DOMESTIC HOMICIDE REVIEW - OVERVIEW REPORT

Safer Lincolnshire Partnership

REPORT INTO THE DEATH OF Natalia

November 2021

Report produced by Simon Steel – Foundry Risk Management Consultancy LTD

Report Completed on 17/02/25.

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FOREWORD

The Safer Lincolnshire Partnership would like to express their condolences to all those affected by the sad loss of Natalia. This review sincerely hopes the learning and recommendations gained from our enquiries and deliberations will help agencies to prevent similar incidents from happening again in the future.

The independent chair of this Domestic Homicide Review panel would like to thank all agencies who contributed to the process in an open and transparent manner. This review has demonstrated that it is crucial to offer appropriate and timely help and advice to victims of domestic abuse, their families, friends, and professionals. The panel is confident that the learning points and recommendations will provide a platform to help national, regional, and local agencies to implement measures designed to embed a preventative approach to addressing domestic abuse.

Following this death, there is emerging evidence of positive change at a local level. We all must do our utmost to take immediate action to protect victims and to deal effectively with the perpetrators of domestic abuse and the chair would urge everyone to take note and act on the findings of this review. Together we must take the threat and harm posed by domestic abuse seriously at a leadership, frontline, and community level to help bring these types of incidents to an end.

1. INTRODUCTION

1.1 This Domestic Homicide Review (hereafter "the review") was established under Sec 9(3) of the Domestic Violence Crime and Victims Acts 2004. It examines agency responses and support given to Natalia who was a resident of a market town in Lincolnshire prior to her death in November 2021. At the time of her death Natalia was a 27-year-old Polish born women who lived with her partner Jakub and their child Cibor in a market town in Lincolnshire. She studied at a University in Poland before flying to England in March 2015, where she had the offer of a job in a market town in Lincolnshire.

1.2 Natalia was reported missing by her partner Jakub in November 2021.

1.3 The review will consider the contact and involvement that services had with Natalia and Jakub from 1st of November 2017 until the discovery of Natalia's remains in February 2022. In addition to involvement of services, the review will also examine the past, to try and identify any relevant background prior to the death and whether support was accessed within the community. By taking this holistic approach, the

review attempts to identify opportunities for improved responses that will make the future safer.

1.4 The key purpose for undertaking reviews of this nature is to enable lessons to be learned from deaths which occur in similar circumstances and with a related background. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand, fully, what happened following each death, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

1.5 This review process does not take the place of the criminal or coroner's courts, nor does it take the form of a disciplinary process.

1.6 The review panel wishes to express its deepest sympathy to the family and friends of Natalia, for their loss and thank them for their contributions and support for this process.

2. TIMESCALES

2.1 Lincolnshire police referred this matter to the Safer Lincolnshire Partnership on the 24th of November 2021. Following a review contact was made with the Home Office on the 15th of December 2021, informing them of the Partnership's intention to carry out a Domestic Homicide Review into this matter. A letter of reply and agreement was received on the 16th of December 2021.

2.2 Peter Stride was commissioned to provide an Independent Chair (hereafter 'the chair') for this review on the 4th of February 2022. Due to the personal circumstances of both the Chair and Author there was then a period of unavoidable delay, and the original author could not ultimately continue. Then on the 30th of August 2023 Simon Steel was commissioned as the independent author (hereafter 'the author') The completed report was passed to the Safer Lincolnshire Partnership on the 7th of May 2025 It was submitted by the partnership to the Home Office Quality Assurance Panel on 12th May 2025.

2.3 Home Office guidance states that a review should be completed within six months of the initial decision to establish one. The time frame for this review was extended for several reasons:

- To allow the criminal trial to conclude in October 2022
- To support engagement with Natalia's family.
- To facilitate a change of author.

- Due to a bereavement of the chair.

- Availability of panel members to complete IMR's and attend panel meetings. There has been a high volume of reviews in the county during this period.

3. CONFIDENTIALITY

3.1 The findings of this review are confidential and will remain so until the Overview Report and Executive Summary have been approved for publication by the Home Office DHR/DARDR Quality Assurance Board. Information is available only to participating professionals/officers and their line managers.

3.2 Details of confidentiality, disclosure and dissemination were discussed and agreed between member agencies during the first panel meeting and all information was treated as confidential and nothing was disclosed to third parties without the agreement of the responsible agency's representative.

3.3 Each agency representative was personally responsible for the safe keeping of all documentation that they possessed in relation to this review and for the secure retention and disposal of that information in a confidential manner.

3.4 It was recommended that all members of the Review Panel used a secure email system, and that information should not be sent in any other way and was also password protected.

3.5 This review has been suitably anonymised in accordance with the statutory guidance. The pseudonyms were agreed with the family and are used in the report to protect the identity of the individuals involved.

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

3.6 As per the statutory guidance, the chair, author, and the review panel members are named, including their respective roles and the agencies which they represent. Agencies that provided information are also identified.

4. Terms of Reference

4.1 Following discussions at initial panel meetings the chair circulated the Terms of Reference (TOR), to the agencies that had contact with the victim and Jakub. The review aims to identify learning from Natalia's death and for actions to be taken in response of that learning with a view to preventing similar deaths and ensuring that individuals and families are appropriately supported in the future.

4.2 The review panel comprised of agencies from the Safer Lincolnshire Partnership, as Natalia lived in their area at the time of her death. They were contacted as soon as possible after the review was established to inform them of the need to identify and secure records and for their participation within this process.

4.3 Key Lines of Enquiry: During the review the chair and panel have considered both the 'generic issues' as set out in the statutory guidance and additional issues specifically relevant to this case. Various discussions have led to the following case specific issues being agreed:

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

4.4 At the initial panel meeting agency members shared a summary of their engagement with Natalia and Jakub. It was agreed that the time focus for this review would be from 1st of November 2017 until March 2022. This period was chosen as it relates to a period when Natalia became pregnant, to allow for an in-depth review of current methods and processes to be carried out, and to ensure that recommendations and learning would be based on existing policies, procedures, and training. Where appropriate, information about the relationship outside of this period has been included to provide context.

5. Methodology

5.1 The report uses the cross-government definition of domestic violence and abuse. This review commenced after the Domestic Abuse Act receiving royal ascent in April 2021 and defines domestic abuse as:

- The Behaviour of a person (A) towards another person (B) if.
    I. A and B are each aged 16 or over and are personally connected to each other and.

II. The behaviour is abusive

- Behaviour is abusive if it consists of any of the following -

1. physical or sexual abuse.
2. violent or threatening behaviour.
3. controlling or coercive behaviour.
4. economic abuse (see subsection (4)).
5. psychological, emotional, or other abuse.

It doesn't matter whether the behaviour consists of a single incident or a course of conduct.

Two people are Personally Connected to each other if any of the following applies.

1. They are, or have been, married to each other.
2. They are, or have been, civil partners of each other.
3. They have agreed to marry one another (whether or not the agreement has been terminated).
4. They have entered into a civil partnership agreement (whether or not the agreement has been terminated).
5. They are, or have been, in an intimate personal relationship with each other.
6. They each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2).
7. They are relatives.

It is defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse, psychological, physical, sexual, financial, and emotional.

5.2 Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

5.3 Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

5.4 This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation and forced marriage and is clear that victims are confined to one gender or ethnic group.[1]

5.5 This review has followed the statutory guidance. On notification of the death, agencies were asked to check for their involvement with any of the parties concerned and secure their records. It was during this scoping process that chronologies were collated and combined. This overview was reviewed by the chair and Individual Management Reviews (IMRs) for all the organisations and agencies that had contact with Natalia were requested.

5.7 Documents Reviewed

In addition to the combined chronology and IMR's, various documents and open-source research has been carried out including:

- Website for commissioned service for domestic abuse support
- Home Office Documents referring to key findings from analysis of previous DHR's
- Citizens Advice document regarding "What is Public Sector Equality Duty"
- Safer Lincolnshire Partnership website – Domestic Homicide Reviews
- Screening women for inter-partner violence in healthcare settings (Review), Cochrane Library. 2015
- The Royal College of Nursing – Roles and Responsibilities of Health care staff.
- The CQC report on the relevant GP Surgery.

5.8 Panel Meetings

Review Panel meetings took place on the 18th of January 2023, 11th of October 2023, 18th of January 2024, 7th of March 2024, 1st of May 2024 and the 15th of November 2024. The chair held several individual agency discussions with panel representatives, and authors, to seek clarification on points within agency IMR's and review Key Lines of Enquiry.

6. Involvement of Family, Friends, Work Colleagues, Neighbours, and Community.

6.1 Following the decision to conduct a DHR the Partnership wrote to the family of Natalia. Details of contact with the family are at Appendix 2.

[1] https://www.gov.uk/government/news/new-definition-of-domestic-violence

6.2 The chair made several efforts to engage with both parents of Natalia. The chair also utilised the Homicide Case working team from Lincolnshire police to try an establish contact. However, both parents declined to take part in the review.

6.3 The chair has noted the comments made by Natalia's mother following the conviction of Jakub. She told the court that Natalia had a heart of gold and that whilst taking Natalia's ashes back to Poland she knew that her heart remained in England, the country that she loved.

6.4 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.

6.5 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.

6.6 The chair was not able to identify any relevant neighbours or community to contribute to this review. This was despite a personal visit to the area, door to door efforts and a related leaflet drop. In addition the chair requested the support of the homicide investigation team to reach out and contact potential witnesses and community leaders who may be able to support the chair and review. Again despite best efforts, this proved to be unsuccessful.

6.7 The chair wrote to Jakub in prison. He declined to take part in this review.

6.8 Efforts were made by the Partnership to contact the victims' employers however, despite thorough and extensive efforts no response was received to the letters that were sent.

6.9 The chair wishes to record their appreciation for the time and assistance given by those who have contributed to this review.

7. Contributors to the Review

7.1 The following agencies and the contributions to this review are:

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

7.2 Quality and Independence of the IMR authors. The IMR's were prepared by authors who were independent of any service delivery or case management regarding Natalia or Jakub. The IMR's were comprehensive and allowed the panel to analyse the contact with Natalia & Jakub. The detail ensured that the panel were able to identify learning and recommendations for this review and where necessary, follow-up meetings were held, and questions sent to agencies. Responses were received, prior to, or at, subsequent panel meetings.

8 Review Panel Members

Name	Role/Job Title	Agency
Peter Stride	Independent Chair	Foundry Risk Management Ltd
Simon Steel	Independent Author	Foundry Risk Management Ltd
Rachel Cox	Detective Chief Inspector	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)
Support to the Panel		
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

9 Chair and Author of the Overview Report

9.1 Simon Steel was appointed by the Safer Lincolnshire Partnership as Independent Author of this Domestic Homicide Review panel. Simon is a retired Thames Valley Police Detective Superintendent. He has considerable experience in the field of domestic abuse, Public Protection and Safeguarding. He was also a Multi-Agency Public Protection Arrangements (MAPPA) 3 chair. His experience includes specialist, strategic and generic investigative roles across the Thames Valley. He has also led complex Domestic Homicide Investigations.

9.2 Since retirement, Simon has established his own consultancy business and has now chaired multiple Domestic Homicide Reviews. Simon has been subcontracted by Foundry Risk Management who have a long history of chairing reviews.

9.3 Simon has also worked as the Head of Adult Support for an autism charity within the voluntary sector who are commissioned by local authorities and Integrated Care Boards (ICB). Simon has also worked as a Learning Disability and Autism Champion for an ICB. Simon believes his work alongside statutory, non-statutory and voluntary sector organisations provides him an enhancement to his policing portfolio.

9.4 Simon has completed Home Office approved Training and has attended subsequent Training by Advocacy After Fatal Domestic Abuse.

9.5 Simon has no connection with the Safer Lincolnshire Partnership.

9.6 Peter Stride was appointed by Safer Lincolnshire Partnership as the Independent Chair of this Domestic Homicide Review panel. 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.

9.7 Since retirement Peter has established his own consultancy business, including coaching and training in a range of risk management environments focusing upon child and adult safeguarding within the public sector.

9.8 He has experience of chairing and authoring a wide range of safeguarding reviews including domestic homicide, statutory reviews following suicide, and adult reviews involving those exploited by criminal gangs.

9.9 Additionally he consults on safeguarding matters with Community Safety Partnerships in the Home Counties and lectures, as an SME, at the National College of Policing.

9.10 Peter has completed Home Office approved Training and has attended subsequent Training by Advocacy After Fatal Domestic Abuse.

9.11 Peter has no connection with Safer Lincolnshire Partnership or any of the agency's involved in this review.

10 Parallel Reviews

10.1 Crown Court: Jakub was 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.

10.2 Coroners Court: In June 2022 an inquest was opened and adjourned pending the outcome of the criminal trial. Following the criminal trial and prosecution in October 2022 HM Coroner confirmed there would not be an Inquest and their investigations were now concluded.

11 Equality and Diversity

11.1 The review panel considered all 9 protected characteristics under the Equality Act 2018 i.e.

- Age
- Disability
- Gender Assignment,
- Marriage and Civil Partnership.
- Pregnancy and Maternity
- Race
- Religion and Belief
- Sex
- Sexual Orientation.

11.2 The panel reflected upon each of these in evaluating the various services provided to Natalia. It is incumbent on this review to consider the duty on public authorities to; remove or reduce disadvantages suffered by people because of a protected characteristic, meet the needs of people with protected characteristics, encourage people with protected characteristics to participate in public life and other activities [1].

11.3 Each protected characteristic was analysed by both individual agencies and the panel, against policies and procedures that were in place at the time of the death of Natalia.

11.4 The panel identifies that women and girls are disproportionally impacted by domestic abuse and other forms of gender-based violence and abuse, whilst also recognising that a significant minority of men also suffer similar issues of violence and abuse. Analysis reveals gendered victimization across both intimate partner and familial homicides with females representing most victims and males representing most perpetrators.

11.5 There was a number of protected characteristics that the panel agree are pertinent to this review. These include examining the circumstances through the lenses of gender and race.

11.6 SEX: Natalia was female, and her partner was male. The gendered nature of domestic abuse is evidenced and recorded in numerous reports and also by specialist organisations. An analysis of DHRs[2] reveals gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators. Women's Aid reports[3], "There are important differences between male violence against women and female

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1 https://www.citizensadvice.org.uk/law-and-courts/discrimination/public-sector-equality-duty/what-s-the-public-sector-equality-duty/

2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf

3 Domestic abuse is a gendered crime - Women's Aid

violence against men, namely the amount, severity, and impact. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt (Walby & Towers, 2017; Walby & Allen, 2004) or killed than male victims of domestic abuse (ONS, 2020A; ONS, 2020B).

11.7 RACE: Natalia was born in Poland in 1994. The extent to which race is a factor regarding domestic abuse may be considered from several perspectives, including whether the prevalence of abuse within the Polish community is fully understood considering the barriers to seeking support.

11.8 The femicide census [1]states that Polish born women are the second most likely group of women in this country to be victims of domestic homicide. Eastern European, post-communist/ post-Soviet countries appear to stand out in the data, constituting four of the most frequently represented countries of birth after the UK: Poland (34 victims), Latvia (12), Romania (11) and Lithuania.

11.9 The Polish Women's experience of Domestic Violence & Abuse in the UK report [2] assists the reader in this review. Within the executive summary it provides a context that domestic abuse is poorly recognised in Poland. The Polish government is critical of domestic abuse and women's rights campaigns as undermining traditional values, the sanctity of marriage and Polish identity. There is limited recognition of non-physical forms of abuse in Polish law and overall neglect of domestic abuse in state policy with funding cuts for services and the threat to withdraw from the Istanbul Convention on combating violence against women. Indeed, Agata experienced many of these challenges.

11.10 Women had to contend with multiple forms of abuse, with coercive and controlling behaviour being most common, but always accompanied by other forms (physical, psychological, economic, sexual). Women's understandings of abuse and possible options were shaped by their migration experience (personal identity, social isolation, practical concerns) along with discourses in Poland around the family and alcohol. Women's responses to abuse: recognising that abuse was taking place was a complex, gradual process that often required outside intervention from friends, family, or services. Socio-cultural and Polish Catholic Church norms about women's roles within families and the shame and stigma of divorce and failed relationships further constrained women's disclosures of violence. Limited space for action was created by perpetrators' controlling behaviour and the need to balance employment, finances, childcare and housing alongside a fear of formal services due to possible repercussions by the perpetrator and persistent worries about children being taken

[1] Femicide-Census-10-year-report.pdf (femicidecensus.org)

[2] Polish-women-and-DVA_project-report_June2022.pdf (bpb-eu-w2.wpmucdn.com)

into care. State policies around benefit entitlements, housing and no recourse to public funds was also a barrier reported by practitioners.

11.11 Family, friends and social networks, including those made through work, often played an important role in enabling women to recognise abuse and in giving emotional and practical support. Yet, these networks could side with the perpetrator, shame women for 'breaking up' the family and ignore the abuse, meaning that women ended up trapped in the relationship for longer. Polish women are often unfamiliar with service provision, legislative frameworks, and practice processes in the UK, including Legal Aid, social housing, child protection and police injunctions. Multiple information flows and referral paths are therefore invaluable to provide a strong safety net. Service responses are only effective if they address the complex dynamics of abuse, including emotional dimensions.

11.12 Most Polish people can identify physical, emotional, sexual and economic abuse and believe it's unacceptable (85% - 90%). However, there is still limited awareness of some types of abuse, such as economic or sexual abuse in Poland. Polish people do not fully understand different types of economic abuse. 14% of people believe that "to dole out money and control family finances means that the spouse has good money management skills" (Kantar, 2019) [1], and 14% of people agree with the statement saying that "private property does not exist in a marriage and a husband can do whatever he wants with the wife's possessions" (TNS OBOP, 2010). 9% of Polish people believe that rape within marriage does not exist (Kantar, 2019).

11.13 Alcohol abuse is a common aggravating factor in domestic violence cases in Poland. 40% of people who experienced abuse said that the perpetrator was under the influence of alcohol. Polish police statistics show that perpetrators' alcohol abuse is a factor in 60% of domestic abuse incidents reported to them. (Kantar, 2019). Data from VESTA's work with clients who contacted their domestic violence helpline show that 71% of victims reported that perpetrators had problems with alcohol, drugs, or mental health; alcohol abuse was the most common factor (Wilcock, 2017).

11.14 RELIGION: The review has not been able to establish whether Natalia was of the Catholic faith, the principal faith in Poland. However, it is understood that even if people are not practicing faith the values could impact on you and those around you. The Faith & Communities Programme by Standing Together in London[2] summarises some of the challenges confronting victims. Many survivors with a faith feel that some specialist services and society, in general, are unable to understand their experiences of abuse, and their barriers to accessing support due to their religious identity, their

[1] Ogólnopolska diagnoza zjawiska przemocy w rodzinie Raport Kantar Polska dla Ministerstwa Rodziny, Pracy i Polityki Społecznej, Kantar, 2019

[2] Faith & Communities Programme — Standing Together

faith community and any spiritual abuse that they may experience at the hands of their perpetrator.

11.15 The panel has acknowledged the challenges faced by Polish service users within this market town in Lincolnshire. Not just services that provide translation services at the point of service but services that provide practitioners trained in Polish culture. In the 2021 census 3800 people (5.4%) in the town Natalia lived in stated their country of birth was Poland. Of course, many of this group will have also had children who were born in England, as in this case. It is recognised it is a challenge everywhere due to different challenges encountered in different geographic locations. It is however acknowledged that the local area as identified later in this report have made significant progress in addressing support for seldom heard communities. Furthermore, considering the Equalities Act, it places a duty on public authorities to; remove or reduce disadvantages suffered by people because of a protected characteristic; meet the needs of people with protected characteristics; encourage people with protected characteristics to participate in public life and other activities. In these circumstances one may argue a greater burden is therefore placed on authorities to be alert to and ask about domestic abuse in their dealings with such individuals.

12. DISSEMINATION

12.1 Once finalised by the Review panel the Executive Summary and Overview Report will be presented to the following Safer Lincolnshire Partnership panel members and chair for approval. Upon approval they will be sent to the Home Office for Quality Assurance.

12.2 The recommendations will be owned by the Safer Lincolnshire Partnership, who will be responsible for disseminating learning through local professional networks as well as managing progress of the Action Plan which is created at the conclusion of this review and in response to the recommendations that have been made.

12.3 The following individuals and agencies have been identified as recipients of both reports.

Agency
Safeguarding Children Partnership
Safeguarding Adults Board
The Office of the Police and Crime Commissioner
The Domestic Abuse Commissioner

Multi-Agency Domestic Homicide Review Oversight Sub-Group
The Family
All Panel Members

12.4 The report will be published online, on the Safer Lincolnshire Partnership website.

13 Background Information (The Facts)

13.1 At the time of her death Natalia was a 27-year-old woman. Natalia had lived in England since 2015 and later that year she started a relationship with Jakub. They lived in a market town in Lincolnshire. They then moved to London in the Autumn of 2016 but moved back to the same market town in Lincolnshire towards the end of 2017. In March 2018 Natalia gave birth to their child, and they remained living and working in this market town in Lincolnshire.

The Death

13.2 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.

13.3 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.

14. Combined Narrative Chronology

14.1 The following section summarises contact between Natalia and Jakub and various agencies. To assist the reader, the table below summarises the names of the organisations and their role in this case. The paragraphs within the narrative chronology are prefaced with the lead agency to identify the primary source of information and assist the reader.

Organisation	Role	Acronym
A market town in Lincolnshire's Council	Local Council	MTL
General Practice	Primary Care	GP
United Lincolnshire Hospitals NHS Trust	Hospital	ULHT
Lincolnshire County Council (Children's Health)	Children's Health	LCCCH
Lincolnshire Police	Police	Police
Lincolnshire Partnership NHS Foundation Trust Mental Health Liaison Trust (LPFT)	Mental Health Liaison Team	LPFT
Lincolnshire Community Health Services (LCHS)	Community Health	LCHS

14.2 MAY 2015

14.2.1 **MTL.** On the 29th Jakub was issued with a Public Space Protection Order Advice Letter following being spoken to by a PCSO. This was issued because he was seen consuming alcohol within the Public Space Protection area. He complied with the request to stop consuming alcohol at the time. It was kept on file for 6 months and was removed from the file after this six-month period with no further incidents of this nature.

14.3 OCTOBER 2017

14.3.1 **GP.** On the 11th both Natalia & Jakub register as patients with the GP. Natalia is recorded as 29 weeks pregnant.

14.4 DECEMBER 2017

14.4.1 **ULHT.** On the 6th seen for an antenatal appointment. Noted all previous antenatal care delivered in London: DA routine enquiry completed and denied any DA.

14.4.2 **LCCCH.** On the 13th there was a notification of prospective parent received into Single Point of Access (SPA) from midwifery.

14.4.3 **ULHT.** On the 20th Natalia was seen for a routine antenatal appointment. Both Natalia & Jakub attended.

14.4.4 **ULHT.** On the 27th Natalia attended antenatal clinic. Referred for Consultant care due to health and welfare reasons. They confirm details to GP in a letter regarding the plan.

14.5 JANUARY 2018

14.5.1 **GP.** On the 3RD Jakub had an appointment with his GP.

14.5.2 **ULHT.** On the 10th Natalia had a routine follow up. DA routine enquiry not completed however was not required at this stage, in line with the guidance in place at that time.

14.5.3 **ULHT.** On the 24th Natalia had a growth scan. DA routine enquiry completed, attended alone DA denied.

14.5.4 **LCCCH.** On the 29th Natalia had antenatal contact completed at home. She spoke about her partner positively in terms of how supportive he was. Asked about domestic abuse which Natalia denied and said he was caring.

14.6 FEBRUARY 2018

14.6.1 **UHLT.** On the 7th Natalia had a routine follow up. DA routine enquiry not completed however was not required at this stage, in line with the guidance in place at that time.

14.6.2 **UHLT.** On the 21st Natalia had a routine follow up. Natalia reported to be well supported by Jakub. General support was offered. Natalia had previously reported to her health visitor (HV) that she was experiencing financial problems. Midwife confirmed that Natalia had attended citizens advice (as per HV advice). Midwife informed Natalia where/how to apply for a Sure Start Maternity Grant.

14.6.3 **UHLT.** On the 26th Natalia had a routine follow up. DA routine enquiry not completed however was not required at this stage, in line with the guidance in place at that time.

14.6.4 Child was born during this time.

14.7 MARCH 2018

14.7.1 **UHLT.** On the 4th Natalia had a midwife visit at friend's house, she was staying with friends for additional support whilst Jakub is at work. DA routine enquiry not completed however was not required at this stage, in line with the guidance in place at that time.

14.7.2 **UHLT.** On the 6th Natalia had a midwife follow up. visit at friend's house, staying with friends for additional support whilst Jakub is at work DA routine enquiry not completed however was not required at this stage, in line with the guidance in place at that time.

14.7.3 **UHLT.** On the 11th Natalia had a midwife follow up. Jakub was in attendance. No concerns raised regarding their joint presentation. DA routine enquiry not undertaken due to Jakub's presence.

14.7.4 **LCCCH.** On the 14th Natalia had a home visit. A DA routine enquiry was made, which Natalia denied. Natalia reported some concerns around her bonding with the baby, advice given.

14.7.5 **LCCCH.** On the 20th Natalia had a home visit to review attachment and bonding. She has moved property and advises she is developing a bond with the baby.

14.8 APRIL 2018

14.8.1 **GP.** On the 11th Natalia had an appointment regarding the baby, minor medical question.

14.8.2 **LCCCH.** On the 17th Natalia had routine follow up. Natalia reported Jakub as supportive denied domestic abuse when asked.

14.9 MAY 2018

14.9.1 **GP.** Natalia had 5 encounters this month with her GP re the baby for routine matters or herself (back ache). One of these encounters was reported as difficult and the GP recorded Natalia had issues with Dr's in the UK. Also, one encounter with **LCCCH** this month.

14.10 JUNE 2018

14.10.1 **LCCCH.** Natalia had 2 routine appointments this month. One of these, DA questions asked and denied.

14.10.2 **GP.** Natalia had 2 encounters with her GP this month routine matters.

14.11 JULY -AUGUST 2018

14.11.1 **GP.** Natalia had 3 routine encounters this month with her GP, 2 for Natalia 1 for Cibor.

14.12 November 2018

1412.1 **GP.** Natalia had 2 routine encounters this month with her GP one for her one for Cibor.

14.13 January 2019

14.13.1 **LCCCH.** On the 17th both Natalia and Jakub attended an 8–12-month baby assessment. Natalia and Jakub reported to speak positively about caring for Cibor and both seen talking to the baby softy and handled with care and confidence.

14.14 February-March 2019

14.14.1 **GP.** Natalia had 2 routine encounters over this time with her GP one for her one for Cibor.

14.15 April 2019

14.15.1 **POLICE.** On the 20th Jakub called the police stating Natalia returned home from an evening shopping trip drunk and that she had been violent towards him. Jakub stated, *"She is now cutting herself with a piece of glass".* An ambulance was called, however due to ETA the police took Natalia to hospital. **ULHT** recorded no clinical treatment required. Did not wish to disclose why she had harmed herself, when asked. Referred to MH Liaison Team (as per A&E process). Denied suicidal ideation. **LPFT** mental health liaison team (LPFT) staff member spoke to Natalia who reported that she did not wish to remain in the hospital and wanted to return home. She declined to wait to be seen by medical staff and signed a self-discharge form before leaving the department.

14.16 May 2019

14.16.1 **UTC.** On the 19th Natalia presented with a 3-day history of arm pain. No bruising, swelling, or deformity seen on examination. Has to do lifting as part of her employment.

14.17 June 2019

14.17.1 **UTC.** On the 22nd Natalia presented with a sore throat with fever, aches and pains. Natalia was observed to look well but with a raised temperature and pulse rate. Diagnosed with tonsilitis.

14.18 November 2019

14.18.1 **GP.** On the 14th Natalia presented with a 4-week history of sore throat, cough and cold, requesting medication to stop the cough. At the same appointment Natalia presented Cibor with a reported cough for 2-3 days, otherwise eating, drinking well and sleeping as normal. GP recorded Cibor was presented as clean, but in a dirty push chair. Cibor was well perfused, no rash or shortness of breath, no signs of dehydration noted. Throat inflamed, diagnosed with an upper respiratory tract infection.

14.19 December 2019

14.19.1 **GP.** On the 1st Natalia and Jakub attended extended hours GP with Cibor. Reported to have started with viral cold 2-3 weeks previously but progressed to more of cough and sore throat. Natalia recorded to have been giving analgesia. Temperature normal range, no skin rash. inflamed throat diagnosed with acute tonsilitis.

14.19.2 **GP.** On the 2nd Natalia requested further prescription for antibiotics as reported to have spilt half the bottle and not enough to complete the course.

14.20 April 2020

14.20.1 **GP.** On the 24th Natalia telephone appointment for contraception.

14.21 June 2020

14.21.1 **LCCCH.** Had a missed telephone appointment for 2-2.5-year review then subsequent contact made.

14.22 July 2020

14.22.1 **MTL.** On the 16th Jakub was issued a warning letter for drinking alcohol in Public Space Protection area. He complied with the request to stop consuming alcohol at the time. The letter was kept on file for 6 months.

1422.2 **GP.** On the 17th Natalia had a consultation requesting contraception.

14.22.3 **MTL.** On the 30th Natalia called on behalf of her father who was due to be evicted that day or the following day. She asked for urgent advice and requested a call on her father's behalf as he speaks very little English.

14.23 September 2020

14.23.1 **LCCCH.** On the 17th a home visit, both Natalia and Jakub seen at home address with Cibor. Growth was assessed as normal, no concerns.

14.24 March 2021

14.24.1 **GP.** Natalia had 4 interactions this month 2 with GP and 2 with sexual health re contraception. This month was the first time GP recorded communication challenges (language).

14.24.2 **LCCCH.** On the 17th telephone 3-year review for Cibor with Natalia.

14.25 April 2021

14.25.1 **GP.** Natalia had a telephone contact due to COVID. Cibor had been coughing for one week, had clear secretions, decreased appetite, but drinking well, reported active. No rash reported, diagnosed with a viral illness.

14.26 May 2021

14.26.1 **LCCH.** Natalia had a missed contact and a contact re follow up for Cibor.

14.27 June 2021

14.27.1 **GP.** Natalia had 2 interactions regarding Cibor's cough.

14.27.2 **LCHS.** On the 26th Natalia attended for a contraceptive prescription to be issued. Social and medical history completed, nil issues raised, no is answered to questions. This proforma includes domestic abuse question. No partner details taken.

14.28 July 2021

14.28.1 **LCHS.** On the 2nd Natalia had telephone contact, she reported Cibor had a cough for last 2 months, seen GP and treatment given. Cibor has since developed a fever above 38 degrees.

14.28.2 **LCHS.** On the 2nd Natalia presented with Cibor who was very distressed. Natalia reported that Cibor was not their usual self, they had a raised temperature and had been unwell for 8 weeks. Had antibiotics and inhaler from GP, no improvement reported by Natalia. unable to examine due to level of distress.

14.28.3 **ULHT.** On the 3rd Cibor was admitted via UTC with cough. Bruise noted to right, knee and shin of Cibor. Natalia unsure how this happened but suggested it may have occurred when they fell from their scooter whilst on a fishing trip with parents. For

Consultant review. Child Protection enquiry undertaken (in response to evidence of bruise).

14.28.4 **LCCCH.** On the 15th HW spoke to Natalia re concerns re toileting so home visit arranged.

14.29 August 2021

14.29.1 **LCCCH.** On the 19TH scheduled home visit took place. Cibor is now toilet trained. Natalia is concerned that Cibor is quite thin and has limiting diet as will not try new foods.

14.30 September 2021

14.30.1 **GP.** On the 1st telephone contact with Natalia, Cibor with coughing symptoms reported coughing at night for 3 -4 months, face to face appointment arranged, seen with Natalia, carried in screaming loudly, difficult to assess initially as so distressed, when calmer could assess. Cibor was running around room climbing on everything, well perfused, good colour, but unable to examine ears.

14.30.2 **GP.** On the 16th a text message was sent to Natalia regarding flu vaccine for Cibor.

14.30.3 **LCCCH.** On the 16TH a home visit took place. Growth monitored and no concerns for Cibor. Both parents participated in the contact.

14.31 October 2021

14.31.1 **GP.** On the 8th a telephone triage due to COVID. Progressed to face-to-face appointment. Consultation with Natalia, concerned Cibor had a cough for 5 days, waking in night, given over counter medication.

14.31.2 **GP.** On the 18th a face-to-face appointment; Cibor seen with Natalia, child crying and shouting continuously tried to examine but unable to as Cibor kicking continuously.

14.32 November 2021

14.32.1 **GP.** On the 11th Natalia did not attend planned appointment with GP

14.32.1 **POLICE.** On the 11th Jakub reports Natalia missing.

15. OVERVIEWS

This section summarises what information about Jakub and Natalia was known to each agency, and what professionals were involved with the family within the review period. Any other relevant facts or information are also included in this section.

15.1 LINCOLNSHIRE POLICE

15.1.1 The only interaction with Lincolnshire police prior to the missing person's report, was on the 20th of April 2019. Jakub called Police to report that Natalia his partner was drunk and had been violent towards him. 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. 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 that his partner was self-harming. 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 self-harmed. 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 a nearby hospital for treatment.

15.2 A MARKET TOWN IN LINCOLNSHIRE COUNCIL

15.2.1 This agency narrative covers interaction with a Market Town in Lincolnshire's Community Safety team, Private Sector Housing team, Customer Service team and Housing Benefits team.

15.2.2 After a review of the systems it was confirmed that Natalia had 2 interactions in relation to housing matters, one for herself and one on behalf of her father. Jakub had 2 interactions in relation to drinking alcohol in a prescribed area.

15.3 LINCOLNSHIRE COUNTY COUNCIL (CHILDREN'S HEALTH)

15.3.1 Lincolnshire County Council Children's Services Department provides both universal and targeted services to 142,000 children and their families across the county. Children's Health Service delivers the Healthy Child Programme (Department of Health 2009) within Lincolnshire. This consists of a universal health visiting service to all children in Lincolnshire from the antenatal period until the end of their reception year in school and a targeted children and young people's (CYPN) nursing service to children with an identified health need from school year 1 to 19 and up to 25 for those with a Special Educations Needs and Disability (SEND).

15.3.2 Children's Services provided a universal health visiting service to Natalia from 13th December 2017 following notification of her pregnancy and subsequently to Cibor. The review of the SystmOne (health records) provided a clear overview of the service provided.

15.4 LINCOLNSHIRE COMMUNITY HEALTH SERVICES

15.4.1 Lincolnshire Community Health Services (LCHS) delivers a range of community health services, including Adult Community nursing, Adult and children's therapy, Sexual Health Services, Care in Community Hospitals, and a range of Urgent Care Services, including the telephone Clinical Assessment Service, Urgent Treatment Centre settings along with some primary care settings. LCHS previously managed services at the GP where Natalia and Jakub were registered patients, but this

contract ended in September 2022. The GP practice is no longer under contract with LCHS. During the scope of the review Natalia had 17 contacts with LCHS services.

15.4.2 There were 2 consultations completed with Jakub at the practice and Natalia presented Cibor on 16 occasions at the practice.

15.5 NEWHAM UNIVERSITY HOSPITAL

15.5.1 Whilst living in London Natalia attended Newham University Hospital on the 30th of June 2017 and registered 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.

15.6 UNITED LINCOLNSHIRE HOSPITALS NHS TRUST

15.6.1 United Lincolnshire Hospitals NHS Trust is one of the largest Trusts in the country, providing services from 3 acute hospitals in Lincolnshire. The Trust also provides a wide variety of outpatient, day case and inpatient services from a range of other community hospitals operated by Lincolnshire Community Health Services or local GP clusters. The Trust provides a wide range of healthcare services delivered by over 7,500 trained staff.

15.6.2 The medical notes for Natalia, Jakub and Cibor were sourced and analysed, to ascertain the care and treatment provided by United Lincolnshire Hospitals NHS Trust (ULHT), during the given scoping period.

15.6.3 Natalia received support from ULHT services throughout the scoping period of this review, predominantly in relation to her pregnancy. At the point at which she presented for antenatal care in Lincolnshire on the 6th of December 2017, she was noted to be 29 weeks' gestation. All prior antenatal care was delivered in Newham, London, and Natalia's documentation suggests she engaged with required scans, appointments, etc. prior to relocating.

15.7 EDUCATION

15.7.1 Cibor attended a private nursery. Lincolnshire County Council Children's Services conducted an interview with the manager from the nursery. The nursery is a privately owned full day care setting within Lincolnshire. The setting is not owned or directly line managed by Lincolnshire County Council. Cibor attended the setting From May 2021-November 2021. The information provided by the setting manager was from the following sources: Information provided by Cibor's key person, the register kept showing attendance and documents kept supporting the setting with Cibor's emerging Special Educational Need Documents that are kept by the setting to record support given.

15.8 LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST MENTAL HEALTH LIAISON TEAM (LPFT)

15.8.1 On 20th April 2019, Natalia was referred to the Mental Health Liaison Team (LPFT) by a market town in Lincolnshire A&E due to self-harming issues. whereby she had

superficially cut her wrist. 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).

16. Analysis

16.1 Hindsight Bias

16.1.1 Both the chair and the author have attempted to view this case, and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight. Hindsight always highlights what might have been done differently and this potential bias or 'counsel of perfection' must be guarded against. There is a further danger of 'outcome bias's' and evaluating the quality of a decision when its outcome is already known. However, I have made every effort to avoid such an approach wherever possible.

16.1.2 The analysis of the combined chronology, IMR's and discussions with panel members and IMR authors revealed themes that are further explored within the individual agency analysis that follows. These include use of translators and domestic abuse services for marginalised communities.

Agency Involvement

16.2 Lincolnshire Police

16.2.1 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 20th of April 2019. He called to report that Natalia was drunk and had been violent towards him.

16.2.2 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.

16.2.3 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.

16.2.4 There was no reference to either Natalia's mother or any child being present at the time of the incident and the PPN was not shared with any partner agency as given the circumstances at the time this action was not required. The Reviewing Officer has spoken with the attending officer who unfortunately has very little recollection of attending the incident almost 4 years ago. He has no specific recollection of any other person/child being present within the address upon his attendance.

16.2.5 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. In a statement provided to police prior to his arrest for Murder Jakub stated, *'Natalia has never on purpose self-harmed as much as I'm aware, there was one situation when she punched a glass door panel and broke it and cut her hand and she said that she could take more of this glass and cut herself more with it, but she was very drunk at that time, and I rang the police for help'. She only used violence against me in our relationship twice. Once she smashed a glass on my head, I would describe her as an impulsive person. Second incident was about 3 years ago, she was taking some tobacco from my pocket, and she ripped my trousers up, then she slapped me, so I slapped her back.'* The panel recognise the context in which he provided this information and that it is self-serving.

16.2.6 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). 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.

16.2.7 Officers have access to EDAN[1] (**E**nding **D**omestic **A**buse **N**ow in Lincolnshire) cards (which is for the Domestic Abuse support service for Lincolnshire) to hand to victims and offer to show them a video to make them aware of the service they offer. When a Public Protection Notification (PPN) is completed by officers, it is flagged for the consideration of a supervisor who will then review the incident and either concur or amend the risk grading, having liaised with the submitting officer. The authorised form is then forwarded to the Police Safeguarding Hub (PSH) for further review to determine if the information should be brought to the attention of a partner agency. On the one occasion Lincolnshire Police were called, the officer determined the risk to be standard. The supervisor concurred with this grading. Neither party involved in the incident had any known history of domestic abuse and were not subject to MARAC or similar multi agency intervention/assistance.

16.2.8 Whilst it cannot be confirmed that their child Cibor, was present at the time of the April 2019 incident, guidance dictates that officers should record the details of any children and refer to whether they attended the time of the incident subject to the PPN. Should it then be deemed appropriate by staff in the PSH, the information could then be shared with Children's Services for their information. There is no reference to a child's name in the PPN and thus no reference to this having been shared with Children's Services as a result of the incident. The officer has no recollection of the incident and cannot recall if there was evidence of a child's clothing or possessions within the property. The Reviewing Officer has been unable to confirm with the officer's supervisor at that time if there was any discussion as to adding the child's name to the PPN, as they are no longer a member of Lincolnshire Police.

16.3 A MARKET TOWN IN LINCOLNSHIRE COUNCIL

16.3.1 Natalia was known to a market town in Lincolnshire A market town in Lincolnshire Council's Private Sector Housing Team. On the 14th 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.

16.3.2 On the 30th 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.

[1] https://edanlincs.org.uk/

16.3.3 On the 29th 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.

16.3.4 On the 26th 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.

16.3.5 It is the view of the panel that the interactions with the local council were appropriate and proportionate given their interactions with Natalia and Jakub.

16.4 LINCOLNSHIRE COUNTY COUNCIL (CHILDREN'S HEALTH)

16.4.1 All health staff have to comply with Lincolnshire Safeguarding Children's Partnership (LSCP) 6-year safeguarding training plan which includes a variety of courses toward domestic abuse, and this is reported via multiple assurance boards. 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 29th of January 2018, 14th of March 2018, 17th of April 2018 and the 12th of June 2018. On all four of these occasions Natalia denied any domestic abuse or coercive and controlling behaviour was taking place. On the 3rd of July 2020 Natalia was asked about her relationship with Jakub and she reported no concerns and reported that she was happy.

16.4.2 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.

16.4.3 The children's health service moved over to Lincolnshire County Council on the 1st of October 2017. The standard operating procedure (SOP) including asking the routine

enquiry for domestic abuse was brought over from Lincolnshire Community Health Services. The SOP dates from June 2015 and documents the expectation of health visitor's in asking the domestic abuse question. This statement is part of the care plans for all core contacts completed by the health visitors (antenatal contact, primary birth visit, 6–8-week review, 1 year review, 2-year review, 3-year review and transfer in contact). The SOP was updated September 2019 and includes the expectation of health visitor in asking the domestic abuse question at every contact. The Lincolnshire Multi-Agency Domestic Abuse Policy and Procedures is embedded in children's services practice but is not relevant to this case as no disclosures were made.

16.4.4 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 8th 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.

16.4.5 Natalia has discussed with the Health Visitor on the 29th 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.

16.4.5 At the antenatal contact on the 29th 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 20th of March 2018 the Health Visitor saw Natalia and the baby at the new address, the lounge was presented as clean and warm.

16.4.6 Natalia signed a consent form for sharing of SystemOne (health record) information with other health agencies on the 14th 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.

16.4.7 A home visit was conducted on the 20th of March 2018 specifically to review attachment and bonding as concerns were identified within the primary birth visit on the 14th of March 2018. A further review was conducted at the 6-8-week assessment on the 17th 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 25th centile to just above the 9th 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 22nd 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 6th June 2018 but she was not weighed due to being asleep. Cibor was reviewed again in clinic on 12th June 2018 and her weight was back on the 25th centile.

16.4.8 On the 3rd 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 17th 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.

16.4.9 All of the above information highlights the assessments conducted by the health visitor which are all as expected when considered against policy and procedures. All decisions on care provided were reached in a professional and informed way. All services offered by the health visitor were in line with universal care as described in the Healthy Child Programme (2021). No disclosures were made around domestic abuse therefore the health visitor did not refer or signpost to any domestic abuse services. All care and assessments are deemed appropriate as aligned to policy and guidance.

16.4.10 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.

16.4.11 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.

16.4.12 The panel agree that the chronology and the IMR both present a high standard of Health Visitor Care with all aspects of the Healthy Child Programme being delivered and continuity of Health Visitor. There have been no learning points identified for Children's Health as all care was provided as per Healthy Child Programme and per Lincolnshire County Council policy. Domestic abuse enquires have been made as per expectations and no disclosures made.

16.5 LINCOLNSHIRE COMMUNITY HEALTH SERVICES (LCHS)

16.5.1 During the scope of the review Natalia had 17 contacts with LCHS services. She was first seen on the 11th 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.

16.5.2 On the 2nd 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.

16.5.3 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.

16.5.4 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 7th 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.

16.5.5 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[1] is more limited

[1] Poland ranked as worst country in Europe for contraception | Notes From Poland

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.

16.5.6 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.

16.5.7 Natalia presented twice to the Urgent Treatment Centre in a market town in Lincolnshire. On the 19th 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 22nd 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.

16.5.8 On the 14th 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 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.

16.5.9 On the 29th 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 24th 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.

16.5.10 On the 4th 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 8th 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.

16.5.11 Jakub had 2 consultations with the GP Practice. On the 11th 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 3rd of January 2018 the GP reviewed some tests and attempted to contact Jakub however the GP was not able to establish contact.

16.5.12 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.

16.5.13 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.

16.5.14 Attendances at the GP practices / Out of Hours services of note were as follows: On the 14th 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 1st 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.

16.5.15 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.*

16.5.16 What is advocated in the area is a clinical enquiry based on SafeLives [1]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.

16.5.17 Gene Feder, a GP in Bristol and Professor of Primary Care at University of Bristol who chaired NICE guidelines on domestic abuse explains: “We, clinicians, have to ask [about domestic abuse] but it has to be in the context of really wanting to know and it has to be triggered by what the patient is presenting. You’re asking is triggered by someone being for example anxious, depressed, chronic pain, maybe difficulty sleeping- a whole range of symptoms we know are associated with abuse.” NICE guidelines state that there is insufficient evidence to recommend screening or routine enquiry in most healthcare settings. Therefore, GPs are recommended to practice clinical enquiry, which sets the threshold for asking low and uses the information from the interaction with the patient to make an assessment.

16.5.18 SafeLives guidance for GP’s recognises that some physical and mental health issues, such as anxiety, depression, chronic pain, difficulty sleeping, facial or dental injuries, chronic fatigue and pregnancy and miscarriage have a strong link to being a victim/survivor of domestic abuse. Patients who present with such symptoms should

[1] Pathfinder GP practice briefing.pdf (safelives.org.uk)

always be asked about abuse. In addition, in heterosexual relationships abusive perpetrators often exert control over a woman's reproduction; GPs should be alert to indicators such as urinary tract infections, unprotected sex, lesion of nipple, STIs, pregnancy and requests for a termination.

16.5.19 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.

16.5.20 All LCHS staff undertake mandatory safeguarding training which includes domestic abuse indicators, assessments and actions where identified. This would have included the staff at the GP Medical Practice whilst under the management of LCHS. Safeguarding supervision was also completed at the GP practice on a quarterly basis, during the scope of this review except during the pandemic. It is mandated for all LCHS staff working in Urgent Care and Sexual Health settings to attend safeguarding supervision twice a year. All LCHS staff have access to safeguarding advice and support from the LCHS safeguarding team.

16.5.21 LCHS has current domestic abuse and safeguarding policies which includes procedures for undertaking DASH assessments and risk management of domestic violence. Resources to support the completion of DASH assessments, safety planning and referrals to Domestic Violence support are all available on both the LCHS Safeguarding intranet, and on a safeguarding resources folder universally available on all employee's computer desktop. Safeguarding supervision was provided on a quarterly basis to the GP practice during the period of the scope of this DHR, where domestic abuse was covered. During the scope of this review, the GP practice was hosted by LCHS so worked to these safeguarding / domestic abuse policies.

16.5.22 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 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.

16.5.23 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.

16.5.24 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.

16.5.25 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.

16.5.26 In the contact with the GP on the 14th 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 1st 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.

16.5.27 Care delivered by LCHS services within the Urgent Care and Sexual Health was delivered within expected LCHS polices 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.

16.5.28 Care delivered by LCHS services within the GP practice was delivered within expected LCHS polices and practice with the exception of clinical DA questioning.

Learning Consideration (LC1) - 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.

16.6 NEWHAM UNIVERSITY HOSPITAL

16.6.1 Natalia attended Newham University Hospital on the 30th 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.

16.6.2 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.

16.6.3 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.

16.6.4 The panel agree that Newham university Hospitals interactions with Natalia were appropriate given the circumstances presented.

16.7 UNITED LINCOLNSHIRE HOSPITALS NHS TRUST (ULHT)

16.7.1 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.

16.7.2 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.

16.7.3 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.

16.7.4 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.

16.7.5 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 details for community MH services prior to discharge.

16.7.6 Cibor accessed ULHT services in order to manage intermittent presentations of a persistent cough. On the 3rd of July 2021, Cibor was admitted to a ward for Paediatric review of her prolonged cough and cold symptoms. During this attendance, bruises were noted to Cibor's right thigh, knee and shin. Natalia reported to be unsure how the bruises could have occurred; however, suggested these might have been sustained as a result of Cibor falling from her scooter whilst on a fishing trip with her parents. A Child Protection enquiry was undertaken (as per expected process) and it was confirmed that there was no previous/current Social Care involvement. The bruises were examined by a Consultant Paediatrician who was satisfied that the bruises matched the mechanism of injury provided by Natalia and so were considered accidental. In relation to Cibor's initial presentation, it was determined that the cough/cold symptoms may be related to a viral upper respiratory tract infection (URTI). Symptom management was advised and Cibor was discharged.

16.7.7 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).

16.7.8 ULHT provides training to all clinical staff in relation to the recognition and management of domestic abuse disclosures/concerns and locally recognised resources are available within the Trust's Domestic Abuse Policy and also via the Trust's intranet. In addition to support available via the Trust's Safeguarding Team, ULHT has access to a Hospital IDVA who is also available to provide training and support to staff members, as required. Compliance with Trust-specific and local Domestic Abuse processes is audited by the Safeguarding Team on a quarterly basis, via a retrospective audit of A&E attendances in which an adult has attended as a result of an assault and/or Mental Health concerns. In response to learning from this and other DHRs, the Safeguarding Midwifery Team also undertakes monthly audits, specifically in relation to use of direct routine enquiry, and the need for/use of

translation services. In all cases, audit findings and concerns re. non-compliance is escalated via Divisional and Trust wide Safeguarding meetings.

16.7.9 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. Overall, the panel believe UHLT provided the appropriate service and support to Natalia.

16.8 EDUCATION

16.8.1 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.

16.8.2 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.

16.8.3 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.

16.8.4 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 nursey 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.

16.8.5 Lincolnshire County Council deliver Designated Safeguarding Leads (DSL) briefings twice a year to all early year's providers. These sessions include sharing information about training that can be accessed through the Lincolnshire Safeguarding Children's Partnership (LSCP) including the domestic abuse training. The Early Years team at Lincolnshire County Council commission LSCP training for the Early Years Providers and this is available to all members of staff in Early Years settings.

16.8.6 At the DSL briefings there is work on case studies along with serious case reviews, missed opportunities are looked at and exploration of different avenues for support. This includes looking at how to complete an Early Help Assessment with families. Over 250 EYs providers attend the DSLs each term, the setting is included in the invitations to attend these meetings.

16.8.7 In regard to Operation Encompass the data has been analysed and a pilot session has been delivered to EYS providers discussing the difference between DA and parental conflict. There were 22 settings in attendance, and this is ongoing work which is being expanded in roll out. Ofsted is the sole arbiter of quality, this EYs setting is

graded good, and therefore it is not within LCCs statutory duty to support settings that are good or outstanding.

16.8.8 The child mind institute[1] 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. However, it is the view of the panel that the setting provided appropriate support to Cibor.

Learning Consideration (LC2) – Raise awareness across schools that the behaviour children exhibit can sometimes be confused as SEND where in fact it is DA trauma.

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

16.9.1 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.

16.10 Key Lines of Enquiry

16.10.1 <u>Pregnancy as a potential trigger point</u>

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

[1] Is It ADHD or Trauma? - Child Mind Institute

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.

16.10.2.1 Barriers to reporting.

Whilst it is noted in this review the opportunities that Natalia was given to disclose, the panel have asked were the opportunities appropriate. Chapter 11 outlines the additional challenges faced by Polish born women. However, the panel have been made aware that the Lincolnshire Domestic Abuse Partnership (LDAP) have recognized 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.

16.10.2.2 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.

16.10.2.3 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 initiative 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

16.10.2.4 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.

16.10.2.5 Further areas of good practice were identified within health. A useful guide about the health service [1]for migrants and also useful translated health information for

[1] PRINT How the NHS works infographic ENGLISH FV (doctorsoftheworld.org.uk)

patients.[1] Also within the partnerships own area a GP practice was identified which produces [2] fact sheets that have been written to explain the role of UK health 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.

Learning Consideration LC (3) – The ICB to promote translation services which explain how the NHS operates to practices who do not currently have them on their website.

16.10.3 Family background and cultural matters

Throughout Natalia's pregnancy there is no evidence of any disclosures of domestic abuse. However, the barriers for Polish women as expressed in chapter 11 must be recognised.

16.10.4 Patterns of domestic abuse from this or previous relationship

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.

16.10.5 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 16.4.3.

[1] TRANSLATED HEALTH INFORMATION FOR PATIENTS - Doctors of the World

[2] Non-English Speakers: South Lincolnshire Rural Primary Care Network (deepingspractice.co.uk)

17. Conclusion

17.1 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.

17.2 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.

Lessons To Be Learnt

17.3 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.

17.4 The themes identified are:

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

18. Recommendations

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.

Local:

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

Appendix 1

Glossary of Terms

Adult Social Care	ASC
Children's Services	LCCCH
Community Safety Partnership	CSP
Designated Safeguarding Leads	DSL
Domestic Abuse Stalking & Harassment	DASH
Domestic Homicide Review	DHR
Domestic Violence Protection Notice	DVPN
Domestic Violence Protection Order	DVPO
Early Years Providers	EYP
General Practitioner	GP

Individual Management Reviews	IMR
Integrated Care Board	ICB
Lincolnshire DA Partnership	LDAP
Lincolnshire Safeguarding Children's Partnership	LSCP
Multi-Agency Risk Assessment Conference	MARAC
Police Community Support Officer	PCSO
Police Safeguarding Hub	PSH
Public Protection Notification	PPN
Standard operating procedure	SOP
Single Point of Access	SPA
Special education needs and disability	SEND

APPENDIX 2

Details of Family Contact			
Name	Relationship	Date of Contact	Nature of Contact
Agata	Perpetrator's Ex-wife	04/07/23	Email
Agata	Perpetrator's Ex-wife	26/09/23	Email
Agata	Perpetrator's Ex-wife	09/10/23	'Teams' Meeting
Agata	Perpetrator's Ex-wife	04/12/23	Email
Agata	Perpetrator's Ex-wife	22/12/23	Email

Caitlyn Hodgson	Victim Support	22/12/23	Email from the chair requesting support in contacting the deceased's parents
Caitlyn Hodgson	Victim Support	27/12/23	Email confirming that the parents did not wish to engage with the review.
Agata	Perpetrator's Ex-wife	10/04/24	Email x2
Agata	Perpetrator's Ex-wife	27/05/24	Email x2

APPENDIX 3

Efforts to engage with the preparator		
Date	**Contact**	**Details**
17/07/2023	HMP Lowdham Grange	Email sent to the perpetrator's Probation Officer, requesting contact and engagement.
27/09/23	Perpetrators Probation Officer	Telephone- Request reaffirmed for the chair and author to visit and interview the perpetrator.
28/09/23	Perpetrators Probation Officer	The Probation Officer has spoken to the perpetrator and asked if he is willing to

		engage, his states that he does not wish to take part in the review or meet the chair.