

# **Safer** **Lincolnshire** **Partnership**

## **DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY**

**Report into the death of NATALIA**

**November 2021**

**Independent Author: Simon Steel**

**Date of Completion: 17 February 2025**

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## 1. THE REVIEW PROCESS

- 1.1 This summary outlines the process undertaken by the Lincolnshire Community Safety Partnership (CSP), Domestic Homicide Review panel in reviewing the circumstances of the death of Natalia.
- 1.2 The following pseudonyms have been in used in this review to protect their identities.

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
Natalia	Victim	27	White-Polish
Jakub	Perpetrator - Partner	40	White-Polish
Cibor	Child	3	White-Polish
Agata	Ex wife of Perpetrator	Unknown	White-Polish

- 1.3 The subsequent investigation led to Natalia's partner Jakub being convicted at Lincoln Crown Court of Natalia's murder in October 2022. He was sentenced to life imprisonment and must serve a minimum of 22 years.
- 1.4 The Lincolnshire CSP reviewed the circumstances against the criteria set out in the Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews and the chair of the CSP determined that a DHR should be undertaken.
- 1.5 Agencies that potentially had contact with Natalia and Jakub prior to the point of death were contacted and asked to confirm whether they had involvement with them.

## 2. CONTRIBUTORS TO THE REVIEW

- 2.1 Agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for 6 organisations that had contact with Natalia and a report for 2 agencies.
- 2.2 The following agencies who had contact and their contributions are shown below.

Agency	Contribution
Lincolnshire Police	Chronology and IMR
Deceased's local market town council	Chronology and IMR
Lincolnshire County Council (Children's Health)	Chronology and IMR
Lincolnshire Community Health Services & also for Primary Care	Chronology and IMR
Newham University Hospital	Summary Report
United Lincolnshire Hospitals NHS Trust	Chronology and Summary Report
Education	Chronology and IMR

Lincolnshire Partnership NHS Foundation Trust Mental Health Liaison Trust (LPFT)	Chronology and IMR
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- 2.3 IMRs were completed by authors who were independent of any prior involvement with Natalia and Jakub.
- 2.4 The authors and panel members assisted the chair further, with a number of one-to-one meetings and answering follow up questions as necessary.

### 3. THE REVIEW PANEL MEMBERS

- 3.1 The review panel members included the following agency representatives.

<b>Name</b>	<b>Role/Job Title</b>	<b>Agency</b>
Peter Stride	Independent Chair	Foundry Risk Management Ltd
Simon Steel	Independent Author	Foundry Risk Management Ltd
Sarah Norburn	DA Coordinator	Lincolnshire Police
Elaine Todd	Named Nurse for Safeguarding Children and Young People	United Lincolnshire Hospitals NHS Trust
Jennifer Parker	Interim Named Nurse for Safeguarding	Lincolnshire Community Health Services
Claire Tozer	Head of Safeguarding Adults and Primary Care	Lincolnshire Integrated Care Board
PH (anonymised)	Community Safety Manager	A market town in Lincolnshire Council
Dawn Waring	Locality Health Manager	Lincolnshire County Council, Children's Health
John O'Connor	Head of Education Support	Lincolnshire County Council, Education Support
Jackie Ward	Lead Advisor for Sector Support and Improvement	Lincolnshire County Council, Early Years
Jane Keenlyside	MARAC (DMR) Manager	EDAN Lincs / LDASS (DA Services)
<b>Support to the Panel</b>		
Toni Geraghty	Assistant Chief Legal Officer	Legal Services Lincolnshire
Jade Thursby	DA Business Manager	Lincolnshire County Council, Community Safety
Teresa Tennant	Senior Business Support Officer (DA Admin)	Lincolnshire County Council, Business Support

- 3.2 The review panel met on 6 occasions.
- 3.3 Agency representatives were of appropriate level of expertise and were independent of the case.

#### 4. AUTHOR OF THE OVERVIEW REPORT & CHAIR OF THE REVIEW

- 4.1 The Author of the Review was Simon Steel. Simon has completed his Home Office approved Training and has attended training by Advocacy After Fatal Domestic Abuse. He completed 20 years-service with Thames Valley Police retiring at the rank of Detective Superintendent. During his service he gained experience in response to Domestic Abuse, Public Protection and Safeguarding.
- 4.2 Simon has no connection with the Lincolnshire Community Safety Partnership, or any agencies involved in this case.
- 4.3 The Chair of the Review was Peter Stride. Peter has completed his Home Office approved Training and has attended training by Advocacy After Fatal Domestic Abuse. Peter is a retired Metropolitan Police Officer and has over 30 years of detective experience in the field of Domestic Abuse, Public Protection and Safeguarding in London. As Detective Chief Inspector he has been the vice chair of two Local Adult and Children's Safeguarding Boards and was responsible for the creation and implementation of various MASH and MACE panels as well as chairing MAPPA and MARAC meetings.
- 4.4 Peter has no connection with the Lincolnshire Community Safety Partnership, or any agencies involved in this case.

#### 5. TERMS OF REFERENCE FOR THE REVIEW

- 5.1 The primary aim of the DHR was defined as examining how effectively Lincolnshire's statutory agencies and Non-Government Organisations worked together in their dealings with Natalia.
- 5.2 The purpose of the review is specific in relation to patterns of Domestic Abuse and/or Coercive Control, and will:
- Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.
  - Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.
  - Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.
  - Apply these lessons to service responses including changes to policies and procedures as appropriate; and
  - Contribute to the Prevention of Homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
  - Highlight any fast-track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life
- 5.3 Case specific key lines of enquiry included the following:

- Pregnancy as a potential trigger point
- Barriers to reporting
- Family Background and cultural matters
- Previous domestic abuse from this or previous relationships

### The Death

- 5.4 On a morning in November 2021 Natalia was reported as missing by Jakub. He stated that he had last seen her at their home address at around 2300hrs 2 days before, when he returned from having drinks with a friend and went to bed, leaving her on the sofa watching TV. When he awoke at 0200hrs she was missing. He further stated they had been having difficulties in their relationship and that she had said, on either the previous Saturday or Sunday, she no longer wished to be in the relationship. He said that she had previously threatened this but subsequently changed her mind.
- 5.5 A missing persons investigation commenced. Later in the investigation Jakub was arrested on suspicion of the murder and subsequently charged and remanded into custody. In February 2022, a member of the public reported finding what they believed to be human remains within a country park in Lincolnshire. Further enquiries revealed that these remains, to be those of Natalia. On the 21st of October 2022, Jakub was found guilty by a jury at Lincoln Crown Court of the murder of Natalia and sentenced to life imprisonment, with a recommendation he serve at least 22 years.

## 6. SUMMARY CHRONOLOGY

### **Family Perspective**

- 6.1 Following the decision to conduct this DHR the Partnership wrote to the family of Natalia. The chair then made several efforts to engage with both parents of Natalia. The chair also utilised the Homicide Case working team from Lincolnshire police to try and establish contact. However, both parents declined to take part in the review.

### **Ex partner of Jakub**

- 6.2 The chair has spoken to an ex-partner of Jakub. She stated she met Jakub in the late 1990's, when they were both quite young and lived in Poland. They quickly became a couple and were very happy for several years. She fell pregnant and the couple were delighted. She said that once she was pregnant everything changed, and Jakub became controlling and abusive. In total the period of abuse lasted for 4 years from when their child was born, until they separated. Following the separation, he perpetrated daily sexual assault against her. She was unable to tell her friends or family, and she reports she was not believed when she reported details to the Polish Police.
- 6.3 She told the Chair she felt she was a victim of domestic abuse during this period. These included Controlling behaviour, verbal abuse, servile treatment, restrictions over who she met and threats to kill her.

## **Lincolnshire Police**

- 6.4 The missing person report which led to the murder enquiry does not form part of the Terms of Reference for this review. Prior to the missing person report Lincolnshire Police only had one other interaction with Natalia and Jakub. This was in relation to a call from Jakub on the 20<sup>th</sup> of April 2019. He called to report that Natalia was drunk and had been violent towards him.
- 6.5 Jakub stated that he lived at the address with his partner, her mother, and their child. He stated that Natalia was being very aggressive towards him, and he was worried about what he would do, not wanting to do anything stupid. An incident log was created, and an officer was dispatched to attend the address. The call taker updated the log that there were some language difficulties, but she could hear shouting and swearing in the background (English expletives) and Jakub reported that “*She is now cutting herself with a piece of glass*”. The officer, who happened to be a Polish speaking officer, attended, and updated the incident log to the effect that an ambulance was required as Natalia had cut her arm. He ascertained there had been no assault and damage had been caused to a pane of glass in the front door that was jointly owned by the parties involved. Due to the fact the ambulance service said it would likely be two hours before an ambulance was free to attend, officers transported Natalia to hospital for treatment.
- 6.6 Following the National Crime Recording Standards, the officer submitted a crime report with regards to the criminal damage caused to the door and a Public Protection Notice (PPN) in relation to the domestic nature of the call. As the damaged property was their own, no further action was taken. The officer assessed there was no assault, the risk assessment as being standard, to which his supervisor concurred.
- 6.7 Other than the report of Natalia as being missing from home in November 2021, there were no further incidents of a domestic abuse nature reported to the police involving Natalia and Jakub. During the murder investigation friends and family mention arguments between Natalia and Jakub that Natalia had mentioned to them. Natalia had disclosed to friends that she intended to ask him to leave the relationship and that she was communicating with other males via Tinder (Jakub was aware of the Tinder contacts).
- 6.8 Jakub was previously married and has a son via that relationship. His previous wife Agata was spoken to by officers as part of the murder investigation and disclosed that she had been sexually assaulted by him during the relationship and also an instance where he allegedly set light to their house. She stated this occurred while they both resided in Poland and that she reported it to the police, but they simply told her that this happens in marriages. The Polish police have no record of any such allegations. Jakub had mentioned within a witness statement, provided as part of the missing person enquiry, that Natalia had not wanted the baby, but he had convinced her to do so. The panel recognise the implication of this and considered whether this was part of controlling behaviour by Jakub. Natalia did report incidents to the police whereby she had been the victim of property related crime.

## **A market town in Lincolnshire Council**

- 6.9 Natalia was known to a market town in Lincolnshire A market town in Lincolnshire Council's Private Sector Housing Team. On the 14<sup>th</sup> of December 2017 she had contact in relation to the flat she lived at. She reported some disrepair issues with the flat she was living in at the time. Natalia left this address in April 2018 and there was no further contact with her. The address was private rented.
- 6.10 On the 30<sup>th</sup> of July 2020 a market town in Lincolnshire Council Customer Services Team received a call from Natalia on behalf of her father who was due to be evicted that same day or the following day. Natalia asked for urgent advice and requested a call on her father's behalf as he speaks very little English.
- 6.11 On the 29<sup>th</sup> of May 2015 Jakub was issued with a Stage 1 Public Space Protection Order Advice Letter following being spoken to by a Police Community Support Officer (PCSO). This was issued because he was seen consuming alcohol within the Public Space Protection area covered by the order. He complied with the request to stop consuming the alcohol at the time. As per the incremental approach with regard to the Public Space Protection Order in a market town in Lincolnshire the advice letter was issued and held on file for six months.
- 6.12 On the 26<sup>th</sup> of July 2020 Jakub was issued with a Stage 2 Public Space Protection Order Warning Letter for consuming alcohol within the designated Public Space Protection area covered by the order. The Stage 2 Warning Letter was issued following being spoken to by the PCSO. Jakub complied with the request to stop consuming alcohol at the time. As per the incremental approach with regard to the Public Space Protection Order in a market town in Lincolnshire the warning letter was issued and held on file for six months. This stage 2 letter was technically an error and should have been stage 1 however the panel are content this was an individual error and had no impact on this case.

### **Lincolnshire County Council (Children's Health)**

- 6.13 Children's Health Services were not aware of any domestic abuse including coercive and controlling behaviour. Natalia was asked direct questions about domestic abuse on four separate occasions, the 29<sup>th</sup> of January 2018, 14<sup>th</sup> of March 2018, 17<sup>th</sup> of April 2018 and the 12<sup>th</sup> of June 2018. On all four of these occasions Natalia denied any domestic abuse or coercive and controlling behaviour was taking place. On the 3<sup>rd</sup> of July 2020 Natalia was asked about her relationship with Jakub and she reported no concerns and reported that she was happy.
- 6.14 The health visitor ensured that routine enquiry of domestic abuse was completed at all mandated contacts with Natalia. The health visitor was not aware of domestic abuse within the couple's relationship as nothing was disclosed. Due to this negative reporting on domestic abuse a DASH assessment was not deemed to be required. All health staff are aware that a DASH can be used to aid discussions and is not just a tool when domestic abuse is disclosed.
- 6.15 The health visitor was advised by the midwife via the notification of prospective parent form (NPP) that Natalia's primary language was Polish. However, on liaison

with the Midwife on the 8<sup>th</sup> of January 2018 there were no concerns. Natalia spoke fluent English and was always able to express her own and her child's needs. Natalia also contacted the Single Point of Access (SPA) to change appointments without any difficulty.

- 6.16 Natalia has discussed with the Health Visitor on the 29<sup>th</sup> of January 2018 that her own mother (maternal grandmother) was visiting from Poland and staying for a brief time to support her. Natalia stated that all her family remain in Poland, but she has a friend in a market town in Lincolnshire who is also pregnant and supports her.
- 6.17 At the antenatal contact on the 29<sup>th</sup> of January 2018 Natalia expressed she was concerned about her finances and the flat where she resided, as it was cold and expensive to heat. Jakub was reported to be working and the Health Visitor advised Natalia to contact the Citizens Advice Bureau to review her benefits status. The Health Visitor contacted the Midwife to inform them of the concerns around finances. The Health Visitor also arranged for provision of a baby basket (Moses' basket filled with baby equipment provided by a Lincolnshire charity). Natalia moved in March 2018 to another property and on the 20<sup>th</sup> of March 2018 the Health Visitor saw Natalia and the baby at the new address, the lounge was presented as clean and warm.
- 6.18 Natalia signed a consent form for sharing of SystmOne (health record) information with other health agencies on the 14<sup>th</sup> of March 2018. Natalia had been directed by the health visitor to the Children's Centre in the local community and was aware of groups and activities that she could attend.
- 6.19 A home visit was conducted on the 20<sup>th</sup> of March 2018 specifically to review attachment and bonding as concerns were identified within the primary birth visit on the 14<sup>th</sup> of March 2018. A further review was conducted at the 6-8-week assessment on the 17<sup>th</sup> of April 2018 which identified that attachment was developing and had improved from the primary birth visit. Advice was given on communication with the baby to support normal development. During this contact, the Health Visitor found the baby's weight had reduced from the 25<sup>th</sup> centile to just above the 9<sup>th</sup> centile. This was not deemed as a concern however the Health Visitor planned a follow up to ensure no further weight loss. Natalia missed an appointment for Cibor at the clinic for a weight review on the 22<sup>nd</sup> of May 2018. She was subsequently seen the day after as the Health Visitor attended the home address. Due to slow weight gain at this contact the Health Visitor saw the baby and Natalia again on 6<sup>th</sup> June 2018 but she was not weighed due to being asleep. Cibor was reviewed again in clinic on 12<sup>th</sup> June 2018 and her weight was back on the 25<sup>th</sup> centile.
- 6.20 On the 3<sup>rd</sup> of July 2020 the Family Health Worker completed the 2-2.5-year assessment via the telephone (telephone contact due to COVID regulations and policy). Natalia was concerned about Cibor's diet and requested a weight review. Subsequently she was seen at home on the 17<sup>th</sup> of September 2020 and growth was assessed as normal. The Family Health Worker agreed to contact Natalia when the baby was 3 years old, which was completed, and some diet and toileting advice was provided. During this time frame, no assessment identified any risks to Natalia or Cibor. All services were provided as per policy schedule and expected follow up was

concluded. Warm and loving interaction was observed between Natalia and Cibor at these contacts.

- 6.21 The health visitor was consistent in their approach around asking the domestic abuse questions and the record keeping was of a high standard. The record keeping was also analytical and highlighted clear plans of care. This particular case also highlights the level of integration between Children's health and social care which aid effective communication and information sharing.
- 6.22 This case has evidenced the expected health visitor practice in line with all local and national policy. The Children's Health Service have a Single Point of Access (SPA) which allows families to contact between Monday to Friday 9am till 5pm. Natalia could have utilised this contact point and option to speak to her own health visitor or a health visitor on central duty. Central duty calls are returned within 1 working day. Natalia made no contact with the service around the time of this incident.

### **Lincolnshire Community Health Services (LCHS)**

- 6.23 During the scope of the review Natalia had 17 contacts with LCHS services. She was first seen on the 11<sup>th</sup> of December 2017 at her GP practice. She was 29 weeks pregnant and attended for a new patient screening after registering at the GP practice. She was recorded to be a Polish national and to be living with her partner.
- 6.24 On the 2<sup>nd</sup> of January 2018 a letter was received by the GP practice from United Lincolnshire Hospital Trust Obstetric services, which confirmed Natalia to be 32 weeks pregnant, to have registered for consultant led antenatal care, and to have been seen in the clinic at the hospital.
- 6.25 After the birth of the child, Natalia was reviewed by the GP with back pain following an epidural. She was prescribed anti-inflammatory medication for pain relief of her symptoms. A few days later Natalia was seen by the GP for her routine post-natal appointment following an emergency caesarean section delivery of her baby. She refused to discuss any issues about her health with the GP other than contraception and bottle feeding. She had previously taken pills for contraception but was not sure what sort, she was able to inform the GP she did not want pills of any description. She refused consent to have her blood pressure checked, reinforcing she only wanted to talk about contraception. Contraception choices were discussed, and it was explained by the GP that they were unable to prescribe for her unless a check of her blood pressure was completed, at which point Natalia gave her consent. Natalia was prescribed a contraceptive offered by the GP but stated medicine in the UK was 'very bad' and she would rather die than see a doctor here. The GP recorded the consultation to have been very difficult.
- 6.26 In the months after the birth of Cibor, Natalia returned to her GP on 3 occasions requesting changes in her contraceptive that was prescribed. She was recorded by the GP as being confrontational and to have been very rude. She was advised to attend the Sexual Health clinic as she felt the GP practice was unable to meet her needs. She returned to the GP practice on the 7<sup>th</sup> of February 2019 and was seen by the Advanced Nurse practitioner for further contraception advice. She informed the

nurse she had been seen by a private gynaecology specialist the previous week and to have stopped her contraceptive patch due to not suiting her working conditions in a cold factory. She was prescribed a new contraception for 3 months and given advice on how to use this. The GP practice continued to provide this on repeat prescription for her.

- 6.27 The panel were advised by the SME that her behaviour in relation to this issue is not unusual. The SME explained that access to contraception in Poland<sup>1</sup> is more limited compared with many other European countries. Sex education is not part of the school curriculum, female sterilisation is not permitted, while vasectomy is available for men. Abortion legislation is highly restrictive and is only permitted in specific circumstances related to health. As a result, there can be significant social sensitivity around reproductive health matters. The SME also noted that some individuals from Poland may have different expectations of healthcare systems. Private healthcare is widely accessible in Poland, and people can often approach both private and public providers directly. In comparison, the UK system requires GP referrals for many services, which may feel more restrictive to those accustomed to more direct access. It is therefore not uncommon for Polish nationals to travel to Poland for specialist treatment, such as dental or gynaecological care. A lack of extensive medical records in the UK may reflect this pattern rather than an absence of healthcare needs. The SME suggested that the concerns raised were unlikely to be due to language difficulties but may instead relate to differences in how healthcare services are structured. For example, needing to visit a GP for repeated referrals for contraception could understandably feel repetitive or frustrating for someone used to a different system.
- 6.28 Also, the panel considered whether there was any sexual abuse perpetrated on Natalia as in his relationship with Agata. The panel considered a number of other options, perhaps she would need more time off work to have to go to the Sexual Health clinic and that would be frustrating also, that this service may not be as well known in the polish community as a stand-alone service, also attending a sexual health clinic could be a stigma for anybody. The Sexual Health Service in Lincolnshire is a primary one for contraception and may not be well known especially if the patient is of a minority ethnicity.
- 6.29 Natalia presented twice to the Urgent Treatment Centre in a market town in Lincolnshire. On the 19<sup>th</sup> of May 2019 with a 3-day history of arm pain. There was no bruising, swelling or deformity identified; she reported that she needs to lift during work. She was advised re analgesia and to see the GP if it became worse or did not resolve. On the 22<sup>nd</sup> of June 2019 she attended this time with a sore throat, antibiotics were prescribed, and she was advised to see her GP. Both these dates were on weekends when her GP practice would not have been open for consultations.
- 6.30 On the 14<sup>th</sup> of November 2019 Natalia was seen by the GP with a cough and sore throat which she had for 4 weeks. The GP recorded that she was a single mother living alone in rented accommodation. She advised there were cats and spiders present in

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<sup>1</sup> [Poland ranked as worst country in Europe for contraception | Notes From Poland](#)

the accommodation. She declined examination by the GP even though offered 3 times during the consultation. She objected to the GP asking her questions about her living circumstances.

- 6.31 On the 29<sup>th</sup> of January 2020 a letter was sent to Natalia requesting she book an appointment for her routine cervical smear screening; she did not respond. On the 24<sup>th</sup> of April 2020 a telephone consultation was completed with the GP (due to the covid pandemic), for the NuvaRing contraceptive, alternatives were discussed with her, but she insisted she had been using this form of contraception for more than 1 year and wished to continue with this. This was prescribed again for her, but she was advised this was no longer an available contraception from GP practices.
- 6.32 On the 4<sup>th</sup> of March 2021 Natalia again contacted the GP practice by telephone requesting contraception and was referred to a face-to-face appointment due to a language difficulty experienced by the practice member speaking to Natalia. Natalia attended a face-to-face appointment on the 8<sup>th</sup> of March 2021 with the Advanced Nurse practitioner. She was again sign posted to the Sexual Health clinic for prescribing of the NuvaRing which was no longer available from the GP practice. Natalia also declined cervical screening at this appointment. Natalia then had an initial telephone assessment and then face to face appointment with the LCHS Sexual Health services requesting prescription of NuvaRing. A full history was taken which included asking about domestic abuse in relationships, which she responded no to. She stated she had a partner, but no further details were recorded. A 3-month prescription of NuvaRing was supplied to her. Later that month Natalia attended a face-to-face review appointment with LCHS Sexual Health Services. She was again asked about domestic abuse, which she answered no. She advised she had a partner, again no further details were recorded. An audit of sexual health records is now completed, which includes a standard to record partners details when the assessment proforma is completed. Had this not been the case this would have progressed to a recommendation.
- 6.33 Jakub had 2 consultations with the GP Practice. On the 11<sup>th</sup> of December 2017 by a Practice Nurse. This was for his new patient screening, following registration at the practice. He reported to live with his girlfriend, was Polish speaking and working in a factory. On the 3<sup>rd</sup> of January 2018 the GP reviewed some tests and attempted to contact Jakub however the GP was not able to establish contact.
- 6.34 Cibor was presented to the GP practice on 16 occasions by Natalia. This included: 4 contacts for routine childhood immunisations which were all completed at the expected age, and at the first appointment requested to attend. Her routine 8-week examination with the GP was also completed at the expected timescale.
- 6.35 Cibor was presented appropriately by her mother for minor illnesses including respiratory illness, constipation and concerns about her weight gain and feeding. As well as the attendances at the GP practice the baby had 2 attendances at LCHS out of hours services. Natalia showed appropriate concern returning her child for reviews where she believed her daughter's condition had not improved or required further

assessment. She also followed advice when following telephone consultations, she was advised to present her daughter for a face - to-face assessment or to return for further care if the baby's condition had not improved.

- 6.36 Attendances at the GP practices / Out of Hours services of note were as follows: On the 14<sup>th</sup> of November 2019 Cibor was presented to the GP by their mother with a history of having a cough for 2-3 days. Her mother reported the child was grinding their teeth and felt this may be due to the cat in the house who she believed to have worms. The baby was observed by the GP to be in a dirty push chair, but to be clean in their own presentation. Natalia had advised the GP that she was a single parent living alone at this appointment. On the 1<sup>st</sup> of December 2019 Cibor was presented by both parents to the GP out of hours service in A market town in Lincolnshire; with a viral cold for the last 2-3 weeks, and a worsening cough and sore throat. This was only 2 weeks after informing the GP that she was a lone parent.
- 6.37 When Natalia was seen by LCHS Sexual Health Services, she was asked the question in her assessment about domestic abuse on 2 occasions. This question is asked of all patients attending the service, and this was fulfilled as per expected practice. Both times Natalia stated there were no concerns regarding domestic abuse. Details of her partner were not recorded, which at the time was not expected practice, but is now expected practice. An opportunity to ask about relationships / potential for domestic abuse would be at the postnatal check by the GP, but it was documented that Natalia refused to discuss anything other than bottle feeding and contraception at this appointment. *Comment: However, there is no evidence of the GP asking the DA question.*
- 6.38 What is advocated in the area is a clinical enquiry based on SafeLives <sup>2</sup>guidance. Page 2 Clinical vs routine enquiry. Clinical vs routine enquiry some health environments undertake routine enquiry of domestic abuse in all female patients. Whilst it does ensure all female patients are asked about domestic abuse, it can make asking the question routinised and therefore inattentive, which can in turn discourage victims/survivors from disclosing.
- 6.39 The panel agree that clinical enquiries are its preferred methodology. It is very clear given Natalia's presentation's she would have fulfilled the clinical threshold and should have been asked about DA. Was this a missed opportunity by the GP to ask targeted DA questions.
- 6.40 LCHS Sexual Health complied with expected practice and asked regarding domestic abuse on both contacts with the victim. The GP practice however did not comply with any proactive questioning about DA. No disclosures of domestic violence were made. With regards to her wishes for contraception, the GP practice when they were no longer able to prescribe her desired contraceptive did attempt to offer alternative choices to her, and when they were unable to meet her need advised and gave contact details for the Sexual Health clinic where the contraceptive of her choice would be made available to her. It is unclear however from her responses and GP practice

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<sup>2</sup> [Pathfinder GP practice briefing.pdf \(safelives.org.uk\)](#)

recording Natalia's manner on consultations if she was unhappy with the contacts or if there was any difficulty of her understanding the information provided. There is no evidence of the use of an interpreter in any consultations with Natalia, but one entry indicating, that she could not understand the conversation over a telephone appointment. All LCHS staff which included the GP practice for the timescales for the scope of the review, had access to telephone interpreter services to assist with patients where English is a second language.

- 6.41 Jakub was only seen on 2 occasions in GP practice, no other information was known to LCHS services regarding Jakub. Natalia and Jakub were of Polish nationality, but there is no record made at their initial new patient contact at the GP practice if there was any language barrier or if an interpreter was required / used which would indicate no difficulties were encountered at this appointment. LCHS staff have access to telephone interpretation services for all contacts where they are required. There is no record of any language barrier difficulties experienced by the Urgent Treatment Centre of Sexual health teams who had contact with either adult or being required to use interpretation services to support consultations.
- 6.42 Natalia appropriately accessed both GP services and appointments in the out of hours Urgent Care Services for herself and her child for minor illnesses and when she was concerned regarding a lack of improvement in Cibor's health. She presented Cibor for routine immunisations as required. When telephone triage services were put into operation by the GP practice during COVID pandemic, Natalia appeared to be able to access the health care she required. It may have been difficult for her to understand why the GP practice was no longer able to prescribe her contraceptive of choice as it was not part of the GP prescribing formulary and could only be provided through Sexual Health Services.
- 6.43 Whilst there is evidence of practice staff attempting to explain how to obtain this in the future, the GP practice consultations with Natalia recorded there to have been difficult conversations in respect of this issue. At no point in the contacts was it considered whether an interpreter may have been of assistance or if it was a language difficulty that was frustrating the consultation. Had this been indicated, the use an interpreter would have been expected to clarify patient understanding of the issues concerned. There was only one occasion at the GP practice where language issues were indicated as a potential barrier. On the 4th of March 2021, Natalia had the telephone consultation with regards to contraception the content of the conversation appeared to create confusion, and a face-to-face appointment was arranged a few days later. It is apparent from the ICB records that this appointment was completed without any language issues. There is no record of any language barrier difficulties experienced by the Urgent Treatment Centre of Sexual Health teams who had contact with either adult or being required to use interpretation services to support consultations.
- 6.44 In the contact with the GP on the 14<sup>th</sup> of November 2019, the GP asked Natalia about the home environment and social history. She informed the GP she was a single parent living alone in rented accommodation, where there were cats and spiders present, but she objected to the GP asking about information of this nature. On the 1<sup>st</sup>

of December 2019 Cibor was presented to the GP out of hours services by both parents, but their names were not recorded. It is expected practice within LCHS Urgent care services to record the name and relationship of the parents / carers accompanying a child for treatment. This standard is reviewed quarterly in Urgent care record keeping audits.

6.45 Care delivered by LCHS services within the Urgent Care and Sexual Health was delivered within expected LCHS policies and practice. The following areas of practice however have been identified and addressed within practice for future learning:

1. It is expected practice in Urgent Care services to record who attends with a child for care by both name and relationship. This standard is audited in all Urgent care settings on a quarterly basis and feedback supplied to managers and individual practitioners where the standard has not been met.

2. LCHS Sexual Health services, have updated the Contraceptive template completed at contacts to include recording details of the patient's partner. Record keeping audits / safeguarding audits are completed within this service on a biannual basis.

### **Newham University Hospital**

6.46 Natalia attended Newham University Hospital on the 30<sup>th</sup> of June 2017 and booked her pregnancy. This was Natalia's first pregnancy. A Polish health advocate was utilised to obtain the history. She was 9 weeks pregnant at the time of booking. All safeguarding questions were asked, there was no disclosure of domestic abuse within the relationship. She disclosed that she and her partner, Jakub, had previously used ecstasy on 2 occasions that month. Referral to Newham Social care was completed. Referral to the Acorn Vulnerable Women's team also completed as well as a health visitor liaison form due to the use of ecstasy.

6.47 Natalia attended a community midwife appointment in August 2017 at 16 weeks pregnant. Her care was consultant led with midwife input. Natalia stated that to the midwife that she only wanted to be seen by a "white doctor or midwife" therefore declined care. Natalia was offered an appointment in the antenatal clinic and was advised that her request could not be guaranteed. Natalia did not attend that appointment. A risk management information form was completed, in view of Natalia's comments and the fact that she has not attend appointments. The maternity team were informed that Natalia was transferring care.

6.48 Within the pregnancy the presence of past or current domestic abuse is a routine question that is asked by midwives. In this case the question was asked at booking via the in-house health advocates within the hospital as English was not the victims first language. At this point of contact the victim did not disclose domestic abuse. However, a referral to Newham Children's social care was triggered by the disclosure of parent's use of Ecstasy.

### **United Lincolnshire Hospitals NHS Trust (ULHT)**

- 6.49 Natalia received support from ULHT services throughout the period of this review, predominantly in relation to her pregnancy. At the point at which she presented for antenatal care in Lincolnshire (December 2017), she was noted to be 29 weeks' gestation. All prior antenatal care was delivered in Newham, London.
- 6.50 Natalia stated she lived with her partner Jakub in rented accommodation; and denied any historic or current mental health and/or social concerns, when asked. Natalia reported that she could speak and read English fluently. Due to Natalia disclosing Ecstasy use in early pregnancy, Consultant-led antenatal care was indicated. Consultant lead care means the patient receives a higher level of clinical oversight by an obstetrician and hospital/community midwife. The direct routine DA enquiry was asked at all the times required and Natalia denied abuse, reporting to be 'fully supported' by Jakub. The process of direct DA questioning has changed since the time period covered in this review. Now the process involves a pregnant women being asked every time there is an interaction when before it was just on 3 occasions. There are a couple of occasions when patients are not required to be asked, and the new system wouldn't have been fully embedded at the time. ULHT was transitioning into that process at the time.
- 6.51 Natalia engaged with Midwifery and Obstetric services for the remainder of her pregnancy, attending planned appointments. Natalia's reluctance to cease smoking during her pregnancy resulted in her receiving additional growth scans. No concerns relating to domestic abuse were identified during her attendances (some of which were attended with Jakub), and domestic abuse was denied on those occasions upon which Natalia attended alone, and direct routine enquiry was required to be undertaken. Natalia's Community Midwife (CMW) was aware that she had previously reported, to her Health Visitor, that she was experiencing financial problems; and it was confirmed with Natalia that she had attended Citizen's Advice Bureau (CAB), as per her Health Visitor's advice. The CMW also informed Natalia where/how to apply for a SureStart Maternity Grant. This shows good evidence of holistic support.
- 6.52 Post birth, Natalia and Jakub were noted to be delivering all care to Cibor, and home visits were undertaken without event. Natalia was reported to be emotionally well post-Natali, and she was discharged from Maternity care in March 2018. Routine post-natal advice was shared, reiterated, and fully understood by Natalia.
- 6.53 On the of 20th April 2019, Natalia attended A&E (unaccompanied) with self-injurious cuts to her wrist. No clinical treatment was required and, when asked, she did not wish to discuss why she had harmed herself. Natalia denied suicidal ideation. She was referred to the Mental Health Liaison Team (LPFT), as per Trust processes; however, although a Team member attended, Natalia did not wish to engage with them whilst in the department and signed to self-discharge. There were no concerns regarding her capacity to discharge herself and she was provided with contact
- 6.54 ULHT had no knowledge of domestic abuse, including coercive and controlling behaviour, in relation to Natalia and Jakub. ULHT records suggest that Jakub was present with Natalia during some of her Midwifery-related attendances and there is no evidence to suggest that any concerns were aroused in relation to their joint presentation or interaction. At the time of Natalia's involvement with Maternity

services, it was recommended that a domestic abuse routine enquiry be undertaken at booking, at 26 weeks and at 36-week appointments (if safe and appropriate to enquire). Notification of the response was recorded using an X/O code within the hand-held records (records that are retained by the pregnant woman).

- 6.55 During the agreed scoping period of this review (and on the occasions during which Natalia was accessing Midwifery care), knowledge of a pregnant woman experiencing domestic abuse would be reliant either on them providing a positive response to the routine enquiry, or via their general presentation. In addition, knowledge of a pregnant woman experiencing domestic abuse might also be ascertained as a result of information shared at MARAC or via another multi-Agency forum. However, since February 2021, discussions between the Police and Midwifery services have resulted in an agreement for the Police to share information with the Midwifery Safeguarding Team should they be involved in any incidents involving a pregnant woman. This allows for appropriate action to be taken should the pregnant woman deny abuse when the routine enquiry is undertaken or at any other stage within the pregnancy. This collaborative work with the police is seen as good practice.

### **Education**

- 6.56 During the scope of the review Cibor attended a private nursery from May 2021-November 2021. They attended for 15 hours a week for their 3- and 4-year-old funded hours and attendance during this time was good. Cibor had a few days off poorly with a regular cough and Natalia thought Cibor might have asthma. During the hours Cibor wasn't at nursery, the setting encouraged Cibor, Natalia and Jakub to go to the park to support with regulating behaviour. This was expressed through behaviours such as lashing out or demanding attention. (some of this is age appropriate) and they knew that Cibor had been to the beach and swimming. At the time the setting were still in their covid recovery process, following the covid lockdowns and parents were not being invited into the setting. Parents always collected Cibor from the setting, no other adults would do the pickup. It would usually be either Natalia or Jakub. This was linked to shift patterns.
- 6.57 On one occasion, a few weeks before Natalia was reported missing both Natalia and Jakub did come to pick up together, they didn't really communicate, and the manager sensed there may have been a disagreement between them. Natalia did not disclose any incidents of DA to the setting. The nursery view was Natalia was able to speak more English than Jakub. The setting would speak to Natalia about concerns they had. Jakub was more difficult to communicate with, his language was a barrier, and he only spoke a few English words. He was always polite, but quiet. The nursery setting did not have access to interpreters. This is a private business, and this is not something that is readily available to them.
- 6.58 Cibor had a really good relationship with Natalia. Natalia was always interested in what they had been doing at the setting and looked at artwork etc when she collected Cibor. Cibor was never distressed when picked up by Jakub. The key person had been working closely with Natalia as there were some concerns about Cibor's behaviour in

the setting (including needing support to regulate emotions and hurting other children) and Natalia was also concerned about Cibor's eating. The concerns about Cibor's behaviour meant additional support was given through Early Years (EY) Inclusion funding and through the support of the Early Years Specialist Teacher. This was early in the process and so the setting was unable to share the impact that this had.

- 6.59 The Key Person for Cibor had a strong attachment with the child and when their behaviour in the setting became dysregulated at times such as tidy up time, or a change in routine, the key person would be able to talk the child around. Cibor would at times bite and hit out at adults and children. The setting was working on targets to support Cibor and trying to assess if this was an emerging special education needs and disability (SEND). Following the lockdown there were other children in the setting experiencing the same issues and so this wasn't something that the setting thought was an unusual behaviour at the time. Cibor really enjoyed sensory play activities at the setting and got a lot of joy from these. Cibor was also good at building and enjoyed small world play such as using cars in the setting. Cibor was not good at tolerating other children attempting to play or playing close by. Natalia had spoken to the nurse setting about worries that she had about her child's eating, saying that Cibor ate very little at home and was slight in build. Cibor was always encouraged to eat at the setting, which they did with the support of their key person. The setting had encouraged Natalia to get some support from the 0-19 health service and she had a recent appointment with them.
- 6.60 The child mind institute<sup>3</sup> provides useful insight into the challenges that practitioners encounter when working with children who present as Cibor did. This however enforces the importance of whilst thinking SEND also think wider and is trauma relevant.

#### **Lincolnshire Partnership NHS Foundation Trust Mental Health Liaison Team (LPFT)**

- 6.61 On the 20th of April 2019, Natalia was referred to the Mental Health Liaison Team (LPFT) by a market town in Lincolnshire A&E due to self-harming. The LPFT staff member spoke to Natalia who reported that she did not wish to remain in the hospital and wanted to return home to get her cigarettes. She declined to wait to be seen by medical staff and signed a self-discharge form before leaving the department. Prior to her leaving, the LPFT clinician made her aware of how to seek appropriate mental health support should it be required in the future and gave the contact number for the Single Point of Access (SPA) for the mental health trust. Natalia was seen by LPFT staff within the specified service time frame of one hour. LPFT staff member acted to ensure she was aware of how to access mental health support if she wanted this. The interaction with LPFT was seen as appropriate.

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<sup>3</sup> [Is It ADHD or Trauma? - Child Mind Institute](#)

## 7. CONCLUSIONS AND KEY ISSUES ARISING FROM THE REVIEW

### Pregnancy as a potential trigger point

- 7.1 Throughout Natalia's pregnancy there is no evidence of any disclosures of domestic abuse. The review found questioning by health visitors and midwifery, appropriate. Opportunities were provided to Natalia to disclose. The review did find that the GP could have asked clinical DA questions. What is not lost on the panel is the point that Jakub became controlling with Agata when she became pregnant however there is no evidence in this review that the situation was the same for Natalia. Nevertheless, the panel would be wrong to consider just because she did not disclose DA, that it was not present as it was with Agata. Having consideration to this, the panel are satisfied that opportunities given to disclose, were as per policy and best practice.

### Barriers to reporting.

- 7.2 Whilst it is noted in this review the opportunities that Natalia was given to disclose, the panel have asked were the opportunities appropriate. The review outlines the additional challenges faced by Polish born women. However, the panel have been made aware that the Lincolnshire Domestic Abuse Partnership (LDAP) have recognised the need in Lincolnshire to enhance the engagement of seldom heard communities and more specifically, the Eastern European Community. Informed by a local needs assessment and prior learning reviews, the current offer of support is summarised below. Activity is regularly reported on and monitored via the Lincolnshire Domestic Abuse Program Board.

**Commissioned Service** – LDASS.org.uk – includes the following provision.

- **Digital Platform** - has the option for users to choose which language to access it in
- **IDVA** – the service has employed an individual of Eastern European nationality who works with victims from the Eastern European community where possible
- **Interpreter services** - as required for face-to-face engagement
- **Outreach & Engagement Team** –
  - **DA Champions** - Domestic Abuse Champions are the eyes and ears around the county helping to support proactive early intervention for those experiencing domestic abuse. Events aimed at professionals, business owners, survivors and members of the public who share a vision for raising awareness in the community. Whilst this initiative is aimed at all cultures there is current representation from the Eastern European Communities.
  - **Community Engagement Events** – continued program of awareness raising events including specific targeting of areas with higher Eastern European population.
  - **Surviving to Thriving** – community groups run by the community for the community, the outreach and engagement team support with set up and delivery of empowerment activities to build confidence of survivors and encourage them to thrive.

- **Scan codes** – posters and stickers with scan codes to support non-English speaking victims to access the website where they can access information in a language of their choice.
- Libraries Initiative – initially planned from January 2024 [JK1] in one Eastern European Community with a view to extending wider across the county. The Domestic Abuse service, Lincolnshire Domestic Abuse Specialist Advisory Service (LDASS), which is provided by EDAN Lincs, began early in 2024 January to October, there was a monthly drop in the provision of legal services and translators made available to the Eastern European community, however, due to very little uptake of those requiring this type of support, this element of the service was stopped, despite efforts being made via community leads to promote this drop in service. Early in October LDASS changed their translation service, where we can now offer on demand translation service to any person contacting the service by phone.
- **DA Training** – all training for professionals explores barriers in understanding and accessing DA services, including cultural perspectives on understanding risks in specific communities and encouraging the use of professional curiosity.
- **MARAC Chairs Events** – learning events for MARAC chairs – Awareness of DA in Eastern European communities and cultural perspectives is part of the wider plan of knowledge sharing.

### **Communications –**

- **Social media and communications campaigns** - including 16 days of Action, are ongoing in collaboration with partner agencies and offer specific content for Eastern European communities.
- **DA Newsletter** – Monthly newsletter distributed to partners with links to specific services and resources including those pertaining to Eastern European communities.
- **Crimestoppers** – The campaign delivered jointly with Lincolnshire Police and Lincolnshire County Council with a specific theme of raising awareness in Eastern European communities of understanding domestic abuse, overcoming myths about the UK system of support and promotion of local services. This campaign has now ended.
- **Lincolnshire County Council website** – content is accessible via an option to translate to chosen language. Links to Eastern European organizations are available for the public and professionals to access advice, guidance and resources.

7.3 The panel discussed the services to the Polish community at length. The SME was able to significantly contribute and provide questions and challenges to the panel. Business engagement was considered key in the area that Natalia resided in. Business engagement was confirmed as follows:

### **Business Engagement –**

- **Local Employer Engagement** ongoing initiative to support Lincolnshire businesses to meet their responsibilities regarding Domestic Abuse under the Health and Safety at Work Act 1974. The four key aims of the engagement program are to support employers to; design and develop safeguarding/domestic abuse procedures and

protocols, develop and deliver briefings to key staff, provide signposting of information and services to employees, and to introduce local services to employees including how to access them. 2023 includes a targeted approach to businesses known to employ a high rate of Eastern European employees.

- **Business Engagement Conference** – annual conference to inspire and motivate employers to engage in the ongoing program of support (see above). Conference invites in 2023 have included a specific approach to businesses known to employ a high rate of Eastern European employees.

- 7.4 It was also confirmed that the Lincolnshire DA Partnership (LDAP) re-commissioned the community-based services within Lincolnshire and the services above are what is available in the provided provision. In terms of specific engagement within the Polish community this has proved challenging. There has been a mixture but to date it has been found that in general there is a reluctance to engage in services. In part this has been due to the Polish community having heard and seen things regarding Children's Services in Britain in a documentary in Poland which they are not comfortable about. The evidence for this thinking has come from work with VESTA the SME on this panel. Therefore, further work is ongoing in the community to ascertain what support is needed and sending out appropriate messages. It is accepted this is a longer-term piece of work to embed these messages into communities to encourage those affected to reach out to services. The DA Champion and Outreach and Engagement Team (OET), through the commissioned service is one of the ways Lincolnshire is trying to engage with communities. There are a number of people across the County that have signed up to be a DA Champion and to run a survivor/thriver group, all of which is monitored through contract management processes. This is in its early stages as it was only put in place just last year (2023). However the team are already having great impacts on communities and have worked with a number of organisations, community groups and community leaders to reach a variety of people in the community, including but not limited to non-English speaking groups, church groups, schools, women and men empowerment groups etc
- 7.5 It was also considered the community groups are not starting from scratch but are linking into existing groups. It was acknowledged that the first point of contact needs to be correct i.e. access to interpreters which should be clearly shown on websites as this will encourage someone to call if English is not their first language. The chair suggested this would be typical of all emergency services and is a good theme. It was confirmed that there is a chat service which can be translated. Once there is an initial contact, there can be through the medium of the service user's choice (e.g. phone call text email etc.) but there needs to be the initial contact first.
- 7.6 Further areas of good practice were identified within health. A useful guide about the health service <sup>4</sup>for migrants and also useful translated health information for patients.<sup>5</sup> Also within the partnerships own area a GP practice was identified which produces <sup>6</sup> fact sheets that have been written to explain the role of UK health

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<sup>4</sup> [PRINT How the NHS works infographic ENGLISH FV \(doctorsoftheworld.org.uk\)](https://www.doctorsoftheworld.org.uk/print/how-the-nhs-works-infographic-english-fv)

<sup>5</sup> [TRANSLATED HEALTH INFORMATION FOR PATIENTS - Doctors of the World](https://www.doctorsoftheworld.org.uk/translated-health-information-for-patients)

<sup>6</sup> [Non-English Speakers: South Lincolnshire Rural Primary Care Network \(deepingspractice.co.uk\)](https://www.deepingspractice.co.uk/non-english-speakers-south-lincolnshire-rural-primary-care-network)

services, the National Health Service (NHS), to newly arrived individuals seeking asylum. They cover issues such as the role of GPs, their function as gatekeepers to the health services, how to register and how to access emergency services. Whilst most of the Polish community are not seeking asylum the guidance is of use and could be easily tailored further to support them. The panel considered this information and believed further awareness, tailoring where required and promotion of these leaflets across the partnership is recommended.

#### Family background and cultural matters

- 7.7 Throughout Natalia's pregnancy there is no evidence of any disclosures of domestic abuse. However, the barriers for Polish women as expressed in this review must be recognised.

#### Patterns of domestic abuse from this or previous relationship

- 7.8 Considering the government definition of domestic violence and abuse, which describes a pattern of incidents of controlling, coercive or threatening behaviour, the Review Panel was able to determine there was not a significant history of known domestic abuse in other relationships involving Natalia. However, it is noted in 16.2.5 in which Jakub describes slapping Natalia. Tragically Natalia is not able to discuss with the panel her experiences with Jakub. However, the panel acknowledges the experiences of Agata and recognise that the same traumas could have been occurring for Natalia. Also, in 16.4.3 the concern Natalia has about her finances is raised. There is evidence of excellent signposting and collaborate work with a charity to assist Natalia. This is again evidenced in 16.7.3 but the prospect of financial control has also been considered. There is also evidence in 16.2.6 which demonstrates that Jakub wanted Natalia to keep the baby and was this a demonstration of his control.
- 7.9 Whilst the panel have not seen any evidence of financial control this could well have been a reason why Natalia was not able to leave Jakub. The concern around finances is acknowledged in this review.

## 8. LESSONS LEARNED

- 8.1 Natalia's untimely death was a tragedy and has affected her family deeply. For those close to Natalia the very nature of her murder has made this all the more difficult.
- 8.2 In approaching learning and recommendations, the Review Panel has sought to do two things. First, to try and understand what happened and consider the issues in Natalia's life that might help explain the circumstances of the death. Second, to use this case to consider a wider range of issues locally, including provision for victims of domestic violence and abuse.
- 8.3 The information provided by the agencies involved through their IMR's have

enabled this review panel to ascertain some learning points that need to be considered due to the tragic death of Natalia. These points have been explored during the review process and recommendations have been made with the intention of supporting victims and survivors facing similar difficulties and challenges to that of Natalia. To that end, the panel has sought to try and understand what happened and recognise the issues in the life of Natalia.

8.4 The themes identified are:

- Advancing and improving understanding and awareness of Polish Culture.
- Polish community understanding of health services provided.

## 9. RECOMMENDATIONS

### 9.1 Local Recommendations:

The following local recommendations have been agreed by the panel.

**Recommendation (R1)** – ICB are to continue to emphasis during training sessions, via newsletters and relevant safeguarding forums that GP practices are utilising clinical DA questioning when required.

**Recommendation (R2)** – Raise awareness across schools that the behaviour children exhibit can sometimes be confused as SEND where in fact it is DA trauma.

**Recommendation (R3)** – The ICB to promote translation services which explain how the NHS operates to practices who do not currently have them on their website.

### National :

**National Recommendation** – The Home office to lobby the department for education to develop and implement a national awareness initiative across all education settings to ensure that children's behaviours are not automatically interpreted as indicators of Special Educational Needs and Disabilities (SEND) when they may, in fact, be manifestations of domestic abuse-related trauma. This initiative should equip school staff with the knowledge and confidence to distinguish trauma responses from SEND presentations, enabling timely, appropriate, and trauma-informed support.