Safer Lincolnshire Partnership

Executive Summary

Domestic Homicide Review

Name: Kamile

Died: June 2020

Chair: Carol Ellwood Clarke QPM

Author: Ged McManus

Date: 12 July 2022

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1 The Review Process

1.1 This summary outlines the process undertaken by the Safer Lincolnshire Partnership, Domestic Homicide Review panel in reviewing the death of Kamile, who was a resident in their area.

1.2 The following pseudonyms have been used in this review for the victim, perpetrator and the victim's child in order to protect their identities.

Name	Who	Age	Ethnicity
Kamile	Victim	30	Lithuanian
Ruben	Perpetrator	34	White African
Leja	Victim's child	Primary school age	Lithuanian
Child 1	Ruben's child	Secondary school age	White African/White European
Child 2	Ruben's child	Primary school age	White African/White European

1.3 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, since January 2020. Ruben was a South African national who had lived in the United Kingdom for 14 years.

1.4 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.

1.5 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.

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

1.7 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.

1.8 The review began in January 2021, after delays due to restrictions in place as a result of the coronavirus. The panel met six times by video conference with further work being conducted by telephone, video conferencing and the exchange of documents. The review was concluded on 27 May 2022 following final consultation with the panel.

2 Contributors to the review

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

3 Members of the Domestic Homicide Review Panel

3.1	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 [domestic abuse service]
	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 Administration

Teresa Tennant	Business Support, Lincolnshire County Council

3.2 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.

4 Chair and author of the overview report

4.1 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.

4.2 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.

4.3 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.

4.4 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.[1]

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

5 Terms of Reference

5.1 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)

5.2 Timeframe under Review

[1] Advocacy After Fatal Domestic Abuse

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

5.3 **Case Specific Terms**

Subjects of the DHR

Victim: Kamile, aged 30

Victim's child: Leja, primary school age

Perpetrator: Ruben, aged 34

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour,[2] 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?

[2] 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).

8. Were single and multi-agency policies and procedures, including the MARAC[3], 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 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?

[3] 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.

6 Summary chronology

6.1 Kamile

6.1.1 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[4] for a short time. The case was heard at MARAC.

6.1.2 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.

6.2 Ruben

6.2.1 Ruben was a South African national who originally came to the UK in 2006. Checks with the South African authorities, after Kamile's death, showed that Ruben had no criminal record in South Africa.

6.2.3 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.

6.2.4 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

[4] 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.

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.

6.3 Relevant information during the review period

6.3.1 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.

6.3.2 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[5] 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.

[5] 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).

6.3.3 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.

6.3.4 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.

6.3.5 In the few days following the alcohol abstinence monitoring equipment 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 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.

6.3.6 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[6] exempting him from work was issued.

6.3.7 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.

6.3.8 On 29 December 2018, Ruben was issued permanent residence in the United Kingdom under the Immigration (European Economic Area) Regulations 2016.

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

6.3.10 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

[6] 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.

with his drinking problem. There was no other evidence and a prosecution was not possible.

6.3.11 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.

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

6.3.13 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.

6.3.14 In November 2019, Leja was taken to see a GP by their 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.

6.3.15 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.

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

6.3.17 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.

6.3.18 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.

6.3.19 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.

6.3.20 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.

6.3.21 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.

6.3.22 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.

6.3.23 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.

6.3.24 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 her father 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 bannister 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.

6.3.25 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.

7 Conclusions

7.1 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.

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

7.3 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.

7.4 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.

7.5 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.

7.6 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.

7.7 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.

8 Learning identified

This learning arises following debate within the DHR panel.

8.1 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.

8.2 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.

8.3 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.

9 Panel Recommendations

DHR Panel

These recommendations have been developed in partnership with the panel.

9.1 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.

9.2 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.

9.3 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.

Single Agency Recommendations

9.6 **Lincolnshire Police**

Report progress in relation to DVDS to the CSP.

9.7 **East Midlands Probation Service – Lincolnshire / Lincolnshire Police**

Lincolnshire Police and The Probation Service to continue to develop a local response to national initiative for a co-located NPS support role in the PVP PSH at Grantham. This will enhance information sharing – from daily arrest lists, pre-sentence checks, [post sentence checks already carried out] – to include call-out/incident information**.**