

9.3. Dr Thompson is entirely independent of Lincolnshire County Council, and of all agencies and services within Lincolnshire.

10. Other Reviews/Investigations

10.1. LPFT would usually undertake a safety or serious incident review where there is a suicide of a person who is accessing Trust services if there are multiple factors that indicate lessons could be learned. However, as agreed with the Trust's commissioners, when an NHS or social care incident meets the threshold for a statutory safeguarding review, the multi-agency review process takes precedence over the single agency review. The LPFT IMR author included additional terms of reference in their IMR to ensure that the needs of a safety/serious incident review were met through the application of the DARDR process.

10.2. The coroner inquest into the death of Kamila concluded on 2nd February 2024, with a conclusion of suicide.

10.3. The coroner inquest into the death of Sean concluded on 23rd January 2024, with a narrative conclusion as follows, "*The deceased died from self-suspension by*

ligature whilst under the influence of controlled drugs. The evidence does not disclose his intention at the time to the required standard."

11. Publication

11.1 This overview report will be published on the website of the Safer Lincolnshire Partnership.

11.2. Family members will be provided with the website addresses and also offered hard copies of the report.

11.3 Further dissemination will include:

- Members of the Safer Lincolnshire Partnership
- Lincolnshire Safeguarding Children Partnership
- Lincolnshire Integrated Care Board
- Lincolnshire Safeguarding Adults Board
- Lincolnshire Police and Crime Commissioner
- Organisations represented on the Review Panel.
- Domestic Abuse Commissioner's Office

12. Background Information

Kamila

12.1. Kamila was born in Poland, and her family continue to reside there. Kamila came to the UK with her husband, Leon, when Child A was six months old.

12.2. Kamila told mental health practitioners that she had found her childhood "difficult" due to her parents separating and then rekindling their relationship. She also described her mother as having "problems with alcohol abuse", and as being "a cold, distant person" who belittled her during childhood. Kamila reported being bullied at school.

12.3. Kamila told mental health practitioners that following Child A's birth, she had experienced mood swings, saying she had been either "very happy or very sad". She also told practitioners that following her move to the UK with Leon, when Child A was six months old, she had become low in mood. This information may indicate post-natal depression,[2] however there is no record of Kamila being diagnosed or treated for this.

12.4. It is thought that Kamila, Leon and Child A moved to Town A in 2012, when they were all registered at the GP Practice A. During the transfer in visit, Health visitors did not raise any concerns about the family circumstances.

[2] Where symptoms of low mood persist beyond a few weeks after the birth of a baby.

12.5. It is recorded that Kamila was living with Child A, Leon and Leon's mother during 2012. Kamila and Leon were working fulltime and were planning to move to their own property soon. The property was seen to be clean and tidy, and Child A was well presented and was playing with his toys.

12.6. The family's GP Practice have on record that Leon and Kamila separated in 2014. However, throughout agency records it is clear that they had a friendly ongoing relationship and co-parented well until Kamila met Sean.

12.7. Kamila and Child A did not come to the attention of any statutory services for anything other than routine appointments until the relationship between Kamila and Sean started.

12.8. Primary School A shared that they had good interaction with both biological parents throughout Child A's time at primary school. Child A had spoken positively about both parents, and the staff were shocked to learn that the couple had been separated.

12.9. Leon provided some background information to the panel to support with the review. He shared that prior to the relationship with Sean; Kamila was very caring about her family and close to her younger sisters. He also recollected that Kamila had a problematic relationship with her mother, and that Kamila felt she was not good enough for her mother. Kamila's father was a long-distance lorry driver and was not home much; as Kamila's mother worked long hours, the care of the younger siblings fell to Kamila.

12.10. Leon had moved to the UK whilst Kamila was pregnant with Child A. Kamila was living back with her parents during this time. When Child A was 6 months old, Kamila joined Leon in the UK. Once in the UK, Kamila had some episodes of self-harm and suicidal ideation, which were linked to problems in Kamila and Leon's relationship. Following the relationship ending, Kamila lived near Leon, with Child A. Leon reflected that the flat was clean and tidy when she lived there alone, and Kamila was always smiling and doing things with Child A, however once she started a relationship with Sean this changed, and Kamila also changed. Eventually, Leon had full care of Child A.

Sean

12.11. Sean had been born, and grew up, in West Yorkshire. Sean had been subject to a child protection plan as a child, due to emotional abuse, although due to the time lapse there is no further information available as the system holding the information was decommissioned some years ago.

12.12. During Sean's court case in July 2023, for the assault upon Kamila, Sean's sister spoke to mental health practitioners about their childhood. She spoke about their mother nailing the windows shut when they were younger and also stated that Sean had been "locked up" from the age of fifteen to thirty-two.

12.13. During 2007 and 2008, Sean was managed as a MAPPA[3] category 2 offender due to robbery offences and being assessed as a high risk to the public.

12.14. West Yorkshire Police hold a large amount of information regarding domestic abuse perpetrated by Sean on to his ex-partner (Ms Y) between 2012 to 2017.

12.15. CSC held non-recent information regarding a previous relationship, where concerns of Sean's coercive and controlling behaviour had been raised during his relationship with Ms Y, who was the maternal grandmother of a child known to CSC in Lincolnshire.

12.16. In 2013, Sean was sentenced to 81 months for a burglary dwelling offence. He was initially released from custody in 2016; however, he was recalled in 2018 for forcibly gaining access to Ms Y's property and assaulting her and subsequently was released again in October 2018. He remained on licence until November 2019, by which time it is thought he was in a relationship with Kamila. It is understood that Kamila and Sean met through work.

12.17. Ms Y was referred to the local Multi-Agency Risk Assessment Conference (MARAC) during 2016, following an incident where Sean was reported to have accessed her property through an upstairs window, whilst Ms Y was out, and had taken items belonging to her. Sean was also reported to be harassing Ms Y from prison whilst in custody.

12.18. Leeds Community Healthcare Services have records of engagement with Sean whilst he was in custody in January 2017, where he was presenting with suicidal intent; and again, in February 2017 where Sean conveyed anxiety about his relationship with Ms Y ending.

12.19. Leeds Probation hold information shared by West Yorkshire Police from 2018 when they were managing Sean, pertaining to domestic abuse. It was alleged by Ms Y that Sean had tried to drown her and had on another occasion hit her in the face and had intentionally crashed the vehicle he was driving with Ms Y as a passenger in an attempt to cause her harm.

12.20. Lincolnshire Probation holds information regarding Sean and Ms Y's relationship into 2019, with a record in January 2019 of their relationship being "turbulent" with jealousy issues on both sides. It is recorded that during this time they had separated and rekindled their relationship on numerous occasions.

13. Equality and Diversity

13.1. The panel addressed the nine protected characteristics (age, disability including learning disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, ethnicity, sex and sexual orientation) as

[3] Multi-Agency Public Protection Arrangements (MAPPA): Guidance

prescribed in the public sector Equalities Act duties and considered if they were relevant to any aspect of this review.

13.2. The panel considered whether access to services or the delivery of services were impacted upon by such issues, along with other matters such as social and environmental issues.

13.3. The panel identified that Kamila's gender, nationality, along with her mental ill health and alcohol use, would have shaped her life experiences; possibly acting as potential barriers creating to accessing services or accept support from services, as well as causing her to remain in a relationship with Sean despite the effect that this relationship was having on her wellbeing.

13.4. Kamila was a woman and a mother. Gender is the term used to refer to the socially constructed cluster of characteristics,[4] or norms, which are deemed to be masculine or feminine. Although a separate concept from the biological definitions of male and female, gender is interlinked with sex because gendered norms are based upon what is expected of each sex.[5] Attributed masculine characteristics include toughness and the expectation that men will be violent[6] and in turn the belief that women need to be protected by other men from this violence.[7]

13.5. The fear of male violence in society and in the home puts men in the position of either predator or protector of women. Jennifer Nedelsky argues that this culture of male violence is a constitutive force which shapes women's and men's lives.[8] Women take the fear of male violence for granted, and structure their lives in a way that aims to mitigate the risk of being a victim of this inevitable violence.[9] Yet many in society deny the gendered nature of violence against women.[10]

13.6. The effects of incidents of male violence shape women's relationships on two levels. The individual woman's feelings of violation and shame exist on one level, whilst society's reaction to the violence, which amounts to judgement, minimisation and shame, exists on a deeper level. Elizabeth Stanko argues that on both levels women view themselves, and in turn other women, through the lens of the male dominated ideology of how women should behave.[11]

13.7. The role of a "mother" is a universally possessed symbol[12] and has a value attached to it. Motherhood itself is affected by gendered norms to a greater extent than

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[4] Fineman, M A *The Autonomy Myth: A Theory of Independence* (2004) p.56

[5] Greenberg, J A "Defining Male and Female, Intersexuality and the Collision Between Law and Biology" *Arizona Law Review* 42 (1999) p.265

[6] Hearn, J *The Violence of Men* (1998) p.36

[7] Nedelsky, J *Laws Relations: A Relational Theory of Self, Autonomy and Law* (2011) p.210

[8] *Ibid* p.204

[9] Stanko, E "Everyday Violence" (1990) p.70

[10] Monckton, J, Williams, A and Mullane, F *Domestic Abuse, Homicide and Gender* (2014) p.19

[11] Stanko, above n 8 p.72

[12] Fineman, M "The Neutered Mother" *University of Miami Law Review* 46 (1992) pp.653-54

fatherhood.[13] As Alison Diduck argues, there is an assumption in the relationship between a mother and her child of "never-ending love…timeless and universal duty… (a) romantic ideal…"[14]

13.8. Kamila was a Polish woman, who was living in the United Kingdom away from her family. Polish cultural and religious norms play a significant role in shaping attitudes toward women's roles within the family.[15] Traditional Polish culture emphasises women's roles as mothers and family caretakers, often prioritising family values over individual rights. Women often face strong expectations to maintain family unity, which can create shame and stigma around divorce or separation. This cultural and religious emphasis on family preservation can lead to women staying in relationships with abusive partners longer, increasing their risk of harm.

13.9. Poland's legal framework for addressing domestic abuse is significant to the culture.[16] Within this framework,[17] domestic abuse is largely understood in terms of physical violence, with little recognition of other forms, such as coercive control or psychological abuse. This limited understanding reduces the opportunities for non-physical abuse being acknowledged or acted upon within the justice system, reflecting a cultural barrier to addressing different forms of domestic violence.

13.10. A recent UK-wide research report[18] highlights how these cultural and religious norms and stigma surrounding gender and motherhood shape Polish women's experiences of domestic abuse in the UK. The study analysed data from 28 life history interviews with Polish survivors of domestic abuse and 18 interviews with practitioners from domestic abuse and statutory services across the UK. The findings indicated that perpetrators widely use tactics of emotional and psychological abuse, including humiliation and degradation, which are specifically targeted at undermining women's sense of self and self-worth. This is tied to gendered expectations and norms of being a woman in Poland.

13.11. English proficiency among Polish women living in the UK often leads to assumptions of full integration, which can cause their unique cultural influences and specific challenges to be overlooked.

13.12. These assumptions may impact a woman's willingness and ability to report domestic abuse, as support services may misunderstand or disregard their distinct needs. A study by Rzepnikowska[19] used in-depth interviews and ethnographic

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[13] Boyd, S "Gendering Legal Parenthood: Bio-Genetic Ties, Intentionality and Responsibility" *Windsor Yearbook of Access to Justice* 25 (1) (2007) p.65

[14] Diduck, A *Law's Families* (2003) p.83

[15] Grzyb, M "The Polish Variant of Patriarchy? Explaining the Relationship Between Gender Inequality and Violence Against Women in Poland" *Violence against Women* 30 (6-7) (2024) pp.1383–1406

[16] *Ibid n.19*

[17] Article 207 of the Polish Penal Code from 1997

[18] Zielinska, I et al (2022) "Polish women's experiences of domestic violence and abuse in the United Kingdom" (2022) *Project Report, June*, *16*.

[19] Rzepnikowska, A "Racism and xenophobia experienced by Polish migrants in the UK before and after Brexit vote" *Journal of Ethnic and Migration Studies 45*(1) (2018) pp.61–77. Journal Reference

methods to examine the effects of Brexit on Polish migrants, with a focus on women's experiences of xenophobia and racism. The study found that, despite speaking fluent English, Polish women in the UK continue to face prejudice, which has worsened since Brexit. This research highlights that English proficiency does not protect Polish women from racial and cultural discrimination, which may discourage them from seeking help from authorities or support services.

13.13. Lloyd et al.[20] conducted a comparative analysis of domestic abuse terminology across languages and found that complex terms like "coercive control" lack direct equivalents in Polish. This language gap can limit Polish women's ability to describe certain abuse dynamics accurately, leading to incomplete or misunderstood reports that complicate their access to effective support services in the UK.

13.14. An ethnographic study on Polish women's interactions with UK support services revealed that language barriers and cultural differences frequently result in misinterpretations, which can profoundly affect these women when seeking support for domestic abuse.[21]

13.15. These findings highlight the need for support services that address both cultural and language barriers faced by Polish women. Without this awareness, Polish women experiencing domestic abuse may lack the resources and confidence to seek help, which may perpetuate their vulnerability.

13.16. Kamila's mental health declined rapidly after she met Sean. His controlling behaviour, alongside his own long-term mental health issues and substance misuse, appears to have had a serious effect on Kamila's life. Leon shared that Kamila was not permitted to speak Polish in front of Sean, and Child A had told Leon that when Sean was around Kamila and Child A had to speak in English, so Sean knew what they were talking about. This is an example of control, which would have impacted on Kamila's wellbeing, particularly linked to communicating with her son and his father in the family's first language.

13.17. As Kamila became mentally unwell, she started to have long periods of absence from work. This would have isolated her from work friends, and in the absence of any other family, particularly as Leon was also intimidated by Sean, she became completely dependent upon Sean.

13.18. Intersectionality was first introduced by American legal scholar Kimberlé Crenshaw in 1989.[22] Crenshaw was arguing that addressing a woman's sex, or race, as single issues, rather than understanding the force of discrimination when a woman's sex and race intersect, denies the "compoundedness" of their situation.

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[20]Lloyd, M et al (2017). Women's experiences of domestic violence and mental health: Findings from a European empowerment project. *Psychology of Violence, 7*(3) (2017) pp.478–487

[21] Johnson, K. (2017) *Domestic Violence, Liminality and Precarity in the British Borderlands Polish women's experiences of abuse and service engagement in Edinburgh* (Doctoral dissertation, Durham University). http://etheses.dur.ac.uk/12406/

[22] Crenshaw, K "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics" *University of Chicago Legal Forum* Issue 1 (1989)

Intersectionality as a way of understanding discrimination, and indeed privilege, can be applied to any of the many characteristics, and circumstances, of any person. As Crenshaw states:

> *"Discrimination, like traffic through an intersection, may flow in one direction, and it may flow in another. If an accident happens in an intersection, it can be caused by cars traveling from any number of directions, and sometimes from all of them."*

13.19. In this analogy the car accident can be seen as the harm caused by the various characteristics, circumstances and/or social environment a person is faced with, or living in.

13.20. The panel were mindful of how Kamila's personal characteristics - including both those described above and any other elements specific to Kamila; intersected, to structure how Kamila experienced and perceived the world, and also how the world perceived Kamila.

14. Chronology

14.1. During February and March 2019, Kamila was signed off work with back pain.

14.2. Throughout 2019 Sean continued to be managed by Probation. He appears to have sporadic engagement with his probation requirements. He often stated he was unable to attend due to his employment, however there is little evidence of the Probation Officer requiring evidence of this, and his reasons for missing appointments seems to have been taken on face value.

14.3. In July 2019, Sean told his Probation Officer that he and Ms Y had separated. He blamed Ms Y for the separation, stating she had been playing "mind games" with him. He stated that he was staying with a friend in Town A until he could organise somewhere else to live. There is no evidence of the impact of this relationship breakdown, and there was a note from the Probation Officer stating, "*no evidence of change in risk of serious harm."* This is despite previous recognition of risk to himself and to Ms Y increasing each time they had separated. A review meeting was booked for six weeks' time.

14.4. The following week Sean was reported to police as a missing person by Ms Y. She had received text messages from Sean which had caused her concern for his welfare. That afternoon Sean contacted his Probation Officer and informed them that he had significantly self-harmed. He spoke about both Ms Y and him *"playing games against each other"* and that both had been seeing other people in order to spite the other. Sean stated he was struggling to come to terms with the relationship ending. There was no follow up with Sean about this.

14.5. Around the same time Sean was under investigation by Lincolnshire Police regarding allegations of harassment made by Ms Y. He was prohibited from

contacting Ms Y or going in the jurisdiction of her home. He was also required to report to the Town A custody suite on 22nd July 2019. Ms Y and Sean were discussed at the MARAC on 18th July. Probation was made aware of the current situation, however there is no record of any follow up with him by the Probation Officer.

14.6. Sean did not attend his next Probation appointment; there was no reason given, or sought, for this.

14.7. On 22nd August 2019, Sean was in police custody following an arrest for possession of an offensive weapon. Whilst in custody he had placed a ligature around his neck. He was referred to CRHTT by the Custody Suite. The CRHTT were unable to contact him by phone despite attempts over the next few days, a letter was then sent, however following no response from Sean he was discharged from CRHTT on 3rd September 2019.

14.8. Sean attended his probation appointment on 25th September 2019, he said that he had moved to a different address, there was no evidence of exploration of this, for example who else lived in the property.

14.9. Sean did not attend the following two appointments, and his licence ended on 2nd November 2019. There was no evidence of a final assessment, which is a policy requirement.

14.10. On 18th November 2019, Kamila saw a nurse at GP Practice A. She stated that sexual intercourse was painful. She had a vaginal examination and swab, but no issues were identified. No name was recorded for Kamila's partner; this would now be expected practice for GP Practice A staff, although it was not a requirement at the time.

14.11. On 17th December 2019, the NSPCC raised a safeguarding concern with Lincolnshire Children's Social Care (CSC), following contact from Ms Y. She raised concerns about Child A being in contact with Sean. A Child and Family Assessment was opened and a social worker allocated on 19th December 2019.

14.12. The following day, the social worker made an unannounced visit to Kamila. Child A was seen with facial bruising. Kamila was not sure how this had happened. She confirmed her relationship with Sean and denied any violence. Leon also joined the visit and also stated he did not know the source of Child A's bruising. Child A was spoken to separately and did not recall how he has been injured, he was aware that when he was in a takeaway restaurant with his mum and Sean, someone had seen them and reported this to the police. A safety plan was completed with Child A, and he noted his teacher as someone he could speak to. Child A also had his own phone and was told to keep it charged up in case of an emergency. He identified his father and his uncle as safe contacts if Kamila was harmed and Child A did not feel safe. The social worker recommended that

Kamila make a Domestic Violence Disclosure Scheme (DVDS)[23] application, which Kamila declined to do.

14.13. The social worker called Sean the following week. Sean stated that he was being victimised and declined a meeting with the social worker. He reported that his ex-partner was stalking him. The social worker recorded a plan to continue to attempt engagement with Sean and for police checks to be made. Children's Health were contacted for information and responded that Child A had been closed to them for six months. The school confirmed with CSC that they had no concerns about Child A.

14.14. On 6th January 2020, Primary School A were contacted by the social worker, who advised the current situation with Sean.

14.15. On 17th January 2020, the social worker attempted a pre-arranged meeting with Kamila. The social worker called Kamila, who stated she had nothing more to speak to the social worker about, and she still did not intend applying for a DVDS. The social worker attended the home on 21st January 2020 for the re-arranged meeting. The social worker noted that Kamila was not prepared to listen to the concerns related to Sean's offences. Kamila stated she knew everything about Sean as he had told her about his ex-partner, who Sean stated was the cause of the problems. The social worker reflected with her supervisor that Kamila appeared to be under the influence of Sean.

14.16. On 20th January 2020, Leon reported to the social worker that when he arrived at Kamila's address to collect Child A, Sean had hit him, and he had sustained injuries which required medical attention. The social worker reported this to the police.

14.17. The Children and Family Assessment was completed on 26th February 2020. During the assessment Child A, Kamila, Leon and a paternal uncle had been spoken to, however Sean had declined consent for agency checks, including police checks. The assessment considered the recent assault on Leon. Risks were identified, and a Child In Need plan was opened. The social worker visited Child A, and Child A told the social worker that he did not like it when Sean drove his car very fast.

14.18. In March 2020, the National Covid-19 restrictions were introduced, these restricted the movement of the general public, requiring people to stay at home and not permitting households to mix.

14.19. On 18th March 2020, the social worker spoke to Kamila who confirmed that Leon was not allowing Child A to see Kamila while she was with Sean. Kamila also stated that Sean's ex-partner had sent messages to her and Leon about Sean's behaviour. Kamila asked for the DVDS procedure to be started, and the social worker followed this up with police the following day. The Police Safeguarding

[23] Domestic Violence Disclosure Scheme (DVDS) Statutory Guidance

Hub led on this process and advised the social worker that due to the Covid-19 restrictions any face-to-face DVDS' were being delayed unless the case involved urgent disclosures due to high risk. It was considered that as Kamila had been with Sean for six months, there has been no recorded incidents of domestic abuse, and Kamila had said she had no concerns about his behaviour; this was not considered a high-risk situation.

14.20. On 27th March 2020, the social worker contacted the police to discuss the information held. They explained that they wanted to see Kamila in person to share information however due to the current situation with face-to-face meetings, and Sean not being considered as posing a high risk, this was not possible. The social worker was given general information about a lack of convictions for violence on a partner but there were concerns of coercive and intimidating behaviour. The social worker updated her supervisor, and it was discussed that as there were no current concerns for Child A, the Child in Need case may be closed.

14.21. The social worker spoke to Child A and Leon on 3rd April 2020. Child A was living with his father and stayed with Kamila one night per week. Leon was home due to being furloughed during Covid-19 and it was considered that as Child A was spending the majority of his time with Leon, the case would be closed.

14.22. In May 2020, Kamila collapsed while at work, she was treated at Hospital A ED, following this she was referred to the Neurology Clinic as an outpatient but was closed in June 2020 due to non-engagement. There was no conclusion as to what was causing Kamila to collapse.

14.23. On 10th June 2020, a police officer spoke to Kamila on the telephone to explain the DVDS procedure. She said she would call the officer back in an hour, however, within minutes the officer received a call from Sean who was irate and abusive and demanded to be provided with the disclosures. Soon after this, Kamila called the officer and denied giving the officers number to Sean; the records state "it was obvious she did". Kamila was told that "she could not be trusted" and that the information would not be disclosed. Kamila said she did not want the information anyway. The DVDS application was closed. CSC were updated, however the Child in Need case was already closed.

14.24. Kamila had consultations with her GP in August and September 2020. She presented as low in mood, and tearful. She stated that following separation from her partner, she no longer had the care of her child. She described herself as stressed, with poor sleep, she could not eat and was finding it difficult to cope. She said she had fainted at work a few weeks before. She was diagnosed with "stress and adjustment reaction", given a medical certificate for absence from work and prescribed Mirtazapine.

14.25. Kamila spoke to GP Practice A on 4th December 2020, to request removal of her contraceptive coil. She was experiencing intermittent bleeding, lower abdominal pain, like a period pain and migraine symptoms, this message was forwarded to

the sexual health nurse who advised a telephone consultation was to be booked with her for the following week. Kamila missed this call, and text message was sent to Kamila, asking her to contact the surgery to rebook if the appointment was still needed. There was no further contact from Kamila.

14.26. During this time, Child A was living between Kamila and Leon's homes.

14.27. On 11th March 2021, the school raised a concern with Leon about Child A's packed lunch, which had minimal food in it. Child A told teachers that his dad could not afford to provide food. He was provided with a school lunch, the Designated Safeguarding Lead was informed, and they called Leon. He confirmed that there was food in the house, and he had put what Child A requested into his packed lunch. He believed that Child A had breakfast before going to school and declined any help with a food parcel as he stated there was plenty of food available.

14.28. On 18th March 2021, Child A was looking upset at school. He wrote down "I feel stressed", and when he was asked to explain, he said he had not wanted to return to school. Child A was reminded that the adults in school were there to support him and could help him with any worries he might have. The most recent set of Covid-19 restrictions had recently been lifted, and pupils had returned to school. When the school followed this up with Kamila, she explained that Child A had not wanted to return to school. Kamila said that she had changed her job so she could be there for Child A in the mornings.

14.29. On 30th April 2021, police were made aware of an incident involving a group of children, which included Child A, stealing from a shop after school. The children had been in uniform and when the local PCSO came into the school the following day, they confessed to stealing toys. Child A was also seen with a butterfly knife. The school reflected that this was very out of character for Child A, who had never been in trouble before.

14.30. On 21st July 2021, the school recorded a concern about Child A coming into school with very little lunch, and having not had breakfast. The school spoke to Leon who said that Child A often made his own lunch when in his care. Child A was given a lunch, and it was planned for the class teaching assistant to monitor Child A's lunch contents.

14.31. On 7th September 2021, Child A again arrived at school without having breakfast. He told his teacher that he had been home alone that morning, and there was nothing to have. He was given a breakfast and was told he could attend breakfast club whenever he needed to. The Designated Safeguarding Lead spoke to Kamila, who confirmed there was food in the house, that they had been shopping together the evening before to ensure the food was what Child A liked to eat, and she was not happy that he had told this story. The Designated Safeguarding Lead spoke to Child A, who confirmed he had been to the shop with Kamila, and there was food in the house, however he had woken up too late and did not make breakfast in time. No further action was taken.

14.32. On 7th September 2021, Kamila was seen at GP Practice A by the Sexual Health Nurse. She requested removal of her contraceptive coil. She stated that she wanted a break from contraception. Her appointment for this procedure took place the following week. There was no exploration of whether her intention was to become pregnant, or discussion of alternative contraception.

14.33. On 9th September 2021, EDAN Lincs received a call from Ms Y, who had previously accessed their services during her relationship with Sean. He had sent her images of bruises to his face and a text to say he had injured Kamila. EDAN Lincs sent a referral to CSC, with information regarding Sean's offending history. CSC requested a police check which did not raise any concerns about the relationship between Kamila and Sean. Considerations were recorded that Sean's ex-partner was making malicious reports, and it was assessed that the threshold for social care intervention had not been met.

14.34. On 1st October 2021, Child A became tearful in class when the pupils were spoken to about not reading enough at home. They had been asked to have their reading journals signed, and Child A had not brought his in. He said he was scared and sad as his mum got angry quickly and shouted at him. He explained that he had not cleaned up after the dogs in the garden when he had arrived home. He described being home alone until Kamila and Sean had come back from work. The school spoke with Leon who said Child A got upset when he visited Kamila because of shouting. Leon agreed to speak with Kamila and work together to co-parent.

14.35. On 13th November 2021, EMAS received a call from Kamila, she stated she was pregnant and had stomach pain. The Clinical Assessment Team called her back and undertook a clinical triage. Kamila made her own way to Hospital A Emergency Department, where she was referred to the Gynaecology Early Pregnancy Unit for further investigations; however, following a number of appointments, during which bloods and scans were performed, it was concluded that Kamila had suffered a miscarriage, and she was discharged from Gynaecological care on 24th December 2021.

14.36. In September 2022, Child A joined Secondary School B. On 29th September 2022, Child A had repeatedly written the word "help" in his exercise book, filling up a whole page, during a talk on domestic abuse.

14.37. Child A suffered a suspected panic attack at school on 8th November 2022, he was observed to be fidgety, shaking, visibility upset and had banged his head on a table three times. He was treated in the medical room and Kamila was advised. No further action taken.

14.38. On 11th November 2022, Child A expressed a concern about returning home. He stated that Kamila and Sean argued all night, and Child A did not get much sleep. Child A said that Sean was paranoid, and had told his dog to bite Kamila, which

the dog had done. There is a record of Kamila being treated by her GP for a dog bite earlier that month. The following is recorded:

> *"My mum's boyfriend is paranoid. Last night the window was closed. Mum's boyfriend said the window was wide open he was in upstairs in bed. He comes downstairs." Worried about someone coming inside the home. "To me nothing happened but he does ask me questions about mum". Mum and boyfriend have argued for a long-time, but Child A does not tell anyone. "I woke up, mum was at work, mum's boyfriend was at home, he called mum and asked if anyone was in the car". Mums' boyfriend looks at the car to see if anyone is in there. "It makes me feel scared, he said when we get back, he wants us out". Child A is worried, he has Dad to go to but where will his mum go. Mum says not to say anything, bad things might happen."*

14.39. The school spoke to Kamila, who is recorded as "minimising" the situation, blaming Child A's anxiety, and stated that everyone was ok. It was agreed that Child A would check in with the Head of Year after the weekend. The school's Designated Safeguarding Lead was updated.

14.40. On 28th November 2022 Kamila called GP Practice A and spoke to a receptionist, the following message was passed to the GP: *"The patient advised that he has been self-harming, cutting his arms with a knife. He is very stressed and unable to deal with this. Partner is worried and doesn't want to leave him on his own, Partner and patient is asking if patient can speak with someone as he is very low at the moment".* Within ten minutes of this message being passed over, the GP made attempts to contact Sean. Eventually, the GP was able to speak to Sean, who stated that he was feeling stressed, and been in low mood for several weeks. Sean said he was experiencing paranoid thoughts regarding Kamila cheating on him, and his daughter had recently been in a car accident. Sean said that he did not want counselling and asked for a sicknote for work. This was issued for two weeks with a prescription for Citalopram. A follow up appointment was booked for 19th December 2022, and a text reminder was sent out.

14.41. Information was recorded on Secondary School B's system about Child A living with Leon but still looking after the dogs at Kamila's property. The school had spoken to Leon on 14th December 2022, who confirmed that Child A would stay with him four days of the week but was staying with him longer as Kamila was away. Child A was to sort out the dogs at Kamila's property and Leon would collect him in the evening. The following day, the school spoke to Kamila who confirmed that Child A stayed with Leon whilst she was in London visiting her father who was in hospital following an accident. The school reflected that this indicated a cooperative co-parenting relationship between Kamila and Leon.

14.42. Sean did not attend his follow up review appointment with the GP on 19th December 2022. A text message was sent to advise Sean of the missed

appointment. There was no further contact made or documentation in the record. No further medication was prescribed.

14.43. Kamila saw her GP on 18th January 2023 and was recorded as having a depressive disorder. She was provided with a medical certificate for absence from her employment.

14.44. On 21st January 2023, Kamila attempted to hang herself while in a hotel room in Leeds. West Yorkshire police and the ambulance service were called by hotel staff. Kamila was taken by ambulance and treated in a local hospital. A police investigation was undertaken, and initially Sean was arrested for attempted murder, however the investigation indicated that when Sean had left the room, Kamila was alive, as they had exchanged messages and calls. Sean had returned to the room and almost immediately had carried an unresponsive Kamila out of the room, shouting for help.

14.45. Kamila was taken into a local hospital in Leeds by Yorkshire Ambulance Service. She was transferred from Emergency Department to Intensive Care and was intubated for four days.

14.46. Sean had been arrested on suspicion of attempted murder. He told officers during interview that there had been an argument, which had led to him leaving the room. Evidence pointed to Kamila's own actions leading to the incident, and no further action was taken. Sean was permitted to visit Kamila in hospital. The hospital also contacted Leon to advise of the incident.

14.47. On 25th January 2023, Ms Y contacted CSC with concerns that Sean had messaged her on social media, earlier in the month, stating he has assaulted Kamila and left her because she had borrowed money from Leon. Kamila had also told Ms Y that there had been an occasion (no date recorded), where Sean had attacked her with a hammer, doused her in petrol and tried to set her on fire. Kamila told her about a miscarriage which had happened due to the abuse. It was also shared that Sean was using cocaine and this was making him paranoid; this had occurred when Child A was present. It was assessed that the threshold for social care had been met, and a Child and Family Assessment was to be completed.

14.48. When Kamila had made enough of a recovery to be spoken to, the Leeds and York Partnership Foundation Acute Psychiatry Service assessed her and spoke to Sean, with Kamila's consent. Sean informed practitioners that he and Kamila had an argument prior to Kamila ligaturing. He said that he had confronted her with his suspicions that she had been keeping secrets. Kamila had told him that she had been in contact with Leon to borrow money from him, and Sean had told her that the relationship was over and had left the room. Sean told practitioners that he *"wanted Kamila to feel as bad as he did."* There is no evidence that Kamila was asked about domestic abuse by the mental health, service, although she did describe Sean as an "amazing boyfriend". She stated that she was not good enough for Sean and that she made him unhappy. Kamila also told practitioners

that she had been off work for two months due to low mood. The plan was made to refer her to LPFT upon discharge back to Lincolnshire.

14.49. That day, the Leeds local hospital contacted LPFT CRHTT to refer Kamila into their services upon hospital discharge. This referral was declined as Kamila was not currently in the Lincolnshire area, and the hospital were advised to refer to the local CRHTT, who would refer into LPFT upon Kamila's return to Lincolnshire. That afternoon, Leeds Mental Health Liaison Team contacted LPFT CRHTT to advise that Kamila was returning to the Lincolnshire area the next day.

14.50. Also, on 25th January 2023, Leon attended GP Practice A with concerns about Child A. He stated that due to Kamila's suicide attempt, Child A was suffering from anxiety. Leon was provided with the contact details for Here4You, which is an LPFT mental health support team for young people.

14.51. When the LPFT CRHTT referral was accepted, it was agreed that CRHTT would contact Kamila on 26th January 2023 to organise a home visit. CRHTT tried to call Kamila and Sean several times that day, but there was no response.

14.52. Following attempts to contact Kamila over a two-day period, CRHTT made a cold call to her house on 27th January 2023. Kamila was present and explained that she did not have her own phone. Kamila agreed to a home visit for two days later. She was recorded as not posing a risk to herself or others. The CRHTT attended as planned two days later, but there was no response. Eventually, CRHTT were able to make telephone contact with Kamila via Sean's mobile phone number on 30th January 2023. Kamila denied any risk to self. Kamila stated she had plans to go to London with Sean for "*the rest of the week"*. Kamila stated she felt able to maintain her safety. Kamila stated she needed to "*be with her partner*". Kamila was aware she would be able to access clinical services in London if required and Kamila stated she would access services if she felt she required additional support. Kamila declined any further support from CRHTT and was discharged. Kamila was in agreement with this plan.

14.53. Leon contacted Here4You on behalf of Child A on 27th January 2023. The service described Child A's response to his mother's attempted suicide as a normal response, and it was recommended that Child A's school provide him with support. Leon was also signposted to online mental health wellbeing support resources to support Child A.

14.54. Following the concerns raised with CSC by Ms Y, CSC contacted Lincolnshire Police on 27th January 2023. CSC were advised there was nothing recent on Sean's or Kamila's records, and that information should have been shared by Leeds Police if there had been an incident.

14.55. Kamila was provided with a medical certificate by her GP from 1st February 2023 for two weeks with a diagnosis of depression.

14.56. The social worker met with Leon and Child A on 7th February 2023. Leon was told about the concerns raised by Ms Y. Leon confirmed that Child A had been in his care for the last two weeks due to the suicide attempt, prior to that Child A had stayed between his mother and father's houses for four nights at a time. Leon shared that he was scared to send Child A to Kamila's house and had read in Child A's diary that "*mum and Sean are fighting again, it is getting worse."*

14.57. The following day the social worker spoke to Leon by phone and asked him if he feared Sean and he stated that he was, as he had been assaulted by him previously, and wasn't sure what else Sean might do. Safety Planning was discussed with Leon by telephone with plan to follow this up during the visit. Plan was for Child A's contact with his mum to be supervised and to take place in a public area or for Leon to make alternative arrangements for a friend of family member to do to manage contact.

14.58. The social worker followed up again with Leon the following day. He said he felt Child A was safe to see Kamila and didn't feel this needed to be supervised. The social worker asked Leon if he was agreeing to this as he feared saying no, and he agreed that this was accurate. The social worker reiterated that Child A should only see Kamila in a public place.

14.59. On 13th February 2023, Kamila reported to the council that Sean was no longer at the property, and she did not know where he had gone.

14.60. Kamila obtained a further medical certificate for another two weeks on 14th February 2023, with the reason "depression, tried to kill herself three weeks ago – still feels like cannot work".

14.61. The social worker had a video call with Kamila on 14th February 2023. She reported having Covid, so was unable to meet in person. Kamila was presented with Ms Y's concerns, which she denied. She confirmed her attempted suicide but stated that Sean had saved her. Kamila also denied that Sean used cocaine. She told the social worker that they did argue but described herself as the perpetrator because she would push Sean and he would have to restrain her.

14.62. During this time Sean was in London. He contacted the Metropolitan Police stating that he had received a text message from Kamila saying, *"I can't handle this anymore you put me in this state and you are too far".* He said he was worried that Kamila was not answering his calls or messages. Lincolnshire Police were alerted and at 11pm that evening, they attended Kamila's address. She was safe and well, she said there had been a misunderstanding with Sean after Kamila had received a text from Ms Y, which had upset her. A PPN[24] was completed with Kamila in which she said that she had suffered from depression since 2010 and three weeks ago had attempted to take her own life by hanging herself. She said

[24] Public Protection Notice – a document recording safeguarding concerns about an adult or a child, which is completed by Police and shared with partner agencies.

that she had no intention of harming herself. The PPN was shared with Mental Health Single Point of Access.

14.63. Child A was seen by the social worker on his own on 15th February 2023. He was asked if he wanted to see his mum and asked what he had witnessed between Kamila and Sean. He was noted as very tearful during this time. He said there were lots of arguments, which made him worried and scared. Child A was visibly shaking and crying. He recalled around four times when Sean had been violent to Kamila. But then was unable to continue, stating he could not remember details. The Child in Need plan was commenced.

14.64. The social worker visited Kamila, she was noted as having lost weight and was not as "sparkly and smartly dressed" as usual. The social worker noted Kamila was defending Sean and could not recognise the risks or concerns which had been raised. She stated that Sean was her "saviour". Kamila called Child A, who came to the property to see the social worker, although the social worker considered that Child A may have already been at the property as he arrived very quickly after being called. The social worker reiterated to Kamila that Child A was not to have contact with Sean whilst the assessment was being completed. The social worker also noted her worries of Kamila's focus being her relationship with Sean over Child A's emotional wellbeing and safety, although the social worker did not say this directly to Kamila.

14.65. Kamila was given a further medical certificate by her GP on 22nd February 2023, she remained off work and told the GP receptionist that she had to always have someone with her during the day.

14.66. On 28th February 2023, Secondary School B received a reason for absence from Leon for Child A, which was described as "family problems" and was shared with the social worker.

14.67. On 1st March 2023, Child A went into school with small cuts to the palms of his hands, the school gave first aid and contacted the social worker. She visited Child A after school, and he opened up to her briefly that Kamila had told him to lie about going to London with her and Sean the previous week. Child A said they had stayed in the hotel room while Sean went to work. Child A was observed as appearing anxious, and after he said this, he seemed to *"*clam up", answering *"I don't know"* to a lot of questions.

14.68. During a wellbeing conversation between the school and Child A, he said:

> *"Mum and boyfriend argued a little, mainly about boyfriend's ex-girlfriend Ms Y and why she said stuff to the social worker. Somehow, she got Dads and Dad's friend's number. Dad was confused who was texting him, he called me downstairs, and I said it was Ms Y. Everyone blames Ms Y."*

14.69. The social worker visited Leon, who confirmed that he had allowed Child A to see his mum. Leon was reminded that contact should be supervised as there were concerns about Sean's behaviour.

14.70. A Child in Need meeting was held on 3rd March 2023. Leon attended but Kamila stated she was not in the local area so could not attend. The school shared that during a workshop about domestic abuse some months before, Child A had written "help", when asked why he said that "help" was an easy word to write. Leon shared that Child A had told him about the journey to London, and that Kamila and Sean had told him to lie about it. Child A had also missed school because of this trip to London, where they sat in the hotel room while Sean worked. Leon shared that there was a tracker on Child A's phone, so he could see he was in London.

14.71. Child A was referred to Children Social Care's IAPT services on 6th March 2023. He had not had contact with Kamila for a week, apart from daily texts checking in on each other. The social worker recorded that he seemed brighter in himself. The following day, Child A banged his head on his desk six times, he was given first aid, and Leon was called, and Child A went home.

14.72. A Multi-Agency Risk Assessment Conference (MARAC) referral was made on 8th March 2023, and Kamila was allocated an IDVA, however as this was sent over with no consent, the IDVA service were unable to contact her. They called the referring agency to advise that the referral was not with consent, but should consent be obtained, they would proceed in contacting Kamila and offering IDVA support.

14.73. At 6am on 15th March 2023, Sean was taken to hospital following a road traffic accident, where he had intentionally driven into the side of a house. He was accompanied to hospital by police officers. He said he had low mood and had been hearing voices, which led to the incident. At 12 noon, a paramedic contacted the LPFT Psychiatric Clinical Decisions Unit (PDCU) to discuss Sean. They shared that Sean had a history of multiple hanging attempts, and he was currently in police custody. Later that afternoon, Sean was detained under Section 136 of the Mental Health Act,[25] and was taken to the Health Based Place of Safety (HBPoS).

14.74. Sean underwent a Mental Health Act assessment which was conducted by the Approved Mental Health Professional (AMHP). During the assessment, Sean recalled that he had lost control of the car and was vague about the use of drugs or alcohol. He stated that he would go on three day "binges" of drugs and alcohol, but that he could also go for weeks, or months without using substances. He was noted to have been subject of MARAC, as a perpetrator, in July 2019, January 2020, and was currently the subject of a MARAC. His offending history included periods in prison for armed robbery, car theft, drug dealing and fighting. Sean felt

[25] Allows the police to remove a person from a public place if they appear to be suffering from a mental disorder and are in immediate need of care.

that the escalation in his mental health and substance misuse had escalated after he found Kamila hanging, which he stated had been approximately one year ago.

14.75. It was recorded that Kamila was currently visiting family in Poland, and she was not therefore contacted by the AMHP as part of their assessment. The decision made was that Sean did not meet the criteria for admission either informally or under a legal framework. Sean accepted a referral to CRHTT for support in the community and he was discharged from the s.136.

14.76. CRHTT spoke to Sean by phone, and arranged an appointment, however Sean did not attend. A cold call was made to his address, and a contact letter was sent to encourage Sean to contact the CRHTT, however Sean did not make contact, and he was discharged back to the GP on 25th March 2023.

14.77. On 22nd March 2023, Child A told a teacher at school that he would not make it to year 11 as he would be dead before then. This was flagged with the social worker and Leon. The social worker arrived at the school to speak to Child A within a couple of hours. Child A was upset and blamed his lack of contact with Kamila on the social worker. Child A wanted to see his mother and viewed not being able to be around Sean as a barrier to seeing his mother.

14.78. On 23rd March 2023, the MARAC was held, and it was shared that Kamila and Sean were still in a relationship. The IDVA linked in with the social worker, to request Kamila be passed information about the domestic abuse service. It was agreed for the social worker to try to contact Kamila to ascertain her whereabouts, specifically if she was currently in Poland or still residing in the UK. There was a discussion about sharing proportionate information with Kamila's employer, and to ask if they knew of her whereabouts, however it was decided that there were no legal grounds to breach GDPR and share information when there were no known risks to others.

14.79. A Child in Need meeting was held the following day, Leon, the social worker and the school attended. Leon shared that Child A was trying each day to contact Kamila, however Leon felt that Sean was controlling Kamila. He shared messages from Kamila's sister to Leon asking him to get the police involved as Kamila's sister was worried about her. The message said that Sean had taken Kamila's passport to stop her visiting family in Poland.

14.80. On 24th March 2023, Kamila called 999 stating that Sean had been receiving threatening messages from two different numbers, and the person sending the messages were unknown. Sean was not aware that Kamila was calling. The incident was graded priority however there were no resources available to attend. Kamila was contacted and provided Sean's number but stated that he was sleeping after working a night shift. Officers attended the home later that afternoon, but Sean was too tired to speak to them. The following week, Kamila attended Town A police station and provided evidence of further texts messages coming from a different number. A crime of making malicious communications was recorded and attempts were made to speak to Sean, however he would not

respond or engage. The outcome was that a letter was sent to Sean stating that without his co-operation the case could not be progressed.

14.81. The Child and Family Assessment was completed on 30th March 2023. During the whole assessment, Child A was living fulltime with Leon. The social worker was concerned about Child A's emotional wellbeing, and noted a referral was to be made to Child and Adolescent Mental Health Service (CAMHS). It was felt by IAPT that Child A's emotional needs were too complex for their services, and they considered he may be experiencing deep trauma. The Assessment also concluded that Kamila did not consider herself at risk from domestic abuse and was not willing to engage with specialist services. Kamila stated that Sean provided her with all the support she needed. She was identified as very isolated, with significant concerns for her vulnerability, and for the impact of the current situation on her mental health.

14.82. On 31st March 2023, the social worker had a phone call with Leon, as Kamila was asking for Child A to stay overnight, which Leon was not comfortable with, he also raised a concern with the social worker about Sean's mental health, however this is not fully captured in the case note. The social worker agreed that Kamila could see Child A at the park, or McDonalds, and that Leon should drop off and pick up Child A. Kamila followed up with the social worker on 4th April 2023, and was described as "very stressed", stating that she was being kept away from her son, and making threats to self-harm if she could not see Child A. The social worker assured Kamila that she wasn't preventing her from seeing Child A, but that it had to be safe contact as there were concerns about Sean's mental health, particularly considering the recent incident where he had intentionally driven into a wall.

14.83. During a planned social work visit to Child A and Leon, Child A became very upset, worried about his mum as she had stopped communicating with Leon. Child A was concerned about Sean's part in this.

14.84. Sean was given a medical certificate on 5th April 2023, due to low mood, and Kamila was given a medical certificate on 6th April 2023 due to depression.

14.85. On 11th April 2023, at around 4am, Sean called 999 stating that despite several attempts to call Kamila, she was not answering her phone. He was in Norfolk and was concerned about her welfare as she had previously attempted to hang herself. Officers located Kamila quickly and recorded that she was safe but struggling with her mental health, she agreed to be conveyed by officers to the local hospital where she was seen by the LPFT Mental Health Liaison Service (MHLS). Kamila said that she had felt distressed after a telephone call from Sean. Kamila informed MHLS staff about her previous ligation attempt in Leeds at a hotel. Kamila spoke about having a "strained relationship" with Sean since her previous ligation attempt. Kamila stated that Sean feels if Kamila had deceived him about borrowing money from Leon, she may be deceiving him about other matters. She stated that Sean had called her that morning at 4am and they had argued. Kamila denied any risk to self at the time of the assessment. Kamila was

discharged home with a plan to see her GP, to discuss being prescribed an antidepressant medication. The MHLS practitioner contacted Child A's social worker following Kamila's MHLS assessment to update them of relevant risk information. There was no evidence of discussions with Kamila about domestic abuse.

14.86. The following day, the social worker spoke with Leon. He shared that he had allowed Child A to stay overnight with Kamila. The social worker discussed their concerns about this, as Kamila was encouraging Child A to lie to Leon and to the social worker. Leon was reminded that Child A had said that Kamila and Sean argued, and that this could be physical.

14.87. On 14th April 2023, the social worker made a referral to Young Person's mental health access service. The referral stated that Child A was presenting as anxious at that time. The social worker documented that Child A had self-harmed and witnessed domestic abuse between Kamila and Sean. Following the referral into CAMHS in March 2023, a face-to-face assessment was arranged. Leon attended without Child A, as he had not realised that Child A should also attend. A further assessment meeting was arranged for two weeks later, following this assessment meeting, it was agreed at the CAMHS multi-disciplinary meeting that the most appropriate intervention for Child A at that time would be to engage with Improving Access to Psychological Therapies (IAPT) within Children's Services. This was shared with the allocated social worker. Child A was discharged from CAMHS and has had no further contact with the Trust since this time.

14.88. Kamila was given a further one-month medical certificate for depression. The GP would have been aware of the domestic abuse at this point, as the practice were updated following the MARAC held the month before.

14.89. On 20th April 2023, Child A went into school with cuts on his hand and said that the evening before he had felt like killing himself. The school informed Leon and the social worker.

14.90. A Child in Need meeting was held. Leon, Secondary School B and the social worker were in attendance, with Child A joining the meeting for a short period. A plan was made for the social worker to write to Kamila to bring her into the process. It was discussed that if Child A were to continue to spend time with Kamila and Sean, that the case may be escalated to Child Protection due to the risks.

14.91. At 11am on 28th April 2023, a neighbour of Kamila and Sean called 999 with concerns that a male was kicking and banging on the door of their property, the male had then climbed onto the roof and got into the flat. He had then left the scene and ran away. Kamila in the meantime had gone into the police station and had told officers that Sean had imagined that she had another male in the flat with her and had come along with a hammer to kill the imaginary male. She stated she could not live with his mood swings anymore; she was afraid he would kill himself. She declined to answer DASH questions. Sean was spoken to and stated

the had just lost his key and had climbed in the window of his own property, he became agitated and asked officers to the leave the property. A PPN was shared with Mental Health Single Point of Access and CSC.

14.92. Kamila was taken into the local council office by police, to make a homeless application. The housing team liaised with the IDVA service and were advised to complete a DASH. The housing team made a referral to the local refuge; however, this was declined due to Kamila's serious mental health. Kamila was provided with food, transport and temporary accommodation.

14.93. Later that evening, Sean was reported to be having a psychotic episode and had stabbed himself in the stomach. Upon attendance the injuries were identified as superficial, he stated that he self-harmed when stressed, and he declined treatment. Kamila is recorded on ambulance service notes as being at the property. Sean told ambulance and police that he was being supported by the CRHTT, although records indicate that Sean was not open to LPFT at that time. Sean said that if his mental health declined, he would go to his family in Leeds. Sean's GP was updated.

14.94. On 2nd May 2023, a MARAC notification was sent by police, for information sharing only, due to the incident on 28th April 2023. It was noted that Kamila had declined a DASH, or any onwards referrals, but stated that she understood the risks and told police that she had not intended to return to the property to care for Sean. It is noted by EMAS crew that upon arrival at the property, Kamila was there, it is not known how long she had stayed away from the property that day.

14.95. On 3rd May 2023 there was a case discission held following the earlier Child in Need meeting. Concerns were raised that Leon was not acting protectively, it was considered unsure if this was due to his fear from Sean, and Kamila's account of Sean's paranoia. The Team Manager agreed to a Strategy Discussion with a view to progressing to an Initial Child Protection Conference.

14.96. The school raised a concern about Child A's risk of self-harming, as they had retrieved two pencil sharpeners from him. Therefore, the social worker visited Child A at school on 5th May 2023, he was seen alone, no disclosures of self-harming intentions were recorded.

14.97. The Strategy Discussion took place on 10th May 2023, where it was agreed that an Initial Child Protection Conference would be arranged for 30th May 2023. The family were updated.

14.98. On 27th May 2023, a call was made by Kamila to emergency services, as Sean was threatening to hang himself. Kamila was not with him, but he had told her, whilst on the phone, that he was tying a rope around his neck. Police and EMAS crew arrived and spoke to Sean through a window. Sean was aggressive and abusive, and stated that he was fine. Police told EMAS that Sean was a repeat caller and could be aggressive most of the time. The EMAS crew left the scene.

14.99. On 27th May 2023, a call was made to NHS 111 service following a concern that Kamila was suicidal, and that she had placed something around her neck. Kamila spoke to NHS 111 and explained that her mental health had been deteriorating due to stress with her son, partner and family. She had been arguing with her partner whilst he was at work, this had escalated and she had said she wanted to kill herself. She was located at the top of her stairs by attending EMAS crew, she was noted to be scared and panicked. She engaged with the crew and discussed her current difficulties and she agreed that she needed help with her mental health. Sean called her mobile phone, and the crew answered as requested by Kamila. Sean was swearing on the phone and told the crew to get out of his house. The crew spoke to Kamila who told them that she was not allowed to see her son because of her partner's abusive behaviour. She said she did not work and was mostly confined to the home. Kamila was taken to Hospital A for assessment and treatment.

14.100. Once at Hospital A, she was seen by MHLS. Kamila reported that the argument had given her thoughts of hanging but she had called EMAS instead. Kamila stated she still felt suicidal and only felt safe when her partner was home and was worried what might happen when he goes to work.

14.101. The Initial Child Protection Conference took place on 30th May 2023. Kamila, Leon and Leon's sister attended the meeting. A Child Protection Plan was put into place for Child A. He was informed by the social worker later that day that he was not allowed to see Kamila alone.

14.102. Following the incident on 27th May 2023, Kamila had been referred to CRHTT for a home visit, and after a few missed calls, Kamila was seen by CRHTT on 4th June 2023. Kamila reported no current suicidal thoughts but disclosed light scratching to her left wrist. She agreed to engaging with the CRHTT and to being prescribed medication. She told the team that she felt like a failure, and that she had let everyone down. She acknowledged needing help and stated she wanted to recover for her family.

14.103. Kamila was seen by CRHTT again on 6th June 2023 and she reported that she was excited to spend a few days in Leeds with Sean visiting his family. Kamila identified that she felt her mood may dip when she returns from Leeds and Sean returns to work, although she did not elaborate on why she thought this might happen. Kamila agreed to speak to her GP about medication. Following this meeting, CRHTT were unable to speak to Kamila again, despite phone calls, a cold call to the address and a follow up letter being sent. Kamila was therefore discharged from CRHTT back to her GP.

14.104. On 7th June 2023, the social worker met with Child A and Leon. Child A had been feeling unwell following a call from Sean telling him that he had to let the dogs out while they were away in Leeds. Sean said that if this did not happen, that Leon would be answerable to Sean. Child A describe feeling scared for his dad. Kamila had dropped the key to the property at Child A's school without any prior notice. The following day, Sean sent a message to Leon stating, *"You stayed in*

my hotel with Kamila watch now" and *"took my misses to this hotel yeah, its' on your maps with your email".* This had not been Leon.

14.105. The core group was held on 9th June 2023, the school reported that Child A seemed much happier.

14.106. On 19th June 2023, a member of the public called with concerns that a female, who was Kamila, was screaming for help from an upstairs window, with a male, who was Sean, trying to pull her back into the property. The incident was graded urgent; officers had attended but Kamila had not allowed them access to the property. She said that she had an argument with Sean, he became angry, so she panicked and shouted for help. Both Kamila and Sean refused to leave the flat as both were concerned about each other's mental health. Both said that they would self-harm if they were forced to leave. A decision was made to leave both Kamila and Sean in the flat. A PPN was completed with Kamila and graded medium risk. She refused permission for it to be shared with other agencies. It was shared with Mental Health Single Point of Access due to Kamila being suicidal and shared by the Police Safeguarding Hub with Children's Services as Child A was on a child protection plan.

14.107. On 23rd June 2023, Sean attended Hospital A's ED following an attempted suicide at home. Kamila had found him hanging from a ladder and had cut him down. Sean had been using cocaine for two days, without sleeping or eating. He was displaying symptoms of psychosis, paranoia and hallucinations. That morning, he had been asking Kamila who she was talking to, when there was no one else in the room. He had become argumentative, so she had left the property for a short time. When she returned, he was hanging from a beam by a dog lead. Upon attendance at ED he was referred to MHLS. He told them he had a strained relationship with Kamila and was currently using around £500 of cocaine per week. It was assessed that Sean's situation had been triggered by his social circumstances. Sean agreed to a referral to CRHTT and was discharged home. There followed multiple failed attempts made to contact Sean by CRHTT, including a cold call to his address. Following no response from Sean, he was discharged back to GP seven days later.

14.108. The social worker saw Leon on 27th June 2023. He had not seen Kamila, and Child A seemed happier, which the social worker also noted.

14.109. On 1st July 2023, a member of the public called police as Sean was seen to hit Kamila in the street on their road. Kamila had a suitcase and was screaming that she was leaving and not coming back. Other men had tried to intervene, and Sean had been aggressive to them. Police attended and spoke to Kamila. A PPN was completed in which Kamila stated that she felt she could not leave the house, because Sean would constantly call her. If she didn't answer her phone, he accused her of having an affair. He also threatened to kill himself if she didn't return home. The risk level was graded as high. Sean was arrested on suspicion of assault. During a search of their home cameras were found in the lounge and the bedroom, which enabled Sean to monitor Kamila's movements.

14.110. The CJDLS were contacted whilst Sean was in custody, he did not want to accept a full assessment at that time, however he agreed to call CJL&D following release from custody. He did not provide a phone number or address to CJL&D .

14.111. A referral was made to MARAC and the IDVA service for Kamila by police. The referral included information about Kamila losing a tooth following an assault, and Sean threatening to set her on fire. She had also told officers that Sean would not allow her to visit her terminally ill mother in Poland, as he said he would take his own life. She described a relationship in which she felt "trapped", in fear of Sean killing himself. Kamila stated that she gave up her job because of Sean's control.

14.112. Sean appeared in court on 4th July 2023 for the offence of common assault; however, the hearing was adjourned. The following day, Kamila attended Town A police station and retracted her statement, however evidence led prosecution was pursued due to there being witnesses and CCTV evidence. Sean subsequently pled guilty to common assault and received a community order along with court costs.

14.113. CJL&D assessed Sean at court on 4th July 2023. He engaged well during the assessment but presented as twitchy. There was no evidence of thought disorder observed, and no acute mental illness evident. He denied alcohol misuse but detailed heavy cocaine use. He was currently subject to bail conditions and stated that he intended to return to Leeds until his partner returned to Poland, then he could return to the home address. He stated he had not been in touch with his family due to Kamila. Sean's sister also spoke to CJL&D and told them that Kamila had previously tried to stab Sean with a fork and had strangled him with a dog lead.

14.114. Kamila was provided with a further medical certificate on 5th July 2023, and prescribed Fluoxetine. She was given a review date for 19th July 2023, which she did not attend.

14.115. On 5th July 2023, Kamila made telephone contact with CRHTT. Kamila was tearful and given support over the telephone. Kamila stated that she had made a statement to the Police regarding Sean when she was under the influence of substances and alcohol and that she felt frightened. Kamila did not disclose further what she was frightened of. Kamila stated that her allegations were not true, and she wanted to tell the Police about this. Kamila also informed CRHTT that she 'had a problem with drugs and alcohol'. Kamila did not indicate any risk to self during telephone contact.

14.116. Following the MARAC and IDVA referral made on 1st July 2023, an IDVA called Kamila on 5th July 2023. She told the IDVA that she had made the allegations of abuse whist she was under the influence of alcohol and substances, and she now wanted to retract these allegations. She stated she felt "manipulated" by Ms Y to make a statement. Kamila was keen to end the call, an initial assessment was

partially completed and following the call, the IDVA sent a text with useful numbers for mental health support, and substance misuse support. A plan was made with Kamila for the IDVA to call again the following day, but Kamila missed this call. The IDVA updated the social worker. On 7th July 2023, the IDVA successfully called Kamila, and completed the initial assessment. Kamila was not able to recognise the abuse, and blamed alcohol and substances. She considered Sean to be vulnerable and believed that support with their relationship would help. The IDVA could not make contact with Kamila again until after Sean died, despite making attempts to do so.

14.117. On 10th July 2023, Sean met with probation for his pre-sentencing report assessment. He told the assessor that he intended moving back to Kamila when he was permitted to. He was currently in Leeds. The assessor noted that there was an indication of previous controlling and aggressive behaviour. He spoke about his jealous behaviour, which he stated was due to the victim's behaviour, yet he also indicated was due to increased paranoia when he was using drugs and there will be no further issues as he had stopped using drugs. The assessor commented that whilst Sean did not have convictions for domestic abuse, it was clear that there had been a history of concerning behaviour linked to this relationship, and past intimate relationships. His actions were recorded as being of significant concern and there appeared to be a pattern of controlling and abusive behaviours against intimate partners. He cited himself as the victim; minimised and denied his own behaviour and blamed partners for poor relationships and abuse. The report also detailed that previous Probation records indicated a history of self-harm and attempted suicide, and this could be linked to relationships, including the end of them and his difficulties in coping. There was an indication that Sean used suicide and self-harm as a method of manipulation and threat towards partners if they do not do as he wishes.

14.118. Sean received a 24-month community order, and to attend the Building Better Relationships programme.

14.119. The social worker met Kamila on 10th July 2023, she was very thin, gaunt in the face and had a small, faded bruise to her eye. She also noticed fresh cuts on Kamila's wrists. Kamila declined to speak about the incident with Sean.

14.120. The MARAC was heard on 20th July 2023. It was shared that Sean was back at the property with Kamila. Probation was given an action to consider MAPPA level 2 for Sean due to high risk of harm, and also to advise the IDVA of Sean's next appointment to enable a safe window for the IDVA to contact Kamila.

14.121. Sean attended probation appointments on 21st and 26th July 2023. He told the Probation Officer that work was going well, and he enjoyed his work. He spoke about Kamila, stating he struggled with trust as Kamila had been unloyal in the past, and he felt she enjoyed male attention. The Probation Officer discussed healthy relationships and how a relationship without trust is likely to lead to arguments in the future, which Sean agreed with but said he will struggle to trust

her again. There is no indication in the notes of any of the MARAC actions being completed.

14.122. The social worker undertook a planned Child Protection visit to Child A and Leon on 26th July 2023. Leon said that everyone had noticed how much happier Child A is since not spending time with Kamila and Sean. Leon said it was like the pressure had been lifted and Child A could be a child. He was described as no longer anxious and was talking a lot more.

14.123. At 8am on 28th July 2023, EMAS received an emergency call for Kamila who had drunk bleach. A third-party provider crew attended the home on behalf of EMAS. Kamila told the crew she had intended to end her life, she said she had felt suicidal, she had not been engaged with mental health services, had recently increased her alcohol consumption and had not been sleeping. Kamila was taken to Hospital A for further assessment and treatment, and the third-party provider submitted a handwritten safeguarding referral two days later.

14.124. Upon attendance at Hospital A, Kamila told staff she did not intend to take her own life, but her actions were a "*cry for help"* due to her "*strained relationship with her ex-partner, his girlfriend and her son*". Her mother had recently received a cancer diagnosis which was adding to her stressors. After receiving medical care, Kamila was referred to the MHLS, and following assessment was discharged home with a referral to CRHTT, which she agreed to.

14.125. The following day EMAS were called by Kamila who had found Sean hanging. She told ambulance crew that they had split up, Sean was upstairs in the bedroom, Kamila left him alone for around ten minutes and when she returned, he was hanging from a wooden beam in the ceiling by a ratchet strap. EMAS documentation reports the presence of drug paraphernalia on the scene. Sean was transferred to the Intensive Care Unit, and a CT scan showed oedema consistent with hypoxic brain injury.[26] Sean was ventilated and sedated, but he remained unstable, and the following day Sean died. Kamila told staff that he had been using cocaine for three days and had also attempted hanging himself three days earlier.

14.126. CRHTT contacted Kamila following Sean's death and visited her the following day. Kamila was given time to express her thoughts and feelings. She was blaming herself for Sean's death and said if she had returned to the room quicker, she could have saved him. She said she was tired but could keep herself safe.

14.127. The IDVA also called Kamila to offer her condolences and updated the social worker regarding their conversation with Kamila. Kamila had asked her GP for a medication, as she was struggling to sleep. Sean's family had been messaging her and calling her a "murderer". Kamila was keen to get the funeral organised and then sort out the house and debts which Sean had left. The IDVA offered referral for grief counselling, and debt management support, which Kamila

[26] Damage to brain, due to lack of oxygen

declined stating that she just wanted to get the funeral organised and then move away from the property.

14.128. Kamila met with CRHTT again the following day. She told them of her plan to move to Poland to be with her mother once the funeral was over. Also, that day, the social worker spoke to Kamila, who told her about Sean's family blaming her for Sean's death. Kamila also shared that she had found Sean had accrued large rent arrears on the flat. Kamila saw her GP the same afternoon and advised them that she was having daily visits from CRHTT.

14.129. The social worker and IDVA liaised following their conversations with Kamila, over the next few days they both helped with rehoming Kamila's dogs.

14.130. On 1st August 2023, CSC planned to end the Child Protection Plan as risk from Sean was no longer a factor, Child A was stepped down to Child in Need. The same day, Kamila told CRHTT that Sean's family were organising the funeral. Later that day, Kamila called the IDVA. She was upset as Sean's family had messaged to say they were coming to collect Sean's belongings and that Kamila had to move from the property. She was meeting with Sean's family the following day. Kamila had made a claim to Universal Credit and was expecting a payment on 8th August 2023.

14.131. The next day, Kamila followed up with the IDVA. She was planning to remain in the property for three weeks, to allow for the funeral and to prepare a move. She said she would return to Poland for a "change of scenery". Kamila had found out that Sean had accrued £5000 of rent arrears, however the landlord was not seeking these from Kamila as she was not liable for them. She was told she had to move out by 27th August 2023. Kamila consented to a Duty to Refer[27] being competed with housing, to assist with long term plans. This was completed on 3rd August 2023.

14.132. Sean's funeral was planned for 22nd August 2023.

14.133. Kamila met with CRHTT and spoke about her plans. She said that Sean had saved her life at the hotel in Leeds, and that his actions had given her a chance which she did not want to waste. Plans were made for discharge from CRHTT, and a referral was made to the Wellbeing Team. The referral detailed the debt which had accumulated, and Kamila's recent bereavement. There was also an outstanding police matter linked to Kamila's car, which Kamila suspected had occurred when she was in Leeds local hospital following her suicide attempt.

14.134. Kamila spoke to CRHTT the following day, the dogs were being rehomed. She had seen Child A which she said was nice. She agreed to being discharged from

[27] Certain named public bodies have a duty to refer users of their service who they have reason to believe are homeless or threatened with becoming homeless within 56 days – to a local authority of the service user's choice. The duty is part of the Homelessness Reduction Act 2017

CRHTT and she had spoken with the Wellbeing Team who had called the day before. The GP was informed of the CRHTT discharge.

14.135. Following Kamila consuming bleach on 28th July 2023, she had been conveyed to Hospital A by a third-party on behalf of EMAS, and a safeguarding referral had been submitted for her by the third-party provider. The referral detailed Kamila's previous suicide attempt, that she had recently increased her alcohol consumption, and that Sean was on the scene stating he *"could no longer cope with Kamila"*. Due to the third-party provider's processes, this safeguarding was not received by ACCW until a week later. Upon receipt, the referral was triaged. However, Kamila died soon after, and the safeguarding was therefore closed.

14.136. In early August 2023, Leon went to Kamila's home as he could not reach her by telephone and was concerned about her welfare. He entered the house, saw an empty bottle of vodka on the side, and when he entered the second floor of the property, he saw Kamila hanging from the ceiling beams. This was the same spot where Sean had hanged himself. Leon called emergency services, and upon arrival EMAS provided CPR, however Kamila was declared deceased at the scene. Child A was at the scene but was not inside the house when Kamila was found.

14.137. Kamila had left suicide notes in English and in Polish. They stated that she could not go on living, knowing that she did not save Sean, and that when he died, she died with him.

15. Overview

15.1. This review has highlighted key themes which cut across all of the agencies involved with Kamila and Sean. The analysis section below at section 16 will therefore be presented as a thematic analysis, and the following section will provide an overview of agency involvement.

15.2. Lincolnshire Police

15.2.1. Lincolnshire Police were involved with Sean as a perpetrator of domestic abuse, prior to his relationship with Kamila. These incidents involved Ms Y, and another female he had been in relationship with. The Police IMR identified some gaps in responses to incidents which fall outside of the scope of this review. It is to be noted that these incidents occurred during 2018 – 2019, and police responses have been enhanced since this period.

15.2.2. Police were then involved with Leon in February 2020 following Sean's assault upon him. Leon decided not to proceed with supporting a prosecution. Within the information shared by Leon to support this review, he stated that Kamila had begged him not to report the incident to the police, and so he asked police to just speak to Sean and ask him to stay away from

Leon and did not want any further action taken. A crime of assault was recorded and finalised that there were evidential difficulties and a suspect had been named, and no further action was taken.

15.2.3. Kamila was involved with Lincolnshire Police between March and June 2020 following her request for a DVDS. This will be analysed in the sections below.

15.2.4. Police were then involved with the couple on a further twelve occasions, all of which feature in the following analysis sections below.

15.3. GP Practice A

15.3.1. GP Practice A provides primary medical services in Town A. Kamila, Leon and Child A had all been patients of GP Practice A since moving to the area in 2012. Sean had registered at the practice when he had moved into the property with Kamila in January 2020. Prior to this, he had been a patient at a Leeds based practice since 2017.

15.3.2. Kamila had consultations at the GP's practice during the scoping period for sexual health matters and to obtain medical certificates linked to periods of absence from work due to mental health issues.

15.3.3. Sean joined GP Practice A in January 2020; he was not seen by the Practice until November 2022 when he called to ask for help following self-harming.

15.3.4. Leon requested support from GP Practice A for Child A's mental wellbeing in January 2023, and for various illnesses and minor ailments.

15.4. Probation

15.4.1. During the earlier part of the scoping period Probation Services were split into Community Rehabilitation Company Probation Services (CRCs). The regional CRCs were responsible for the management of people who posed a low or medium risk of harm. The National Probation Service was responsible for the management of people who posed a high risk of serious harm. This was the model until April 2021. Therefore, during the earlier involvement with probation, May 2013 until November 2019, Sean was managed by the CRC. During the latter involvement with probation, from July 2023 until his death, he was managed by the reunified Probation Service.

15.5. United Lincolnshire Hospitals NHS Trust

15.5.1. Kamila was seen in the Hospital A Emergency Department in November 2021 and was referred to the gynaecology department. This is the department which involves the treatment of conditions affecting the female reproductive system.

15.5.2. Kamila had three other attendances at Hospital A Emergency Department due to self-harm, suicidal ideation, and suicide attempts.

15.5.3. Sean was conveyed to the Hospital A Emergency Department in June 2023 following a suicide attempt and was also conveyed to Hospital A on the day before he died, when he was conveyed by ambulance and was treated in the Intensive Care Unit.

15.6. Lincolnshire Partnership Foundation NHS Trust

15.6.1. Kamila, Sean and Child A all accessed the following LPFT services during the scoping period.

Single Point of Access Team (SPA)	provides a single point of referral for all external referrals and enquiries.
Mental Health Liaison Services (MHLS)	working in acute care hospitals in Lincolnshire.
Psychiatric Clinical Decisions Unit	purpose built clinical assessment unit.
Health Based Place of Safety (HBPoS)	for people detained under s.136 of the Mental Health Act.
Crisis Resolution Home Treatment Team (CRHTT)	community teams that support people in mental health crisis.
Criminal Justice Liaison and Diversion (CJL&D)	supports vulnerable people when first suspected of having committed a criminal offence.
Children and Adolescent Mental Health Service (CAMHS)	a range of clinical interventions for children and young people.

15.6.2. Kamila was seen by MHLS in Hospital A on each of her admittances, the MHLS assessments led to referrals into CRHTT. Throughout all of Kamila's three CRHTT referrals, out of a possible 34 contacts, only 15 contacts were successful. Out of these contacts, nine were via telephone, usually through Sean's phone as Kamila was recorded as not having her own phone, and six contacts were face to face. Three of these face-to-face contacts were after Sean had died.

15.6.3. Sean was seen by MHLS in Hospital A in June 2023, this led to a CRHTT referral, however they were not able to contact Sean.

15.6.4. Sean was referred to CJL&D whilst in custody on 1st July 2023. This was received by CJL&D on 3rd July 2023. Sean did not want to accept a full

assessment and stated that he would contact CJL&D via telephone when he was released from custody. Sean was then assessed by CJL&D whilst at court on 4th July 2023, there was no further contact with Sean following this assessment.

15.6.5. Child A was referred into CAMHS on two occasions, however following an assessment it was not considered that CAMHS was an appropriate service for Child A's needs.

15.7. East Midlands Ambulance Service (EMAS)

15.7.1. EMAS were called out for Sean on four occasions, two of these calls resulted in Sean being conveyed to Hospital A. He was often identified as being aggressive.

15.7.2. EMAS was called out for Kamila on three occasions and on each occasion, she was conveyed to Hospital A.

15.8. Adult Social Care (ACCW)

15.8.1. Sean was involved with the Advanced Mental Health Professional (AMHP) in March 2023, where he was assessed under the Mental Health Act. An AMHP is a professional who is approved to carry out functions under the Mental Health Act 1983.

15.8.2. The Wellbeing Service is a countywide service funded by Lincolnshire County Council that supports adults to lead fulfilled, confident and independent lives, through a range of services. Kamila was referred to the Wellbeing Team a few days prior to her death, the referral referenced the death of Sean, how Sean had been abusive within their relationship, and pressures on Kamila following his death which included rent debt. The Wellbeing Team had not been successful in speaking with Kamila prior to her death.

15.8.3. A third-party provider working on behalf of EMAS submitted an adult safeguarding referral following the call to Kamila when she had ingested bleach. This was sent on a handwritten form and did not arrive with the safeguarding team until the day before Kamila died, therefore was not actioned.

15.9. Lincolnshire Domestic Abuse Specialist Service (LDASS)

15.9.1. This service has been commissioned by Lincolnshire County Council since April 2023. EDAN Lincs deliver the Independent Domestic Abuse (IDVA) Service. IDVAs support victims of domestic abuse, by providing advocacy and support.

15.9.2. Town A housing team liaised with the IDVA service in April 2023, when Kamila presented as homeless, and in early July 2023 Kamila was referred in the IDVA service following Sean's arrest for assault upon her.

15.9.3. The IDVA referral remained open, however apart from an initial conversation where the Individual Safety and Support Plan (ISSP)[28] was completed, the IDVA was not able to speak to Kamila until after Sean died towards the end of July 2023. The IDVA made several attempts to speak to Kamila, however it was not until after Sean's death that Kamila fully engaged with the IDVA.

15.9.4. The IDVA team consists of 2 Eastern European Polish speaking IDVAs. Kamila was allocated a Polish speaking IDVA that also understood the Eastern European community.

15.10. Children's Social Care (CSC)

15.10.1. A referral was made into CSC in December 2019 which resulted in the allocation of a social worker, the completion of a Children and Family Assessment and a Child in Need[29] plan was active from January 2020 to April 2020.

15.10.2. A further safeguarding concern was raised in September 2021, which did not result in any further action as it was not deemed that the threshold for Social Care had been met.

15.10.3. A further safeguarding concern was raised in January 2023, which resulted in a Child and Family Assessment. A Child in Need plan was commenced in February 2023.

15.10.4. Child A was stepped up to Child Protection[30] in May 2023 following further incidents involving Sean and Kamila and concerns that Leon could not protect Child A from Sean. This was stepped down to Child in Need following Sean's death in July 2023.

15.10.5. It should be noted that the same social worker was allocated to Child A in 2020 and 2023. This is good practice and offered consistency of support for Child A and Leon.

15.11. Town Council A

15.11.1. Following the incident on 28th April 2023, Kamila was taken to see Town Council A's Housing Options Team as she felt unsafe to remain at the property with Sean. The Housing Team liaised with the LDASS IDVA and tried to find a refuge space for Kamila.

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[28] The Whole Picture SafeLives Strategy

[29] www.childrenscommissioner.gov.uk/resource/what-is-this-plan-for-the-purpose-and-content-of-children-in-need-plans/

[30] Arrangements for Children who are Subject to a Child...

15.11.2. Kamila was supported by the housing Domestic Abuse Lead. The referral to the local refuge was declined due to Kamila's mental health issues. However, the Domestic Abuse Lead organised food, transport and temporary accommodation for Kamila, although she did not remain there and returned home that evening.

15.11.3. Since the period of the review the funding for the Domestic Abuse Lead in the Housing Team has been extended. The role does not carry a case load, and the panel considered that this could be a positive development for the role, taking into account the proactive practice which was highlighted by the Lead in this review. It is also considered that a commitment to longer term funding would benefit the stability of the team, and their offer to victims of domestic abuse.

15.11.4. Since the period of the review, LDASS have are now commissioned to deliver a complex needs IDVA linked to refuge provision, and this is detailed further in the lessons learnt section of the report.

16. Analysis

16.1. Coercive and Controlling Behaviour

16.1.1. It is clear from the information shared within this review, that Sean was exercising control over Kamila. The following section will outline the offence and the principle of coercive control, in order to inform the subsequent analysis subsections, and situated Kamila's experiences within her relationship with Sean.

16.1.2. Coercive and Controlling Behaviour was introduced as an offence through the Serious Crime Act 2015.[31] The offence is an act or pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim. The elements of the offence are as follows:

A person (A) commits an offence if —

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

[31] S.76

16.1.3. In 2007, Professor Evan Stark introduced the concept of entrapment in the context of coercive control.[32] Since then, the introduction of the offence of Coercive and Controlling Behaviour has promoted a societal understanding of the uses of control by perpetrators, to entrap their victims into a relationship which is uneven in power dynamics.

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

16.1.5. The Crown Prosecution Service provides the following definition of behaviour that is controlling or coercive:

> *"A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour."*[33]

16.1.6. Perpetrators of domestic abuse exercise power and control over their partners by behaving in a way that reduces their partners' choices outside of the relationship.[34] Whilst many use violence to control, physical abuse is only one form of abusive behaviour.

16.1.7. Evan Stark equates living with a coercively controlling partner to living in an invisible cage. He describes how *'[the] barrage of assaults, locked doors, missing money, rules for cleaning, text messages…[are] recognised as bars'.*[35] Marianne Hester describes coercive control as a *'long thin offence'*, explaining that abusers often do not stand around with blood on their hands waiting to be arrested and victims do not always present to professionals with visible injuries.[36]

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[32] Stark, E *Coercive Control: How Men Entrap Women in Personal Life* (Oxford University Press, 2007),

[33] Controlling or Coercive Behaviour in an Intimate or Family Relationship

[34]For an in-depth explanation of abusive tactics see: L Thompson, *Impossible Expectations: A Study of Abused Mothers in the Child Protection System* (Queen Mary Thesis Collection, 2018) 60-77, available at <qmro.qmul.ac.uk/xmlui/handle/123456789/56808>

[35] Stark, E *Coercive Control: How Men Entrap Women in Personal Life* (Oxford University Press, 2007) 198

[36] Hester, M 'Domestic Abuse Masterclass: Thames Valley Police' (October 2013), cited in J Monckton Smith, A Williams and F Mullane, *Domestic Abuse, Homicide and Gender: Strategies for Policy and Practice* (Palgrave Macmillan, 2014), 17.

16.1.8. Emma Williamson frames the abuser's world as an *'unreality'*[37] that their partner must negotiate in order to survive. The rules of this world change without notice and the abused partner must keep up with the new rules or suffer the consequences.

16.1.9. Stark describes coercive control as:

> *"A course of conduct that subordinates (the victim) to an alien will by violating their physical integrity (violence), denying them respect and autonomy (intimidation), depriving them of connectedness (isolation) and appropriating or denying them access to resources required for personhood and citizenship (control)."*[38]

16.1.10. Judith Herman explains that coercive control leads to the victim behaving in a way which goes against their own belief systems:

> *"Terror, intermittent reward, isolation and enforced dependency may succeed in creating a submissive and compliant prisoner. But the final step in the psychological control of the victim is not completed until she has been forced to violate her own moral principles and to betray her basic human attachments."*[39]

16.1.11. Coercive control is invisible in plain sight, as the behaviours of an abuser are nuanced and private, only really meaning something to their partner. Once a victim has been conditioned by their partner, all it takes is a look, a comment, a single word or a simple gesture, and the victim will understand what is expected of them, or they suffer the consequences. The outside world may not understand the abuser's look, comment, word or gesture as anything significant.

16.1.12. Living in this cage, in a world where the goal posts move and the victim often second guesses themselves, will inevitably lead to struggles with mental wellbeing and this further feeds into the coercive control. Abusers use mental illness to further control; the abuse becomes self-perpetuating and eventually the victim loses all sense of self.

16.2. Suicide timeline

16.2.1. The analysis of agency involvement with Kamila and Sean has been enhanced by the application of Professor Jane Monckton-Smith's[40] Eight

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[37] Williamson, E 'Living in the World of the Domestic Violence Perpetrator: Negotiating the Unreality of Coercive Control' (2010) 16 *Violence Against Women* 1412.

[38] Stark, E *Coercive Control: How Men Entrap Women in Personal Life* (Oxford University Press, 2007) p.15.

[39] Herman, J *Trauma and Recovery: The Aftermath of Violence* (1994) p.83

[40] Jane Monckton-Smith - Staff Profiles

Stages of Homicide, otherwise known as The Homicide Timeline.[41] The following section will introduce the timeline and briefly present Kamila and Sean's relationship in terms of the stages of the timeline.

16.2.2. The timeline has been developed from Professor Monckton-Smith's ground-breaking research which has spanned many years. The homicide timeline lays out identifiable stages in which intimate relationships where one partner is coercive, can escalate to murder. The timeline aims to support a better understanding of coercive control and domestic homicide amongst professionals responding to domestic abuse.

16.2.3. Although the timeline was initially developed specifically for the identification of risk of homicide within intimate partner relationships, Professor Monckton-Smith has developed the timeline to enable an understanding of domestic abuse related suicides and apparent suicides, and the panel will be applying this understanding of the timeline to the circumstances of Kamila and Sean's relationship.

16.2.4. By applying Sean's previous relationships and behaviours within the relationship with Kamila, and using the benefit of hindsight, Sean's behaviours are clearly identifiable as coercive and dangerously escalating. Whilst the use of the timeline in this review is not intended as a predictive tool, there is learning to be found within the application of the timeline, which may illuminate the past to make the future safer for victims of domestic abuse and coercive control.

16.2.5. Stage one of the timeline requires the identification of the perpetrators previous relationships, to recognise whether they have the propensity for behaving in a controlling and abusive way. This is clearly identified in Sean's case, as the panel were presented with two previous relationships which required the involvement of police, especially following the relationships ending. This was particularly apparent in Ms Y's case, and in fact Ms Y raised concerns about Kamila and Child A's welfare following the relationship between Kamila and Sean starting.

16.2.6. Stage two of the timeline is the commitment whirlwind, where the relationship moves at a very fast pace, with early declarations of love, possessiveness and jealousy. Kamila and Sean moved in together very quickly, and in fact it would seem this happened immediately after the relationship with Ms Y ended.

16.2.7. The third stage of the timeline is where the perpetrator manipulates and controls the victim, putting rules in place, and tests the victim's commitment to them. During this time, Sean quickly isolated Kamila. This may have been easy to do, as she did not have any family, beyond her ex-husband and child, living in the UK. During this time, Kamila's mental health

[41] Monckton-Smith J *In Control: Dangerous Relationships and How They End in Murder* (2021)

deteriorated, and she was away from work due to this. Leon was attacked by Sean and was scared to come to the house. Child A spent more time with Leon, and eventually moved in with Leon, and it was deemed unsafe for Child A to spend time with Kamila due to Sean's behaviour. Sean used self-harm and his own mental health to isolate Kamila, as she was scared to leave the house in case Sean self-harmed or attempted suicide.

16.2.8. Stage four is the trigger. This happens when the perpetrator perceives that they are losing control of the victim and of the situation. In terms of Sean's trigger, this was when Kamila tried to leave the relationship, and when she fled the home following his behaviour escalating. Following the trigger, the perpetrator's behaviour escalates to regain control, and in Sean's case this was self-harming episodes, and suicide attempts.

16.2.9. The timeline can cycle through these first five stages many times, and this happened in Sean and Kamila's case. Each time, Kamila lost more control of her own life, became increasingly isolated and her mental health deteriorated.

16.2.10. Stage six is a change in thinking, stage seven is planning, and stage eight is the homicide or suicide. These stages tend to occur very quickly. It may be the case that Sean's first attempt of suicide by hanging was a serious attempt, where he reached these stages, and it can also be considered that Kamila's suicide attempt by hanging was also her being at stage eight of the timeline due to Sean's behaviour which was intended to for Kamila to die by suicide in the context of domestic abuse.

16.2.11. Sean's final act of suicide can be recognised as the ultimate form of control, where despite his death, he is still controlling Kamila to the point where she feels there is no other option but to take her own life.

16.3. Identifying and Recognising Risks

16.3.1. Sean had a history of abusive behaviour against partners. This is indicative of stage one of the homicide, and in turn the suicide, timelines as detailed above.

16.3.2. During July 2019, Sean told probation that his relationship with Ms Y had finished, and that they had been playing "mind games" with one another. There was a lack of exploration of the impact of this relationship breakdown: despite a known history of incidents which had happened following the relationship breaking down, and Sean moving from the address which had been approved by Probation. During this time Sean should have been more closely managed, and consideration given to who the new "friend" was who Sean had moved in with.

16.3.3. Also, around this time Sean was under investigation by Lincolnshire Police regarding allegations of harassment made by Ms Y, and the couple were discussed at MARAC on 18th July 2019. Following this period, he missed a series of appointments with his Probation Practitioner. However, there was no management of Sean by Probation, it was unclear where he was living, and he was not seen face to face to review the level of risks he posed.

16.3.4. Kamila and Sean's relationship appear to have moved very quickly. They appear to have moved in together soon after they met. Although it is not clear, she may have been the "friend" he referred to when he moved out of Ms Y's property in July 2019. He had also only just ended his involvement with probation following a recall to prison in 2018, which had been due to abusive behaviour against Ms Y. There may have been an overlap between his relationship with Ms Y ending, and the relationship with Kamila starting. This is indicative of stage two of the timeline.

16.3.5. The Covid-19 restrictions were introduced a few months after Kamila and Sean moved in together. This may have provided the perfect circumstances for controlling Kamila in the early part of their relationship. The timeline highlights that stage three is the period where controlled is established and maintained. Evan Stark likens coercive control to being taken hostage by the perpetrator, stating *"The victim of coercive control becomes a captive in an unreal world created by the perpetrator, entrapped in a world of confusion, contradiction and fear."*[42]

16.3.6. As introduced above, the element of serious effect within the offence of coercive and controlling behaviour requires a recognition of the effects of the abuse on the victim. It is necessary to identify how the victim has changed, how their lifestyle, their engagement with the world outside of the relationship with the abuser, and their personal circumstances. For example, their mental and physical health, has changed. From January 2023, Kamila presented to her GP as depressed, and from then was provided with numerous medical certificates for depression. Prior to this, she had not been treated for mental ill health.

16.3.7. Throughout the scoping period, there was a lack of curiosity from Kamila's GP regarding the source of her low mood. She mentioned issues with Child A, however there was a lack of exploration around the wider situation.

16.3.8. There was a missed opportunity for the Practice nursing team to explore with Kamila her contraception plans, when she attended for her contraceptive coil to be removed in September 2021. This would have been a good opportunity for clinical enquiry and could have opened up

[42] Stark E "Living with the Dominator" (2007)

a dialogue about Sean's current behaviours, including what Kamila's motivation was for having the coil removed.

16.3.9. Kamila had consultations with her GP during August and September 2020, where she presented as low in mood and tearful, she said she had poor sleep, could not eat and was finding it hard to cope, and spoke about no longer having the care of her child. This was taken on face value, the GP did not ask about domestic abuse, and she was diagnosed with "stress and adjustment reaction". This would have been a good opportunity to explore the reasons for her no longer having the care of her child, however the GP gave her a diagnosis, prescribed her medication and continued to sign her off work.

16.3.10. In February 2023, when requesting a medical certificate, she told the GP receptionist that she had to always have someone with her, this was not explored. For example, who had told her this, and was this Sean controlling her movements.

16.3.11. There had however been more curiosity by the GP regarding Sean's presentation to the Practice. Although both were provided with medical certificates when they presented with low mood, only Sean was asked about the possible causes of his low mood, whereas Kamila was simply provided with medication and medical certificates. This was despite the Practice being aware of the MARACs which had been heard.

16.3.12. Both Kamila and Sean attended ED due to concerns relating to their mental health. On each occasion, a referral to the MHLS was initiated appropriately, however there appeared to be no further exploration by ED staff following some of the comments they made. For example, on one occasion Kamila stated her suicide attempt had been a *"cry for help"* which was not explored, and on another occasion, Sean told staff that he had a *"strained relationship with his partner"* which did not lead to any exploration by staff.

16.3.13. There appeared to be a reliance upon MHLS to explore the root causes of Kamila and Sean's suicide attempts, self-harm incidents, and subsequent presentations at ED. However, by the time they spoke to MLHS, the moment may have been lost. As highlighted by Women's Aid,[43] there is often a small window of opportunity for disclosures of domestic abuse, therefore practitioners should feel equipped to ask appropriate exploratory questions whenever possible.

16.3.14. It was identified by LPFT during the DARDR process, that incidents with Kamila and Sean were triggers which led to Kamila's involvement with mental health services. The staff working with the couple referred to the relationship as "toxic", however there was a lack identification of

[43] https://www.womensaid.org.uk/what-we-do/change-that-lasts/askme/

domestic abuse, and no exploration with Kamila about the unhealthy nature of the relationship.

16.3.15. In November 2022, Child A talked to his school about Sean's paranoid behaviour and how he was afraid for his mum. Secondary School B did not identify this as coercive and controlling behaviour, and considered that having spoken to Kamila, she had minimised the behaviours. Six weeks before this disclosure, Child A had repeatedly written *"help"* in his book, and three days before he had experienced a panic attack. These events were not considered in relation to one another and were each viewed as a standalone incident. This is despite information being shared by Primary School A about Sean being *"very violent"*, a previous MARAC having been held, and Child A previously being opened to social care. Since this period, Secondary School B have re-structured the way that safeguarding is staffed across the school, meaning that currently there is always at least one highly trained staff member available to deal with disclosures such as this.

16.3.16. Kamila had attempted to take her own life in January 2023, viewing this incident in the context of coercive control, and the suicide timeline, Kamila may have been trying to regain control by her suicide attempt, or she may not have felt she could not cope with the situation any longer. This may have then become the trigger for Sean's controlling behaviour to escalate, as can be seen at stage four of the timeline. What is clear, is that following this incident, Kamila spoke about *"owing her life"* to Sean which indicates an unhealthy level of dependency.

16.3.17. During a visit to Kamila in February 2023, the social worker noted that Kamila did not appear as *"sparkly and smartly dressed"* which, taken in the context of coercive control, can be recognised as a further indicator of serious effect as she had previously been well presented. The social worker had discussed Sean's behaviours, and noted that Kamila appeared to defend Sean, and was not able to recognise the risks which had been raised. Kamila called Sean her *"saviour"*. Within her notes, the social worker does not appear to link Kamila's perception of the situation to Sean's coercive and controlling behaviours, and there is no indication that she challenged or explored this matter with Kamila. The social worker was aware of domestic abuse concerns and could have explained coercive and controlling behaviour to Kamila and helped her to understand what was happening.

16.3.18. During staff interviews with MHLS staff, they identified that Kamila appeared to be *"besotted"* with Sean, and she was *"fearful"* of the relationship ending. This highlights an unhealthy power imbalance. There were missed opportunities to explore this with her further when she was seen by MLHS and CRHTT staff alone.

16.3.19. The presence of a MARAC alert on Kamila's ED record, which was applied on 15th March 2023, and remained visible until her death, would have provided ED staff with the opportunity to explore whether Kamila's subsequent attendances were related to her experiencing coercive control within her relationship with Sean. However, there is no documentation to suggest the alert was recognised and/or explored.

16.3.20. Sean was involved with the AMHP Service in March 2023. He spoke about Kamila's suicide attempt in January 2023 and how this had impacted upon him. He spoke about his increased drug and alcohol use, and paranoia about Kamila being unfaithful. There was no exploration with Sean about domestic abuse, however on analysing the engagement with the AMHP, they were not aware of the abuse therefore there was no expectation on them to ask about abuse.

16.3.21. On 11th April 2023, Sean had called emergency services in the early hours of the morning with concerns about not being able to contact Kamila, upon arrival at Hospital A she had spoken to MHLS about Sean calling her at 4am and telling her that he could not trust her. There does not appear to have been any consideration by professionals that Sean's actions were intended to control Kamila despite him not being physically with her. There was no discussion with Kamila about coercive and controlling behaviour. This would have been an ideal opportunity for this discussion as she was in a place of safety, Sean was out of the area, and she may have had space for reflection about his behaviours.

16.3.22. With each self-harm incident, and suicide attempt by both Kamila and Sean the relationship dynamics became more unbalanced. This can be identified as stage six of the timeline, where the control, and behaviours escalated. During the latter part of the scoping period, physical incidents became more apparent, happening outside in the street and in clear view of other people. Sean was also using more cocaine, he was increasingly paranoid, and his behaviour was becoming riskier for Kamila. This culminated in an arrest and subsequent guilty plea for an offence of assault against Kamila, there was a short period of separation, however their relationship continued, and Kamila was increasingly using alcohol. At this point both Kamila and Sean were at risk, from one another and from themselves.

16.3.23. In July 2023, probation completed an assessment as part of the court report for sentencing. This identified a risk of serious harm to Kamila by Sean as high. There had been no opportunity to respond to this risk as Sean died a short while after, however there had been an intention for the Probation Practitioner to complete an accredited programme for interpersonal violence with Sean.

16.3.24. Sean's previous Probation records indicated a history of self-harm and attempted suicide, and this was reiterated in the court report prepared in

July 2023 as an area of potential concern. This behaviour was assessed as being linked to relationships and his difficulties in coping when these ended. It was noted that Sean could use this as a method of manipulation and threat towards partners if they did not do as he wished. This was an area which was planned for exploration in supervision.

16.3.25. Sean had stated following sentencing that he was returning to live with Kamila, and the Probation Practitioner did not demonstrate sufficient enquiry into the impact of this on Sean's risks to others, or how he was managing his current situation. This would have been expected practice, given Sean's offences and patterns of abusive behaviours.

16.3.26. The social worker met Kamila on 10th July 2023, she was very thin, had a bruise on her eye, and fresh cuts on her wrists. There is no record of Kamila being asked about the self-harm wounds; however, it must be noted that the social worker was only able to catch up with Kamila whilst in a shopping centre car park and this environment would not have been conducive with asking about the self-harm or any abuse. The social worker should be commended for the tireless efforts she made to speak with Kamila.

16.3.27. Since the scoping period for the review, practices have been introduced which include an expectation for professionals to complete a skeleton DASH with any information that has been gathered during conversations. This change in practice was a result of a recommendation within another DARDR in Lincolnshire. However, this was not in place during the period under review.

16.3.28. Kamila had been identified by the IDVA as adjusting her routines and decision making to appease Sean. She told professionals that she had not been able to visit her family in Poland, due to Sean's threats of suicide.

16.3.29. Kamila described Sean as vulnerable and blamed his behaviours on his mental health and substance use.

16.3.30. Following Sean's death, Kamila was able to be open about his controlling behaviour, however she was blamed for his death by his family, and she told professionals that she also blamed herself.

16.3.31. Intensive Care Unit staff were concerned regarding Kamila's presentation at the time of Sean's death, with her disclosing to staff she had previously attempted to self-ligate in January 2023. She is also quoted as stating: '*I hope I don't end up as your next patient'*. The escalating risk was recognised, and contact was made with the Hospital Chaplaincy service and the MHLS. The MHLS practitioner was aware of Kamila and advised that the CRHTT would be best placed to support. As such, a discussion was held with the CRHTT team and a plan for the CRHTT practitioner to 'cold call' Kamila's property was agreed.

16.3.32. Kamila rehomed her dogs and had planned to leave the property after Sean's funeral, however one week after his death she took her own life. Her suicide notes stated that he had saved her life, and she had died when he had died. Her preparing for suicide (stage seven on the timeline), can be seen in organising the dogs to be rehomed and clearing her possessions from the home she had shared with Sean.

16.3.33. The IDVA service panel members reflected on the sudden change in Kamila following Sean's death. Whereas prior to his death she had been very emotional and struggling to regulate these emotions when speaking to the IDVA, following Sean's death Kamila presented as very calm and able to discuss future plans. Whilst it is not possible to say with certainty whether the change in Kamila was due to no longer being controlled, or due to her making plans to take her own life, this change was recognised by the IDVA and shared with other agencies at the time. However, Kamila died very soon after.

16.4. Isolation as a risk factor

16.4.1. This review highlights the use and impact of isolation, in the context of coercive control.

16.4.2. Following Sean's death, Kamila told the Wellbeing Hub that she didn't *"have a lot of friends locally to the nature of her relationship with Sean. Most of the people she associated with were his friends and family."*

16.4.3. Also following Sean's death, Kamila spoke to the CRHTT about feeling restricted by Sean when he was alive, she stated that he had to know where she was going, including when she went to the toilet. These elements of control had not been shared by Kamila prior to Sean's death.

16.4.4. Sean was able to isolate Kamila from her family fairly easily, because Kamila was from Poland, her whole family remained in Poland, and as discussed above, Sean's threats of suicide stopped Kamila from visiting her family and friends in Poland. It is also thought that Kamila's mother was terminally ill, and Kamila cancelled a trip to visit her which had caused upset amongst the family.

16.4.5. Two months after the initial concern about Sean's risk to the family was raised in January 2020, the national Covid-19 restrictions began. This enforced isolation would have enabled Sean's behaviours to go unnoticed for a long period, including removing Child A from the safety of school. Primary School A had been made aware of the possible abuse from Sean, and concerns were shared with class teachers to be observant for signs of abuse. However, Child A was educated remotely until July 2020 and was therefore not seen physically again until the next school year.

16.4.6. Kamila had been seen daily by Primary School A, until the Covid-19 restrictions began. However, the following school year she no longer took Child A to and from school, and it was considered that her work patterns may have changed, and Child A was old enough to come into school himself.

16.4.7. During Kamila's contact with CRHTT during January 2023, it was recognised that she was on a long-term sickness absence from work, in her role as a supervisor in a local factory. She was isolated from her work colleagues; due to the stress she was experiencing. Her isolation from influences and positivity outside of the coercively controlling relationship with Sean, may have increased her stress and led to her requiring more time off work. She may have felt completely stuck in this cycle.

16.4.8. Kamila told CRHTT that she did not have a phone, and contact needed to be made via Sean. Perpetrators of domestic abuse often either destroy phones, or insist on sharing phones, so that they can gatekeep the contact their victim has with third parties, including friends, family and professionals. There was no curiosity employed by CRHHT staff upon learning that Kamila did not have her own phone and this may have been a missed opportunity to explore this with her.

16.4.9. From January 2023, when Kamila attempted suicide, her contact with Child A also greatly reduced due to concerns for Child A's welfare, should Child A come into contact with Sean. Separation from Child A would have had a big impact on Kamila and her mental wellbeing. During their first visit to Kamila at home, she asked CRHTT for assistance with calling Leon to arrange contact with Child A. She no longer had her own phone and was reliant on using Sean's. CRHTT declined to help her with this, stating that their role was confined to supporting her with her mental health. It has been reflected through this review, that this may have been shortsighted, as helping to facilitate contact with Child A would have helped her mental health.

16.4.10. There are points throughout the scoping period where it appears that Kamila, and sometimes also Child A, accompanied Sean to London for work. In March 2023, Kamila told his dad that they had remained in the hotel room whilst Sean was at work. This would have been incredibly isolating for Kamila, and at times no one would have even known where she was.

16.4.11. Although it was not entirely clear from the records held by agencies during March 2023; it would appear that when Sean intentionally drove his car into the wall of a local shop, Kamila was in Poland visiting family. She may have been on her way to Poland, or she may have already been in Poland. However, it is clear from viewing this with hindsight, that Sean was exerting control by his actions to harm himself in her absence,

and following this incident Kamila felt unable to leave the house or be away from Sean in case he harmed himself again.

16.4.12. Kamila did not attend follow up appointments with CRHTT or with the IDVA service, and following a very short period of temporary accommodation in April 2023, which was possibly not even one night away, she returned to Sean, as he had self-harmed and was reported to be experiencing psychosis.

16.4.13. Following Sean's arrest, it was identified that Sean had installed cameras in the property, to monitor Kamila's movements. When she spoke to the IDVA following Sean's death, Kamila indicated that she had been aware of the cameras and felt they afforded her extra safety in case she experienced a panic attack when Sean was in London with work.

16.4.14. Sean used threats of suicide to isolate Kamila. During her conversation with the IDVA, following Sean's death, Kamila shared that she had ended her employment because she was scared that Sean would take his own life, or that he would be paranoid and accuse her of being unfaithful. The threat of suicide from Sean was real, as she had witnessed his attempts, and he had hung "nooses" on the beams in the bedroom where Kamila slept, these were likely to have been there as a reminder of his threats of suicide.

16.4.15. The LDASS IMR author reflected that Sean's threats of harm to himself, along with Kamila's isolation, did not allow her any "space for action" in order to protect herself. It is clear from the information reviewed for the DARDR that Kamila's life was inextricably linked to Sean's; his control and her own deteriorating mental health shaped her decision making. An example of this was Kamila's reluctance to even leave the house, as she believed that Sean would harm himself if and when she did leave the house. Kamila had good reason to believe this, as detailed in the chronology above, Sean did indeed harm himself when she tried to leave him, and even when she tried to visit her family in Poland. It is evident that this element of coercion was not fully recognised by agencies at the time, as none had the full picture, which the DARDR process has provided.

16.4.16. Following Sean's arrest and subsequent bail conditions in July 2023, the IDVA liaised with the social worker to make plans to engage with Kamila, whilst Sean was residing in Leeds with his family. However, Kamila declined support from the IDVA and indicated that she would be resuming her relationship with Sean.

16.5. Think Family

16.5.1. There appeared to be a lack of consideration of wider risks to and from family members, beyond the risks identified between Kamila and Sean.

16.5.2. The effects of Sean's behaviours were not limited to Kamila. Both Child A and Leon were directly affected by Sean's aggressive and controlling behaviour but were also affected by Kamila's mental ill health.

16.5.3. Leon was open about his fear of Sean, who had assaulted him in January 2020, causing an injury. This assault had impacted on Leon in the long term. Following CSC becoming involved in 2023 and contact between Kamila and Child A requiring some level of supervision, Leon was worried about enforcing this, through fear of reprisals from Sean.

16.5.4. The social worker spoke to Leon about this, however there appeared to be a lack of proactive follow up of this discussion. Leon was advised not to allow unsupervised contact, there did not appear to be any challenge of Sean by professionals, and Leon may have felt powerless to manage this risk.

16.5.5. Sean sent Leon a series of threats during 2023, accusing him of having an affair with Kamila, and Leon was advised to report this to police.

16.5.6. During a Child in Need meeting in March 2023, Leon shared that Child A had told him about the journey to London, where Kamila and Child A had remained in the hotel room whilst Sean was at work. He said he had seen that Child A was in London via a GPS app on Child A's phone. Child A had been told to lie, and Leon seemed powerless to do anything about this. He was reminded that he should not allow unsupervised contact between Kamila and Child A, but it does not seem that he had the ability to manage this himself.

16.5.7. A case discussion was held by CSC on 3rd May 2023, and concerns were raised that Child A's emotional wellbeing was affected by his worry for Kamila being harmed by Sean, and concerns raised by professionals that Leon could not protect Child A from Sean. Leon himself confirmed at the time, and later, that he was in fear of Sean's behaviour. At this time, Child A was stepped up to an Initial Child Protection Conference due to the ongoing risks posed by Sean. Sean's behaviour towards Kamila was impacting the whole family at this time.

16.5.8. In June 2023, despite contact between Kamila and Child A being restricted, Sean sent Child A a message to say that he was to take care of the couple's dogs when they were visiting Sean's family in Leeds, and that Leon was to support with this otherwise there would be repercussions. Kamila had also taken a key to the property into Secondary School B to facilitate this happening and this was without Leon's prior knowledge. This situation illustrates the level of control which Sean was exerting over Child A and Leon, even when he was physically absent from them.

16.5.9. Another element to a Think Family approach, is recognition of cultural barriers, for Kamila but also possibly for Leon and Child A. As presented

in previous sections, Kamila and Leon both grew up in Poland, and may have had an internalised understanding of mental health, domestic abuse, and services available to support families, which was shaped by their Polish culture. An example of this is the recognition of domestic abuse in Poland, which fails to recognise non-physical forms of abuse in Polish law. It is considered that the Polish government is critical of domestic abuse and women's rights campaigns as undermining traditional values, the sanctity of marriage and Polish identity, and there is a lack of domestic abuse reference in state policy.[44] Although Kamila lived in the UK, her family remained in Poland and it is entirely possible that she continued to carry her cultural understanding of domestic abuse with her throughout her relationship with Sean.

16.5.10. Vesta is a Polish specialist family support service, which has recently ceased providing services due to funding cuts; they state that the vast majority of Polish people they have supported, had little to no understanding of the British care system, and cite language barriers as a significant issue for Polish people.[45] Although it is recorded that Kamila and Leon spoke good English, there are some English words and phrases which do not directly translate into Polish; one of these is coercive control which may have caused confusion or a lack of understanding about what was happening to the whole family due to Sean's behaviour. Vesta also highlights that Polish men often do not ask for support, although this review is focused on Kamila as the direct victim of domestic abuse, it has been detailed above how Leon was also impacted by Sean's behaviour.

16.5.11. It is vital that all agencies undertake risk management and safety planning through a Think Family approach, which focuses on an understanding of risk as cumulative and intersecting across and between different family members. This includes those not living in the family home. This approach encourages an understanding of how various forms of risk, from domestic abuse, mental ill-health, substance use and other factors, can intersect to form more complex risks. Professionals are encouraged through a Think Family approach to consider the whole family in this context, in place of considering each individual in isolation.

16.6. Children as direct victims of abuse

16.6.1. This review also highlights the impact of domestic abuse on children, and the importance of recognising them as victims of domestic abuse, rather than collateral damage in the abuse perpetrated upon the adults around them.[46]

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[44] Executive Summary: Polish Women's Experiences of DVA

[45] Suicide, domestic abuse and homelessness among the Polish community

[46] Stark, E "Children of Coercive Control (Interpersonal Violence)"

16.6.1. Throughout the scoping period, there was a lack of recognition of where Child A fit within the context of domestic abuse. The GP was made aware of the concerns via the MARAC and the Child Protection Process, however there was a lack of proactive follow up with Leon around this, despite Leon contacting the surgery for medical advice for Child A.

16.6.2. In March 2021, Child A was upset at school and said he did not want to return home, Kamila was spoken to and said this was due to Covid-19 restrictions being lifted, and Child A not wanting to return to school. This explanation was taken on face value, and there was no further exploration with Child A about his concerns about returning home. A month later there was an incident where Child A acted completely out of character, stealing from a local shop and carrying a knife, again there was no further exploration of this, or consideration of a link to previous CSC involvement, and Child A not wanting to return home.

16.6.3. One area of great concern was when Child A filled up a whole exercise book page with the word “help” during a session in school about domestic abuse in November 2022. Six weeks before this, Child A had spoken to school staff about Sean’s paranoid behaviour and how he was afraid for his mother’s safety. As detailed above, the school did not identify this as coercive and controlling behaviour and did not link these events; instead viewing them as standalone incidents. As detailed above, the school has identified learning from this review and have implemented changed to safeguarding structures in the school

16.6.4. Child A had been told by Sean and Kamila to lie to other adults, which would have caused him distress. He was also asked to put a tracker app on his phone, which he refused to do and spoke to his dad and the social worker about. Following the journey to London in March 2023, he did not see Kamila for some time, and in early April 2023, he became very distressed stating that Kamila had stopped communicating with Leon and he was worried about her. Child A verbalised that he was worried about Sean’s part in Kamila’s lack of contact, indicating that he was well aware of the risk that Sean posed. This highlights how children, even when they are not directly in contact with an abuser, are directly affected by the abusive behaviour.

16.7. **Managing Risks**

16.7.1. The following section will analyse the management of risks: from Sean’s coercive and controlling behaviour, threats of violence towards Leon, risk of suicide from both Sean and Kamila, and the impact this whole situation had on Child A.

16.7.2. In March 2020, following concerns being raised by Ms Y, and the resulting CSC involvement, Kamila appeared ready to hear about Sean’s previous offending history. There were delays in this happening due to

the Covid-19 restrictions, and Kamila's situation not being deemed sufficiently high risk to warrant a face-to-face disclosure. The rationale for this decision appears overly simplistic and was based upon no reported incidents of domestic abuse since the relationship had started, and Kamila's lack of concern about Sean's behaviour. It should be noted that the relationship was in its early stages, meaning that Sean's behaviours had not yet escalated, and also that this could have been an ideal time to share this information before Kamila became too embroiled in Sean's controlling behaviours.

16.7.3. The social worker followed this up a couple of weeks later, which illustrates proactive risk management. She was told that police wanted to disclose the information in a face-to-face meeting, but this was not currently possible, however they gave some general background of coercive and intimidating behaviour. This led to the social worker and their supervisor agreeing a lack of risk for Child A and closing the Child in Need case. This appears to be a reasonable action considering the circumstances, however with the benefit of hindsight, and the general understanding of how Sean's coercive and intimidating behaviour was continuing to impact Child A, the Child in Need plan could have continued in order to provide more support to Child A.

16.7.4. In June 2020, a police officer spoke to Kamila on the phone, to explain the DVDS procedure. There followed a series of events where Sean called the officer to demand what information was held about him. This was obviously controlling behaviour. It is recorded by the officer that Kamila had given Sean the officer's number, although she said she had not, and that she *"could not be trusted"* with the information. The DVDS was closed, and CSC were updated, although as the Child in Need case was closed at this point, and Child A was living with Leon, there was no further action. This whole DVDS process was problematic. Sean could have been with Kamila when she took the call, he could have heard the call, he may have been able to easily access Kamila's phone, even remotely, and was able to control the narrative. It was also found later in the scoping period that Sean had cameras at the house, to monitor Kamila's movements, and this could have included listening devices. By indicating that Kamila could not be trusted, the blame for Sean's behaviour was placed on her, further isolating her from outside influences.

16.7.5. From analysing the DVDS process followed in this review, it appears to have been very process heavy with very little room for the use of, and the impact of coercive and controlling behaviour; or any room for human behaviour in general. This is despite the purpose of the DVDS process being to share Sean's coercive and intimidating behaviours. By refusing to provide information to Kamila, the purpose of the DVDS was not fulfilled. The officer knew that Sean used coercive and intimidating

behaviours, yet Kamila was penalised for possibly being coerced and intimidated by Sean.

16.7.6. Following learning identified by the Primary and Secondary schools throughout the review process, both schools have strengthened their safeguarding practices and have upskilled their staff around an understanding of coercive and controlling behaviours, the effects of this on children, and that children are direct victims of abuse regardless of their proximity to the direct abusive behaviours.

16.7.7. When EMAS attended to Kamila on 1st June 2023, she disclosed that she was experiencing a mental health crisis, that her partner was controlling and that she had a child who she was estranged from due to this control. The attending crew did not offer Kamila a referral into domestic abuse services and did not share this information with CSC. It is considered that the circumstances indicated possible high risk of harm, and therefore a safeguarding referral for the child would not have required consent.

16.7.8. From April 2023, LDASS have been offering support to children and young people exposed to domestic abuse. However, LDASS could only offer this support if the adult victim was open to engaging with the LDASS service, and a referral for the child required the consent of the adult victim. So, where both parents are known to not be the perpetrators, if consent is granted by the victim, we can consider suitability. In Child A's case this could have been offered with consent of Kamila however in order to facilitate they would have also needed to have had spoken to Leon and for this consent was not had. In hindsight, the social worker could have been asked to speak to Leon and gain consent to contact him as he would need to be included because Child A resided with Leon.

16.7.9. Since the period of the review, the LDASS children and young person's support has become more embedded in the local offer, and there are now often discussions at MARACs about the appropriateness of the service for the children of victims being heard at MARAC.

17. Good Practice

17.1. In December 2019, following the report to NSPCC by Ms Y, and subsequent referral to CSC, the social worker spoke to Sean. Addressing the issues directly with Sean was good practice.

17.2. During both interventions it is positive that the same social worker was able to be allocated. This is positive as this prevents the family history being re-told or having to be understood and meant the social worker was already aware of the family history from previous involvement and was a familiar person to the family. Whilst

this cannot be guaranteed in all cases, this is a positive practice when it does happen.

17.3. During the review process, Leon reflected on the positive support he and Child A received from the social worker. Child A mentioned in an earlier section above, the same social worker should be commended for her proactive and tenacious approach to engaging Kamila after Child A no longer lived with her.

17.4. LDASS IDVA service has two specialists Polish IDVAs in the team, one of which was allocated to Kamila. As described in earlier sections of the report, Kamila's culture may have impacted her understanding of domestic abuse, mental health and her ability to engage with services. The availability of the Polish IDVA may have reduced these barriers once Kamila engaged with the service following Sean's death.

18. Conclusions

18.1. The review identified Sean's coercive and controlling behaviour, which was the central context for understanding the risks faced by Kamila, Sean and Child A. However coercive control was not consistently recognised as a pattern of behaviour, particularly where it presented through Kamila's isolation, his surveillance of Kamila, the enforced dependency upon Sean, his threats of self-harm, the changes to Kamila's physical presentation, and both parties' mental health deterioration. For practice, this means professionals should look beyond individual incidents and consider cumulative patterns, changes in the behaviour of victims, and the wider impact of abuse on a victims' autonomy, and overall wellbeing.

18.2. A further area of learning relates to professional curiosity. There were repeated opportunities across health, mental health, education, ambulance service, police, probation, domestic abuse and children's services to explore what was happening within the relationship. This was particularly relevant, when Kamila presented to professionals with low mood, self-harming behaviours, seemingly "choosing" Sean over Child A, leading to loss of contact with Child A, having no access to her own phone, feeling fearful of being away from Sean, and comments made which should have pointed to coercive control. The implication of this for practice is that practitioners should be confident and supported to ask direct, sensitive questions about domestic abuse and coercive control, especially when mental health concerns and suicide attempts, of both parties, are evident.

18.3. The application of the homicide and suicide timelines highlights the importance of recognising escalation, perceived loss of control, threats of suicide from the abuser, and rapid changes in thinking or behaviour as significant risk indicators. In practice, agencies should ensure that suicide risk is assessed in the context of domestic abuse where relevant, and that threats or acts of self-harm by a perpetrator are considered as potential tools of coercion as well as indicators of risk to self and others.

18.4. The review also reinforces the need for a Think Family approach. Sean's behaviour affected not only Kamila, but also Child A and Leon, who experienced fear, distress, family disrupted contact and feeling a responsibility for managing risks they could not control. Children should be recognised as direct victims of domestic abuse, and risk assessment and safety planning should include all affected family members, including those living outside of the household. Cultural context, language and isolation from family networks should also be considered when assessing need and planning support.

18.5. Overall, the implications for practice are that agencies should improve recognition of coercive control, strengthen information sharing, robustly record and connect concerns over time, and ensure that domestic abuse expertise informs assessments involving mental health, substance use and suicide risk. Effective practice requires professionals to create safe opportunities for disclosure, whilst understanding the impact of coercion on decision making. Subsequently, interventions should be planned, which increase space for action for victims and their children.

19. Lessons to be Learnt

19.1. The review highlighted various barriers victims face when attempting to end a relationship with an abuser, and also barriers they face in accessing services. Practitioners must be aware that ultimately, the abusive behaviour of the perpetrator forms a barrier for victims accessing support and also attempting to end a relationship. There are often other barriers, which intersect and strengthen one another, however it must be highlighted that all victims of abuse face the universal barrier to support, which is the abusive, coercive and controlling behaviour.

19.2. In Sean's case, he used his mental health to control Kamila. She was afraid to leave him, or even leave the home, because she feared that Sean would self-harm or attempt to take his own life. Sean isolated Kamila in this way, and in other ways; for example, his violent and aggressive behaviour led her to be isolated from Child A, as it was unsafe for Child A to be near Sean.

19.3. A further barrier to engagement for Kamila may have been her Polish culture. It is not clear from the information gathered for the review that this was the case, however it is clear that this was not explored with her by any practitioners. It is important that professionals do not assume that because an individual speaks fluent English and has been living in the UK for some years, that their native culture doesn't continue to shape their views and understanding of the world. Practitioners should be mindful of cultural competency and seek to access information and training to support them with this.

19.4. A Culture and Faith learning bulletin, which was created following learning from a previous statutory review,[47] has recently been shared across the multiagency by the Safer Lincolnshire Partnership. The panel recommend that this bulletin be reshared across the partnership, alongside Kamila's story.

19.5. Consideration by all professionals, across all agencies, should be given to working creatively in order to engage victims of domestic abuse in a range of ways, which will allow the breaking down of barriers, and the building of trust over time.

19.6. Since the review's scoping period, Op Komoran has been introduced by Lincolnshire Police. This is a pathway for professionals to report non-urgent crimes for cases that are heard, or due to be heard at MARAC. This allows professionals to share information, which builds a picture of the circumstances, without making a formal report which may lead to a breakdown of trust between the professional and the victim.

19.7. Learning was also identified in this review regarding the identification and assessment of risks, across and between whole family systems. In Kamila's case, she was at risk from herself, and from Sean; Sean was at risk from himself; and Child A and Leon were at risk from Sean. These risks intersected and exacerbated one another in certain circumstances, for example when Child A was spending time with Kamila when Sean was present, or when Sean was intoxicated and self-harming due to Kamila leaving the property.

19.8. Agencies have been developing their approaches to a Think Family model. For example, the LPFT Safeguarding Hub contains details in relation to the concept of Think Family, as does the LPFT Safeguarding Policy 11. All LPFT Children and Young People/Domestic Abuse training packages reiterate the need for children and young people to be given due consideration in any situation where safeguarding concerns are present or have arisen.

19.9. In June 2024, the Lincolnshire Family Justice Board Conference was held. The conference had the focus of domestic abuse, and with permission of the family, a local statutory review[48] was included as a case study example of the importance of agency checks for adult family members during CSC interventions, to form whole family assessments.

19.10. A further area of learning linked to the identification of suicide risks, is the need for practitioners to take a contextual view of identifying risks of suicide. Any type of risk is fluid, and this includes suicide risk. The National Suicide Prevention Strategy[49] indicates that previous attempts, self-harming incidents, and bereavement from suicide are indicators of current suicide risk. Kamila's risk of suicide undoubtedly increased following Sean's suicide, and indeed in hindsight the LDASS panel members reflected that Kamila's presentation and outlook

[47] DHR Overview Report-Natalia
[48] A Combined Local Child Safeguarding Practice and Domestic Homicide Review
[49] Suicide Prevention Strategy

rapidly shifted following Sean's death; however there appeared to be little to no recognition of the time being a period of high suicide risk.

19.11. A recently published report[50] highlighted that in 2023 more victims of domestic abuse died by suicide than were murdered by their intimate partner and hypothesised that around 1800 domestic abuse related suicides were happening each year.

19.12. In April 2025, NHS England published guidance entitled "Staying Safe from Suicide"[51] which introduces a shift from traditional risk prediction tools to a more holistic, person-centred approach. The guidance encourages professionals to gain an understanding of each individual's situation and manage their safety through therapeutic engagement.

19.13. Since June 2025 the DASH assessment tool has been updated to include an enhanced question about suicide risk. This has been shared across all agencies, alongside guidance on its use. All DASH documents are available to professionals[52].

19.14. Lincolnshire County Council have also developed a Suicide Toolkit. This is a multifaceted toolkit to support professionals in identifying and responding to suicidal ideation. It includes contextual guidance, which is aligned to NHS England guidance, along with helplines and best practice for sensitive engagement. The toolkit will become a live document by the end of 2025. Upon publication, the Suicide Prevention Toolkit will be available on the professionals' resources link and will also be linked to the guidance for the updated DASH.

19.15. Early learning from the review has been shared with GP Practice A staff. Following this review, GP Practice A identified a need for additional training and guidance on professional curiosity, particularly for patients who had recently attempted suicide and were requesting multiple repeat medical certificates. The Practice have highlighted that patients who present in this way should be seen face to face, and practice staff should be empowered to ask for reasons for repeat medical certificates.

19.16. Since the scoping period of the review, all MARAC updates received by GP Practice A are discussed at practice safeguarding meetings.

19.17. Following learning from this review, UHLT identified the need for their domestic abuse policy to include the links between domestic abuse and mental ill health. This was updated in May 2025.

19.18. LPFT have identified learning for the Mental Health Liaison Service and CRHT around the completion of DASH assessments when they see patients in Accident and Emergency Departments. There were no DASH assessments completed

[50] The person most likely to kill a victim of domestic abuse is themselves

[51] NHS England » Staying safe from suicide

[52] DASH Resources - Professional Resources

when Kamila was seen by these services in the hospital. LPFT identified the need for more professional curiosity, to gain further knowledge around domestic abuse, and the need for safety planning with potential victims of domestic abuse.

19.19. The LPFT safeguarding team will be delivering DASH workshops with CRHT staff to help develop their knowledge and encourage the use of professional curiosity. LPFT's safeguarding training has been developed to include a greater focus on domestic abuse and completing DASH's.

19.20. LDASS have recently funded external training which enhances the identification of suicide warning signs to inform risk management strategies to support domestic abuse victims who have suicidal ideation. All LDASS staff have attended this training. LDASS have also introduced a suicide policy to ensure staff are aware of how to manage both practical and emotional wellbeing of the victims they are supporting.

19.21. The review has highlighted learning regarding the DVDS process; however, the process has substantially changed since the scoping period of the review which includes an online platform. This process has been rolled out nationally across all police forces.

19.22. Since the scoping period of the review, LDASS have been contracted to deliver a refuge provision with additional units, and through a model that improves the response to victims who may not be suited to residing in a multiple occupancy space. The model includes a specialist refuge IDVA to support victims with additional complexities, which may usually act as a barrier to accessing a general needs refuge.

19.23. When reviewed for this DARDR, some of the ASC records should have given further clarity regarding which organisations and agencies had been liaised with, and the information that had been received, or sent. This learning has led to recording guidance being reviewed, updated and embedded into practice.

19.24. The Town Council A Housing Team continues to have a Domestic Abuse Lead within the team; however, this funding has only been extended for a further year, and the role is therefore unstable. The panel considered that longer term funding and the development of the position into a caseload holding role, would enhance the offer available to victims who present at Town Council A as homeless and fleeing domestic abuse.

19.25. In July 2024, CSC signed up to be part of the launch of locality based Multi-Agency Child Protection Teams (MACPT) - through the Families First for Children Pathfinder Programme. A key element of this development was the establishment of a standalone Independent Child Protection Chair post in each locality. This change enables Independent Child Protection Chair's to focus solely on child protection.

19.26. CSC have identified that children living in homes where domestic abuse is a regular occurrence are significantly underrepresented in the number of children

being heard at Child Protection Conferences, because they are captured within the category of neglect. Lincolnshire CSC have raised the need for a standalone domestic abuse category, with the DfE, as this would reflect more accurate reporting of risk, and reason for the child protection plan. In the meantime, Independent Child Protection Chair's will support and facilitate discussions in each conference regarding the categories as part of the multi-agency decision making forum.

19.27. GP Practice A identified the need for their staff to reflect children as victims of domestic abuse in their own right. The Practice's Lead Safeguarding GP will undertake additional training to this end and will be attending safeguarding forums which occur three times per year.

19.28. Secondary School B have developed their policies and general understanding across their staff teams regarding the identification of domestic abuse, and of children as victims of domestic abuse. The Designated Safeguarding Leads, and their Deputies have attended training on the voice of the child when considering safeguarding concerns, and the use of consultations offered by Lincolnshire CSC.

19.29. Since July 2024, Primary School A have included a mandatory requirement for all staff to undertake LSCP "Children Who Experience Domestic Abuse" training on a bi-annual basis. All members of the safeguarding team must also complete the Key Adult Briefing Trainings from Operation Encompass.

19.30. The availability, and criteria of the Children and Young Person IDVA service, delivered by LDASS, should be reshared across multiagency services.

19.31. The EMAS safeguarding brochure for frontline crews has been updated to include guidance on recording details of perpetrators wherever possible. The updated brochure is scheduled for launch in April 2026 and will be made available to all frontline crews.

19.32. EMAS - As part of the three-year blended education programme, the forthcoming safeguarding brochure for frontline crews will incorporate guidance on recording perpetrator details wherever feasible. The updated brochure is scheduled for dissemination on 1st April 2026 and will be made available to all frontline crews.

19. Recommendations

19.1. East and West Lincolnshire Probation Service should link in with regional and national quality development units, and their Quality Assurance exercises to ensure that Probation Practitioners are completing high quality and timely reviews of OASys. Senior Probation Officer should have oversight of this.

19.2. East and West Lincolnshire Probation Service hold accountability meetings with the local team managers, and the regional case assurance tool should contain a specific focus on enforcement activity and responses to missed appointments, in line with policy.

19.3. Specific activities should continue to be rolled out in East and West Lincolnshire Probation Service team “protected learning days” - on professional curiosity and domestic abuse - with the completion of these being monitored by head of service/deputy head of service. The impact of these should be monitored through continued completion of the case assurance exercises.

19.4. This DARDR will be discussed with clinical and non-clinical staff at GP Practice A. Non-clinical staff will be asked to access some additional training. GP receptionist and admin staff who don’t have the same level of safeguarding training as clinicians but are often the first contact point, need to complete the controlling and coercive behaviours online training through LSAB. This will be rolled out and completed within the coming 6 months.

19.5. To discuss with GP partners regarding putting a reminder on system to advise the number of sick notes issued and prompt for face-to-face review with the patient. Having discussed with partners initially, it was decided if a patient has requested multiple sick notes, it should raise professional curiosity to review the number of sick notes, if the person has not been seen, invite them in for a face-to-face review. This will be reviewed via Audit in 6 months’ time.

19.6. ASC will circulate a short briefing to the Safeguarding Team which focuses on the updates of the recording guidance with particular focus on the recording of referrals and multiagency involvement.

19.7. A recently published DHR in Lincolnshire, which pertained to the death of a local Polish woman, highlighted learning cultural expectations and the cultural competency of professionals. The panel recommend that the learning briefing from DHR Natalia[53] be shared alongside learning from DHR Kamila, in order to highlight the need for professionals to understand how culture impacts decision making and engagement with services.

[53] DHR Overview Report-Natalia