Domestic Homicide Review

Overview Report

'Kamile'

Died June 2020

Chair: Carol Elwood-Clarke

Author: Ged McManus

Date: 12 July 2022

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1 Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Kamile[1] and her child, Leja[2], who were residents of Lincolnshire prior to her death. The panel would like to offer their condolences to Kamile's family on their tragic loss.

1.2 Kamile was a Lithuanian national who had lived in the United Kingdom for over 10 years. Kamile was divorced and her former husband is the father of her child. Kamile had reported domestic abuse in the relationship with her former husband. She had been in a relationship with her partner, Ruben[3], since January 2020. Ruben was a South African national who had lived in the United Kingdom for 14 years.

1.3 In June 2020, Kamile and Leja attended a barbecue in the garden of a shared house which was rented by Ruben and two friends. During the evening, Leja was picked up by her father: Kamile stayed at the house. She often stayed over since forming a relationship with Ruben around January 2020, and it is thought that she had, in effect, been living at the house for about a month. The last guests left at about 1.30 am, leaving Kamile, Ruben and the two housemates at the house.

1.4 At about 5.30 am, Ruben's housemates got up for work and on doing so found him hanging from the banister of the stairs in the house. They attempted CPR, whilst calling the police and ambulance service, but Ruben was pronounced dead at the scene by a paramedic. Police officers searched the house and found Kamile deceased. She had facial injuries, reddening to her neck, and appeared to have been beaten. A post-mortem examination concluded that the cause of Kamile's death was application of pressure to the neck.

1.5 The subsequent police investigation concluded that Kamile had been murdered by Ruben: he had then taken his own life.

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

[1] A pseudonym chosen by the DHR panel.
[2] A pseudonym chosen by the DHR panel.
[3] A pseudonym chosen by the DHR panel.

1.7 The review will consider agencies' contact and involvement with Kamile, Leja and Ruben from 1 January 2018 to Kamile and Ruben's deaths in June 2020. This period was chosen because it encompassed incidents which the panel felt may be relevant to the review – although it is thought that Kamile and Ruben's relationship did not start until early 2020.

1.8 The intention of the review is to ensure agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide, violence and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.9 **Note:**
It is not the purpose of this DHR to enquire into how Kamile and Ruben died. That is a matter that has already been examined by the police investigation and during an inquest held by the Lincolnshire coroner. [see paragraph 10.1 for inquest details].

2 Timescales

2.1 The review began on 18 January 2021 and was concluded on 27 May 2022, following final consultation with the panel. See paragraph 5 for further information.

3 Confidentiality

3.1 The findings of each review are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family, including their support worker, during the review process.

3.2 Pseudonym's were chosen by the panel from a list of popular names relevant to the subjects' country of origin, and have been used to protect the identity of all the subjects of the review. This option was chosen as the panel was unable to engage the victim's family in the review.

4 Terms of Reference

4.1 The Panel settled on the following Terms of Reference at its first meeting on 19 January 2021.

4.2 The purpose of a DHR is to:

Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

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

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

Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice.

(Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7)

4.3 Timeframe under Review

The DHR covers the period 1 January 2018 to Kamile and Ruben's deaths in June 2020.

4.4 Case Specific Terms

Subjects of the DHR

Victim: Kamile, aged 30

Victim's child: Leja, primary school age

Perpetrator: Ruben, aged 34

Ruben's children: Child 1, secondary school age

Child 2, primary school age

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour,[4] did your agency identify for Kamile?

2. What knowledge did your agency have that indicated Ruben might be a perpetrator of domestic abuse, and what was the response? Did that knowledge identify any controlling or coercive behaviour?

3. How did your agency assess the level of risk faced by Kamile, and any children of current or previous partners from Ruben? In determining the risk, which risk assessment model did you use, and what was your agency's response to the identified at risk?

4. What services did your agency provide for the subjects of this review; were they timely, proportionate and of an acceptable level in relation to the identified levels of risk?

5. What did your agency do to safeguard any children exposed to domestic abuse?

6. What was your agency's response to the lived experiences of the children? Did that include an understanding of how their lived experiences impacted on their emotional and physical development?

7. Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?

8. Were single and multi-agency policies and procedures, including the MARAC[5], followed; were the procedures embedded in practice and were any gaps identified?

9. Were there any issues in relation to capacity or resources in your agency that affected its ability to provide services to the subjects of this review, or on your agency's ability to work effectively with other agencies? N.B. Please also

[4] The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).
[5] MARAC is a multi-agency meeting which facilitates the risk assessment process for individuals and their families who are at risk of domestic violence and abuse. Organisations are invited to share information with a view to identifying those at "very high" risk of domestic violence and abuse. Where very high risk has been identified, a multi-agency action plan is developed to support all those at risk.

consider any additional capacity/resource issues with agency contact during the Covid-19 pandemic.

10. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the subjects of this review?

11. Were there any examples of outstanding or innovative practice?

12. What learning did your agency identify?

13. Do the lessons arising from this review appear in other reviews held by this Safer Lincolnshire Partnership?

14. Has any relevant practice changed since the events under review?

5 Methodology

5.1 Following the death of Kamile and Ruben, a formal notification was sent by Lincolnshire Police to the Safer Lincolnshire Partnership on 3 July 2020. A meeting of the DHR decision panel, on 29 July 2020, confirmed that the case met the DHR criteria and the Home Office was informed.

5.2 In October 2020, Carol Ellwood-Clarke and Ged McManus were appointed as Chair and Author, respectively.

5.3 The review began in January 2021 after delays due to restrictions in place as a result of the coronavirus. The first meeting of the DHR panel determined the period the review would cover. The review panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce Independent Management Reviews (IMRs).

5.4 Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made. The written material produced was distributed to panel members and used to inform their deliberations. During these deliberations, additional queries were identified and auxiliary information sought.

5.5 Thereafter, a draft Overview Report was produced which was discussed and refined at panel meetings before being agreed.

5.6 The panel met six times by video conference, with further work being conducted by telephone, video conferencing and the exchange of documents.

6 Involvement of Family, Friends, Work Colleagues and Wider Community

6.1 Kamile's parents

6.1.1 Kamile's parents live in Lithuania and do not speak English. Her former husband was used by police as an intermediary to facilitate communication. They indicated through Kamile's former husband that they did not wish to contribute to the DHR as they now wished to try and put their terrible experience behind them.

6.1.2 The DHR enquired with the Lincolnshire coroner as to how the inquest had been conducted and was told that communication had been facilitated by Kamile's former husband.

6.1.3 The DHR panel was uncomfortable relying solely on Kamile's former husband for communication with her parents. The Chair obtained a verified email address for Kamile's mother from the police and sent a letter and appropriate Home Office explanatory leaflets (translated into Lithuanian) by email. The letter invited Kamile's parents to make contact with the Chair. At the time of closure of the DHR process, no contact had been received.

6.1.4 The Chair also spoke with the Police Family Liaison Officer who confirmed that the DHR process had been discussed with the family during the course of the police investigation and inquest. Towards the end of the process, a further communication was sent to Kamile's parents updating them and giving a further opportunity to contribute. They did not reply. The panel decided that the next communication with the family should be prior to publication.

6.2 Kamile's former husband

6.2.1 The Chair of the review was introduced to Kamile's former husband by the Police Family Liaison Officer. He agreed to contribute to the review. Kamile's former husband described their relationship as a roller coaster of a relationship that had its good days and bad days. Good days involved laughter, love and holidays. He stated that this was really good. Bad days he described as arguing and fighting between them. They tried to resolve their differences by separating on more than one occasion and then getting married to try and make things work, but ultimately that was unsuccessful.

6.2.2 Kamile's former husband did not really know Ruben. He had seen him around town and had heard rumours that he was violent towards women, but he described this as just rumours.

6.2.3 He stated that their child Leja is doing really well at school. They are being supported by a specialist charity and have literature that he uses to help Leja understand their mother's death. He would not consent to Leja speaking to anyone, including a specialist advocate, about her experiences in order to contribute to the DHR.

6.2.4 Kamile's former husband's narrative was not challenged. The panel acknowledged that these were his views of his relationship with Kamile and felt it appropriate for them to be reported. The panel also noted that Kamile had reported domestic abuse from her husband, and that her voice could not now be heard. The panel do not endorse the views and interpretation of Kamile's former husband's description of their relationship.

6.3 Friends

6.3.1 During the police investigation into her murder, the police spoke to people who had attended the barbecue with Kamile and Ruben. The Chair of the DHR wrote to the friends inviting them to contribute to the review and enclosing appropriate Home office leaflets. No response was received. The panel thought it was particularly important to speak to friend one, if possible, and therefore a further approach was made via the Police Family Liaison Officer. Although she gave permission for her contact details to be given to the Chair, she did not reply to any further communication.

6.3.2 The following information contained in a statement made by Friend 1 was disclosed by the police for the purpose of the DHR.

This friend said Kamile met Ruben through her as she and Ruben used to work together. She had been best friends with Kamile for a couple of years.

She was invited to the barbecue by Kamile and said that things became a little emotional at one point when Kamile became upset and said that her and Ruben were going to break up soon anyway. When asked why, Kamile informed her that Ruben would text other women when they had even the smallest relationship issues, trying to make her jealous.

Friend 1 stayed at the barbecue until 1.30 am. As she left, she was laughing with Kamile and made arrangements to see her the next day.

Friend 1 said that Ruben did not like Kamile to be alone and was jealous. Kamile had told her that he had previously smashed her laptop and mobile. When asked why, Kamile told her that Ruben had been taking ecstasy which caused him to become jealous and angry: he would then text other women. Kamile had said to Ruben that if he texted other women then she would text other men: this had led him to throw her laptop out the window. On another occasion, Leja had a cut on their foot which Kamile said was caused by standing on a perfume bottle that belonged to Kamile and had been smashed by Ruben. Friend 1 said that she avoided going to Ruben's house due to how he was, and said she had seen a number of occasions in the preceding two weeks prior to the murder which were indicative of domestic abuse within Kamile and Ruben's relationship. Examples include:

Kamile started to use the app 'Viber' in order to communicate with her ex-husband: as Ruben did not like her having contact with him. This was because Ruben did not know about the Viber app.

Ruben wouldn't allow Kamile to speak in Lithuanian to her friends or be alone with them. He insisted that they spoke in English so that he understood what was being said. Kamile's friend thought that this was controlling and prevented Kamile confiding in her.

Ruben would only allow Kamile to visit her old home to see Leja for a few minutes, as he was jealous of Kamile seeing her former husband.

6.3.3 **Friend 2**

Friend 2 was also friends with Ruben's former partner (Partner 3) and was aware of domestic abuse in that relationship. She describes the relationship between Kamile and Ruben as difficult owing to Ruben liking a lot of girlfriends. This friend said that she had seen Ruben with a black eye which he said Kamile had caused.

6.3.4 **Ruben's housemates**

Ruben shared the house with two other men. They were both present at the barbecue and found Ruben's body the next day. Both confirmed that Kamile spent a lot of time at the house but did not disclose any domestic abuse. One of them said that about a week prior to his death, Ruben disclosed that Kamile had hit him.

6.4 **Employers**

6.4.1 Ruben was a factory worker and had worked for the same employer since 2017. He complained to his GP of stress at work and that he felt untrained for his role

as a supervisor. On 3 February 2020, Ruben was dismissed from his job following a series of conduct issues centred on attendance and breach of protocols – these had taken place throughout 2019. He was paid three months' pay in lieu of notice and was not required to work any further. He was not known to be working at the time of his death.

6.4.2 The Chair of the review contacted Ruben's employer to invite them to contribute to the review. Through their Human Resources department, the employer indicated that they were unable to provide anything but basic employment details, which were already known to the review.

6.4.3 Kamile was also a factory worker for a different employer. In January 2020, she was unable to work due to back pain and told her GP that her work as a quality controller was hard, physically. The factory where Kamile worked was closed down in September 2020, before the start of the review, and it has not been possible to engage with Kamile's employer.

6.5 Property

6.5.1 The agent responsible for letting a property to Ruben was spoken to by the Chair of the review but was unable to provide further information than had already been provided to the police. This is outlined at paragraph 14.1.9.

6.6 Wider Community

6.6.1 The DHR panel was keen to ensure that they consulted with people with knowledge of the Lithuanian community in Lincolnshire. Two professionals were identified who were able to assist the panel.

6.6.2 A member of police staff of Lithuanian nationality was identified and agreed to assist the panel with her knowledge of Lithuanian culture. She has current links with, and knowledge of, Lithuania and had recently returned from a visit to the country.

6.6.3 She told the Chair and Author of the report that Lithuanian families generally were keen to present a picture of happy family to the outside world, whatever their problems. She related this to the country's occupation by Russian forces when families did not want to engage with the authorities. She said it was common for females in Lithuania to accept domestic abuse as part of their life. One of the factors in this is that the Lithuanian authorities are said to intervene quickly to remove children where domestic abuse is suspected, and women fear losing their children.

6.6.4 She also told the Chair and Author of the report that there are additional factors in relation to Lithuanian women living in the UK. Some women will contact the police in crisis but then withdraw their cooperation in the days afterwards. Factors here may include that they lack money, childcare, and other support. Combined with a difficulty in dealing with official agencies when English is not their first language, Lithuanian women suffering from domestic abuse may feel isolated and as a result quickly rekindle their relationship. In general, there was thought to be a lack of knowledge in the local Lithuanian community about how agencies would respond to domestic abuse: fears about children being taken away are based on Lithuanian rather than UK experiences.

6.7 Academic research

6.7.1 The Chair and Author of the review were able to speak with a researcher who is engaged on a project funded by Lincoln university and EdanLincs. The aim of the project is primarily to research domestic abuse within the Polish community living in the UK, with a focus on investigating the barriers to women seeking help for domestic abuse. Whilst focussed on the Polish community, the research also covers Lithuanian and Bulgarian communities. The research project was not completed at the time the Chair of the review spoke to the researcher (September 2021) and will not be finalised until Summer 2022.

6.7.2 Emerging findings of the cited academic research

6.7.3 There is low awareness in the community of what constitutes domestic abuse. There is a tendency for situations to become really serious before a report is made.

There is a culture of families staying together whatever their situation. This is especially so when there are children in the relationship. This can result in the wider family not being supportive of a woman who wants to leave a relationship. Consequently, women can feel very isolated.

Women who do not speak English well tend not to report domestic abuse and try to cope with the situation on their own.

Attitudes towards the police are tainted due to the experience of policing and the background of former communist countries where the police were seen as part of the state machine and not an organisation there to help people.

There is a fear that children will be taken away if domestic abuse is reported.

There can be a clash of cultures in terms of expectations and behaviour when a woman from Poland/ Lithuania/ Bulgaria forms a relationship with a man from a different cultural background.

Women can be distrustful of their own local community.

6.7.4 Prior to the publication of this DHR the research was published and a reference is included here[6]

[6] Zielinska, I., Anitha, S., Rasell, M. and Kane, R. (2022) Polish women's experiences of domestic violence and abuse in the UK. Interim research report. Lincoln: EDAN Lincs and University of Lincoln.

7 Contributors to the Review/ Agencies submitting IMRs[7]

7.1	**Agency**	**Contribution**
	Lincolnshire Police	IMR
	Lincolnshire County Council Children's Services	IMR
	Humberside, Lincolnshire and North Yorkshire Community Rehabilitation Company	IMR
	Ruben's GP practice	IMR
	Kamile's GP	Brief information
	Department for Work and Pensions	Brief information
	South Holland District Council	IMR
	East Midlands Ambulance service	Chronology
	Other Agencies Contacted	
	Lincolnshire Fire and Rescue Service	No relevant information held
	Lincolnshire County Council Adult Services	No relevant information held
	ULHT	No relevant information held
	Out of area services contacted in relation to Ruben's children who now live out of area	No relevant information held

7.2 As well as the IMRs, each agency provided a chronology of interaction with the subjects of the review, including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR) and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion on their own

[7] Individual Management Reviews (IMRs) are detailed written reports from agencies on their involvement with Kamile, Leja and Ruben.

agency's involvement and to make recommendations where appropriate. Each IMR author had no previous knowledge of the subjects of the review nor had any involvement in the provision of services to them.

7.3 The IMR should include a comprehensive chronology that charts the involvement of the agency with the victim and perpetrator over the period of time set out in the 'Terms of Reference' for the review. It should summarise: the events that occurred; intelligence and information known to the agency; the decisions reached; the services offered and provided to the subjects of the review; and, any other action taken.

7.4 It should also provide: an analysis of events that occurred; the decisions made; and, the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened, but why.

7.5 The IMRs in this case were of good quality and focussed on the issues facing the subjects of the review. They were quality assured by the Author, the respective agency, and by the Panel Chair. In addition, the panel's legal advisor carried out a quality audit of all IMRs. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation.

7.6 **Information in relation to agencies contributing to the review**

7.7 **Lincolnshire County Council Children's Services**

Lincolnshire County Council Children's Services Department provides both universal and targeted services to 142,000 children and their families across the county. The services provided to children are governed by a raft of legislation and regulatory requirements. The statutory framework is wide-ranging and includes services to protect children from harm, and to identify and respond to children who are in need.

The authority also provides Health Visiting and Children and Young Peoples Nurse (CYPN) services, following transition from LCHS to Children's Services on 1 October 2017.

South Holland District Council

South Holland is a rural district in the south of Lincolnshire, bordering Peterborough in Cambridgeshire and King's Lynn in Norfolk. South Holland District Council is 1 of 7 districts in Lincolnshire and serves a population of approximately 95,000 residents. District councils provide a wide range of services to residents including housing, collection of waste and recycling, planning, leisure, culture, licensing, environmental health, business support and benefits. Some of the services are provided by Public Sector Partnership Services Ltd, these include customer services, ICT and revenues and benefits. Public Sector Partnership Services Ltd also provided these services to East Lindsey District Council at the time of this incident.

East Midlands Ambulance Service

East Midlands Ambulance Service NHS trust (EMAS) employs over 2915 staff over 65 sites, and respond to 786,744 emergency calls every year. EMAS covers an area of approximately 6,425 square miles across 6 counties: Nottinghamshire, Derbyshire, Leicestershire and Rutland, Lincolnshire and Northamptonshire.

Lincolnshire Police

In terms of geographic area, Lincolnshire Police is one of the largest forces in the United Kingdom, covering 2,284 square miles – the current population of the force area is approximately 757,000.

The force consists of three operational commands, each led by a Chief Superintendent. Two of the commands are territorial, East and West, which are made up of four Districts, each led by a Chief Inspector, and there are eleven Neighbourhood Policing Areas each led by an Inspector. It is operational officers from within the Neighbourhood Policing Areas who initially respond to and investigate incidents, including incidents of domestic abuse.

The third command is the Crime Department which has responsibility for central specialist services including the Crime and Criminal Justice, the force's intelligence functions, and the Protecting Vulnerable Person's (PVP) unit. The PVP unit includes specialist investigative and safeguarding teams and the PVP Police Safeguarding Hub (PVP–PSH), which is the force's single point of contact for all child and adult protection referrals.

Under collaborative arrangements with other forces in the East Midlands, all homicide investigations are now undertaken by the East Midlands Special Operations Unit, Major Crime (EMSOU MC), and an SIO from that unit will be

appointed to lead the enquiry. However, the early stages of such a crime are initially responded to and managed by local officers.

Humberside, Lincolnshire, and North Yorkshire (HLNY) Community Rehabilitation Company (CRC) [Now amalgamated into the Probation Service]

HLNY CRC was a criminal justice organisation and provider of Probation Services across the geographical areas of Humberside, Lincolnshire and North Yorkshire. CRCs were introduced by 'Transforming Rehabilitation – A Strategy for Reform' in 2013, whereby probation service contracts were awarded to private providers to deliver specific aspects of probation services. CRCs manage service users who have been convicted by the courts and sentenced to either a custodial or community disposal and who have been assessed by the National Probation Service as posing a Low or Medium risk of causing Serious Harm to others. Each service user is allocated a Case Manager who is responsible for discharging the requirements of the sentence, assessing risk, planning and delivering interventions (including face-to-face supervision), and implementing clearly defined procedures in the event of non-compliance. Although the Case Manager has flexibility to determine the most effective way to discharge these responsibilities, processes and policies exist to ensure the timeliness and quality of interventions measured through regular management reporting and minimum standards of oversight.

Note: From June 2021, CRCs and National Probation Service were amalgamated into a single unified service called the Probation Service. The Probation Service was represented on the DHR panel and arrangements are in place within the Probation Service to take forward learning identified from the review.

8 The Review Panel Members

Carol Ellwood-Clarke	Independent Chair
Ged McManus	Independent Support to Chair and Report Author
Tony Mansfield	Lincolnshire Partnership Foundation Trust
Gemma Cross	Lincolnshire Community Health Services
Claire Tozer	Safeguarding Adult and Children Lead, Lincolnshire CCGs [now NHS Lincolnshire ICB]
Claire Saggiorato	Lead Nurse, Safeguarding Lincolnshire County Council
Rachel Freeman	Head of service LCC Children's Services
Matthew Morrissey [meeting 1&2]	HLNY CRC
Becky Bailey [meeting 3 onwards]	Probation Service, Head of Probation delivery unit, East and West Lincolnshire
Lucy Gascoigne	East Midlands Ambulance Service
Dee Bedford / Emily Holmes	South Holland District Council
Jane Keenlyside	EDAN Lincs
Karen Ratcliff	We Are With You
Jade Thursby	Domestic Abuse Lead, Lincolnshire County Council
Sarah Norburn	Lincolnshire Police
Legal Advisor to Panel	
Toni Geraghty	Legal Services, Lincolnshire
DHR Adminstration	
Teresa Tennant	Business Support, Lincolnshire County Council

8.1 The Chair of the Safer Lincolnshire Partnership was satisfied that the Panel Chair and Author were independent. In turn, the Panel Chair believed there was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report. Panel members had not previously been involved with the subjects or line management of those who had.

9 Author and Chair of the Overview Report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016, sets out the requirements for review Chairs and Authors. In this case, the Chair and Author were separate people.

9.2 Carol Ellwood-Clarke was chosen as the Chair of the review. She retired from public service (British policing – not Lincolnshire) in 2018, after thirty years, during which she gained experience of writing Independent Management Reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives.

9.3 Ged McManus was chosen as Author of the review. He is an independent practitioner who has chaired and written previous DHRs and other reviews. He has experience as an Independent Chair of a Safeguarding Adult Board (not in Lincolnshire) and was judged to have the skills and experience for the role. He served for over thirty years in different police services in England (not Lincolnshire). Prior to leaving the police service in 2016, he was a Superintendent with particular responsibility for partnerships including Community Safety Partnership and Safeguarding Boards.

9.4 Between them, they have undertaken over sixty reviews including the following: Child Serious Case Reviews; Safeguarding Adults Reviews; multi-agency public protection arrangements (MAPPA) serious case reviews; Domestic Homicide Reviews; and, have completed the Home Office online training for undertaking DHRs. They have also completed accredited training for DHR chairs, provided by AAFDA.[8]

9.5 Neither of them has previously worked for any agency involved in this review. Carol Ellwood-Clarke was the author of a previous Lincolnshire DHR.

[8] Advocacy After Fatal Domestic Abuse

10 Parallel Reviews

10.1 Inquests in relation to both Kamile and Ruben were opened and adjourned in July 2020, and concluded in May 2021.

10.2 In relation to Kamile, the record of inquest states that the medical cause of death was: `**Application of pressure to the neck'.**

The circumstances of death are recorded as:

The deceased was murdered by her partner who applied forceful pressure to her neck on [date redacted] that resulted in her death at [address redacted]

The coroner's conclusion as to death was: **'Unlawful killing'.**

10.3 In relation to Ruben, the record of inquest states that the medical cause of death was: **'Hanging'**

The circumstances of death are recorded as:

'The deceased was found suspended by a ligature on [date redacted] at [address redacted] after he had just murdered his partner. The toxicology report showed he had also consumed excessive amounts of alcohol'.

The coroner's conclusion as to death was: **'Suicide'**

10.4 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised; they should remain separate to the DHR process. There is no suggestion that any agency involved in the review has initiated any disciplinary action or internal review.

11 Equality and Diversity

11.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

- **age** [for example an age group would include "over fifties" or twenty-one year olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation

even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So a gay man and a lesbian share a sexual orientation].

11.2 Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if:
(a) P has a physical or mental impairment, and
(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

None of the subjects of the review is known to have had any diagnosed physical or mental impairment which would have defined them as disabled.

11.3 Domestic homicide and domestic abuse in particular, is predominantly a crime affecting women, with women by far making up the majority of victims, and by far the vast majority of perpetrators being male. A detailed breakdown of homicides reveals substantial gender differences. Female victims tend to be killed by partners/ex-partners. For example, in 2018, the Office of National Statistics homicide report stated:

'There were large differences in the victim-suspect relationship between men and women. A third of women were killed by their partner or ex-partner (33%, 63 homicides) in the year ending March 2018. In contrast, only 1% of male victims aged 16 years or over were killed by their partner or ex-partner'.

'Men were most likely to be killed by a stranger, with over one in three (35%, 166 victims) killed by a stranger in the year ending March 2018. Women were less likely to be killed by a stranger (17%, 33 victims)'.

'Among homicide victims, one in four men (25%, 115 men) were killed by friends or social acquaintances, compared with around one in fourteen women (7%, 13 women)'.

11.4 The Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) states that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act.

11.5 It should be noted that although addiction to alcohol, nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Care Act 2014 (care and support) assessment is completed. Neither Kamile or Ruben came to the attention of Adult Social Care during the review period and therefore there was no opportunity for Adult Social Care to consider whether a care and support assessment was appropriate. There has been no indication in the review that either Kamile or Ruben had care and support needs.

11.6 Ruben's previous offending behaviour had often featured excessive alcohol consumption. In 2018, he was sentenced to an order (Alcohol Abstinence Monitoring Requirement) and a requirement not to drink alcohol for 90 days, which meant that he was fitted with alcohol monitoring equipment. There were a number of breaches of the order, but Ruben did achieve a period of abstinence of 77 days. He did not seek help to deal with his excessive alcohol consumption. The toxicology report after his death showed that he had consumed excessive amounts of alcohol.

11.7 Kamile was a Lithuanian national who had lived in the UK for approximately 10 years prior to her murder. Kamile spoke fluent English and had no communication difficulties. As a Lithuanian citizen and a national of the European Economic Area, Kamile was entitled to live in the United Kingdom.

11.8 Ruben was a South African national who came to the UK in 2006 while on a gap year from college. He chose the UK for his gap year as he had a friend in the UK with whom he was planning on going travelling. He remained in the UK and went on to have two children with his ex-partner. (Partner 2).

11.9 On 29 December 2018, Ruben was issued permanent residence in the United Kingdom under the Immigration (European Economic Area) Regulations 2016. The application for permanent residence relied on proof of an ongoing relationship with partner 2. Records show that Ruben produced extensive documentation which satisfied UK Visas and Immigration (part of the Home Office) that his relationship with partner 2 was genuine and ongoing. The DHR has uncovered evidence that this was untrue in that it is clear from information available to the review that Ruben was no longer in a relationship with partner 2 at the time the application was decided, but was in a new relationship with partner 3. The relevance of this is that the test of whether a relationship was enduring under these regulations, was that the relationship had been established for five years and was ongoing. It appears that Ruben may have provided false information to UK Visas and

Immigration for the purposes of his application for permanent residence. UKVI are now aware of this. If this information had become known to UK Visas and Immigration whilst Ruben was alive, then his case would have been referred to the UKVI Status Review Unit. The Status Review Unit could have considered revocation of Ruben's permanent residence.

11.10 UK Visas and Immigration did take into account Ruben's history of convictions for domestic abuse when the decision to grant permanent residence was taken. At the time, the application was considered under the relevant regulations: the threshold for an applicant to be refused was that they had been convicted of a criminal offence and sentenced to a period of 12 months or more in detention. Although Ruben had three convictions for domestic abuse, he had never been sentenced to imprisonment, and his criminal record was not sufficiently serious for the application to be refused under the regulations which derived from European law.

11.11 It should be noted that the Immigration (European Economic Area) Regulations 2016 are no longer in operation, following the withdrawal of the United Kingdom from the European Union.

11.12 Although the regulations under which Ruben's permanent residence was issued are no longer in operation, the panel was aware that many applications for permanent leave to remain and citizenship are considered under other regulations. The panel wished to make clear their thoughts that a person with three domestic abuse convictions against three different women was a potentially dangerous individual, and that this scale of offending should be given thorough consideration in future cases.

This is a learning point which leads to panel recommendation 3.

11.13 Both Kamile and Ruben consulted their GPs for routine medical treatment. Neither of them had a known physical or mental impairment which would have meant they were disabled within the meaning of the Equality Act.

12 Dissemination

Safer Lincolnshire Partnership
All agencies contributing to the review
Lincolnshire Police and Crime Commissioner
Domestic Abuse Commissioner

13 Background, Overview and Chronology

This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information. The narrative is told chronologically. It is built on the lives of Kamile, Ruben and their children, and punctuated by subheadings to aid understanding. The information is drawn from documents provided by agencies and from the police investigation following Kamile's murder and Ruben's suicide. The information in this section is factual: analysis appears at section 14 of the report.

Relevant information prior to the review period

13.1 Kamile

13.1.1 Kamile came to the UK to work (approximately 2010). She initially lived in London before moving to Lincolnshire which is where she met her husband. The couple had Leja together, before Kamile reported domestic abuse in 2013 and 2014. Leja was present during the assault in 2014 and as a result was involved with Children's Services as a Child in Need[9] for a short time. The case was heard at MARAC.

13.1.2 Records show that Kamile married her husband (Leja's father) in August 2016. According to council tax records, Kamile's husband left their home in December 2017 and moved back in April 2019. They divorced in April 2020.

13.2 Ruben

13.2.1 Ruben was a South African national who originally came to the UK in 2006. Further detail of his immigration status is at paragraph 11. Checks with the South

[9] https://www.legislation.gov.uk/ukpga/1989/41/section/17

Section 17 of the Act places a general duty on all local authorities to 'safeguard and promote the welfare of children within their area who are in need.'. A child will be considered in need if:

- they are unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the Local Authority;
- their health or development is likely to be significantly impaired, or further impaired, without the provision of services from the Local Authority;
- they have a disability.

African authorities, after Kamile's death, showed that Ruben had no criminal record in South Africa.

13.2.2 In 2007, Ruben was arrested following an assault on his then partner (Partner 1) when he pushed her to the floor then punched and kicked her to the arms, neck, head and face. He also grabbed her around the throat and squeezed her arms and when she tried to get up; he then pushed her back down causing her to bang her head on a glass table. When interviewed, he made a full admission to the offence and, on the advice of the Crown Prosecution Service, he was given a police caution.

13.2.3 Between 2011 and 2017 there were six domestic abuse incidents involving Ruben as the perpetrator against partner 2, with whom he had two children. The most notable incident was the first of these in 2011, when partner 2 made a 999 call to report that she was upstairs at their address with their 5-month-old baby and that Ruben had hit her in the face and she was very scared. She said that they had been arguing about possibly separating and it escalated. Officers attended and saw that partner 2 had reddening to her face and neck. Ruben was arrested and, when interviewed, he admitted that following an argument, he had grabbed partner 2 by her throat and slapped her face. Ruben was charged with assault. When he appeared at court, he pleaded guilty and was given a conditional discharge for 18 months and ordered to pay costs.

13.3 Relevant information during the review period

13.3.1 There were five domestic abuse incidents reported to the police involving Ruben and his next partner (Partner 3). These occurred between 15 April 2017 and 3 May 2020. The most notable one was the second domestic abuse incident which was reported in the early hours of 5 March 2018: this was the first domestic abuse incident that was reported during the period of this review.

13.3.2 On 5 March 2018, partner 3 called the police on 999. Partner 3 said that Ruben was drunk and crazy, he had hit her, and had put his hands round her throat and tried to kill her. She said that Ruben had gone out the previous evening and got drunk. On returning home he became angry and aggressive, he punched her in the face and tried to strangle her by putting his hands around her neck and applying pressure; however, she managed to fight him off. She added that he had pulled a handle off a wardrobe door and used it to threaten her. He was arrested for assault and threats to kill; however, when interviewed, he made no

comment. The following morning, a witness statement was recorded from partner 3 and, on the advice of the CPS, he was released without charge for the threats to kill allegation but charged with the assault: he was subsequently bailed. A DASH[10] risk assessment was completed and graded as high risk, resulting in a referral to MARAC. A PPN stop abuse child referral form was completed in respect of partner 3's child, with details forwarded to Children's Services. Partner 3 later made a statement withdrawing her support for a prosecution.

13.3.3 On 20 March 2018, Ruben saw a nurse practitioner at his GP surgery. His father had recently died in South Africa: he had only been able to have one day off work and so could not go to the funeral and was worried about his mother in South Africa. He also expressed that he felt stressed and undertrained for his role as a supervisor at a factory. He had separated from his girlfriend the week before. He was tearful and in low mood. He reported that he had poor appetite the last few days and poor sleep. He appeared well presented, had good eye contact and tearful but consoled. He had no thoughts of self-harm or suicide, but felt he needed time off work to grieve. He was given a sick note for 2 weeks, was made aware that it could be extended if required, and of the phased return to work option. The grieving process and bereavement counselling was discussed, and he was advised regarding where he could call for help if things felt worse.

13.3.4 On 25 May 2018, Ruben appeared at court for the assault on Partner 3 and pleaded guilty. He was ordered to pay costs and compensation, and agreed to alcohol abstinence monitoring equipment being fitted (Alcohol Abstinence Monitoring Requirement). He was also given a community order to abstain from drinking for 90 days. The case was allocated to Humberside, Lincolnshire North Yorkshire (HLNY) Community Rehabilitation Company (CRC). Oral report templates are usually saved on to the probation case management system (nDelius). In this case there is no copy of the template uploaded to the system, which is seemingly an IT error. As such, it is not possible to assess whether alternative sentences were considered; however, the role of the Court Probation Officer is to consider all potential community sentencing options.

13.3.5 In the few days following the alcohol abstinence monitoring equipment being fitted, Ruben recorded several violations, including both alcohol and tag

[10] The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council (NPCC).

tampering alerts. These violations led to a breach of the requirement and the order being returned to court. The breach was heard at Magistrates Court on 13 August 2018, resulting in the AAMR requirement being extended for a further period of 20 days. Although Ruben's compliance with the AAMR requirement was initially poor, the last AAMR violation recorded was on 27 June 2018 – 77 days before the requirement expired on the 12 September 2018. This period represented a significant period of abstinence by Ruben.

13.3.6 On 9 October 2018, Ruben saw a GP regarding stress and feeling overloaded at work, as he had been covering for 2 people. He had also received a call to tell him that his child had had surgery as they had got a piece of Lego stuck in their ear. He did not feel supported by his employer. He reported he was stressed, not sleeping well, not eating well, no weight loss, no panic attacks, and no thoughts of self-harm. Red flags (these are high-risk features such as plans or actions of deliberate self-harm or harm to others, or persistent agitation) were discussed and he was advised how he could access additional help. The plan was to review in 3-4 weeks: a fit note[11] exempting him from work was issued.

13.3.7 On 18 October 2018, Ruben again saw a GP with the same issues. A further fit note exempting him from work, for a week, was issued. This was repeated on 25 October 2018.

13.3.8 On 29 December 2018, Ruben was issued permanent residence in the United Kingdom under the Immigration (European Economic Area) Regulations 2016. [see paragraph 11.8, et al.].

13.3.9 On 21 January 2019, Ruben submitted a claim for Universal Credit. This was ultimately unsuccessful.

13.3.10 Part of Ruben's sentence included up to 10 Rehabilitation Activity Requirement days. RAR activity commenced on 2 February 2019. In total, five days of RAR activity were recorded, during which alcohol and their impact on offending behaviour, relationships (both partner and children) and health were discussed –

[11] https://www.gov.uk/government/collections/fit-note
Doctors issue fit notes to people to provide evidence of the advice they have given about their fitness for work. They record details of the functional effects of their patient's condition so the patient and their employer can consider ways to help them return to work.

in addition to what supportive relationships look like and the benefits of good communication within relationships.

13.3.11 On 2 March 2019, the police received a call from a third party, who partner 3 had contacted, reporting a concern for her safety. When the police attended at Partner 3's address, Ruben was very drunk and was arrested for common assault. A DASH risk assessment was completed and was graded as medium risk. A PPN stop abuse child referral form was completed in respect of partner 3's child, and details forwarded to Children's Services. Partner 3 did not support a prosecution and did not support a Domestic Violence Protection Notice. She said that she wanted Ruben home and wanted to support him with his drinking problem. There was no other evidence and a prosecution was not possible.

13.3.12 An incident which happened in May 2019 was not reported by partner 3 until she was seen as part of the investigation in Kamile's murder. Partner 3 told police that Ruben had asked her to drive him to a friend's house. She said that when she refused, because she had an appointment that day, he suddenly grabbed her left arm and then took a knife and pointed it under her chin. She said the knife touched her skin and he started to move it upwards. This forced her to tilt her head backwards and it left a mark on her skin. In a state of fear, she agreed to drive him but when she got the chance, she got into her car and drove away without him. In doing so, she panicked and collided with a neighbour's car. She said that Ruben later sent a message to her apologising. They remained apart that weekend and they finally separated in July/August 2019.

13.3.13 On 24 May 2019, Ruben's period of supervision by HLNY CRC expired.

13.3.14 On 6 June 2019, Kamile contacted her GP. She said that she had split up with her husband and was struggling at work. She was advised to make an appointment but did not do so.

13.3.15 In November 2019, Leja was taken to see a GP by her father and Kamile together. The panel did not think that the reason for the appointment was relevant to the review. However, it was considered relevant to include this brief detail as the panel thought it showed that Kamile and her ex-husband retained at least a working relationship in relation to their child.

13.3.16 On 2 January 2020, Kamile had a telephone call with a GP. She complained of back pain and stated that she had already been off work for a week. She was given a physiotherapy appointment for 16 January. Kamile said that she was a quality controller at a factory which was heavy work. She was assessed and given advice on how to manage her condition. Kamile was given a series of fit notes advising against work; however, by early March 2020, her condition had improved and she was back at work.

13.3.17 At some time in January 2020, Kamile and Ruben were introduced by a mutual friend who worked with Ruben, and they began a relationship.

13.3.18 On 3 February 2020, Ruben was dismissed from his job following a series of conduct issues which had taken place throughout 2019. He was paid three months' pay in lieu of notice: he was not required to work any further.

13.3.19 On 21 February 2020, Ruben moved into the property where he and Kamile were found deceased in June 2020. The property was shared with two male friends.

13.3.20 On 6 March 2020, Ruben asked the property agent if his girlfriend could also move into the property. The panel could not be certain when Kamile moved into the property but information from the police investigation is that she stayed there most of the time from around March 2020.

13.3.21 On 16 March, the Prime Minister Boris Johnson made a televised statement saying "now is the time for everyone to stop non-essential contact", referring to it both as "advice" and a "very draconian measure".

It was not until 23 March 2020 that Mr Johnson told people they "must" stay at home, and said that "we will immediately" close some businesses.

This had been referred to as the start of lockdown by government ministers, including Mr Hancock and Mr Johnson.

Legally, the main restrictions in England actually began at 1pm on 26 March, when The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 came into force.

13.3.22 In April 2020, Kamile and her husband divorced.

13.3.23 On 17 April 2020, South Holland District Council received a noise complaint from a neighbour regarding noise emanating from Ruben's address. This resulted in the neighbour recording some noise using a noise monitoring app.

13.3.24 On 22 April 2020, Kamile had a telephone appointment with a nurse at her GP surgery. Kamile was given health advice and did not disclose any information that was indicative of domestic abuse.

13.3.25 On 3 May 2020, partner 3 reported to the police that Ruben had called her and threatened to kill her. This was because partner 3 had been contacted by Kamile who asked if Ruben had ever abused her. Partner 3 told Kamile that he had and the threatening call was as a result of this. Partner 3 did not want a prosecution but asked for the matter to be recorded. A crime report was recorded and a DASH risk assessment completed: this was graded as medium risk. Partner 3 declined to engage in any further support.

13.3.26 In her subsequent statement made to the police after Kamile's murder, Partner 3 outlined more details in respect of this incident. She stated that after receiving a text message from Kamile about Ruben, she replied telling her to be very careful because he was an aggressive and dangerous person. Kamile asked: "Has he hit you?" and partner 3 replied: "Yes many times. Be careful, you cannot change him". Kamile replied: "I will change him". She said that later that evening Ruben tried to call her several times, but she did not answer and eventually he left a voicemail saying: "Why have you spoke with Kamile. You have hurt her and now you will see what I will do to you". This then prompted her call to the police on that occasion.

13.3.27 On 7 May 2020, the noise complaint was closed following information from the neighbour that the situation had got better.

13.3.28 On 2 June and 9 June 2020, noise complaints were again received from a neighbour about noise emanating from Ruben's property, as well as concerns about the number of people coming and going from the property during the Covid-19 lockdown. This resulted in a letter being sent to Ruben from South Holland District Council advising of the noise nuisance, and the involvement of the property agent to attempt to resolve the noise issue.

13.3.29 In June 2020, Kamile and Leja attended a barbecue in the garden of the shared house which was rented by Ruben and two friends. During the evening, Leja was picked up by Kamile's ex husband and Kamile stayed at the house. She often stayed over since forming a relationship with Ruben around January 2020. Ruben asked the property agent if his girlfriend could move into the property in March 2020 and it was thought that Kamile spent much of her time there after that. Friend 1 [para 6.3.2] told police that Kamile had been living there full-time for around a month at the time of her death. The last guests left at about 1.30 am, leaving Kamile, Ruben and the two housemates at the house. At about 5.30 am, Ruben's housemates got up for work and on doing so found him hanging from the banister of the stairs in the house. They attempted CPR, whilst calling the police and ambulance service, but Ruben was pronounced dead at the scene by a paramedic. Police officers searched the house and found Kamile deceased.

13.3.30 A subsequent post-mortem examination concluded that the cause of Kamile's death was application of pressure to the neck. A post-mortem examination of Ruben concluded that the cause of his death was hanging. The toxicology report showed he had consumed excessive amounts of alcohol.

14 Analysis

14.1 What indicators of domestic abuse, including coercive and controlling behaviour, did your agency identify for Kamile?

14.1.1 Ruben completed a period of supervision with HLNY CRC on 24 May 2019, following his conviction for domestic abuse assault on his then partner. His relationship with Kamile did not start until January 2020 and therefore HLNY CRC had no knowledge of the relationship. Ruben attended his GP once for a routine medical issue during his relationship with Kamile: there was no indication to the GP of any relationship or domestic abuse issues at that time.

14.1.2 There were no reports to the police or other agencies of domestic abuse within Kamile and Ruben's relationship until Kamile's murder. Police records show that Kamile had been the victim of domestic abuse in a previous relationship, and that Ruben was a domestic abuse perpetrator in three previous relationships.

14.1.3 The police were not directly aware that Kamile and Ruben were in a relationship. However, on 3 May 2020, Ruben's former partner (Partner 3) reported to the police that Ruben had called her and threatened to kill her. This was because partner 3 had been contacted by Kamile who asked if Ruben had ever abused her. Partner 3 told Kamile that he had: the threatening call was as a result of this. Partner 3 did not want a prosecution but wanted the matter recording. A crime report was recorded and a DASH risk assessment completed, which was graded as medium risk. Partner 3 declined to engage in any further support. In a subsequent statement made to the police after Kamile's murder, partner 3 outlined more details in respect of this incident. She stated that after receiving a text message from Kamile about Ruben, she replied telling her to be very careful because he was an aggressive and dangerous person. Kamile asked: "Has he hit you?" and partner 3 replied: "Yes many times. Be careful, you cannot change him". Kamile replied: "I will change him".

14.1.4 This incident was dealt with correctly within policy, as far as the approach to partner 3 was concerned. However, it was clear from the information that partner 3 gave to the police that Ruben now had a new partner. Ruben was known to be a serial domestic abuser who had exhibited high-risk behaviours, for example strangulation. There is no evidence that consideration was given to making enquiries as to who Ruben's new partner was, or what risks she may face. Had Kamile been identified by the police at that time, it may have been possible for protective measures to be offered to her. For example, a disclosure under the

Domestic Violence Disclosure Scheme (DVDS)[12] could have been offered. Partner 3 did not provide to the police, nor was she asked by the police, for Kamile's details

14.1.5 The police IMR author identified that the officers involved did not consider taking further steps to identify Ruben's new partner (i.e. Kamile) to potentially offer her the benefit of the DVDS. The officers should have recognised that she was a potential person at risk. Steps should have been taken to identify and locate her to assess any potential safeguarding concerns, and consider whether the DVDS would have been appropriate for her. The officers were spoken to as part of the review process and accept that they should have considered scoping the matter further by seeking to identify Kamile. They explained that at that time, they only considered matters concerning partner 3, as she was the main target of the drunken threat from Ruben. The panel thought that the additional step in identifying and tracing Kamile would have been helpful in seeking to disrupt Ruben's offending behaviour. This is a learning point which is further developed at paragraph 14.12.

14.1.6 Had Kamile been identified by the police at that point, it would have been appropriate for the police to share information with Children's Services. That may have given the opportunity for Children's Services to speak to Kamile about her situation, and how to protect herself and her child Leja from domestic abuse. Kamile would only have been spoken to or visited by Children's Services if the contact was screened as meeting the threshold for social care intervention and being allocated to a social worker. In the opinion of the Children's Services DHR panel member, this information would not meet the threshold.

14.1.7 Children's Services were aware, separately, of Kamile and Ruben's history as a domestic abuse victim and perpetrator, respectively. The couple's records were not

[12] **Domestic Violence Disclosure Scheme [Clare's Law]**
The purpose of Clare's Law is to provide members of the public with a way to make enquiries about an individual who they are in a relationship with, or who is in a relationship with someone they know if they suspect that the individual may be abusive toward their partner.

Anyone can make a request for disclosure if there is concern that an individual may harm their partner, not just the potential victim. However, just because a third party has made the application it would not necessarily mean that the disclosure is made to them; it may be more appropriate for someone else to receive the information.

The Right to Ask gives the victim (actual or potential), third parties (neighbours, friends and relatives) and agencies the ability to make an application to the scheme.

The Right to Know is when the police make a proactive decision to disclose details when they receive information to suggest a person may be at risk.

linked in any way. Children's Services were notified by the police of the incident of 3 May 2020 involving Ruben and partner 3. They were not, however, aware that Kamile was his current partner. Children's Social Care's involvement with Kamile, after she reported domestic abuse in 2014, had ended some years previously and there was no ongoing contact with her.

14.1.8 Kamile had a number of contacts with her GP surgery during the time period of her relationship with Ruben. These were for routine medical issues which are known to the DHR panel. The panel decided that details of the consultations were not relevant to the review and there was no indication of domestic abuse and therefore the issue of routine enquiry was not relevant in this situation.

14.1.9 South Holland District Council received complaints from a neighbour of Ruben's about loud noise coming from the house. The Chair and Author of the report have seen in previous DHRs in other areas, that noise nuisance complaints can be related to domestic abuse. In this case, noise recordings taken by the complainant do not provide any evidence of domestic abuse. The agent for the property was spoken to by police as part of the murder investigation. The agent had known Ruben for several years as a repeat customer and had no previous problems in properties that he had rented. The Independent Chair of the review spoke to the property agent who was unable to add anything further to the information which had already been shared with the police.

14.1.10 No agency had direct knowledge that Kamile and Ruben were in a relationship. There was therefore no identification by any agency of any indicators of domestic abuse.

14.2 **What knowledge did your agency have that indicated Ruben might be a perpetrator of domestic abuse, and what was the response? Did that knowledge identify any controlling or coercive behaviour?**

14.2.1 Ruben was known to the police as a domestic abuse perpetrator as early as 2007. In total, he was recorded as the perpetrator in 13 domestic abuse incidents involving his three known partners – before his relationship with Kamile. Several of those incidents show he exercised acts of assault, threats, humiliation and intimidation to harm or frighten the victims. Although some of those incidents happened before the offence of 'Controlling or coercive behaviour in an ongoing relationship between intimate partners or family members' (Section 76 Serious

Crime Act 2015), which came into force on 29 December 2015, the panel recognised Ruben's behaviour overall as being controlling and coercive.

14.2.2 An example of such behaviour has been given at paragraph 14.1.3, when Ruben threatened partner 3 because she had disclosed his abusive behaviour to Kamile. The panel thought this was relevant in terms of Ruben's pattern of behaviour, whilst acknowledging that it fell outside the terms of the controlling or coercive behaviour legislation at that time – due to Ruben and partner 3 not being in an ongoing relationship or living together.

14.2.3 Ruben was supervised by HLNY CRC (now succeeded by the Probation Service) between 25 May 2018 and 24 May 2019, following his conviction for common assault and battery on partner 3. On 5 March 2018, he had punched partner 3 in the face, strangled her, and threatened to kill her.

14.2.4 HLNY CRC had an extensive and detailed domestic abuse policy which formed the basis for employee training. OASys[13] and SARA[14] risk assessments were completed and antecedent information sought from the police. Work with Ruben during supervision was undertaken to address the factors assessed to be contributing to his behaviours. These included alcohol, thinking and behaviour, lifestyle, relationships, and victim awareness. Structured Rehabilitation Activity Requirement work built on this during the latter stages of the order. Appropriate enforcement action was taken when Ruben failed to adhere to the requirements of his order.

14.2.5 Children's Services were aware of Ruben. Assessments were undertaken during Children's Social Care's involvement following Ruben's domestic abuse of partner 2 (the mother of his two children). However, this was before the timeframe of the review and Children's Social Care had no knowledge of Ruben's relationship with Kamile.

[13] OASys is the abbreviated term for the Offender Assessment System, used in England and Wales by Her Majesty's Prison Service and the Probation Service nationally from 2002 to measure the risks and needs of criminal offenders under their supervision.

[14] Spousal Assault Risk Assessment

14.3 **How did your agency assess the level of risk faced by Kamile, and any children of current or previous partners from Ruben? In determining the risk, which risk assessment model did you use, and what was your agency's response to the identified at risk?**

14.3.1 During the period of this review, there were no incidents reported to any agency concerning Kamile or her relationship with Ruben. There were no risk assessments regarding their relationship.

14.3.2 Although there were no incidents reported involving Ruben and Kamile prior to her murder, Ruben was the perpetrator in three domestic abuse incidents during the time period of the review. Partner 3 was the victim on all these occasions. A further incident came to light after Kamile's murder.

14.3.3 The incident reported on 5 March 2018, resulted in the arrest of Ruben for the assault on partner 3. On attending the scene, officers checked on the safety and welfare of her two children (one of adult age), a DASH risk assessment graded as high was completed, and a stop abuse child referral form was submitted to Children's Services. A critical register marker was made for her address (ensuring officers would be aware of the situation if further incidents occurred), a personal alarm was issued, the DVDS was explained to her, and she was offered the opportunity, but declined, to go to a refuge. She was seen by a domestic abuse officer and a MARAC referral was made. Her employers were contacted on her behalf and they agreed to ensure that there was no contact with Ruben, who worked for the same company. Officers also contacted her landlord and arranged for her tenancy to be renewed, and for Ruben to be removed from it. When Ruben was released from police custody, he was given bail with conditions not to return to partner 3's address – to help him comply with those conditions, officers removed his belongings from the home so that he had no reason to return there. An action from the MARAC meeting was to check on Ruben's immigration status. That check found that he was legally in the United Kingdom and therefore no further action was taken on this.

14.3.4 Children's Services undertook a Child and Family Assessment as a result of Ruben's assault on partner 3. He did not engage with professionals in respect of this assessment. The Signs of Safety Assessment Model was used alongside the

Department of Health Assessment Framework. It was recognised within this framework that there was a level of risk to the child, who became subject to a Child in Need Plan for a short time.

14.3.5 Ruben's risk of causing serious harm was assessed on 2 July 2018 by HLNY CRC through an OASys assessment. This includes assessment in relation to the public, known adults, children, self-harm, staff, and risk to other prisoners in custody. OASys includes assessment of both dynamic and static risk factors. An OASys was completed initially, which was reviewed during the period of the order. In addition, a Spousal Assault Risk Assessment (SARA) was completed, which was also reviewed during the period of the order.

14.3.6 It is expected that the probation case manager completes an OASys assessment within 15 days of the first contact with the service user. The OASys is a recognised assessment tool which, if completed correctly, identifies who is at risk, the level of risk (categorised as either Low, Medium or High), and the factors contributing to the risk. The OASys also contains a Risk Management Plan (RMP); the purpose of which is to provide a clear outline of the plan to work with the service user to manage the risk of serious harm they pose. The RMP should be collaboratively developed with the service user. Taking an open, transparent approach when developing and delivering the RMP should encourage the service user to accept their level of risk and take responsibility for managing it.

14.3.7 The initial OASys and SARA were completed within the 15-day target from the first appointment. The OASys correctly identified relationships, alcohol, thinking, behaviour and attitudes as the main causes of concern; however, the assessment lacked detailed analysis. Ruben's ongoing risk was limited to the information provided as part of the index offence, and the limited information in relation to alleged previous incidents provided by the same victim. The assessment did not include the previous police call-out information which indicated a pattern of concerning behaviour towards women (This was not available until later but should have prompted a review). The OASys appropriately identified a medium risk to known adults.

14.3.8 In addition to partner 3, her youngest child was also identified as potentially being at a medium risk of harm through witnessing or becoming involved in an incident between Ruben and partner 3. There is no evidence a formal request for information in relation to partner 3's child was made or received from Children's

Services. Although an entry within the OASys assessment, completed on 2 July 2018, suggests that partner 3's child "is not known" to Children Services, it is unclear how this information was obtained or who supplied it. In fact, the assertion was incorrect as the child was subject to a Child in Need plan on that date. The opinion of the CRC IMR author is that the assessment failed to meet the minimum quality standards. The potential existed for the CRC to contribute to the multi-agency approach to support a safety plan for the child. The Probation Service consider this to be a performance issue in relation to a member of staff who has now left the service, and not a wider learning point. The panel heard that significant work has now taken place to train and inform Probation Service staff in relation to local working practices with Children's Social Care. In addition, the Probation Service now has access to the Children's Social Care MOSAIC computer system, which means safeguarding checks are more easily completed pre- and post-sentence. Prior to access to this system, safeguarding enquiries had to be processed via telephone or email to Children's Social Care. The panel is therefore satisfied that a recommendation is not required on this point.

14.3.9 Spousal Assault Risk Assessment (SARA)

This is a risk assessment tool devised to identify dynamic risk factors in relation to intimate partner violence. The assessment is intended to inform the overall risk assessment, appropriate interventions, and risk management strategies. Overall, the SARA in this case lacked enough detail to add context and evidenced reasoning to the assessment. Although the assessment concluded that Ruben presented a high risk towards partners, there is little evidence to indicate how this affected the Risk Management Plan, or had any impact on the strategies employed to manage risk to partner 3. There is no recorded evidence that a referral to MARAC was considered or any recorded rationale for not doing so. The opinion of the CRC IMR author is that the assessment failed to meet the minimum quality standards.

14.3.10 The OASys and SARA assessments were reviewed in October 2018. The review included changes to both assessments, but the police call-out information, available since June 2018, was not included. The overall risks were assessed as remaining the same. The opinion of the CRC IMR author is that the review assessment failed to meet the minimum quality standards.

14.3.11 Ruben's case was transferred to a different member of staff in January 2019. The OASys was reviewed when the case was terminated in May 2019. The review reflected on the achievements of Ruben and the progress that had been made

during the order. There is no evidence that CRC was aware of, or took into account, the further domestic abuse incident on 2 March 2019, in which Ruben displayed similar behaviours towards the same victim as those which had resulted in his conviction and supervision by the CRC. The panel heard that, in the professional opinion of the Probation Service panel member, if the information had been known, it may have changed the termination risk assessment. It could not have changed the fact that Ruben's court imposed period of supervision was at an end. In 2019, there was no established process to routinely share information on incidents relating to people under probation service supervision. The Offender Manager would not have been aware of the incident unless it had been disclosed by Ruben, or they had reason to complete a further police check. The panel was told that work is now ongoing to establish such a process. This can be summarised as follows:

- Probation now receive daily arrest lists which are checked and actioned accordingly in terms of arrests for those already subject to probation supervision. Domestic abuse checks are completed at pre-sentence stage where the person is appearing for a domestic abuse related offence and completed post sentence by probation practitioners. Probation staff also have access to MODUS and update accordingly for MARAC cases.

New funding has been allocated for a co-located probation role. This is part of a national initiative and as such a National Information Sharing Agreement is being drawn up between police and the Probation Service to support a 0.5 Full Time Equivalent role per Probation Delivery Unit – to be co-located with police colleagues for the purposes of supporting information sharing re: domestic abuse and safeguarding.

The Probation Service and Lincolnshire Police have agreed a joint action to implement the new role, and report progress to the Community Safety Partnership. This is reflected in the action plan at Appendix A. The panel were informed in July 2022 that this national Information Sharing Agreement is now in place.

14.3.12 The incident on 2 March 2019, resulted in the arrest of Ruben for an assault on partner 3. A stop abuse child referral was made to Children's Services by the police, and a DASH risk assessment graded as medium was completed. When partner 3 was seen the day after this incident, she declined to make a complaint and declined the offer of a DVDS. However, a MARAC referral was still made. The panel thought that this was appropriate given the potential risks involved.

14.3.13 The police recorded that partner 3 did not support an application for a Domestic Violence Protection Notice and therefore this was not pursued. Domestic Violence Protection Notices and Domestic Violence Protection Orders were introduced by the Crime and Security Act 2010. Their effect is to exclude a potential domestic abuse offender from the home and give the victim breathing space to make informed decisions. They do not require the consent of the victim. The panel was told that the failure to pursue a DVPN in this case was as a result of a misunderstanding by an officer, which has been addressed.

14.3.14 Since this time, Lincolnshire Police have taken a number of actions to address the use of DVPN/DVPO. These include:

- Streamlined guide for DVPN/O for officers and authorising Superintendents.
- Creation of the Offender Management Unit (OMU) for auditing and clarity of processes. OMU oversee all applications for the force, they are able to pick-out any and all 'likely' mistakes before it gets to court, which has reduced the amount of applications being rejected at court or adjourned causing delays and impacting on potential safeguarding.
- Communication on when to apply for a DVPN.
- A renewed push around accountability from Officers to check on breaches.
- Domestic Abuse Matters training around better understanding of Domestic Abuse.
- Domestic Abuse Conference with Criminal Investigation Department (CID) held in March 2022 – OMU had a presentation input on DVPN/Os.
- Continuous Professional Development (CPD) inputs from OMU – the OMU manager reports an uplift in particular areas, i.e. North/South Kesteven, due to various CPD inputs they have done there in the past few months.

The work had, to date, resulted in a 30% increase in applications for DVPNs measured against previous years. The panel was satisfied that no further recommendation is required on this point.

14.3.15 A further domestic abuse incident on 3 May 2020, in which partner 3 was the victim, has already been outlined at paragraph 14.1.3.

14.4 **What services did your agency provide for the subjects of this review; were they timely, proportionate and of an acceptable level in relation to the identified levels of risk?**

14.4.1 The main interactions of the subjects of the review and the police and Children's Services have been discussed in previous paragraphs and are not therefore repeated here.

14.4.2 A feature of Ruben's offending behaviour was that he had often consumed alcohol. At the time of his conviction and sentencing for assault on partner 3, HLNY CRC was involved in an Alcohol Abstinence Monitoring Requirement (AAMR) pilot scheme. This allowed for perpetrators who were assessed as having problematic alcohol use relating to their offending behaviour, to be compelled to abstain from alcohol use for a specified period of time not exceeding 120 days. Abstinence was monitored throughout the specified period by a transdermal electronic tag fitted to the service user's ankle, which would provide compliance data via a specialised portal (accessible to the Case Manager). Any failure to comply with the abstinence order, or any attempt to tamper with or remove the tag, would represent a breach of the requirement and could lead to the service user being returned to court.

14.4.3 After some initial delays, the tag was fitted on 20 June 2018. In the few days following the tag being fitted, Ruben recorded several violations including both alcohol and tag tampering alerts. These violations led to a breach of the requirement and the order being returned to court. The breach was heard at Boston Magistrates Court on 13 August 2018, resulting in the AAMR requirement being extended for a further period of 20 days.

14.4.4 Although alcohol was a feature of Ruben's offending and the court imposed the AAMR order, there is no evidence that a referral was made or considered by HLNY CRC to substance misuse treatment services. The panel heard that operational guidance for AAMR is that a referral to substance misuse services should be made, but that it had not happened in this case. The Probation Service acknowledge that policies and procedures were not followed by a member of staff in this case during the pilot phase of AAMR: this is an isolated incident and not indicative of a wider systemic problem.

14.4.5 When Ruben attended his GP and presented with stress, his mental health and home situation was explored. The IMR author concluded that the action taken, and advice given, were appropriate.

14.5 **What did your agency do to safeguard any children exposed to domestic abuse?**

14.5.1 Incidents attended by the police on 5 March 2018 and on 2 March 2019 show that when officers attended the domestic abuse incidents, children present were seen and their safety and welfare were checked. Details of children present at the incidents were recorded on DASH risk assessments, stop abuse referrals were made to Children's Services, and MARAC referrals were made. The DVDS was explained and offered, and appropriate safeguarding advice measures were offered for the family. On both occasions, Ruben was arrested, removing him from the home and reducing any imminent threat to the victims.

14.5.2 An appropriate assessment was undertaken by Children's Services and the child was made subject of a Child in Need plan. This enabled a period of time to ensure that the safety plan agreed by partner 3 and wider family could be implemented and evaluated.

14.5.3 It was HLNY CRC's policy to liaise with all relevant agencies at the earliest opportunity following the allocation of a case: making safeguarding enquiries and referrals where appropriate. A safeguarding enquiry to Children's Services, and a request for police domestic abuse call-out information, must be made in every case. In any case where there are known children, known concerns regarding children, or known relationship/domestic abuse concerns, case managers must follow these enquiries up to obtain a response, and consider submission of a referral if the children are not known to safeguarding services. As already outlined at paragraph 14.3.8, there is no evidence on the case management records that formal contact with Children's Services was made in this case and erroneous information was recorded. This was not in accordance with policy. The Probation Service acknowledges that policies and procedures were not followed by a member of staff in this case: they consider this an isolated incident and not indicative of a wider systemic problem.

14.5.4 It is expected that a home visit is conducted for domestic abuse cases. It is best practice to complete a home visit at the earliest opportunity (normally within four weeks of the order commencing). Home visits would have provided an opportunity to assess the suitability of Ruben's accommodation and identify any new risk issues or concerns, including how he interacted with others in the household. There is no evidence that a home visit by HLNY CRC staff took place.

14.5.5 Healthy relationships and victim awareness work was the subject of one-to-one intervention conducted by HLNY CRC staff during supervision and Rehabilitation Activity Requirement days. There is no evidence of consideration or referral to a

domestic abuse perpetrator programme. Given the high-risk behaviours exhibited by Ruben, the panel discussed whether this could have been considered: they were informed that Ruben would not have met the threshold for a recognised intervention such as Building Better Relationships.[15] This would need to have been considered at the point of sentence as a referral cannot be made post sentence. The panel was advised by its Probation Service member that the AAMR requirement, supported by one-to-one interventions, was appropriate in the circumstances.

14.6 **What was your agency's response to the lived experiences of the children? Did that include an understanding of how their lived experiences impacted on their emotional and physical development?**

14.6.1 Any potential impact on Leja, of the relationship between her mother (Kamile) and Ruben, was unknown to services until after Kamile's murder. Prior to Kamile's murder, Leja's care had been shared between Kamile and Leja's father. Leja then went to live with her father full-time, as he was the only person with parental responsibility. Children's Services worked with Leja's school to establish that there were no safeguarding concerns.

14.6.2 Ruben's relationship with partner 2, the mother of his two children, had ended some time before the review period. Services have no relevant information in relation to those children, as they lived outside the Lincolnshire area for much of the review period. It is believed that Ruben had little contact with them.

14.6.2 As set out in previous paragraphs, when Ruben was arrested for assaulting partner 3, Children's Services conducted an assessment which resulted in a brief Child in Need plan. This took into account the child's lived experience.

14.7 **Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?**

14.7.1 As Kamile and Ruben's relationship was not known to services prior to her murder, there was no opportunity to offer services to her. The panel thought it relevant that when she reported domestic abuse several years earlier in her previous relationship, Kamile was made aware of the options and choices open to her. The risk assessment was graded as high and referrals were made to Children's Services

[15] Building Better Relationships is a nationally accredited group work programme designed to reduce reoffending by adult male offenders convicted of violence against an intimate partner.

and MARAC. Kamile also had contact with a police domestic abuse officer and IDVA[16], who offered their advice and support.

14.7.2 In May 2020, when partner 3 received threats from Ruben following her disclosure to Kamile about having been previously assaulted by him, partner 3 did not make a statement or support a prosecution: she simply wanted the threats to be recorded. On that occasion, the officers dealt with the incident itself effectively, in that they correctly dealt with partner 3 as a victim, a crime and a PPN were recorded, and she was given appropriate stay safe advice. As highlighted at paragraphs 14.1.4 – 14.1.6, the officers dealing with the matter should have been more inquisitive in relation to the identity of Ruben's new partner (Kamile).

14.7.3 In relation to Ruben, he was signposted to psychological therapies by his GP. There is no evidence that he engaged in this service. During his last appointment with the CRC, he was given information in relation to local substance misuse services. There is no evidence that he engaged with those services. Given the features of this case, the panel felt that it would have been appropriate for this discussion to have taken place earlier in his supervision. [see also paragraph 14.4.4].

14.8 **Were single and multi-agency policies and procedures, including the MARAC, followed; were the procedures embedded in practice, and were any gaps identified?**

14.8.1 During the review period, referrals were made to Children's Services and MARAC in respect of the domestic abuse incidents involving Ruben and partner 3. These resulted in appropriate action by agencies and no gaps were identified.

14.8.2 The GP IMR author identified that staff are aware of domestic abuse processes and that there is engagement with the MARAC process via the Clinical Commissioning Group. There were, however, no indications of domestic abuse in consultations.

14.8.3 Non-compliance with policy by HLNY CRC staff when supervising Ruben, has been outlined in previous paragraphs and is not therefore repeated here. HLNY CRC (now Probation Service) is represented on MARAC and has processes embedded into practice to enable appropriate referrals to take place. The view of the HLNY CRC IMR author is that Ruben's case may have met the threshold for referral to

[16] Independent Domestic Violence Advocates (IDVAs) are specialists who are SafeLives accredited. IDVAs provide high-risk victims of domestic abuse with a tailored and person centered safety and support plan so that victims and their families are protected from abusive behaviour.

MARAC, but this was not considered. In fact, a referral had already been made by the police.

14.9 **Were there any issues in relation to capacity or resources in your agency that affected its ability to provide services to the subjects of this review, or on your agency's ability to work effectively with other agencies? N.B. Please also consider any additional capacity/resource issues with agency contact during the Covid-19 pandemic.**

14.9.1 Capacity and resource were an issue for HLNY CRC at the time that Ruben was allocated to the organisation for supervision. This is evidenced by the fact that Ruben was initially allocated to a senior case manager due to a lack of capacity within the case manager grade to deal with his AAMR requirement. That member of staff later took sick leave before leaving the organisation. This resulted in the reallocation of his case, together with others, to a second member of staff. HLNY CRC had a Supervision and Appraisal Policy which required team managers, known as 'Interchange Managers', to have regular one-to-one supervision sessions with staff. This was in place for both practitioners in this case. Supervision included review of workload, discussion regarding specific cases the practitioner wishes to raise, review of training, equality and diversity, health and safety, plus the opportunity for any other issues to be discussed. As such, practitioners had a forum for one-to-one practice supervision. The panel was informed that the Probation Service has now introduced a new management oversight model (Touchpoints), which means that every case is discussed with a manager.

14.9.2 There were no capacity or resource issues identified by other agencies. No agency has identified additional Covid-19 issues as impacting on the case.

14.9.3 The panel did, however, look for general information in relation to how the Covid-19 pandemic had affected domestic abuse.

The Office of National Statistics produced a report – 'Domestic abuse during the coronavirus (COVID-19) pandemic, England and Wales: November 2020'[17]. The publication presents data on domestic abuse from April 2020 onwards using a

[17] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseduringthecoronaviruscovid19pandemicenglandandwales/november2020

range of sources to assess the impact of the coronavirus pandemic on domestic abuse in England and Wales. The main points in the report detail:

- Police recorded crime data show an increase in offences flagged as domestic abuse-related during the coronavirus (COVID-19) pandemic, however, there has been a gradual increase in police recorded domestic abuse-related offences over recent years as police have improved their recording of these offences; therefore, it cannot be determined whether this increase can be directly attributed to the coronavirus pandemic.
- There has generally been an increase in demand for domestic abuse victim services during the coronavirus pandemic, particularly affecting helplines as lockdown measures eased; this does not necessarily indicate an increase in the number of victims, but perhaps an increase in the severity of abuse being experienced, and a lack of available coping mechanisms such as the ability to leave the home to escape the abuse, or attend counselling.
- The total number of cases discussed at multi-agency risk assessment conferences (MARACs) decreased in April to June 2020 compared with the previous quarter; this may reflect the difficulties high-risk victims faced when attempting to safely contact the police (the main source of referral to MARACs) during the lockdown period.

14.9.4 As part of the local response to the Covid-19 pandemic, Lincolnshire monitored domestic abuse reported incidents on a weekly basis for the first nine months, and then on a monthly basis during the second and third lockdowns. The partnership specifically monitored police incidents, MARAC referrals, homelessness presentations and enquiries, as a result of domestic abuse, to District Councils and referrals to domestic abuse specialist services including Refuge. Throughout this period, the figures remained stable and there were no significant increases or decreases in incidents or referrals. There were some changes in the usual patterns of referral rates at different times of the year. There was a small decrease in referrals in the first few weeks of the pandemic; however, this was temporary and could be due to services across the partnership having to adapt to the new circumstances and finding alternative ways for people to contact the services they needed.

14.10 **How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the subjects of this review?**

14.10.1 Within the review period, Kamile's engagement with agencies was limited to medical appointments. Although English was not her first language, she was able to communicate fluently and there were no barriers to her accessing medical services.

14.10.2 Within the review period, Ruben was engaged with the police, HLNY CRC, and his GP. He communicated fluently in English and there were no barriers identified to his access to services.

14.10.3 The panel had no direct information that Kamile had been the victim of domestic abuse from Ruben prior to her murder. However, the panel noted information from Kamile's friend that indicated behaviour which may have amounted to controlling and coercive behaviour. The panel reflected on the findings of the academic research and cultural information provided to the review, and surmised that this may have been a barrier to Kamile reaching out to services. The panel considered how information is communicated to diverse communities and were informed that the Domestic Abuse Partnership hosts the cross-partnership communications group which brings together several agendas to look at a collaborative approach to communication activity. This includes an agreed calendar of joint campaigns. Some of these campaigns are targeted to specific audiences and some are more generic to the whole public – using social media, local shops and business venues, etc. As well as joint campaigns, each partnership has their own communications' strategies and plans. The Domestic Abuse Partnership also does specific learning and engagement work with local businesses, has a programme of healthy relationship education in schools through the stay safe partnership, and has a suite of training available to partners, community groups, etc.

This is one of the key identified priorities for the Domestic Abuse Partnership and communications group, and is heavily featured in the Domestic Abuse Strategy 2021–2024 and partnership delivery plan. The Domestic Abuse Partnership has developed a robust community engagement programme, including targeting specific communities that have been identified through the domestic abuse needs assessment: one of those being communities where a large percentage speak English as a second language.

The panel felt that there was further learning around accessibility to information within diverse communities. This is set out in the learning at paragraph 16.1, 16.2 and recommendation 1 and 2.

14.11 **Were there any examples of outstanding or innovative practice?**

14.11.1 The panel did not identify any outstanding or innovative practice in this case.

14.12 **What learning did your agency identify?**

14.12.1 Under the CRC delivery model at the time, only certain cases required automatic management oversight in supervision – this case would not have required management oversight as it was initially allocated to a Senior Case Manager. This has now been resolved by the Touchpoints Model, which requires management oversight input for all people on probation supervision.

14.12.2 In relation to Lincolnshire Police, although the DVDS has been highlighted in this review, training in respect of it and the DVPN/DVPO schemes has been included in the initial training for new officers since July 2014. Also, in DASH training since March 2014 and in Vulnerability and Risk training since October 2018. The force also introduced a DVDS action plan in 2019/20 which focussed on delivering this training to those operational officers who had not received it during their service.

14.12.3 Lincolnshire Police acknowledges opportunities for DVDS were an issue in this case, as well as others prior to this. Therefore, a wider range of actions are currently underway in force, which include:

- A business case for the recruitment of, and long-term employment of, 2 x DVDS Officers – who will assist in the timely identification, risk review and delivery of DVDS. The business case goes to the force Capabilities Board on the 16th March 2022.

- Lincolnshire Police is working with partners to identify the most appropriate resource to inform the potential victim of the DA history, i.e. IDVAs, Children's Services, etc. The disclosure does not always have to be a police employee but should be someone who is already engaged with the victim.

- DVDS Applications will be available to the public (including partners) from late March 2022 through Single Online Home platform on the force website. This will provide an access point rather than waiting on 101 to submit an

application. Communications with the public and partners will also be part of the launch to inform them of this change.

- DA Matters training has commenced roll out in Lincolnshire Police from February 2022. This case and other learning re DVDS has been collated and shared through the delivery of this course to delegates, which covers 770 'first responders' between now and the end of September 2022.

- The force also has a new Command and Control system forthcoming in 2022, and this will also improve information to the front line re research and background of history/previous contact.

Lincolnshire Police agreed to a single agency action and reported progress on these issues to the Lincolnshire Domestic Abuse Partnership in December 2022.

14.13 **Do the lessons arising from this review appear in other reviews held by the Safer Lincolnshire Partnership?**

14.13.1 A previous review (DHR2017N) identified that police officers who complete the DASH/PPN risk assessments were not prompted to complete more research in respect of the parties involved, nor to record the level and extent of that research. It was recognised that such a prompt would particularly help officers establish more details about any potential history of abuse by the offender against the victim or other victims, including whether there were any previous incidents or convictions for domestic violence. As a result of that review, a recommendation was subsequently made to the force which resulted in the PPN document being amended to include a previous history search and a prompt for officers to inform victims about the DVDS.

14.14 **Has any relevant practice changed since the events under review?**

14.14.1 A local Practice Brief was circulated to all Lincolnshire CRC staff reiterating processes and criteria for safeguarding checks and referral. Revised pan CRC safeguarding guidance was also released. The safeguarding Lead for Lincolnshire led work to embed Lincolnshire Children's Safeguarding Partnership, Inter-Agency Safeguarding Children and Young People training across CRC staff – take up and feedback from staff was positive.

14.14.2 In 2020, all HLNY CRC staff completed refresher Risk of Serious Harm training, which included a focus on risk assessment including safeguarding. In addition, a

number of staff have completed additional domestic abuse and safeguarding training.

14.14.3 The Alcohol Abstinence Monitoring Requirement pilot ended in August 2019. AAMR has now been adopted and rolled out nationally by the Ministry of Justice. Tags are now fitted and maintained by Electronic Monitoring Services (EMS), rather than probation staff. This mitigates the risk of delays to tag fitting as seen in this case. As the roll out is now national, the risk of lack of equipment supply is also reduced. The HLNY pilot had a finite number of tags to be used across the area of Humberside, Lincolnshire and North Yorkshire.

14.14.4 A major reform of probation service delivery has taken place since the timeframe of this review. From June 2021, CRCs and National Probation Service have been amalgamated into a single unified service – the Probation Service.

Since Probation Unification all probation practitioners have refreshed safeguarding, domestic abuse and risk of harm training as part of transition learning. As detailed, work is ongoing to enhance multi- agency information sharing with regard to domestic abuse and safeguarding. A revised HMPPS Child Safeguarding Policy Framework was introduced in March 2022. There is continued national and regional focus on quality practice in respect of domestic abuse, risk of serious harm and safeguarding practice.

15 Conclusions

15.1 Ruben was a serial domestic abuser who had been convicted for domestic abuse offences against three different women before he met Kamile. Sadly, she was to be his fourth and last victim.

15.2 Kamile too had previous experience of domestic abuse when she had been a victim of abuse in her marriage before she met Ruben.

15.3 In December 2018, Ruben was issued permanent residence in the United Kingdom. It is now known that he provided false information in order to secure that status. Although his application was potentially fraudulent, it is not possible to say with any certainty whether a refusal or revocation of his status would have led to his removal from the United Kingdom.

15.4 Kamile and Ruben began their relationship in January 2020. In March 2020, Ruben asked his property agent if Kamile could move in the house he was renting with friends. It is thought that she, in effect, lived there after that. Although there were some noise nuisance complaints from a neighbour, these were not related to domestic abuse but more in relation to general behaviour and noise. For example, parties.

15.5 The existence of the couple's relationship was not known to any agency. Although a domestic abuse incident reported to the police on 3 May 2020, by Ruben's former partner (Partner 3), arose from a disclosure to Kamile from partner 3 that Ruben had been abusive to her, this did not result in Kamile's identity becoming known. Had Kamile's identity become known to the police then it may have been possible to offer her a disclosure about Ruben's previous domestic abuse offending using the Domestic Violence Disclosure Scheme.

15.6 Whilst agencies did not know of the couple's relationship, information from Kamile's friends indicates that there was already domestic abuse prior to Kamile's murder.

15.7 The panel noted the information gathered during the review about the difficulties Lithuanian women in the United Kingdom may face in leaving a relationship, and felt that these applied to Kamile. In addition to the usual barriers of finance, accommodation, etc. that all Lithuanian women face in the United Kingdom, Kamile faced additional barriers which may have combined to make it too difficult to leave the relationship.

16 Learning

This learning arises following debate within the DHR panel.

16.1 Narrative

The panel heard that domestic abuse victims from the Lithuanian community, and other communities of Eastern European origin which are prevalent in Lincolnshire, have additional cultural barriers which may prevent them from engaging with agencies.

Learning

Cultural and language barriers have a role in reducing the likelihood that domestic abuse victims from the Lithuanian community, and other communities of Eastern European origin, will report domestic abuse or stay engaged with services if they do make a report.

16.2 Narrative

There appears to have been an unwilling acceptance by partners and the community of Ruben's poor behaviour over a number of years and different relationships. Although some abuse was reported, research shows that it is very likely that more abuse was not reported.

Learning

Diverse cultural attitudes can result in community tolerance of unacceptable abuse.

16.3 Narrative

Ruben's repeated domestic abuse offending against three different women did not meet the threshold for confirmation of his permanent residence to be rejected.

Learning

Existing regulations are not sufficient to recognise and act upon the risk posed by a serial domestic abuse offender who exhibits high-risk behaviours, unless they have been sentenced to 12 months or more in prison.

17 **Recommendations –**

DHR Panel

These recommendations have been developed in partnership with the panel.

17.1 Lincolnshire Community Safety Partnership should coordinate and monitor a programme of activity in place to support domestic abuse victims from communities of Eastern European origin in engaging with local agencies.

17.2 Lincolnshire Community Safety Partnership should develop a programme of activity to build community confidence and knowledge of what is unacceptable behaviour relating to domestic abuse. The programme should ensure that information on reporting domestic abuse, third party reporting, access to services, and non-acceptance of abuse is promoted to communities of Eastern European origin.

17.3 The Home Office should take steps to ensure that repeated domestic abuse offending is taken into consideration when permanent leave to remain, citizenship, and other immigration applications are decided.

17.4 **Single Agency Recommendations**

17.5 Single agency recommendations are contained within the action plan.