BRENT COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the death of Elena

June 2018

Independent Chair and Author of Report: James Rowlands

Associate Standing Together Against Domestic Violence

Date completed: July 2019

1. Preface

1.1 Introduction

1.1.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.1.2 This DHR (hereafter 'the review') examines agency responses and support given to Elena[1], who was murdered by her partner Razvan[2] at their home in the London Borough of Brent (hereafter 'Brent').

1.1.3 Early one morning at the start of June 2018, Razvan called the London Ambulance Service (LAS) and told them he had killed someone. Both the Metropolitan Police Service (MPS) and the LAS attended the property. Tragically, Elena was pronounced dead at the scene. Razvan was arrested and charged with murder. At the time of her death, Elena was approximately six months pregnant. Sadly, her unborn child also died. Razvan was later charged with an additional offence of child destruction[3].

1.1.4 This review will consider agencies contact/involvement with Elena and Razvan from the 1st January 2016 (the start of the year when the relationship is believed to have begun) to her murder at the start of June 2018.

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

1.1.6 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

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

1.1.8 The Review Panel expresses its sympathy to the family and friends of Elena for their loss.

1.2 Timescales

1.2.1 After a referral by the Metropolitan Police Service (MPS), the Safer Brent Partnership (the local Community Safety Partnership), in accordance with the December 2016 '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'*

[1] Not her real name. See 1.3.3 for more information.

[2] Not his real name. See 1.3.3 for more information.

[3] Child destruction is the name of a statutory offence in England and Wales. It refers to the crime of killing an unborn but viable foetus; that is, a child "capable of being born alive", before it has "a separate existence".

(hereafter 'the statutory guidance'), commissioned this DHR. The Home Office was notified in June 2018.

1.2.2 Standing Together Against Domestic Violence (STADV) was commissioned to provide an independent chair (hereafter 'the chair') for this DHR in mid-June 2018. The completed report was handed to the Safer Brent Partnership in July 2019. In August 2019 it was signed off by the Chair of the Safer Brent Partnership, before being submitted to the Home Office Quality Assurance Panel in August 2019. In February 2020, the completed report was considered by the Home Office Quality Assurance Panel. In May 2020, the Safer Brent Partnership received a letter from Home Office Quality Assurance Panel [re: DHR into the death of Elena] the report for publication. The letter will be published alongside the completed report.

1.2.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. This timeframe was not met due to:

- The timing of the first panel (held in September 2018 to ensure agencies could attend);
- To allow the completion of the criminal trial (this concluded in January 2019);
- Attempts to engage with family and friends (commenced from September 2018, see 1.9 below); and
- Attempts to interview the perpetrator in prison (commenced in February 2019, see 1.10 below).

1.3 Confidentiality

1.3.1 The findings of this review are confidential until it has been approved for publication by the Home Office Quality Assurance Panel. In the interim, information is available only to participating officers/professionals and their line managers.

1.3.2 This review has been anonymised in accordance with the statutory guidance. The specific date of the homicide has been removed. Only the chair and Review Panel members are named.

1.3.3 To protect the identity of the victim, the perpetrator, family members and friends, the following pseudonyms have been used:

- The victim – Elena;
- The perpetrator – Razvan;
- Elena's sister – Bianca;
- Elena's cousin – Gabriela;
- Elena's brother – Andrei (spouse of Oana);
- Elena's Sister in Law – Oana (spouse of Andrei);
- Elena's friend – Florina; and
- Elena's neighbour – Cristina.

1.3.4 Unfortunately, given the limited contact with Elena's family as part of this review (see 1.9 below), it has not been possible to discuss the choice of pseudonyms with family members. Consequently, the pseudonyms used in the review have been chosen by the chair. A selection of names common in Romania were identified, then cross referenced with the names of family members and friends identified by the Metropolitan Police Service (MPS) during their murder enquiry. Any names that were the same or similar were excluded. This allowed the chair to minimize the potential risk of causing offence or hurt to family or friends.

1.3.5 Additionally, the limited contact with Elena's family as part of this review means it has not been possible to establish whether they have any ongoing contact with the family or friends of Razvan. Consequently, it is not clear whether there could be any potential risk to Elena's family associated with publication. However, the Review Panel has identified that Elena and Razvan came from the same town, that Razvan was engaged in criminality and is reported by at least one witness to have made threats to Elena's children. Consequently, the chair and the Review Panel have recommended that only the Executive Report is published.

1.4 Equality and Diversity

1.4.1 The chair and the Review Panel considered the Protected Characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the review process.

1.4.2 At the first meeting of the Review Panel, it was identified that the Protected Characteristic of sex required specific consideration, as Elena was female, and Razvan is male. Sex should always require special consideration. Recent analysis of domestic homicide reviews; reveals gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators.[4]

1.4.3 The Review Panel also agreed to specifically consider:

- Pregnancy and Maternity (Elena was pregnant at the time of her death); and
- Race (Elena and Razvan was/is a Romanian National).

1.4.4 Additionally, based on the information available at the start of the DHR, the Review Panel agreed to consider whether the following issues were pertinent to the homicide, in particular how they may have impact on risks, needs or helped or hindered access to services:

[4] "In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over". Home Office, "*Key Findings From Analysis of Domestic Homicide Reviews*" (December 2016), p.3.

"Analysis of the whole STADV DHR sample (n=32) reveals gendered victimisation across both types of homicide with women representing 85 per cent (n=27) of victims and men ninety-seven per cent of perpetrators (n=31)". Sharp-Jeffs, N and Kelly, L. "*Domestic Homicide Review (DHR) Case Analysis Report for Standing Together* " (June 2016), p.69.

- Immigration status (Elena and Razvan were/are Romanian Nationals and citizens of a European Union (EU) country. As European Economic Area (EEA) nationals they could legally reside in the UK but would have had to pass the habitual residence test to be eligible for welfare benefits and housing. They may have also accessed a range of informal (community) networks); and
- Language (English was a Second Language for both Elena and Razvan).

1.4.5 These issues are considered throughout the review and summarised in 5.3 below.

1.4.6 While the Review Panel included a range of agencies, the Refuge - Eastern European Independent Gender Violence Advocacy Service[5] was also invited to participate despite having had no involvement with the case. This was in order to ensure appropriate consideration to the identified characteristics and to help understand crucial aspects of the homicide.

1.5 Terms of Reference

1.5.1 The full Terms of Reference are included at **Appendix 1**. This review aims to identify the learning from this case, and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.

1.5.2 The Review Panel comprised agencies from Brent, as the victim and perpetrator were living in that area at the time of the homicide. Agencies were contacted as soon as possible after the review was established to inform them of the review, their participation and the need to secure their records.

1.5.3 As information was provided during the review, it was established that Elena and Razvan may have had contact with agencies in other parts of the country, specifically Luton. Agencies were contacted for information and this is discussed in 1.7.2 below.

1.5.4 At the first meeting, the Review Panel shared brief information about agency contact with Elena and Razvan, and as a result, established that the time period to be reviewed would be from the 1st January 2016 (the start of the year when the relationship is believed to have begun) to Elena's murder at the start of June 2018. Where there was agency involvement with either subject prior to 2016, agencies were asked to summarise this, and identify any issues pertinent to the review.

1.5.5 *Key Lines of Inquiry:* The Review Panel considered both the 'generic issues' as set out in statutory guidance and identified and considered the following case specific issues:

- The communication, procedures and discussions, which took place within and between agencies;
- The co-operation between different agencies involved with Elena / Razvan [and wider family];

[5] Refuge is national provider of specialist services for victims of gender-based violence, including domestic abuse. It offers a range of services, including a specialist advocacy service, staffed by multi lingual expert practitioners, for Eastern European women and children. For more information, go to: https://www.refuge.org.uk/our-work/our-services/culturally-specific-services/.

- The opportunity for agencies to identify and assess domestic abuse risk;
- Agency responses to any identification of domestic abuse issues;
- Organisations' access to specialist domestic abuse agencies;
- The policies, procedures and training available to the agencies involved on domestic abuse issues;
- Specific consideration to the following issues;
  - Immigration status
  - Language
  - Substance misuse
  - Criminality; and
- Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

1.6 Methodology

1.6.1 Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-government definition of domestic violence and abuse as issued in March 2013 and included here to assist the reader, to understand that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The new definition states that domestic violence and abuse is:

"*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.*

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.

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."

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

1.6.2 This review has followed the statutory guidance. On notification of the homicide, agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) from those agencies that had been in contact. A total of 15 agencies

were contacted. 12 agencies returned a nil-contact, three agencies submitted IMRs and chronologies, and one agency provided a Summary Report due to the brevity of their involvement. The chronologies were combined, and a narrative chronology produced.

1.6.3 During the course of the review, the additional agencies approached for information provided nil-returns (see 1.7.2).

1.6.4 *Independence and Quality of IMRs:* The IMRs were written by authors independent of case management or delivery of the service concerned. Some IMRs were not submitted within the requested timescales and this led to the IMR meeting being re-scheduled. However, all the IMRs received were comprehensive and enabled the panel to analyse the contact with Elena and/or Razvan and to produce the learning for this DHR. Where necessary further questions were sent to agencies and responses were received.

1.6.5 Each of the IMRs submitted made recommendations of their own and evidenced that action had already been taken on these. The IMRs have informed the recommendations in this report. The IMRs have helpfully identified changes in practice and policies over time, and highlighted areas for improvement not necessarily linked to the terms of reference for this Review.

1.6.6 *Documents Reviewed:* In addition to three IMRs, as well as other information submitted by participating agencies, the other documents reviewed during the Review process have included:

- The findings of a number of parallel reviews (see 1.11.4 below); and
- Previous DHR reports in area (see 1.13 below).

1.6.7 *Interviews Undertaken:* The chair spoke briefly with a family member of Elena during the course of the review (see 1.9 below). No further interviews were undertaken.

1.7 Contributors to the Review

1.7.1 The following agencies were contacted, but recorded no involvement with either Elena or Razvan:

- Advance[6];
- Brent Clinical Commissioning Group (CCG) (this means that no General Practitioner (GP) was identified for either Elena or Razvan);
- Brent Council – Adult Social Care;
- Brent Council – Community Safety (including the Multi-Agency Risk Assessment Conference);

[6] Advance is a regional specialist domestic abuse service which works across a number of boroughs in London. They offer support to women, men and young people assessed as being at medium and high risk of domestic abuse and living in Brent. For more information, go to: http://advancecharity.org.uk/our-work/.

- Brent Council – Housing;
- Central and North West London NHS Foundation Trust (CNWLT) (Mental Health service);

- LAS (bar attendance at the home of Elena and Razvan at the start of June 2018, after Razvan called LAS and told them he had killed someone)[7];
- Maternity Services in the London Region[8];
- National Probation Service (NPS);
- Refuge; and
- Victim Support.

1.7.2 During the course of the review, a number of additional agencies were approached (this contact was facilitated by the Safer Brent Partnership):

- Two Romanian community organisations in Brent, as well as with the Luton Community Safety Partnership and a Romanian community organisation in Luton. This was to identify any contact with organisations serving the Romanian community, and because some information indicated that Elena may have had a link to Luton. Neither Elena nor Razvan were known; and
- A sex work project in Brent, as there were concerns that Elena had been sexually exploited by Razvan. Neither Elena nor Razvan were known.

1.7.3 The UK Visas & Immigration (UKVI), part of the Home Office, were also contacted to confirm Elena and Razvan's immigration status. UKVI confirmed that both Elena and Razvan were EEA nationals. Elena was recorded as having arrived in the UK on the 12th March 2017, when she was granted admission as an EEA national. Razvan was recorded as having arrived in the UK on the 29th October 2016, when he was granted admission as an EEA national. He was admitted again on the 7th March 2017.

1.7.4 The following agencies had contact with Elena or Razvan and their contribution is as follows:

Agency	Contribution
Brent Council - Children and Young People (CYP), including the Brent Family Front Door (BFFD)[9]	IMR and Chronology
London North West Healthcare University NHS Trust (LNWHT) in	IMR and Chronology

[7] During the course of the review, additional contacts by the LAS were identified. These are detailed in the chronology and addressed further in the analysis.

[8] The Deputy regional maternity lead for the NHS England London Region contacted maternity services at the London North West University Healthcare NHS Trust (LNWHT), Imperial College Healthcare NHS Trust and Chelsea and Westminster Hospital NHS Foundation Trust.

[9] The BFFD is a Multi-Agency Safeguarding Hub (MASH) which co locates a range of agencies; including police; local authority children's social care; health professionals; with access to other council services to share information and spot emerging problems early, and to make risk assessments based on as full a picture as possible. The BFFD acts as a single point of contact when there are concerns about a child and their family with the aim of treating those concerns with the urgency appropriate to the need and identifying the most appropriate services to meet the family's level and type of need. For more information, go to: https://www.proceduresonline.com/brent/chservices/p_contacts_referral.html.

relation to Emergency Department at Northwick Park Hospital[10]	
MPS	Summary Report
Westminster Drug Project (WDP)[11]	IMR and Chronology

1.7.5 Additionally, although they had no contact with Elena or Razvan, the Review Panel requested a Thematic Report from the Refuge's Eastern European Independent Gender Violence Advocacy Service. This high-quality report summarised key issues in relation to East European (and specifically Romanian) victims of domestic violence and abuse. The Review Panel benefited considerably from the involvement of this service, noting that this illustrates the importance of specialist providers, because they can provide expertise in relation to the needs of particular communities.

1.7.6 Additionally, to assist the deliberations of the Review Panel, information was provided by:

- Advance (the local specialist domestic violence and abuse provider) – describing the local care pathway for victim/survivors of domestic violence and abuse; and
- Brent Community Safety Team – summarising local assessments of need in relation to the local Romanian community.

1.8 The Review Panel Members

1.8.1 The Review Panel members were:

Name	Role	Agency
Beata Felinczak	Senior Service Delivery Manager	Victim Support
Cathy Hickey	Violence and Vulnerability Support Officer	Brent Council – Community Safety Team
Clare Capito	Deputy Regional Maternity Lead for London	NHS England
Colin Wilderspin	Community Safety Manager	Brent Council – Community Safety Team
Detective Sergeant Helen Rendell	Specialist Crime Review Group (SCRG)	MPS
Dionne Phillips	Criminal Justice Team Manager	WDP
Francisca Chifambaon	Safeguarding Adults Manager	Brent Council – Adult Social Care

[10] LNWHT is an Acute Healthcare Trust providing Emergency care at its Emergency Departments at the Northwick Park and Ealing Hospital sites. Additionally, LNWHT has maternity services on three sites: Central Middlesex Hospital and Ealing Hospital have Antenatal clinic services and Northwick Park Hospital has antenatal postnatal, community and delivery services. For more information, go to: https://www.lnwh.nhs.uk.

[11] WDP deliver 'New Beginnings' in Brent. This is a fully integrated service delivered in conjunction with Central and North West London NHS Foundation Trust (CNWL) and B3. It offers a free and confidential support service for individuals and their families affected by drug and alcohol problems. For more information, go to: https://www.wdp.org.uk/find-us/brent.

Grace Nartey	Named Midwife Safeguarding	LNWHT
Herburt Luzige	Senior Practitioner	CNWLT
Janice Altenor	Interim Head of Safeguarding and Quality Assurance	Brent Council - CYP
Joy Maguire	Designated Nurse for Safeguarding Adults	Brent CCG
Lesley Tilson	Designated Nurse for Safeguarding Children	Brent CCG
Julia Dwyer	Senior Operations Manager	Refuge
Martina Palmer	Senior Operations Manager	Refuge
Ioana Hanis[12]	Eastern European Independent Gender Violence Advocacy Service	Refuge
Melissa Altman	Director of Domestic Violence and Abuse Services	Advance
Sharon Loving-Charles	Team Leader Homelessness Prevention and Relief	Brent Council – Housing Needs Service

1.8.2 *Independence and expertise*: Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

1.8.3 The Review Panel met a total of three times, with the first meeting on the 12th September 2018. A second meeting, to review IMRs, was scheduled for the 13th November 2018 but was cancelled as not all agencies had submitted the required information. This meeting was subsequently held on the 22nd January 2019. A further meeting was held on the 9th April 2019. The Overview Report and Executive Summary were agreed electronically thereafter, with Review Panel members providing comment and sign off by email in June 2019.

1.8.4 The chair wishes to thank everyone who contributed their time, patience and cooperation.

1.9 Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

Family

1.9.1 In August 2018, the Safer Brent Partnership notified Elena's family in writing of their decision to undertake a DHR. The family's first language is Romanian, and steps to translate / interpret during contact attempts are described below. The primary contact with Elena's family was her sister, Bianca.

[12] Left Refuge during the course of the review.

Known in the review as	Relationship to Elena	Means of involvement
Bianca	Sister	Short telephone conversation
Gabriela	Cousin	No response received
Andrei	Brother	No response received
Oana	Sister in Law	No response received

1.9.2 The chair and the Review Panel acknowledged the important role Elena's family could play in the review. The chair wrote directly to Elena's family in September 2018. The letter was accompanied by the Home Office leaflet for families, as well as a leaflet describing the support available from Advocacy After Fatal Domestic Abuse (AAFDA)[13]. In sending these letters, the Safer Brent Partnership and the chair are grateful for the support of the MPS, which arranged for translation and also passed the letters to the family via the Family Liaison Officer (FLO).

1.9.3 Checks were also completed with AAFDA and the Victim Support Homicide Service[14] to determine if they had any contact with Elena's family. Neither had received a referral for, nor had they been contacted by, Elena's family. In relation to any potential support offer:

- The Victim Support Homicide Service noted that they are only able to provide support to families living in the UK, although they indicated that they would support a family that resides abroad when they visit; and
- AAFDA confirmed that they would try and assist families who reside abroad but receive no funding for this.

1.9.4 The Review Panel felt this was a potential gap in provision in this case and was also likely to be an issue for other DHRs. For example, the 2017 Femicide Census reported that 20% of victims in that year were known or believed to have been born outside of the United Kingdom (UK)[15]. While the Femicide Census includes data on a number of different types of homicide, a majority of the cases relate to domestic homicide. It is likely that a number of the families in such cases will also reside outside of the UK. Reflecting on his own experience, the chair has also led a number of DHRs where the family of the victim were not resident in the UK.

[13] AAFDA provide emotional, practical and specialist peer support to those left behind after domestic homicide. For more information, to: https://aafda.org.uk.

[14] The Victim Support Homicide Service supports bereaved families to navigate and know what to expect from the criminal justice system and providing someone independent to talk to. For more information, go to: https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service.

[15] Long, J., Harper, K., and Harvey, H. (2018) *The Femicide Census: 2017 Findings*, Available at: https://www.womensaid.org.uk/what-we-do/campaigning-and-influencing/femicide-census/ (Accessed: 28th February 2019).

As set out in the statutory guidance, families should be given the opportunity to be integral to DHRs and should be treated as a key stakeholder. This is because their participation is likely to increase the quality and accuracy of a DHR. To facilitate this, families should have access to specialist and expert advocacy. The fact that a family resides outside of the UK should not be a barrier to accessing specialist and expert advocacy in relation to the DHR process.

Recommendation 1: The Home Office to review funding arrangements for the provision of specialist and expert advocacy for the families of victims who reside outside of the UK.

1.9.5 No response had been received from Elena's family by the time that the criminal trial had concluded in January 2019. As a result, the chair approached the MPS FLO to ask them to attempt contact again. In early February 2019, the FLO was able to facilitate contact with Elena's sister (Bianca). This contact was undertaken by a Romanian speaking Police Officer. Bianca was residing with a family member in the UK and gave consent for her address and telephone number to be shared with the chair.

1.9.6 A second letter was subsequently sent by the chair in February 2019, with translation being arranged by Brent Council.

1.9.7 This was followed by a phone call in early March 2019. An interpreter was arranged by Brent Council. The chair was able to have a brief conversation with Bianca, who indicated that she would be willing to participate in the review and would send a text in a few days to follow up, including providing consent to share the witness statement she had given to the MPS. As no text was received, the chair liaised with Brent Council to have a short text message translated. This was sent from the chair to Bianca in mid-March 2019. Unfortunately, no response was received.

1.9.8 Letters were also sent from the chair to other family members, including Elena's cousin (Gabriela), as well as her brother (Andrei) and Sister in Law (Oana). Translation was arranged by Brent Council, with the letter to Gabriela being hand delivered by the FLO and the other two letters being sent by post. Unfortunately, no response was received.

1.9.9 The Review Panel were concerned that the absence of family involvement would affect the extent to which Elena could be represented in the review. For example, unlike many DHRs, this review has not been able to include a Pen Portrait of Elena. Additionally, the family have not had an opportunity to comment or feedback on the draft report.

1.9.10 Consequently, it agreed that:

- A final letter would be sent from the chair to Bianca. This letter was translated and sent in June 2019. It explained that the review was nearing completion and invited Bianca (or any other family member) to contact the chair if they wanted to comment or feedback on the final draft. Additionally, the letter included a named contact at the Safer Brent Partnership to whom any future requests could be made. Unfortunately, no response was received; and

- The Safer Brent Partnership would make a further attempt to contact Elena's family prior to the review's publication.

Informal network

1.9.11 Consideration was given to approaching friends and other members of Elena's informal network. As with correspondence with Elena's family, it was identified that English was not the first language of the individuals being approached. A letter for Florina was translated into Romanian, with the letter to Cristina being translated into Bulgarian. Unfortunately, no response was received.

Known in the review as	Relationship to Elena	Means of involvement
Florina	Friend	No response received
Cristina	Neighbour	No response received

1.10 Involvement of Perpetrator

1.10.1 In March 2019 Razvan was sent a letter from the chair via the prison governor with a Home Office leaflet explaining DHRs and an interview consent form to sign and send back. Translation (into Romanian) was arranged by Brent Council. No response was received. Consequently, Razvan has not contributed to this review.

1.10.2 During the murder enquiry, the MPS did not identify any family or friends of Elena in the UK. As Razvan did not respond to requests to participate, it was also not possible to ask him to identify any family or friends he felt could contribute to the review.

1.11 Parallel Reviews

1.11.1 *Criminal trial*: Razvan was arrested and charged with murder, with an additional charge of child destruction being added later once it was confirmed that Elena had been approximately six months pregnant when murdered. The criminal trial began in November 2018 and concluded in December 2018. Sentencing took place in January 2019.

1.11.2 The MPS Senior Investigating Officer (SIO) was invited to the first meeting of the Review Panel. It was agreed that approaches would not be made to witnesses until after the criminal trial had been concluded, with the exception of an introductory letter to Elena's family as described in 1.9 above. However, as the trial was concluded shortly after this first meeting, this had relatively limited impact on the timeframe of the review.

1.11.3 *Coroner's Inquest:* The Coroner decided no investigation was required and therefore, no inquest was held. Consequently, following the completion of the criminal

investigation and trial, there were no reviews conducted contemporaneously that impacted upon this review.

1.11.4 *Parallel Reviews:* A number of parallel reviews were identified:

- *LNWHT Serious Incident (SI) Investigation Report* – This was completed in parallel to the review and was approved on the 30th April 2019. A copy of the SI report was shared with the chair and, as appropriate, is referenced in this report;
- *Maternal Death Review* – This was considered but not undertaken, although a notification was made to MBRRACE (Mothers and Babies: reducing risk through audits and confidential enquiries across the UK);
- *Serious Case Review (SCR)* – The case was discussed at the Brent Local Safeguarding Children Board (LSCB) SCR Sub-Committee, but it did not meet the threshold for a SCR. However, it was agreed that the Brent Council CYP representative would act as a liaison as necessary, with several other members of the Review Panel also being members of the LSCB; and
- *Other children* – Although there were no other parallel reviews relating to any children (because did Elena have any children living with her in the UK), the Review Panel were conscious that Elena did have two other children from a previous marriage (as discussed in 2.2 below). Normally, it would be best practice for the responsible Children's Social Care department to include a copy of the review in a child(ren)'s social care record. Unfortunately, as neither child is in the UK, this was not possible.

1.12 Chair of the Review and Author of Overview Report

1.12.1 The chair and author of the review is James Rowlands, an Associate DHR Chair with STADV. James Rowlands has received DHR Chair's training from STADV. James Rowlands has chaired and authored six previous DHRs and has previously led reviews on behalf of two Local Authority areas in the South East of England. He has extensive experience in the domestic violence sector, having worked in both statutory and voluntary and community sector organisations.

1.12.2 Standing Together Against Domestic Violence (STADV) is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides

1.12.3 STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 60 reviews, including 41% of all London DHRs from 1st January 2013 to 17th May 2016.

1.12.4 *Independence:* James Rowlands has no current connection with the local area or any of the agencies involved. James has had some contact with Brent prior to 2013 in a

former role, when he was a Multi-Agency Risk Assessment Conference (MARAC) Development Officer with SafeLives (then CAADA)[16]. This contact was in relation to the development of the local MARAC as part of the national MARAC Development Programme and is not relevant to this case.

1.13 Dissemination

1.13.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the Safer Brent Partnership Board for approval and thereafter will be sent to the Home Office for quality assurance.

1.13.2 The Executive Summary and Overview should also be presented to the LSCB. This is particularly important as there has been significant learning in the course of the review relating to domestic violence and abuse, as well as safety netting practices when there are safeguarding referrals. This learning, and the resulting single and multi-agency recommendations, should subject to scrutiny through the LSCB.

1.13.3 Once approved for publication by the Home Office, the Review Panel has recommended that only the Executive Summary be published.

1.13.4 The Community Safety Team will undertake a range of dissemination events to share learning following publication.

1.13.5 The Executive Summary and Overview Report will be shared with the Commissioner of the MPS and the Mayor's Office for Policing and Crime (MOPAC).

1.13.6 The action plan will be monitored by the Community Safety Team on behalf of the Safer Brent Partnership. The Community Safety Team will be responsible for monitoring the recommendations and reporting on progress.

1.14 Previous learning from DHRs

1.14.1 This is the fifth DHR commissioned by the Safer Brent Partnership. Of these previous DHRs, one concerned the death of another Eastern European Victim (the case of Anna)[17]. The Review Panel has considered the learning and recommendations from this case in this review.

[16] For more information, go to: http://www.safelives.org.uk.

[17] For more information, go to: https://www.brent.gov.uk/your-community/crime-and-community-safety/domestic-abuse-and-vawg/.

2. Background Information (The Facts)

The Principle People Referred to in this report						
Referred to in report as	**Relationship to V**	**Age at time of V death**	**Ethnic Origin**	**Faith**	**Immigration Status**	**Disability Y/N**
Elena	Victim	28	Romanian	Unknown	EEA National	Unknown
Razvan	Partner	43	Romanian	Unknown	EEA National	Unknown
Bianca	Sister	-	-	-	-	-
Gabriela	Cousin	-	-	-	-	-
Andrei	Brother	-	-	-	-	-
Oana	Sister in Law	-	-	-	-	-
Florina	Friend	-	-	-	-	-
Cristina	Neighbour	-	-	-	-	-

2.1 The Homicide

2.1.1 *Homicide:* Elena was murdered by her partner Razvan at their home in Brent. Early on a morning at the start of June, Razvan called the LAS and told them he had killed someone. The MPS were informed and attended the property. Police Officers were met by Razvan. When they entered the building, they discovered Elena lying on the bathroom floor. Elena had sustained multiple stab wounds. Police officers noted that Elena appeared to be pregnant. The LAS also attended the property and tragically pronounced Elena dead shortly thereafter. Her unborn child also died.

2.1.2 *Post Mortem:* A post mortem examination was conducted by a Home Office pathologist. The cause of Elena's death was recorded as a stab wound to the neck. It was confirmed Elena was approximately six months pregnant (i.e. between 21 and 24 weeks pregnant).

2.1.3 *Criminal trial outcome*: Razvan was found guilty of murder and child destruction. He was sentenced in January 2019 to a minimum 26-year term and given a concurrent 14-year term for the destruction of an unborn child.

2.1.4 *Judge sentencing summary:* At sentencing, the judge said: "*This was a prolonged and brutal attack in which you showed her* [Elena] *no mercy*."

2.2 Background Information on Victim and Perpetrator (prior to the timescales under review)

2.2.1 *Background information relating to Elena:* At the time of her death, Elena was 28 years old. She was White, a Romanian National and had no known disability or religious affiliation.

2.2.2 Although Elena was from Romania she had been living in another European country (Country A)[18]. She initially came to the UK in 2013. She stayed for six months before returning to her husband and two children in Country A. In May 2015, Elena returned to the UK with her husband and children. They lived with her cousin in Haringey for a number of months, before moving to Brent. In 2016, Elena ended her relationship with her husband, who subsequently returned to Country A with their two children[19].

2.2.3 Elena's parents are deceased. She had three siblings.

2.2.4 Elena was recorded by UKVI as arriving in the UK on the 12th March 2017. However, as noted above, Elena initially came to the UK in 2013 and, as will be described in the chronology, her first contact with services was in 2016.

There is no evidence that Elena worked in formal employment. As discussed below, it is possible that Elena was being sexually exploited by Razvan.

2.2.5 *Background information relating to Razvan*: When Razvan murdered Elena, Razvan was 43 years old. He was White, a Romanian National and had no known disability or religious affiliation.

2.2.6 Razvan may have been married in Romania, and there is a report that he had a daughter from that relationship. The Review Panel has not been able to determine the nature of this relationship. Information in some of the witness statements provided to the MPS as part of the murder enquiry indicated that Razvan was still in contact with his wife.

2.2.7 Razvan was recorded by UKVI as arriving in the UK on the 29th October 2016 and was also recorded as being admitted on the 7th March 2017. However, as will be described in the chronology, his first contact with services was prior to this.

2.2.8 During one contact with the MPS, Razvan said that he worked in a carwash. The Review Panel was not able to identify any further information in relation to this and there was no other information available about any other source(s) of income, with the exception of the possible sexual exploitation of Elena.

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[18] The country is not named to protect the anonymity of Elena's family.

[19] The Review Panel explored whether it would be possible to contact Elena's husband and / or her children. Unfortunately, this was not possible. Because they resided in a different country, only limited information was available about Elena's former husband and / or her children from the MPS murder enquiry. Additionally, no other services had historical or more recent contact records. Finally, in the absence of contact with Elena's family, it was not possible to facilitate contact through this route.

2.2.9 *Synopsis of relationship with the Perpetrator*: In 2016, Elena and her husband rented a room in their house to Razvan. Elena had known Razvan as a child, as they had grown up in the same neighbourhood of a city in eastern Romania.

2.2.10 In this same year, Elena began a relationship with Razvan and ended her relationship with her husband. Elena returned to Romania with Razvan for a few months, before they both came back to the UK and moved to another address in Brent. This was a privately rented property. It has not been possible to establish whether Elena and / or Razvan were the named tenants. This was the address where she was subsequently murdered.

2.2.11 Both Razvan and Elena were known to the police. Elena was convicted for theft in 2006. Razvan has five previous convictions for separate offences between 1998-2009 including offences of theft, causing criminal damage and failing to surrender to bail.

2.2.12 During the course of the review, the MPS were asked to identify whether there was any intelligence relating to either Elena or Razvan beyond their contacts with the police as described in this report. The Review Panel wanted to establish whether there was an indication that either Elena or Razvan were involved in an Organised Crime Group (OCG), particularly in relation to either Razvan's income or the possible sexual exploitation of Elena. No intelligence was shared to indicate that either Elena or Razvan were known to the police in this context.

2.2.13 *Members of the family and the household*: There were no other members of the household.

3. Chronology

3.1 Background to the Chronology

3.1.1 During the course of the review, it became apparent that there was relatively little contact between Elena and / or Razvan and local agencies. For that reason, the Review Panel felt it appropriate to provide a summary of contact prior to the timeframe for the review, as well for the years 2016, 2017 and 2018.

3.2 Contact before 2016

3.2.1 Between 2007 and 2011, the MPS had contact with Razvan on numerous occasions relating to suspicion of theft, burglary, criminal damage. He received five convictions for separate offences between 1998-2009 for offences of theft, causing criminal damage and failing to surrender to bail.

3.3 Contact in 2016

3.3.1 In January, Razvan was arrested for a number of burglaries committed in 2015. Following Crown Prosecution Service (CPS) advice, the charges were dropped due to insufficient evidence. However, this did lead to a 'Subject Profile'[20] being completed in the same month, as well as a request for information on his previous convictions in Romania.

3.3.2 In March, Elena was recorded as passenger when a vehicle (believed to have been involved in thefts from a cash machine) was stopped by the MPS.

3.3.3 In October, Razvan was arrested by the UK Border Force[21] when he returned to the UK from another country. This was for an offence of theft. No further action was taken.

3.3.4 In December, the MPS stopped a vehicle in which both Razvan and Elena were travelling. No further action was taken.

3.4 Contact in 2017

3.4.1 No contact with any agencies was recorded in this year, bar a single presentation at the Emergency Department at Northwick Park Hospital. Razvan was brought to the

[20] A Subject Profile may be commissioned during an investigation in order to provide a detailed report about a suspect.

[21] The UK Border Force Border Force carry out immigration and customs controls for people and goods entering the UK. For more information, go to: https://www.gov.uk/government/organisations/border-force.

hospital by the LAS on the 23rd July 2017 with abdominal pain. He was alone. Razvan was admitted on the 24th July 2017. He was discharged on the 26th July 2017.

3.5 Contact in 2018

3.5.1 On the 29th April, both Razvan and Elena were arrested on suspicion of fraud. They were both interviewed, and both denied the allegations. Subsequently, no further action was taken.

3.5.2 On the 30th April, a Merlin PAC[22] was completed by Police Officers and sent to the BFFD in relation to the unborn child. The report included the following information:

> *"This report relates to an unborn female. Mother is currently about 4.5 months pregnant"*
>
> *"Subject's mother states she uses crack, saying she smokes about three times a day. She looks very thin and unkempt, with her teeth showing very visible signs of crack abuse and disintegration"*
>
> *"Both parents have given differing [sic] addresses and both ones given in custody do not appear to actually exist. Their appearance and apparent substance abuse suggest that they are in fact of no currently fixed above. Subject's mother has stated that she has two other children, aged 3 and 5, and that they are currently in her children's care"*
>
> *"There are very high concerns from our point of view regarding the welfare of the new born – mother is a crack cocaine user who appears to be using a criminal lifestyle to fund her habit along with a male believed to be the baby's father. It is unknown where the unborn would be living as neither parent has provided a credible address"*

3.5.3 In addition to noting the issues with the addresses provided, commentary elsewhere in the Merlin PAC confirmed that the addresses given to the MPS could not be verified. It was also noted that there was no phone number for either Elena or Razvan.

3.5.4 The MPS identified a previous address in Harrow, and initially shared information with the MASH in that borough after consultation with the BFFD. However, there was no trace of Elena or Razvan in that area. The case therefore remained with the BFFD.

3.5.5 Elena's disclosure that she had two older children (aged 3 and 5, and who were looked after by Children's Social Care) appears to be a reference to her children from her

[22] A Merlin PAC should be completed by police officers when they encounter a child in circumstances that cause concern in relation to that child. This information is then shared with the relevant Children Social Services department.

marriage. No agencies had any record of these children. Moreover, as discussed in 2.2, the information available to the Review Panel suggests that Elena's children would have been in the care of her husband in another European country (Country A) at the time of this contact.

3.5.6 Both Razvan and Elena were drug tested while in custody. The results were positive for crack cocaine. They were both issued with a compulsory Criminal Justice Initial Assessment[23]. In Brent these assessments are conducted by WDP. Both Razvan and Elena met with a drugs worker from the WDP for an Initial Assessment. During this meeting, a Follow Up Assessment was agreed: Razvan and Elena had appointments booked on the 2nd May, with Razvan due to attend at 2pm and Elena at 3pm.

3.5.7 On the 1st May, on the request of the MPS, the BFFD undertook a check to determine if Elena or Razvan were known. No information was found.

3.5.8 On the 2nd May, there was communication between the BFFD and the Multi Agency Safeguarding Hub (MASH)[24] in Barking and Dagenham, as well as Redbridge. These contacts were an attempt to try and identify an address for Elena or Razvan, specifically the BFFD had made these requests based on a street name that was included on the Merlin PAC, but which did not exist in Brent. There was no trace of Elena or Razvan in either borough.

3.5.9 On the same day, both Razvan and Elena were due to attend WDP for their Follow Up Assessment. Razvan failed to attend and the assessment was re-arranged for the 10th May 2018.

3.5.10 Elena rang WDP stating she was unable to attend her Follow Up Assessment as she had to collect her sister's children from school. Elena stated that she lived with her sister in Luton[25]. Elena was encouraged to attend her appointment, as failing to attend and not re-arranging would result in a breach. In the call, Elena was asked whether she had any children; she said she had two children who were currently not in school, and that she was four months pregnant. When the staff member asked Elena whether she was receiving antenatal care, Elena hung up the phone.

3.5.11 Elena rang WDP back within a few minutes. The staff member asked for her number in case the phone got cut off, but Elena refused to provide it and hung up a second time.

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[23] When someone has tested positive for the presence of a Class A drug like Crack Cocaine upon arrest, they are required to undergo an assessment with a qualified drugs worker. The purpose of the initial assessment is to: determine whether the person is dependent on, or has a propensity, to misuse a Class A drug; determine whether the person would benefit from a follow up assessment or treatment; and to provide an explanation of the treatment available.

[24] A MASH brings key professionals together to facilitate early, better quality information sharing, analysis and decision-making, to safeguard vulnerable children, young people more effectively.

[25] It has not been possible to confirm this as there has been only limited contact with Elena's family (see 1.9 above), although the Review Panel was able to confirm that Elena was not known to agencies in Luton (see 1.7.2 above).

Elena then rang back again. In this last call she was encouraged to attend the service by 3pm that day.

3.5.12 On the 3rd May a female presented to the WDP, claiming to be Elena's sister[26]. She informed a staff member that Elena would not be able to attend her appointment as she was collecting her two children from school. She was told that she was unable to attend Elena's appointment on her behalf, and that Elena would need to attend the service herself.

3.5.13 Elena later attended the service but did not complete the assessment and refused any further treatment. The case records do not provide any detail about how the assessment ended but WDP confirmed that Elena left before the assessment was completed.

3.5.14 Due to Elena's pregnancy and lack of ante natal care, the WDP made a referral to the BFFD[27].

3.5.15 On the 3rd May, the BFFD reviewed the Merlin PAC from the Police.

3.5.16 The WDP referral was also reviewed by the BFFD. In addition to information about the incident on the 29th April, the WDP referral also noted: the issues around Elena's attendance; the attendance of an unknown female; and the information disclosed by Elena about her children and pregnancy.

3.5.17 There was no phone number or address included on the WDP referral. As reported in the case record, a social worker at the BFFD called WDP to try and gather more information. It appears that this contact was unsuccessful as the case record indicates that the social worker emailed the referrer at WDP requesting them to contact the BFFD urgently[28]. There was no further follow up by the social worker recorded on the case file.

3.5.18 A social worker in BFFD then reviewed the case file, using the information from both the MPS and WDP referrals. A decision was made to take no further action. A Signs of Safety[29] Analysis and Rationale was completed. This stated:

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[26] It has not been possible to confirm that this was indeed Elena's sister.

[27] The Review Panel requested a copy of this referral. However, WDP were unable to provide this. Issues in relation to record keeping by WDP are addressed in the analysis of agency contact.

[28] The Review Panel attempted to confirm whether this email had been received by WDP. However, WDP were unable to locate any records relating to this correspondence. Issues in relation to record keeping by WDP are addressed in the analysis of agency contact.

[29] Signs of Safety is an integrated framework for how to carry out child intervention work - the principles for practice; the disciplines for practitioners' application of the approach; a range of tools for assessment and planning, decision making and engaging children and families; and processes through which the work is undertaken with families and children, and including partner agencies. More information on the implementation of Signs of Safety in Brent can be found at: http://brentlscb.org.uk/article.php?id=490&menu=3&sub_menu=23.

"It is concerning that Elena was arrested for fraud and tested positive for Cocaine whilst in Wembley Police station where she claimed to have 2 children and is 4 ½ months pregnant with her 3rd child. It is also worrying that Elena's alleged children cannot be identified, she gave false address details to the police which would indicate that she has no fixed abode and if she is 4 ½ months pregnant appears to be using a criminal lifestyle to fund her habit along with the male who is believed to be the alleged unborn baby's father.

BFFD SW unable to progress the case as the family are not known to the police and following MASH Checks the family cannot be identified as living in Brent.

Based on the information gathered above, BFFD SW is of the view that at this stage of intervention the case should be closed NFA until the correct identities, and address details is confirmed. Recommended the following:

With management agreement the case to close NFA."

3.5.19 On the 4th May, the BFFD received further information from the Surrey MASH, who had also been asked about the family, confirming that they had no information. On the same day, the case was closed to BFFD.

3.5.20 On the 10th May, Razvan failed to attend his re-booked Initial Assessment with WDP. He was breached for failure to attend and the MPS were notified.

3.5.21 On the 18th May, BFFD sent an outcome letter to the WDP, following their referral, stating that they were closing the case and no further action was being taken. It is not clear if the MPS were informed of the outcome.

3.5.22 On the morning of 29th May, the LAS received a call from Razvan. He said that:

- He and Elena had been smoking crack cocaine and Elena had become unwell; and
- They smoked every day / regularly.

3.5.23 An ambulance was dispatched, met by Elena and Razvan, and then conveyed them both to the Emergency Department at Northwick Park Hospital.

3.5.24 Just after 12 noon, Elena presented at the Emergency Department. Razvan was present as well and was described by Elena as her 'husband'. Both reported having smoked crack cocaine and presented with the following symptoms:

- Elena reported abdominal pain and vomiting; and
- Razvan reported chest pain and throat tightness.

3.5.25 Both Elena and Razvan were booked in separately as patients.

3.5.26 Elena was initially triaged by a nurse who took a brief history regarding the reason for her attendance at the Emergency Department. Elena told the nurse that she was pregnant but was unsure "*how far she was*" and that she was not in contact with a GP or midwife. This was recorded in the notes, with a query noting that Elena was possibly pregnant. At handover, the nurse stated that a safeguarding referral was needed.

3.5.27 Elena was moved into the Rapid Assessment Unit and seen by a locum doctor shortly after 1pm. Elena disclosed:

- Abdominal pain immediately after smoking crack cocaine that day. The pain had subsequently resolved and was not present when assessed. She had vomited twice;
- That she was approximately 6 months pregnant but had not received any medical care;
- That her crack cocaine use was "*regular for the past year*"; and
- No significant past medical history.

3.5.28 During a subsequent examination, Elena reported that her abdominal pain had ended, and her observations were within a normal range. Elena was observed to be visibly pregnant. An ultrasound was completed, and a foetal heartbeat was detected.

3.5.29 At approximately 2pm, Elena left the Emergency Department without having been discharged.

3.5.30 In response:

- The doctor discussed the case with one of the Emergency Department's consultants. The consultant included the Trust's Named Nurse for Safeguarding Children, who was by chance present, in this discussion;
- The Named Nurse contacted BFFD's Duty Social Worker to discuss the case, including the concerns identified and that Elena had left before she was formally discharged, or referrals could be made;
- The Duty Social Worker confirmed that neither Elena, nor Razvan, had any other children that may have been at risk in the community;
- A formal Child Safeguarding referral (using the Trust's Interagency Enquiry / Referral Form) was completed for Elena's unborn child. This was emailed to the BFFD to confirm the details discussed and the concerns raised in the aforementioned telephone call; and
- A copy of this referral form was also emailed to the Trust's Paediatric and Maternity Liaison Service (PMLS) generic email box for follow up.

3.5.31 Like Elena, Razvan left without having been discharged.

3.5.32 Elena was documented as being accompanied by her partner throughout the time in the Emergency Department.

3.5.33 Later that day, BFFD received a referral from the LAS. This related to the incident in the morning, and included the following information:

> *"Elena is six months pregnant and not booked at any Hospital, and she has never been to a Hospital since she fell pregnant and only found out that she was pregnant by test kit, not knowing her due dates, no ante-natal classes attended.*
>
> *Both spoke very little English, they were dressed adequately, not aggressive, both were coherent"*

3.5.34 In the BFFD, following a management review, a social worker was directed to:

- Review the case file;
- Contact the Emergency Department at Northwick Park Hospital, including establishing whether they undertook a pregnancy test; and
- To undertake further checks and attempt to contact the parents.

3.5.35 BFFD also received a referral from the Emergency Department at Northwick Park Hospital, highlighting that:

> *"Elena Complained of abdominal pain after smoking crack cocaine this morning.*
>
> *Abdominal pain had completely subsided, and she was medically well (after history and examination).*
>
> *Patient not enrolled in any antenatal services whatsoever. No GP.*
>
> *Safeguarding concern regarding the unborn baby – due to parent using crack cocaine during pregnancy. Razvan states he also uses crack cocaine".*

3.5.36 Following checks, it was decided that a Child and Family Assessment would be completed, and that the case should be allocated to one of Brent CYP's Locality Teams. The Signs of Safety Analysis and Rationale stated:

"Safeguarding concern regarding the unborn baby – due to parent using crack cocaine during pregnancy, Elena is reported to be 6 months pregnant. Pregnancy itself has not been medically confirmed. Despite Elena being seen and assessed at hospital, medical staff did not undertake any test to confirm that Elena is pregnant and so the risk to the baby is unknown.

Additional safeguarding concerns identified following review of case history. Although case was closed at the time as the family could not be identified as living in Brent, given the new additional information and address provided, further follow up is required to confirm the pregnancy. Once pregnancy is confirmed, case will need to escalate to ensure the unborn is safeguarded.

Unborn baby- at significant risk of harm from parental drug misuse -concerns about mother's parenting ability and capacity, risk to child due to drug misuse in pregnancy. Razvan states he also uses crack cocaine".

3.5.37 Having made referrals, both the LAS and the Emergency Department at Northwick Park Hospital were advised that an assessment was being taken forward.

3.5.38 On the morning of the day before the homicide, within the allocated Brent CYP Locality Team:

- A further health check was undertaken to try and locate any further information on the family now that address details were known. No information was found. Additional checks were also completed with the MPS, as well as with education;
- A social worker also contacted the Emergency Department at Northwick Park Hospital, trying to determine if a pregnancy test had been completed when Elena had attended. The case record indicates that the social worker was informed that no test had been completed[30];
- The social worker also attempted two telephone calls to Elena to discuss the referrals, with the second being answered. Elena initially answered then passed the call to Razvan. The social worker noted that it was a poor line. They also asked if an interpreter was required. Razvan advised that a Romanian interpreter was needed; and
- After the call, there was a discussion between the managers of the Locality Team and the at the BFFD. It was agreed that a family home visit would be conducted.

[30] Health professionals on the Review Panel explained that a pregnancy test would not have been undertaken because Elena was visibility pregnant and an ultrasound had been completed. Issues in relation to communication in relation to Elena's pregnancy are addressed in the analysis of agency contact.

3.5.39 A home visit was conducted on the afternoon of the day before the homicide. Two social workers attended with a Romanian interpreter. As summarised in the case record:

- Elena and Razvan said they lived in the privately rented property for 1 year and 3 months but had been asked to move as they could not have a baby in the property;
- Elena said her two children lived with their father in Romania;
- Elena stated that she stopped using cocaine when she found out she was pregnant. She said she was not registered with a GP or hospital for ante-natal care;
- They stated that at their recent visit to the Emergency Department at Northwick Park Hospital the [unborn] baby had been fine;
- They stated they were both employed[31] and used this money for Razvan's cocaine habit. Razvan stated he was willing to seek treatment;
- Both Elena and Razvan were noted by the social workers as appearing to have just woken up and presenting as "*unkempt*". The social workers also noted that Elena and Razvan engaged appropriately during the home visit and the interactions between them described as "*positive*".

3.5.40 During this visit:

- There were no triggers or indications that raised concerns apart from the presenting issues regarding the substance use; and
- Elena and Razvan were spoken to together (i.e. they were not seen separately).

3.5.41 Following the visit, the allocated social worker was of the view that the case met the threshold for an Initial Child Protection Conference (ICPC)[32]. It was agreed that a Strategy Discussion[33] would be held and a request was sent to the MPS Child Abuse Investigation Team (CAIT)[34] to arrange this.

3.5.42 At the start of June, Razvan murdered Elena.

3.5.43 At the start of June, Brent CYP contacted the Romanian Embassy requesting information on the Elena and Razvan and any other children. It was identified that two children lived abroad.

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[31] As discussed in 2.2, there is no evidence to indicate that either Elena or Razvan were in formal employment.

[32] An ICPC must be convened when concerns of significant harm are substantiated and the child is judged to be suffering, or likely to suffer, significant harm.

[33] A Strategy Discussion (sometimes referred to as a Strategy Meeting) is normally held following an assessment which indicates that a child has suffered or is likely to suffer Significant Harm.

[34] CAITs investigate abuse committed within families, as well as by professionals and other carers in paid or unpaid roles.

4. Overview

4.1 Background to the Overview

4.1.1 As detailed in 1.9, attempts were made to contact a number of family members, as well as a friend and neighbours, of Elena to inform them of the review and invite their participation. Unfortunately, most of those who were approached chose not to participate. Consequently, with the exception of brief contact with Elena's sister (Bianca), the following section is based on the witness statements provided to the MPS as part of the murder enquiry. However, as the individuals who provided witness statements did not consent to participate in the review, their witness statements have not been used directly. Instead, the following section is based on a summary of witness accounts provided by the MPS.

4.2 Summary of Information from Family, Friends and Other Informal Networks

4.2.1 During the murder enquiry, Bianca (Elena's sister) told the MPS that Elena had talked about her experience of domestic violence and abuse by Razvan. Bianca also said that Elena had told her that Razvan had forced her to take drugs (crack cocaine).

4.2.2 Bianca said she had once asked Elena whether she was being sexual exploited, with this referred to in the witness statement as 'pimping'. Elena is reported to have replied "[it's] *none of your business*". Some point latter, Elena contacted Bianca in distress and said that Razvan had been forcing her to have sex with men. In this contact, Bianca also told the MPS that Elena said that she wanted to end her relationship with Razvan, but she was fearful as he threatened to kill her children. Bianca said that she told Elena that she should leave, but Elena had not wanted to do so because she was in love with Razvan.

4.2.3 Witness statements were also collected by MPS during the murder enquiry from other family members, as well as a friend and a neighbour. In summary, these provided the following information about the relationship and Elena's experiences:

- Razvan was violent, which included kicking, slapping and punching Elena;
- Razvan would shout at Elena, with one witness describing an incident when they had been present (Razvan's shouting included sexualised language and threats);
- Razvan made threats to kill Elena;
- On at least one occasion a family member witnessed Razvan slapping Elena. Both they and Elena were thrown out of the flat shared by Elena and Razvan.

Additionally, Razvan later rang this member of the family and told them not to tell anyone what they had seen; and

- Several witness statements referred to seeing Elena with different injuries at different times. These included: a black eye, bruises on an arm, a broken arm, a bump on the head, and a missing tooth.

4.2.4 In most of the witness statements there was also a reference to changes in contact with Elena, with this reducing over time, becoming infrequent and principally by phone or online.

4.2.5 Several witnesses refer to money being an issue, with one witness saying that Elena was often short of money. Several witnesses said this was because Razvan would send money back to Romania[35].

4.2.6 There were different accounts of controlling behaviour described by the witnesses. These included: Elena being beaten if she had not cooked meals or had been in contact with family members. One witness said explicitly that Razvan would control Elena's access to the phone.

4.2.7 Several witnesses also referred to substance use, saying either that Razvan had introduced or forced Elena to use drugs.

4.2.8 One witness corroborated what had been said by Bianca, specifically that Elena was being sexual exploited and was being forced by Razvan to have sex with other men.

4.2.9 Several witnesses referred to Elena's wish to leave Razvan. One said that Elena had contacted them in considerable distress, saying she wanted to leave. When they asked Elena if she would go to the police, she said she was afraid that Razvan would threaten her children. Another two witnesses described different attempts by Elena to leave, each of which was thwarted by Razvan. One witness told the MPS that they had purchased travel tickets for Elena to help her leave, but that Razvan had destroyed these.

4.2.10 Elena also talked about her concerns for the future, telling another witness that if she did not leave Razvan *"things would end badly"*.

4.3 Summary of Information from Perpetrator:

4.3.1 The information on Razvan is limited for a number of reasons, not least because during the criminal enquiry, Razvan answered 'no comment' to all questions. Additionally,

[35] Several witnesses described this money being sent back to Razvan's 'wife'. As described in 2.2 above the Review Panel has limited information about Razvan's background, including his reported marriage.

Razvan did not respond to a letter from the chair of the review inviting him to participate (see 1.10 above).

4.4 Summary of Information known to the Agencies and Professionals Involved

Elena

4.4.1 Elena had very limited contact with services, with this contact relating principally to the MPS, WDP, health services and children services.

4.4.2 In relation to the MPS, while Elena came to attention for a number of potential offences, her substantive contact was after an arrest for fraud in April 2018. Although no further action was taken, during this contact it was identified that Elena was pregnant, a crack cocaine user and potentially homeless (or at least, her address was undermined). As a result, the MPS made a referral to the local drug project (WDP) for a compulsory Criminal Justice Initial Assessment. The MPS also made a referral to the BFDD, given concerns about Elena's unborn child.

4.4.3 The WDP had contact with Elena in relation to her drug use in May 2018. This contact was limited, and an initial assessment was begun but not completed. In this contact, there were examples of good practice (for example, Elena was allocated to a female member of staff. Staff also identified potential concerns regarding children and pregnancy and made a referral to the BFFD). However, it is unclear why WDP did not take any further action after Elena failed to complete her initial assessment. This could have triggered a further appointment or a notification to the MPS that she was in breach of a compulsory Criminal Justice Initial Assessment.

4.4.4 Elena was taken by the LAS to the Emergency Department at the Northwick Park Hospital (part of LNWHT) on the 29th May 2018. In this contact, her medical needs were appropriately assessed and a concern about her crack use, as well as absence of any medical care in relation to her pregnancy, was identified. However, Elena was not seen alone (i.e. she was in the company of Razvan throughout) and there was no consideration of the risk of domestic violence and abuse. While staff made a referral to the BFFD, internal procedures were not followed, which meant that there were no further actions taken in relation to the lack of medical care regarding her pregnancy. Elena left before being discharged. It is of note that Elena had no other contact with health professionals, not least because she was not registered with a GP.

4.4.5 Brent Council – CYP (via the BFDD) received referrals for Elena and Razvan on two occasions. The first of these followed the arrest of Elena and Razvan on the 29th April 2018. While the BFDD made extensive attempts to locate Elena's address (based on the information she and Razvan had given to the MPS), they subsequently closed the case. This was despite the potential concerns regarding her vulnerability, having

children and being pregnant. After Elena and Razvan attended the Emergency Department at the Northwick Park Hospital on the 29th May 2018, referrals were made by the hospital and LAS. This triggered a prompt decision to conduct a Child and Family Assessment and Elena and Razvan were visited at home a day before the homicide. This was good practice, as was the use of an interpreter. However, Elena and Razvan were seen together and there was no consideration of the risk of domestic violence and abuse.

Razvan

4.4.6 Razvan had limited contact with services. He was reasonably well known to the MPS for a number of offences. His most recent contact with the MPS was after an arrest for fraud in April 2018. However, no further action was taken in relation to this incident, although a referral was made to the BFDD given concerns about Elena's unborn child.

4.4.7 Like Elena, the MPS made a referral for Razvan to the local drug project (WDP) for a compulsory Criminal Justice Initial Assessment. However, he did not attend and was breached.

4.4.8 Razvan had some contact with health services, specifically the Emergency Department at the Northwick Park Hospital (part of LNWHT). He had a single attendance in 2017, with the only other significant contact being when he and Elena where taken by the LAS to the Emergency Department on the 29th May 2018. He had limited contact with staff during this attendance and left before being discharged. Throughout his time at the hospital, Razvan accompanied Elena.

4.5 Any other Relevant Facts or Information:

4.5.1 No other relevant facts or information were identified during the course of the review.

5. Analysis

5.1 Domestic Abuse/Violence

5.1.1 Tragically, Elena's death means that it will never be possible to know the full extent of her experiences. However, considering the government definition of domestic violence and abuse, information gathered by the MPS as part of the murder investigation, provided by other agencies, and accounts from those who knew her, the Review Panel concluded that Elena was subject to a range of violence and abuse by Razvan.

5.1.2 As described by those who knew her, the violence and abuse experienced by Elena included physical and emotional abuse, as well as coercion, threats and intimidation.

5.1.3 It also appears that Elena experienced coercive control. This is evident in Razvan's reported expectations about behaviour around the home (e.g. expectations around cooking) and contact with family (e.g. controlling access to the phone). It also seems that Razvan used his knowledge of Elena's family, as well as the fact that they came from the same town. For example, there is at least one report that Razvan made threats towards Elena's children.

5.1.4 In the context of coercive control, it is of note that Razvan is reported to have limited Elena's access to her phone. Alongside this, those who knew Elena said their contact with her was reduced over time, becoming infrequent and principally by phone or online. In the absence of contact with family and friends, or an interview with Razvan, it is not possible to explore this further. However, the Review Panel were mindful of the increasing awareness of how perpetrators are using technology to facilitate abuse. In this case, if Razvan had access to Elena's phone, he could have used that to monitor or restrict her contact with family and friends, with this being particularly effective in relation to her family as they were mostly not resident in the UK. A 2017 report 'Tech vs Abuse'[36] highlighted victims and survivors' activities can be monitored through technology – most commonly through internet use, social media profiles and linked online accounts such as bank statements.

5.1.5 An additional issue is economic abuse. The organisation Surviving Economic Abuse (SEA) defines economic abuse as being:

"*When someone interferes (through control, exploitation or sabotage) with their partner's ability to acquire, use and/or maintain economic resources. Economic resources include: money, housing, transportation, utilities such as heating or items such as food or clothing*"[37].

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[36] Snook., Chayn, and SafeLives (2019) *Tech vs Abuse: Research Findings*, Available at: http://www.safelives.org.uk/tech-vs-abuse (Accessed: 25th March 2019).

[37] For more information, go to https://survivingeconomicabuse.org/economic-abuse/what-is-economic-abuse/.

5.1.6 In this case, there are indicators of economic abuse:

- References to 'financial 'problems' were attributed to Razvan sending money back to Romania;
- There are reports that Razvan prevented attempts by Elena to leave by destroying travel tickets; and
- Elena and Razvan rented a property. Although the Review Panel did not have access to any information regarding the tenancy, as Elena was not in formal employment and she appears to have been subject to exploitation (discussed below), this means she may have been dependent on Razvan for her accommodation.

5.1.7 It also appears that Elena was being sexually exploited by Razvan. There are reports that Elena was being forced by Razvan to have sex with other men. This would mean that Elena was being raped.

5.1.8 While a DHR is not empowered to make a decision in relation to criminal behaviour, the Review Panel noted that, as described, such behaviour could be criminal. For example, Razvan may have committed an offence under Section 53(1) of the Sexual Offences Act 2003 (controlling for gain). The men involved may have committed an offence under Section 53A of the Sexual Offences Act 2003, inserted by Section 14 of the Policing and Crime Act 2009 (which created an offence of paying for sexual services where some is subjected to force)[38].

5.1.9 From the information available to the Review Panel, the sexual exploitation of Elena by Razvan was also linked to the supply of drugs. Indeed, there are reports that Elena's drug use may itself have been forced.

Being an EEA national

5.1.10 The Review Panel considered Elena's status as an EEA national. As recorded in section 2.2, the dates for the respective entry of Elena and Razvan into the UK as recorded by the UKVI are unreliable. Significantly, being an EEA national means Elena (and Razvan) would not have required leave to enter or to remain in the UK. However, after an initial period of three months, to exercise their treaty rights they would need to be a 'qualified person' (for example, being a: Jobseeker; Worker; Self-employed; Self-sufficient person; or a Student). If someone is not a qualified person, they are likely to have limited entitlement to benefits or housing assistance i.e. they would have No Recourse to Public Funds (NRPF). For a victim of domestic abuse, this can present significant barriers in accessing help and support, including for example refuge accommodation.

[38] For more information, go to: https://www.cps.gov.uk/legal-guidance/prostitution-and-exploitation-prostitution.

5.1.11 It is not possible to know if Elena was aware of the potential limits to her entitlements, although it is clear she had considered leaving Razvan. Sadly, the information available to the Review Panel suggests that if Elena had sought help, she may have been assessed as having NRPF.

5.1.12 In its submission as part of the UK Governments Domestic Abuse Bill Consultation in 2018, the No Recourse to Public Funds Network identified significant gaps in the response to victims with NRPF, including for EEA nationals[39]. In its subsequent response in 2019, the UK Government addressed issues for victims with NPRF but did not identify any actions specifically in relation to EEA nationals.

5.1.13 In Elena's case, as an EEA national, she would have been eligible to apply to the EU Settled Status Scheme[40]. Members of the Review Panel expressed a concern that vulnerable, controlled and isolated victims may find it difficult to apply for this scheme, particularly if they are unable to provide proof of their status or have limited access to the technology and / or ability to speak English.

There are significant challenges for EEA nationals who have NRPF in accessing help and support.

Recommendation 2: The Safer Brent Partnership to review the local training offer to ensure all front-line practitioners have a good awareness of the barriers and support options for a person with NRPF.

Recommendation 3: The Home Office to ensure that there is consistent access to immigration and/or benefits advice, support and pathways out of destitution, for EEA nationals who are victims of domestic violence and abuse but have NRPF.

5.1.14 In this context, the Review Panel also discussed whether Elena was a victim of Modern-Day Slavery. This reflected the information available in relation to possible sexual exploitation, but also the reports of criminality by Razvan. Modern Day Slavery is a serious crime in which individuals are exploited for little or no pay. Exploitation

[39] For more information, go to: http://www.nrpfnetwork.org.uk/Documents/domestic-abuse-bill.pdf.

[40] This scheme is for citizens from the EU, an EEA country or Switzerland. It allows an individual (or their family) to apply to continue living in the UK after the 30th June 2021. For more information, go to: https://www.gov.uk/settled-status-eu-citizens-families.

includes, but is not limited to, sexual exploitation, forced or bonded labour, forced criminality, domestic servitude and the removal of organs[41].

5.1.15 The Review Panel concluded that, if Elena was indeed being sexually exploited, she may have been considered a victim of Modern-Day Slavery. If this had been identified by any agency, Elena could have been referred to the National Referral Mechanism (NRM). The NRM is a framework for identifying and referring potential victims of modern slavery and ensuring they receive the appropriate support[42]. However, no agency had any information available at the time which might had been an indicator that Elena was a victim of Modern-Day Slavery.

While no agency was aware that Elena was likely a victim of Modern-Day Slavery, this case is an important reminder of the need for practitioners to be aware of the issue of Modern-Day Slavery and the NRM.

Recommendation 4: The Safer Brent Partnership to work with the Brent LSCB and Safeguarding Adults Board (SAB) to ensure all front-line practitioners are aware of the signs and indicators of Modern-Day Slavery as well as the NRM.

5.2 Analysis of Agency Involvement

5.2.1 Given the relatively limited agency contact in this case, the Review Panel agreed to summarise findings by agency, before considering the lines of enquiry as set out in the Terms of Reference.

5.2.2 To aid reading, the agency involvement is ordered chronologically from the point of first contact.

MPS

5.2.3 The MPS had limited contact with both Elena and Razvan prior to the homicide. The contact they had before 2018 related to Razvan. On two occasions, Elena was recorded in the presence of Razvan when a vehicle was stopped. However, there was no indication of any concerns and no further actions were taken.

[41] For more information, go to: https://www.antislaverycommissioner.co.uk/about-modern-slavery/.

[42] For more information, go to: https://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms/guidance-on-the-national-referral-mechanism-for-potential-adult-victims-of-modern-slavery-england-and-wales.

5.2.4 The substantive contact with Elena and Razvan occurred in April 2018, when they were both arrested on suspicion of fraud. Police officers followed procedure and, because of concerns about possible children and pregnancy, made a referral to the BFFD. This was good practice.

5.2.5 The co-location of WDP at the Police Station meant that, when Razvan and Elena were drug tested having been arrested for a drug offence, they could be referred to this service. WDP's contact is discussed further below.

5.2.6 Finally, the MPS were contacted by Brent CYP to be part of a Strategy Discussion a day before the homicide, however Elena was murdered before this could be arranged.

5.2.7 There is no information to indicate that translators were considered or used in any of these contacts.

5.2.8 The MPS IMR did not make any recommendations and the Review Panel, mindful of the limited MPS contact, accepted this.

LAS

5.2.9 As recorded in 1.7.1 above, the LAS was approached for any information as part of the DHR. They provided a 'nil return', bar attendance at the home of Elena and Razvan, after Razvan called LAS and told them he had killed someone.

5.2.10 However, during the course of the review, two further contacts were identified:

- In July 2017, the LAS conveyed Razvan to hospital; and
- On the 29th May 2018, the LAS received a call from Razvan and subsequently conveyed both Razvan and Elena to Emergency Department at Northwick Park Hospital. Because of safeguarding concerns relating to both Elena being pregnant and lack of health care, LAS made a referral to BFFD (this was good practice).

5.2.11 The reason that these contacts were not identified earlier is unclear. LAS noted that without an address these types of calls can be hard to find, as its computer system operates on location data.

5.2.12 The Review Panel has not made a recommendation for the LAS but felt the difficulties of searching for its contact where there is not an address available is problematic. The LAS should consider reviewing this in any future changes to its computer systems.

LNWHT (Northwick Park Hospital Emergency Department)

5.2.13 LNWHT identified that it had contact with Razvan on the 23rd July 2017. Razvan was admitted for a short period. There were no indicators or disclosures that would indicate any other concerns.

5.2.14 LNWHT's substantive contact with Elena and Razvan was the 29th May 2018 when they both attended the Emergency Department at Northwick Park Hospital having become ill after smoking crack cocaine. There is no record in relation to either Elena or Razvan to indicate that staff identified any issues with their English and / or considered translation.

5.2.15 No disclosures about domestic violence and abuse were made during in the handover provided by the LAS or the interaction between Elena and staff at the hospital. The medical response (including triage and assessment) was appropriate. This included an ultrasound, with this being undertaken because Elena reported that she was pregnant.

5.2.16 However, Elena left the Emergency Department before she could be discharged. This led to a decision to make a referral to the BFFD. This was because of the reported substance misuse, concerns relating to the unborn child and the fact that Elena had not been in receipt of any antenatal care to that point.

5.2.17 This referral was an example of good practice, in which professional curiosity lead to a prompt safeguarding response. In this case:

- The doctor who had seen Elena discussed the case with more senior members of staff (a consultant, and the Named Nurse);
- The Named Nurse then contacted the BFFD and spoke with a social worker;
- A referral (using the Trust's Interagency Enquiry / Referral Form) was completed and emailed to the BFFD to confirm the details that were shared in the phone call; and
- A copy of this form was sent internally to the PMLS generic email box for the liaison health visitors to follow up.

5.2.18 However, the LNWHT IMR (and SI report) identified a number of issues.

5.2.19 First, LNWHT's '*Non-Obstetric Care: Guidelines for the Care and Management of Maternity Admission to the Emergency Department*' were not followed. Under these guidelines, Elena would have been considered a 'high risk pregnancy' given her disclosures of substance misuse and the lack of health care. In these circumstances, she should have seen by an experienced doctor from the Obstetrics / Gynaecology team or a midwife. However, as Elena left the Emergency Department before being discharged, it was not possible to make a referral. As a result, the Obstetrics / Gynaecology team or a midwife did not review her care on the day as part of an 'on-call' response.

5.2.20 Even in the absence of an 'on-call' response, there is provision to ensure that information in such cases is considered. Information should be shared with the PMLS, so that a case can be discussed at the weekly Paediatric Emergency Department

Safety Net meeting[43]. However, for this to be considered two different pieces of information are required – a paper 'Safety Net' form needs to be completed by the relevant member of staff, while a copy of the Trust's Interagency Enquiry / Referral Form should also be shared. In this case, only the latter was sent, with this being sent electronically to the PMLS email inbox. However, no paper 'Safety Net' form was completed. This meant that, despite the emailed referral being received by the PMLS team, it was not forwarded on to the Trust's Safeguarding Midwife and nor was the case added for discussion at the Safety Net meeting.

5.2.21 Second, Elena was jointly triaged with Razvan and they remained together throughout their time in the Emergency Department.

5.2.22 Third, while it is good practice that LNWHT has a domestic abuse policy, it was not followed in this case. As a result, routine enquiry was not undertaken. While it is not possible to know if Elena would have made a disclosure if she had been asked, such an enquiry would have been appropriate. This is particularly pertinent given the evidence that pregnancy and substance misuse are known to be risk factors for domestic violence[44].

5.2.23 The immediate reason why screening was not undertaken was because Elena and Razvan were together throughout their time in the Emergency Department. However, the underlying reason was that neither the nurse nor doctor identified the potential risk of domestic violence and therefore did not consider trying to speak to Elena alone. The LNWHT SI report identifies several factors that contributed to this omission. These included:

- Staff may have perceived Razvan's presence as indicative of his 'supportive nature';
- Neither the nurse nor doctor were familiar with the LNWHT domestic abuse policy. Additionally, as a locum, the doctor could not access the intranet and therefore could not access any LNWHT policies. Furthermore, the consultant did not advise locum of '*Non-Obstetric Care Guidelines'*; and
- Neither the nurse nor doctor were aware that routine enquiry for domestic violence and abuse requires a person to be seen alone.

5.2.24 While Elena was not screened, the Review Panel noted that if she had made a disclosure, there is a pathway for victims to be referred to a Health Independent Domestic Violence Advisor (HIDVA) who is based at the hospital. This is good practice.

5.2.25 The LNWHT IMR made the following recommendations:

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[43] Where cases with Child Safeguarding concerns from the previous week are discussed within a multidisciplinary setting.

[44] NICE (2014) *Domestic violence and abuse: multi- agency working (PH50)*, Available at https://www.nice.org.uk/guidance/ph50 (Accessed 28th May 2019).

- *"Establish a standardised screening tool for use by Emergency Department clinicians in patients presenting to the Emergency Department routine enquiry will identify those experiencing domestic violence, with a particular focus on those that have not presented as a result of suspicious injuries or after a disclosure of domestic violence.*
- *Ensure training to Emergency Department clinicians (doctors and nurses including bank/agency/locum staff) on use of the tool and actions to be taken if the patient is screened positive, with training to be repeated at regular intervals.*
- *Aim to implement this screening tool within the next 3 months and regularly audit its use, with training adapted to the results of this audit.*
- *ED staff to be reminded of the importance of mini booking that it is essential in all un-booked pregnant women wherever they attend in the Trust and a referral to maternity should be made.*
- *ED staff to familiarise themselves with the 'Non-Obstetric Emergency Care: Guideline for the Care and Management of Maternity Admission to the Emergency Department".*

5.2.26 The LNWHT SI report also included recommendations. Some of these duplicated the IMR recommendations already noted and are not repeated here. The new recommendations were:

- *"Adult patients should be seen alone during their attendance in hospital if there is a safeguarding concern.*
- *Staff to be reminded of the importance of completing documentation appropriately".*

5.2.27 Additionally, the LNWHT IMR also made recommendations to streamline the child safeguarding referral process to support information sharing internally and with external agencies:

- *"Develop an online platform for child safeguarding referrals that will enable clinicians from the Trust to complete a single form with information regarding their concerns that can be shared with different professionals (depending on the case) from Social Care, the Trust's PMLS team, the Trust's Safeguarding Midwife, the Trust's IDVA, the Adult Psychiatric Liaison Service, the Children's and Adolescent Mental Health (CAMHS) team and local Substance Misuse teams. This will reduce the number of different forms clinicians need to complete for a single patient, reducing time away from direct clinical care and produce a simpler system which will be easier to train staff members on then the current very complex system.*
- *The online platform will also enable a robust method for the PMLS to identify all Child Safeguarding referrals sent from the ED (as well as the rest of the Trust) to*

ensure they are appropriately actioned, information shared as required and establish a clear governance structure for these cases".

5.2.28 The Review Panel accepted these recommendations.

5.2.29 The Review Panel identified two further issues of note:

- In making a referral to the BFFD, LNWLT confirmed that Elena was pregnant. A date of birth was given for the unborn child for the end of August 2018. Although this was not explicitly stated, the referral is clearly in relation to an unborn baby and therefore would enable an estimate to be made that Elena was around 6 months pregnant at the point she presented; and
- Normally, when someone attends the Emergency Department, a discharge notification would be generated and sent to the patient's GP. However, as neither Elena nor Razvan had a GP, no discharge notification was generated. This means that, for the purposes of the wider health system, there was no further 'safety net'. The Review Panel was deeply concerned by this. This issue is discussed further in 5.3.25 below.

WDP

Contact with Elena

5.2.30 The WDP first had contact with Elena, following her arrest in April 2018. At this point, an Initial Assessment was completed.

5.2.31 During an Initial Assessment a risk assessment is completed by a drugs worker. WDP informed the Review Panel that domestic abuse is asked about specifically in the risk assessment. During her Initial Assessment, Elena did not disclose any abuse and no indicators were identified which might have suggested this was a concern. During this contact Elena was asked by the drugs worker if she needed a translator and she said that she did not.

5.2.32 The drugs worker also issued paperwork informing Elena of her Follow Up Appointment. Although she did not specifically request this, as Elena was pregnant, she was booked in to see a female member of staff. This was good practice given, as will be discussed below, the importance of a gender informed response to women in Liaison & Diversion (L&D) services.

5.2.33 On the 2nd May 2018, Elena was due to attend her Follow Up Appointment. She did not initially attend but did contact the WDP by phone. In response, staff encouraged Elena to attend, and also asked her for a telephone number (she declined to provide one[45]).

5.2.34 During this contact, Elena disclosed that she had two children and was pregnant. In response, staff made further enquiries about her antenatal care, although this initially led to Elena hanging up the phone, although she called back shortly after.

5.2.35 After speaking with Elena, the information gathered was passed to the drugs worker who was due to see Elena if she attended her Follow Up Appointment. The drugs worker was also advised to make a children social care referral. This was good practice.

5.2.36 On the 3rd May 2018, someone described as Elena's sister attended WDP. She was appropriately advised that Elena would have to attend an appointment herself.

5.2.37 Later that day Elena did attend the appointment. As this was unscheduled, she saw the duty worker. This worker was male.

5.2.38 The UK Government's '*Female Offender Strategy*'[46] notes that L&D services should respond to women in a gender-informed way, as many women struggle to disclose details about their circumstances. The strategy identifies reasons for this, including fear the negative consequences of any admissions of mental health problems or substance misuse issues, particularly if they have dependents or are in an abusive relationship.

L&D providers should routinely be able to respond to a female offender in a gender informed way. Currently, such provision is not routinely available in WDP as part of its 'drop ins'.

Recommendation 5: WDP to work with its commissioners to ensure that female offenders can access a female member of staff as part of unscheduled 'drop ins'.

5.2.39 Although Elena's attended her Follow Up appointment, it was not completed. In the event that a client cannot attend or does not complete a Follow Up Assessment, they are given one opportunity to re-schedule the appointment. At this point, they should be reminded that the new appointment is enforceable and that they must remain for the

[45] WDP confirmed that this is normal practice: if a telephone number is not provided to the MPS at the time someone is arrested, they will ask for contact details as part of the assessment process.

[46] Ministry of Justice (2018) *Female Offender Strategy,* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/719819/female-offender-strategy.pdf (Accessed 28th May 2019).

duration of the appointment. Thereafter, if a client does not attend or complete their Follow Up appointment, then WDP would breach the client and notify the MPS. WDP's policy is the MPS should be informed within 24 hours. Usually this means the client would be arrested and charged for failing to attend the original appointment. There are occasions when the MPS may contact WDP for another required appointment.

5.2.40 In Elena's case, this process was not followed. During the review, WDP was asked why no further action – which could have included re-booking the appointment or a breach - was taken when Elena did not complete the Follow Up appointment.

5.2.41 WDP has not been able to ascertain why Elena was not breached, as the staff member involved is no longer with the organisation. However, since this incident, staff have received further guidance/support to ensure breaches are completed in line with policy. The Review Panel accepted this and was also provided evidence of the monthly monitoring undertaken in relation to breaches.

5.2.42 WDP made a referral to the BFFD. In relation to the quality of this referral, the WDP IMR noted issues around the completeness of case records. In particular, not all the case notes were documented (this means that some information is missing, see 3.4.16 and 3.4.19 above) and there was no record of any follow up after the referral being made.

Contact with Razvan

5.2.43 Razvan had an appointment with WDP on the 2nd May 2018 at 2pm. As he did not attend this, it was re-arranged for the 10th May 2018. He did not attend this second appointment. In line with the procedures discussed in 5.2.38 above, Razvan was breached for non-attendance. WDP sent a notification to the MPS, which confirmed that this notification was received on 16th May 2018. Although, unlike Elena, this breach was made the Review Panel noted that the time taken to make the notification exceeded the timeframe specified in local procedures. WDP has not been able to ascertain why Razvan was not breached within the recommended timeframe.

5.2.44 The WDP IMR made the following recommendations:

"Independent Domestic Violence Advisor (IDVA) worker – It has been identified that a specialist Domestic Violence Practitioner would be beneficial within the service. A Criminal Justice Practitioner has been identified to complete the IDVA qualification to commence in their specialised role.

Review of Safeguarding Standard Operating Procedure (SOP) – The local Safeguarding SOP has recently been developed and expanded. It now directs staff to ensure they scan all referrals made to safeguarding (children and adults) onto the case management system. They also need to follow up the outcome once the referral has been made before being able to discharge the service user.

Audit of procedures and guidance compliance – The organisation will be undertaking an internal audit aimed at ensuring local compliance with organisational policy and procedure within an agreed timeframe are taking place.

Risk management – A guidance tool on how to write a comprehensive risk management plan has been developed, discussed and distributed amongst staff. We will be developing a workshop for staff on how to identify and assess risk, and then write an effective risk management plan.

Case notes – A case note format and guidance has been devised and implemented. Staff have been advised on when and how to document case notes correctly and efficiently through a workshop that was mandatory for all staff to attend. The template has been shared to all staff, and it will be included in any new staffs' induction, so the good practice continues.

Criminal Justice 'Follow up appointment' – The criminal justice team have been advised that all service users who come through the Criminal Justice route should be offered both the compulsory 'Initial Assessment' and a 'Follow Up Appointment'. Service users will be breached if they fail to attend either of these appointments. This gives staff the opportunity to engage and build a relationship with service users, so they feel more comfortable to disclose their life situations.

5.2.45 These recommendations were accepted by the Review Panel.

Brent CYP (BFFD)

5.2.46 The involvement of Brent CYP can be broken into two distinct phases.

5.2.47 The first phase was in early May 2018 when referrals were received by the BFFD from the MPS (on the 1st May 2018) and the WDP (on the 3rd May 2018). Both referrals related to each agency's respective contact with Elena and Razvan after their arrest on the 29th April 2018. These highlighted concerns, specifically that Elena was pregnant, had no antenatal care, was using crack cocaine and had no fixed abode. Additionally, the WDP and MPS referral contained information that Elena had two children.

5.2.48 An attempt was made to contact the WDP for further information (specifically a phone number or address). Based on the evidence on the case file, there was no response received. There is no evidence that this was followed up again. This is discussed further in 5.3.1 below.

5.2.49 Additionally, the BFFD made various checks with other local authority areas, as part of an attempt to locate an address for Elena and Razvan using a street name that was included on the Merlin PAC, but which did not exist in Brent. This was good practice.

5.2.50 After checks had been conducted, as no trace was found of the two children and no address could be identified in Brent, the case was closed on the 4th May 2018.

5.2.51 The Brent CYP IMR made one recommendation in response to this first phase of contact:

"Awareness raising with multi-agency partners that referrals to the Brent Family Front Door should be as complete as possible (a correct address and contact details are needed to progress referrals)".

5.2.52 While the Review Panel accepted this recommendation, it was concerned that this places the responsibility solely on the referring agency, which in this case was a non-statutory service, who did not have contact details in this case.

5.2.53 The Review Panel concluded that, during this first phase of contact, BFFD could have been more proactive in following up whether the WDP had a telephone number or address for Elena (albeit that this would not have identified any details because WDP did not have contact details for Elena). Additionally, in this instance, BFFD were also aware that another statutory service (the MPS) were involved. They could have contacted the MPS for further assistance.

5.2.54 Additionally, the Review Panel also discussed whether a pre-birth assessment should have been considered. Brent CYP has guidance in relation to this issue based on the London Child Protection Procedures[47]. These state that, where there is a potential risk of harm to an unborn child, a pre-birth assessment should be undertaken on all pre-birth referrals as early as possible, preferably before 20 weeks. Thereafter, when appropriate, a strategy meeting / discussion should be held.

5.2.55 At the start of May, Elena would have been approximately five months pregnant (i.e. between 17 and 20 weeks pregnant). Although the BFFD would not have known this information specifically, the information shared by MPS in their referral included the information that "*Mother is currently about 4.5 months pregnant"*.

5.2.56 There were also identified concerns about substance misuse, as well as factors that might have affected Elena's capacity to provide appropriate care (e.g. potentially being of no fixed abode and having no antenatal care).

5.2.57 The Review Panel concluded that a pre-birth assessment should have been considered in this first phase of contact. While it is not possible to know the outcome of this assessment, this would have provided an opportunity to try and engage with Elena. This could also have been an opportunity to consider the risk of domestic violence and abuse.

[47] These are accessible online at http://www.londoncp.co.uk/index.html.

Any organisation participating in a DHR needs to be able to ensure that the implications of any case specific learning are considered beyond the professionals and / or area involved in a case. This is in order that the organisation can be confident that the issues identified were either localised or, if they have a wider reach, this is identified with appropriate remedial action being taken. The Review Panel therefore made the following recommendation:

Recommendation 6: The Brent LSCB to undertake a case audit to explore the issues identified in this case (relating to the undertaking of a Pre-Birth Assessment and identification of domestic valence risk) and identify any actions required to improve performance.

5.2.58 While the checks made with other local authority areas to try and locate the address that had been provided for Razvan and Elena were good practice, it is concerning that – having failed to locate any trace of Razvan, Elena or any children – Brent CYP made the decision to close the case. While a notification of this decision was sent to WDP and the MPS, it means that a pregnant woman who was clearly vulnerable was left without any further agency safety net. The Review Panel was deeply concerned by this. This issue is discussed further in 5.3.25 below.

5.2.59 The second phase of Brent CYP's contact was at the end of May 2018 when referrals were received from the LAS and LNWHT on the 29th May 2018. These referrals addressed concerns about cocaine use, as well as Elena being pregnant. As soon as information was received, all checks were appropriately completed to identify any information about the family. A decision was reached within 24 hours that a statutory Child and Family Assessment would be completed.

5.2.60 This was good practice, with the Review Panel agreeing that the response to this second phase of contact was both appropriate and prompt. However, the Review Panel identified one issue, specifically that when Elena and Razvan were seen together. Additionally, as noted in the discussion of LNWHT's contact with Elena earlier in the month, pregnancy and substance misuse are known to be risk factors for domestic violence. There does not appear to have been any consideration as to whether the circumstances of the case might suggest domestic violence and abuse could have been a concern and / or that Elena should have been seen alone.

5.2.61 The Review Panel concluded that the risk of domestic violence should have been considered in this second phase of contact.

Any organisation participating in a DHR needs to be able to ensure that the implications of any case specific learning are considered beyond the professionals and

/ or area involved in a case. This is in order that the organisation can be confident that the issues identified were either localised or, if they have a wider reach, this is identified with appropriate remedial action being taken. The Review Panel therefore made the following recommendation:

Recommendation 7: Brent CYP to ensure that mandatory domestic abuse training is undertaken by all staff to ensure they are familiar with indicators of domestic abuse, as well as the need to speak to people separately.

5.2.62 During the second episode of contact, BFFD made a number of attempts to confirm with Northwick Park Hospital whether Elena was pregnant. While this would likely have been resolved as part of a fuller assessment, which had been agreed, it is unclear why this information was not available. This is summarised in 5.3.1 below.

5.2.63 Brent CYP asked Elena / Razvan whether an interpreter was required and, when they said yes, an interpreter was provided. This was good practice.

5.3 Addressing the Terms of Reference

The communication, procedures and discussions, which took place within and between agencies.

5.3.1 There was a breakdown in communication between WDP and Brent CYP in relation to WDP's referral in early May. Brent CYP contacted WDP to seek a telephone number and / or address for Elena, but only appear to have done this once. Conversely, it is unclear whether WDP received or responded to this query, because case documentation was not kept up to date. These issues are discussed above.

5.3.2 There was also a lack of clarity as to whether Elena was pregnant or not, particularly in relation to the second phase of Brent CYP's contact. It is not clear why this information was not available to Brent CYP or provided by LNWHT, given the doctor who had seen Elena had completed an ultrasound scan. However, this would have been fully explored as part of the Child and Family Assessment. This issue is discussed above.

The co-operation between different agencies involved with Elena / Razvan [and wider family].

5.3.3 Issues relating to co-operation between the agencies involved with Elena / Razvan are discussed in the analysis of agency contact above.

The opportunity for agencies to identify and assess domestic abuse risk.

5.3.4 None of the agencies who had contact with either Elena or Razvan were aware of the potential of domestic violence and abuse. However, as discussed in the analysis of agency contact above (particularly by LNWHT and Brent CYP) there were opportunities for professionals to consider the potential of domestic violence and abuse and respond accordingly. Given the short period of time between Elena becoming known to agencies and the homicide, it may be that no actions could have been taken to assess or indeed respond to any risk. Nonetheless, in this case some key learning is that the focus appears to have been on substance misuse and pregnancy and that this obscured the possibility of domestic violence and abuse in the thinking of professionals.

Agency responses to any identification of domestic abuse issues.

5.3.5 None of the agencies who had contact with either Elena or Razvan were aware of the potential of domestic abuse.

Organisations' access to specialist domestic abuse agencies.

5.3.6 Locally, Brent Council commissions specialist domestic abuse provision, with a new provider in place since December 2017. The Review Panel noted that a change of provider can sometimes lead to some disruption in local pathways, but such a consideration is not relevant to this case because no agencies identified domestic violence or abuse. Nonetheless, it was positive that during the course of the review agencies demonstrated an awareness of the pathways to specialist domestic abuse service.

5.3.7 Local services are as follows:

- Advance became the commissioned provider in December 2017 – Advance provide advocacy support services with co-location of Independent Domestic Violence Advisors (IDVAs) within Wembley Police station, across Brent CYP and within the local MASH. Advance offer support to women, men and young people assessed as being at medium and high risk of domestic abuse and living in Brent; and
- Refuge also provides an Eastern European Independent Gender Violence Advocacy Service). While Refuge operates in Brent it does not receive any funding from local commissioners. Instead, the service receives funding from the Big Lottery. This

funding is due to end in February 2021. The service provides culturally-specific support to Eastern European women experiencing all forms of gender-based violence, including domestic violence, sexual violence, stalking, female genital mutilation, forced marriage so-called 'honour'-based violence and human trafficking and modern slavery. The service supports women in the boroughs of Brent, Ealing and Hounslow, as well as providing a pan-London support to Eastern European women experiencing human trafficking and modern slavery (including sexual exploitation, forced labour and domestic servitude). Issues in relation to community awareness, as well as access to specialist services, are discussed further in 5.3.14 – 24 below and recommendations have been made.

The policies, procedures and training available to the agencies involved on domestic abuse issues.

5.3.8 In the IMRs submitted, agencies identified a range of internal, singe agency training that was available to staff. Issues in relation to training in relation to work with Eastern European communities is noted above.

Specific consideration to the following issues:

Immigration status

5.3.9 Issues relating to Elena being an EEA national and having NRPF are discussed above.

Language

5.3.10 English was the second language of both Elena and Razvan, and there is a lack of clarity in relation to whether this was an issue for their access to services. For example, there is no information available from the MPS or LNWHT as to whether there was a language barrier for Elena (or Razvan). Meanwhile, Elena told the WDP that she did not need a translator, although issues with recording mean it is not possible to be certain that Elena did not encounter barriers to her engagement. Yet, LAS recorded both Elena and Razvan as speaking "*little English"* and, when Brent CYP contacted Elena and Razvan on the day before the homicide, Razvan requested an interpreter.

5.3.11 In the absence of contact with family and friends the Review Panel has no way of establishing the extent of Elena's English, and whether she may have needed an interpreter. As a result, the Review Panel felt unable to reach a conclusion about this issue but did note that this highlights the importance of all services being able to identify those clients who may need access to an interpreter and also providing accessible information. These two issues are addressed further below in 5.3.14 – 24 below and recommendations have been made.

Substance misuse

5.3.12 Issues relating to substance misuse are discussed above, specifically in relation to the use of crack cocaine and referral of both Elena and Razvan to the WDP.

Criminality

5.3.13 The Review Panel considered evidence of criminality, including whether Razvan was linked to any OCG. There is no evidence of this, although Razvan was known to the MPS for fraud. The Review Panel has however identified Razvan's criminality in relation to Elena, including reports of sexual exploitation. This is discussed further above in section 5.1 above.

Analyse any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

Awareness of domestic abuse

5.3.14 As noted in 1.14, this is the second DHR in Brent involving an Eastern European victim. The first DHR, into the death of Anna, included the following recommendation:

- *"Brent Community Safety Partnership, working with local specialist service providers who have experience of supporting Eastern European women experiencing domestic violence/abuse, to identify the most effective way to increase awareness of domestic abuse, and support services, in Eastern European communities and to develop an action plan to implement this".*

5.3.15 The Review Panel asked what specific actions had been undertaken in response to this recommendation. The Community Safety Team reported that Refuge's Eastern European Independent Gender Violence Advocacy Service was commissioned by the Brent Safer Neighbourhoods Board to deliver the following:

- 2015/16 – Community champions against domestic violence: female domestic violence community champions for the Polish, Romanian and Lithuanian communities to be identified and trained; and
- 2016/17 – Community champions against domestic violence follow-up: a follow-up session for champions to enable them to share good practice and help them to consider how to operate their future mutual support network.

5.3.16 In relation to these activities, 29 Champions (18 Romanian, seven Polish, two Lithuanian, and two professionals who support EE clients), many of whom were survivors themselves, were trained by Refuge. This training helped these champions raise awareness of domestic violence among their own communities and ensure they understood how to report it and help peers to access support.

5.3.17 Additionally, Brent Safer Neighbourhood Board produced an A4 flyer which was handed out with other resources advertising domestic violence support. A stall was also run at a local Romanian Church.

5.3.18 It is of note that, although this activity was commissioned by the Brent Safer Neighbourhoods Board, it was provided using funding from MOPAC. Perhaps more importantly, none of this activity has been sustained.

It is essential that, where appropriate, local areas can identify the specific actions they will take to support the needs of specific communities.

Recommendation 8: The Safer Brent Partnership to develop a comprehensive engagement and communications strategy. This should identify the actions the partnership will take to deliver both a sustained awareness raising campaign and community outreach (including developing resources to meet the needs of Eastern European communities and ensuring access to interpretation where appropriate).

5.3.19 The Mayor of London has published the London Tackling Violence against Women and Girls Strategy 2018-2021 'A Safer City for Women and Girls'[48]. This addresses a range of issues, including challenging the cultural norms which give some men the belief that it is acceptable to attack, abuse, harass and degrade women, as well as encouraging a culture of respect towards women and girls and a better understanding of their rights. In implementing the above recommendation, the Safer Brent Partnership should explore opportunities to work with MOPAC.

Access to specialist services

5.3.20 While local agencies were aware of the locally commissioned specialist service (Advance), the Review Panel explored whether this service was accessible to Romanian communities. In the first three financial quarters of 2018/19 (between the 1st March 2018 and the 31st December) Advance informed the Review Panel that it received a total of nine referrals from victims from Eastern European communities.

5.3.21 In contrast, between the 19th February 2018 to the 18th February 2019) Refuge's Eastern European Independent Gender Violence Advocacy Service received 85

[48] Greater London Authority. (2018) The London Tackling Violence against Women and Girls Strategy. Available at: https://www.london.gov.uk/sites/default/files/vawg_strategy_2018-21.pdf [Accessed: 28th May 2019].

referrals from Brent. The service as a whole, which operates across Ealing, Hounslow and Brent, received 385 referrals in this period.

5.3.22 During the course of the Review, Refuge reported that the Eastern European Independent Gender Violence Advocacy Service had until recently had a Romanian speaking Eastern European community outreach and modern slavery worker who primarily supported victims of modern slavery and Romanian victims of domestic violence. However, they have recently left the service, which has in their place recruited an Albanian speaking worker as Albanians are the largest group of victims accessing the modern slavery service. While this is a reasonable operational decision, it means there is no longer a Romanian speaking worker. A further worker cannot be recruited as the service does not have sufficient funding.

5.3.23 While it is not possible to know if Elena considered accessing help locally, it is evident from the number of referrals received that having a specialist Eastern European service makes a difference for victims from this community. The Review Panel was therefore concerned to learn that the funding for this service is due to end (see 5.3.7) and that specific capacity in relation to Romanian communities has already been lost.

It is important for a local area to be aware of its population, including the level of need for specific communities. However, for boroughs in London it is neither possible nor desirable to work alone. There are opportunities in relation to Eastern European communities to develop provision at a regional level, with Brent exploring shared commissioning arrangements with neighbouring boroughs (such as Barnet and Harrow) which have large Eastern European communities.

Recommendation 9: The Safer Brent Partnership to scope the requirement for specialist provision for Eastern European communities in the borough.

Recommendation 10: The Safer Brent Partnership to work with neighbouring boroughs such as Barnet and Harrow, and MOPAC, to develop sustainable specialist provision for Eastern European communities at a regional level.

5.3.24 The Review Panel also noted that Brent Council's Violence against Women & Girls (VAWG) strategy, which ran from 2015 – 2017, has not been refreshed[49]. In its place, the Community Safety Strategy 2018-2021[50] includes a 'Domestic Abuse Action Plan'.

[49] Safer Brent Partnership (2015) *A strategy to tackle Violence against Women & Girls (VAWG)*, Available at: https://www.brent.gov.uk/media/16402498/brent-vawg-strategy-2015.pdf (Accessed: 28th May 2019).

[50] Safer Brent Partnership (2015) *Community Safety Strategy 2018-2021*, Available at: https://www.brent.gov.uk/media/16412708/safer-brent-community-safety-strategy-2018-2021.pdf (Accessed: 28th May 2019).

It is beyond the remit of this Review Panel to assess the robustness of this action plan; however, it is disappointing that there are no specific actions identified in relation to the needs of Eastern European communities.

It is essential that, where appropriate, local areas can identify the specific actions they will take to support the needs of specific communities.

Recommendation 11: The Safer Brent Partnership to review its existing strategy and action plans in relation to domestic abuse, to explicitly identify the actions it will take to ensure that the needs of Eastern European victims are met, including ensuring:

- **Staff can access single and multi-agency training, so they have appropriate skills and knowledge**
- **There are robust pathways in place locally.**

This recommendation should be implemented in consultation with the Brent LSCB and SAB.

Falling through the gaps

5.3.25 The review has addressed a range of issues in relation to Elena and Razvan's contact with services. However, the Review Panel identified a significant concern in this case. Put simply, different agencies knew that Elena was pregnant, using crack and may have been homeless. Yet, after their initial response, Elena 'fell through the gaps'. This was for two different reasons:

- For LNWHT, after their contact on the 29th May, a referral was made to Brent CYP. This has been discussed from 5.2.9 above. However, because Elena did not have a GP, no discharge notification was made. This meant that from a health perspective there was no 'safety net'. What is more, during the course of the Review Panel discussion, it become apparent there is also no other mechanism available to share an alert in these circumstances, for example, to other local or regional Emergency or to Maternity Departments; and
- For Brent CYP, the first period of contact with Elena and Razvan was triggered after receiving referrals from the MPS and WDP respectively on the 1st and 3rd May 2018. This led to attempts being made to identify where Elena, and the children she was reported to have with her, lived. This included seeking information from other local authorities. However, having failed to identify an address, no further action was taken, and the case was closed.

5.3.26 Additionally, one might also make similar observations about the MPS involvement in this case; however as it has not been possible to determine whether Brent CYP informed them that they had closed the case during their first contact, the Review Panel cannot not say if there was a reasonable expectation of further action.

It is deeply concerning that a case involving a woman who is potentially homeless, using crack, pregnant and is believed to have children, can be closed because they have no GP and / or for whom no address can be found. As a minimum, the statutory services involved consider what, if any, 'safety netting' can be put in place should that individual re-present for help in the future.

Recommendation 12: The Brent LSCB to review the learning identified in the case and develop an interim policy and procedure to ensure that no case is closed by health or children's social are without consideration of safety netting options.

Recommendation 13: The Brent LSCB to escalate the learning identified in this case to the national Serious Case Review Panel for consideration.

5.4 Equality and Diversity

5.4.1 The Review Panel identified the following protected characteristics of Elena and Razvan as requiring specific consideration: sex and race.

5.4.2 *Sex:* As discussed above (see 1.4), sex is a risk factor in domestic violence, with women being disproportionality affected by domestic homicide. As explored in the analysis, Elena appears to have been subjected to extensive domestic violence and abuse, as well as sexual exploitation, by Razvan.

5.4.3 *Race*: Both Elena and Razvan were Romanian. The limited involvement of family and friends in this review means that it has not been possible to explore the potential impact that this may have had on Elena. Additionally, as Razvan did not participate in the review, it has also not been possible to explore his perspective. However, although it is impossible to know, the Review Panel sought to consider Elena's perspective. It is reasonable to assume that her cultural context may have affected both her perception of her experiences, and also the help and support she felt she could access.

5.4.4 *Pregnancy and maternity:* This review has identified that Elena was pregnant during her contact with services. While this was identified as a concern, a pre-birth assessment was not completed. Furthermore, despite the fact that Elena was pregnant, along with other concerns relating to housing and substance misuse, staff did not identify this as a possible indicator of domestic violence and abuse. It was noted that, while several

agencies asked about Elena's pregnancy and access to services, it is unclear if they advised her that she could self-refer to any hospital.

5.4.5 In relation to the other protected characteristics:

5.4.6 *Age*: Although age was not identified by the Review Panel as having a particular impact in this case, Elena was 28 at the time of her death, while Razvan was 43. A large age gap in intimate relationships has been identified as a risk factor[51].

5.4.7 No information was available to the Review Panel that suggested any of the following Protected Characteristics had an impact on the response either Elena or Razvan received or the homicide itself: *Disability*; *Gender Reassignment*; *Marriage and Civil Partnership*; *Religion or Belief*; or *Sexual Orientation*. However, the Review Panel noted that the limited information about Elena (and Razvan) meant that there is much that is unknown in this case. For example, the Review Panel has not been able to establish if Elena had a faith and, if so, whether this would have affected her experience and / or perception of domestic violence.

5.4.8 The Review Panel also considered the impact of *Immigration Status* and *Language*. These issues have been discussed earlier in the analysis.

5.4.9 Several reports published by Imkaan[52] provide a way to consider these different issues alongside one another, using an intersectional approach. An intersectional approach considers how the experience of violence can intersect with different sites of oppression (such as age, caste, class, disability, sexuality, race, belief and religion)[53]. Elena's experience of domestic violence and abuse might have been affected by her different identities (for example, as a Romanian woman, and as a pregnant woman) and circumstances (as someone for whom English was a second language, and as an EEA national who had moved to another country). This may have had a range of consequences. For example, it is noticeable that Elena initially hung up when a worker at the WDP asked about her pregnancy, while she left the Emergency Department at Northwick Park Hospital soon after having an ultrasound. While it is not possible to know, Elena may have been fearful of the consequences of disclosure in terms of the response of statutory authorities, or she may have been fearful of Razvan who may not have wanted her to speak to the very same authorities. Even if Elena had felt able to

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[51] Sebire, J. (2017) 'The Value of Incorporating Measures of Relationship Concordance When Constructing Profiles of Intimate Partner Homicides: A Descriptive Study of IPH Committed Within London, 1998-2009', *Journal of Interpersonal Violence*, 31 (10), pp. 1476-1500.

[52] Imkaan is a UK based, national second tier women's organisation dedicated to addressing violence against Black and 'minority ethnic' (BME) women and girls. For more information go to http://imkaan.org.uk.

[53] Larasi, M. with Jones, D. (2017) *Tallaw* Elena*: a briefing paper on black and 'minority ethnic' women and girls organising to end violence against us,* Available at : https://www.imkaan.org.uk/resources (Accessed 28th May 2019).

access help and support, her options may have been limited because she likely had no NRPF.

5.4.10 Taken together, these reflections are an important reminder both that agencies should consider someone's unique needs and experiences in the round, but also that migrant women may be particularly vulnerable to violence and abuse and yet face significant challenges in accessing help and support.

6. Conclusions and Lessons to be Learnt

6.1 Conclusions (key issues during this Review)

6.1.1 The death of Elena, as well as her unborn child, was a tragedy. Sadly, the limited contact with family and friends in this case means that the Review Panel has not been able to develop a picture of Elena. Consequently, there is a limited sense of Elena as a person in this review. However, she had family and friends, who will each have known her, as well as her hopes and dreams, in their own way. The Review Panel extends its sympathy to all those affected by her murder, as well as the death of her unborn child.

6.1.2 The Review Panel also noted that Razvan did not respond to an invitation to participate in the review. This has meant that, in many ways, Razvan is 'absent' from the review. However, as set out in the analysis, the Review Panel has concluded that Elena was likely subject to an extensive range of domestic violence and abuse, including coercive behaviour, as well as sexual exploitation. Razvan has been found guilty of Elena's murder, as well as the death of their unborn child.

6.1.3 There has been significant learning identified during the course of this review, which the Review Panel hopes will prompt individual agencies, as well as the appropriate partnerships, to further develop their response to domestic violence and abuse. This learning is summarised below.

6.2 Lessons To Be Learnt

6.2.1 There has been extensive learning in this case, despite the relatively limited contact that Elena and Razvan had with services.

6.2.2 The most significant learning relates to the ability of professionals to identify indicators of domestic violence and abuse and take appropriate actions, particularly in a health and children's social care setting. This should include making attempts to speak to an individual alone if possible. In this context, the review has also identified how other presenting issues (e.g. substance use) can obscure a consideration of domestic violence and abuse, as well as missed opportunities to trigger an enquiry (e.g. as part of a pre-birth assessment). While recommendations have been made to address these issues, this is not 'new' learning. Rather, it repeats a consistent message from reviews: that staff need to be trained and existing policies and procedures followed.

6.2.3 Further learning relates to multi-agency working and case closure. The Review panel identified examples where agencies did not communicate clearly or did not keep adequate records. Most significantly, it is not acceptable that a vulnerable victim's contact with statutory services can simply end when there has been no consideration to

possible safety netting. Recommendations have been made to address this locally and also escalate this matter for consideration at a national level.

6.2.4 While there has been limited information about the lived experiences of Elena available to the Review Panel, this review has identified potential barriers to her help seeking. Locally and nationally the Review Panel has therefore recommended that further work is undertaken to meet the needs of EEA nationals subject to domestic violence and abuse. In this context, the Review Panel has also made recommendations for the Safer Brent Partnership in relation to the actions that should be taken to ensure that the needs of Romanian (and more broadly, Eastern European) victims are met. This includes awareness raising, as well as access to training for staff and the provision of specialist services for victims.

6.2.5 Recommendations have also been made in relation to the provision of L&D services in a substance misuse setting, in particular the importance of gender informed provision.

6.2.6 While this review has identified extensive learning, it is also important to note there were multiple examples of good practice. This included professionals making safeguarding referrals (including the MPS, WDP, LAS and LNWHT). In the second phase of their contact with Elena and Razvan, Brent CYP also responded promptly to safeguarding concerns. Some agencies also asked about, and when requested provided, translation.

6.2.7 Following the conclusion of a DHR, there is an opportunity for agencies to consider the local response to domestic violence and abuse in light of the learning and recommendations. Frustratingly, the Review Panel has identified that while a DHR relating to another Eastern European women was completed locally, a recommendation in relation to community awareness only led to a small number of actions being undertaken and these have not been sustained. This is disappointing. Learning from DHRs is relevant to agencies both individually and collectively, but the ambition of DHRs – to reduce the likelihood of future homicides – can only be achieved if there is a shared commitment to change (including implementing recommendations and delivering improved responses). The Review Panel hopes that the response to this DHR will be underpinned by a recognition that the response to domestic violence is a shared responsibility, that requires sustained action, as it really is everybody's business to make the future safer for others.

7. Recommendations:

7.1 IMR recommendations (Single Agency)

7.1.1 The following single agency recommendations were made by the agencies in their IMRs. They are described in section three following the analysis of contact by each agency and are also presented collectively in **Appendix 2**. These are as follows:

Brent CYP

7.1.2 Awareness raising with multi-agency partners that referrals to the Brent Family Front Door should be as complete as possible (a correct address and contact details are needed to progress referrals).

LNWHT

7.1.3 Establish a standardised screening tool for use by Emergency Department clinicians in patients presenting to the Emergency Department routine enquiry will identify those experiencing domestic violence, with a particular focus on those that have not presented as a result of suspicious injuries or after a disclosure of domestic violence.

7.1.4 Ensure training to Emergency Department clinicians (doctors and nurses including bank/agency/locum staff) on use of the tool and actions to be taken if the patient is screened positive, with training to be repeated at regular intervals.

7.1.5 Aim to implement this screening tool within the next 3 months and regularly audit its use, with training adapted to the results of this audit.

7.1.6 ED staff to be reminded of the importance of mini booking that it is essential in all un-booked pregnant women wherever they attend in the Trust and a referral to maternity should be made.

7.1.7 ED staff to familiarise themselves with the 'Non-Obstetric Emergency Care: Guideline for the Care and Management of Maternity Admission to the Emergency Department.

7.1.8 Adult patients should be seen alone during their attendance in hospital if there is a safeguarding concern.

7.1.9 Staff to be reminded of the importance of completing documentation appropriately.

7.1.10 Develop an online platform for child safeguarding referrals that will enable clinicians from the Trust to complete a single form with information regarding their concerns that can be shared with different professionals (depending on the case) from Social Care, the Trust's PMLS team, the Trust's Safeguarding Midwife, the Trust's IDVA, the Adult Psychiatric Liaison Service, the Children's and Adolescent Mental Health (CAMHS)

team and local Substance Misuse teams. This will reduce the number of different forms clinicians need to complete for a single patient, reducing time away from direct clinical care and produce a simpler system which will be easier to train staff members on then the current very complex system.

7.1.11 The online platform will also enable a robust method for the PMLS to identify all Child Safeguarding referrals sent from the ED (as well as the rest of the Trust) to ensure they are appropriately actioned, information shared as required and establish a clear governance structure for these cases.

WDP

7.1.12 Independent Domestic Violence Advisor (IDVA) worker – It has been identified that a specialist Domestic Violence Practitioner would be beneficial within the service. A Criminal Justice Practitioner has been identified to complete the IDVA qualification to commence in their specialised role.

7.1.13 Review of Safeguarding Standard Operating Procedure (SOP) – The local Safeguarding SOP has recently been developed and expanded. It now directs staff to ensure they scan all referrals made to safeguarding (children and adults) onto the case management system. They also need to follow up the outcome once the referral has been made before being able to discharge the service user.

7.1.14 Audit of procedures and guidance compliance – The organisation will be undertaking an internal audit aimed at ensuring local compliance with organisational policy and procedure within an agreed timeframe are taking place.

7.1.15 Risk management – A guidance tool on how to write a comprehensive risk management plan has been developed, discussed and distributed amongst staff. We will be developing a workshop for staff on how to identify and assess risk, and then write an effective risk management plan.

7.1.16 Case notes – A case note format and guidance has been devised and implemented. Staff have been advised on when and how to document case notes correctly and efficiently through a workshop that was mandatory for all staff to attend. The template has been shared to all staff, and it will be included in any new staffs' induction, so the good practice continues.

7.1.17 Criminal Justice 'Follow up appointment' – The criminal justice team have been advised that all service users who come through the Criminal Justice route should be offered both the compulsory 'Initial Assessment' and a 'Follow Up Appointment'. Service users will be breached if they fail to attend either of these appointments. This gives staff the opportunity to engage and build a relationship with service users, so they feel more comfortable to disclose their life situations.

7.2 DHR recommendations

7.2.1 The Review Panel has made the following recommendations, which are also described in section three as part of the analysis and are also presented collectively in **Appendix 3**.

7.2.2 These recommendations should be acted on through the development of an action plan, with progress reported on to the Safer Brent Partnership within six months of the review being approved. In relation to the recommendations with national implications, the Chair of the Safer Brent Partnership should write the relevant government department, to share these recommendations and updates on the actions taken should be provided within six months of the review being approved.

7.2.3 **Recommendation 1:** The Home Office to review funding arrangements for the provision of specialist and expert advocacy for the families of victims who reside outside of the UK.

7.2.4 **Recommendation 2:** The Safer Brent Partnership to review the local training offer to ensure all front-line practitioners have a good awareness of the barriers and support options for a person with NRPF.

7.2.5 **Recommendation 3:** The Home Office to ensure that there is consistent access to immigration and/or benefits advice, support and pathways out of destitution, for EEA nationals who are victims of domestic violence and abuse but have NRPF.

7.2.6 **Recommendation 4:** The Safer Brent Partnership to work with the Brent LSCB and Safeguarding Adults Board (SAB) to ensure all front-line practitioners are aware of the signs and indicators of Modern-Day Slavery as well as the NRM.

7.2.7 **Recommendation 5:** WDP to work with its commissioners to ensure that female offenders can access a female member of staff as part of unscheduled ‘drop ins’.

7.2.8 **Recommendation 6:** The Brent LSCB to undertake a case audit to explore the issues identified in this case (relating to the undertaking of a Pre-Birth Assessment and identification of domestic valence risk) and identify any actions required to improve performance.

7.2.9 **Recommendation 7:** Brent CYP to ensure that mandatory domestic abuse training is undertaken by all staff to ensure they are familiar with indicators of domestic abuse, as well as the need to speak to people separately.

7.2.10 **Recommendation 8:** The Safer Brent Partnership to develop a comprehensive engagement and communications strategy. This should identify the actions the partnership will take to deliver both a sustained awareness raising campaign and community outreach (including developing resources to meet the needs of Eastern European communities and ensuring access to interpretation where appropriate).

7.2.11 **Recommendation 9:** The Safer Brent Partnership to scope the requirement for specialist provision for Eastern European communities in the borough**.**

7.2.12 **Recommendation 10:** The Safer Brent Partnership to work with neighbouring boroughs such as Barnet and Harrow, and MOPAC, to develop sustainable specialist provision for Eastern European communities at a regional level.

7.2.13 **Recommendation 11:** The Safer Brent Partnership to review its existing strategy and action plans in relation to domestic abuse, to explicitly identify the actions it will take to ensure that the needs of Eastern European victims are met, including ensuring:

- Staff can access single and multi-agency training, so they have appropriate skills and knowledge
- There are robust pathways in place locally.
- This recommendation should be implemented in consultation with the Brent LSCB and SAB.

7.2.14 **Recommendation 12:** The Brent LSCB to review the learning identified in the case and develop an interim policy and procedure to ensure that no case is closed by health or children's social are without consideration of safety netting options.

7.2.15 **Recommendation 13:** The Brent LSCB to escalate the learning identified in this case to the national Serious Case Review Panel for consideration.

Appendix 1: Domestic Homicide Review Terms of Reference

This Domestic Homicide Review (DHR) is being completed to consider agency involvement with Elena and Razvan following the death of Elena in June 2018. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of DHR

1. To review the involvement of each individual agency, statutory and non-statutory, with Elena and Razvan from the 1st January 2016 (when the relationship is believed to have begun) to the start of June 2018 (the date of the homicide) (inclusive). To summarise agency involvement prior this time period where relevant.
2. To establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
3. To identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
4. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
5. To prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
6. To contribute to a better understanding of the nature of domestic violence and abuse.
7. To highlight good practice.

Role of the Independent Chair, the Review Panel the Safer Brent Partnership

8. *The Independent Chair of the DHR will:*
   a) Chair the DHR Panel.
   b) Co-ordinate the review process.
   c) Quality assure the approach and challenge agencies where necessary.
   d) Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

9. *The Review Panel:*
   a) Agree robust Terms of Reference (ToR).
   b) Ensure appropriate representation of your agency at the panel: panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
   c) Prepare Individual Management Reviews (IMRs) and chronologies through delegation to an appropriate person in the agency.
   d) Discuss key findings from the IMRs and invite the author of the IMR (if different) to the IMR meeting.
   e) Agree and promptly act on recommendations in the IMR Action Plan.

f) Ensure that the information contributed by your organisation is fully and fairly represented in the Overview Report.
g) Ensure that the Overview Report is of a sufficiently high standard for it to be submitted to the Home Office, for example:
   - The purpose of the review has been met as set out in the ToR;
   - The report provides an accurate description of the circumstances surrounding the case; and
   - The analysis builds on the work of the IMRs and the findings can be substantiated.
h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
i) On completion present the full report to the Safer Brent Partnership.
j) Implement your agency's actions from the Overview Report Action Plan.

10. *The Safer Brent Partnership will*:
    a) Translate recommendations from Overview Report into a SMART Action Plan.
    b) Submit the Executive Summary, Overview Report and Action Plan to the Home Office Quality Assurance Panel.
    c) Forward Home Office feedback to the family, Review Panel and STADV.
    d) Agree publication date and method of the Executive Summary and Overview Report.
    e) Notify the family, Review Panel and STADV of publication.

Definitions: Domestic Violence and Coercive Control

11. The Overview Report will make reference to the terms domestic violence and coercive control. The Review Panel understands and agrees to the use of the cross-government definition (amended March 2013) as a framework for understanding the domestic violence experienced by the victim in this DHR. The cross-government definition states that domestic violence and abuse is:

    "*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.*

    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.

    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."

    This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

Equality and Diversity

12. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both Elena and Razvan (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any additional vulnerabilities to consider (e.g. armed forces, carer status and looked after child).
13. The Review Panel identified the following protected characteristics of Elena and Razvan as requiring specific consideration for this case:
    a) Sex (Elena was female, Razvan is male)
    b) Pregnancy and Maternity (Elena was pregnant at the time of her death)
    c) Race (Elena and Razvan was/is a Romanian National).
14. The following issues have also been identified as particularly pertinent to this homicide, in particular how they may have impact on risks, needs or helped or hindered access to services:
    d) Immigration status (as Romanian Nationals, Elena and Razvan were/are a citizen of an EU country but would have had to pass the pass the habitual residence test to be eligible for welfare benefits and housing. They may have also accessed a range of informal (community) networks)
    e) Language (whether English as a Second Language was a barrier for Elena and / or Razvan)
    f) Substance misuse (there is an indication of cocaine use by both Elena and Razvan)
    g) Criminality (there are reports of criminal activity by Razvan as well Elena).
15. Consideration will be given by the Review Panel as to whether either the victim or the perpetrator was an 'Adult at Risk' Definition in Section 42 the Care Act 2014:

    "*An adult who may be vulnerable to abuse or maltreatment is deemed to be someone aged 18 or over, who is in an area and has needs for care and support (whether or not the authority is meeting any of those needs); Is experiencing, or is at risk of, abuse or neglect; and As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it*."

    Abuse is defined widely and includes domestic and financial abuse. These duties apply regardless of whether the adult lacks mental capacity.

16. If it is the case that any party is an adult at risk, the review panel may require the assistance or advice of additional agencies, such as adult social care, and/or specialists such as a Learning Disability Psychiatrist, an independent advocate or someone with a good understanding of the Mental Capacity Act 2005.

    The Care Act 2014 states; "*Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances*."

17. *Expertise:* The Review Panel will include the following service as an expert/advisory panel member to ensure appropriate consideration to the identified characteristics and to help understand crucial aspects of the homicide: Refuge - Eastern European Independent Gender Violence Advocacy Service

18. If Elena and Razvan have not come into contact with agencies that they might have been expected to do so, then consideration will be given by the Review Panel on how lessons arising from the DHR can improve the engagement with those communities.
19. The Review Panel agrees it is important to have an intersectional framework to review Elena and Razvan life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one's experience with local services/agencies and within their community.

Parallel Reviews

20. There is an inquest into the death Elena and the panel will ensure the DHR process dovetails with the Coroner Inquest.
21. As the DHR will consider issues in relation to a maternity death, the Review Panel noted that issues may be identified that relate to how agencies work together to safeguard and promote the wellbeing of children. The Review Panel agreed that it was important that a link is made to Brent Local Safeguarding Children Board (LSCB).
22. It will be the responsibility of the Independent Chair to ensure contact is made with any other parallel process if these are identified during the DHR process.

[Criminal trial disclosure dealt with in disclosure paragraph below]

Membership

23. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
24. The following agencies are to be on the Review Panel:
    a) Brent Adult Social Care Services
    b) Brent Children and Young People
    c) Brent Clinical Commissioning Group (CCG)
    d) Brent Community Safety Team
    e) Brent Housing services
    f) Central and North West London NHS Foundation Trust – Mental Health
    g) General Practitioner for the victim and [alleged] perpetrator
    h) Local domestic violence specialist service providers: Advance, Refuge (including the Eastern European Independent Gender Violence Advocacy Service)
    i) London North West Healthcare NHS Trust (LNWHT) – Accident & Emergency (A&E)
    j) Metropolitan Police Service Specialist Crime Review Group, and Senior Investigating Officer (for first meeting only)
    k) NHS England (Maternity Services for London)
    l) Probation Service
    m) Victim Support
    n) Westminster Drug Project Substance misuse services
25. The representatives from Brent Children and Young People will be the panel member to ensure good cross communication with parallel review (see paragraph 39).

Role of Standing Together Against Domestic Violence (Standing Together) and the Panel

26. Standing Together have been commissioned by the Safer Brent Partnership to independently chair this DHR. Standing Together have in turn appointed their DHR

Associate (James Rowlands) to chair the DHR. The DHR team consists of two Administrators and a DHR Manager. The DHR Support Officer (Amy Hewitt) will provide administrative support to the DHR and the DHR Team Manager (Gemma Snowball) will have oversight of the DHR. The manager will quality assure the DHR process and Overview Report. This may involve their attendance at some panel meetings. The contact details for the Standing Together DHR team will be provided to the panel and you can contact them for advice and support during this review.

Collating evidence

27. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted and secure all relevant records.
28. Chronologies and Individual Management Review (IMRs) will be completed by the following organisations known to have had contact with Elena and Razvan during the relevant time period:
    a) Brent Children and Young People
    b) London North West University Healthcare NHS Trust - A&E
    c) Metropolitan Police Service
    d) Westminster Drug Project
29. Each IMR should:
    - Set out the facts of their involvement with Elena and/or Razvan;
    - Critically analyse the service they provided in line with the specific terms of reference;
    - Identify any recommendations for practice or policy in relation to their agency;
    - Consider issues of agency activity in other areas and review the impact in this specific case.
    - Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Elena and Razvan in contact with their agency.
    - Further agencies may be asked to completed chronologies and IMRs if their involvement with Elena and Razvan becomes apparent through the information received as part of the review.
30. To inform the deliberations of the Review Panel, thematic reports are also sought in relation to the follow areas. These reports should address the strategic context, evidence of local need, pathways, provision, gaps and issues in relation to:
    a) The local Romanian community and / or East European communities more generally (to be provided by the Brent Community Safety Team)
    b) The local care pathway for victims/survivors of domestic violence and abuse, including those from East European communities (to be provided Refuge and Advance)

Key Lines of Inquiry

31. In order to critically analyse the incident and the agencies' responses to Elena and/or Razvan, this review should specifically consider the following points:
    a) Analyse the communication, procedures and discussions, which took place within and between agencies.
    b) Analyse the co-operation between different agencies involved with Elena / Razvan [and wider family].
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d) Analyse agency responses to any identification of domestic abuse issues.
    e) Analyse organisations' access to specialist domestic abuse agencies.

f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
g) Specific consideration to the following issues:
- Immigration status
- Language
- Substance misuse
- Criminality.

h) Analyse any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

As a result of this analysis, agencies should identify good practice and lessons to be learned. The Review Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.

Development of an action plan

32. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the Safer Brent Partnership on their action plans within six months of the Review being completed.
33. The Safer Brent Partnership to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Liaison with the victim's family and [alleged] perpetrator and other informal networks

34. The review will sensitively attempt to involve the family of Elena in the review, once it is appropriate to do so in the context of on-going criminal proceedings. The chair will lead on family engagement with the support of the Metropolitan Police Service Family Liaison Officer (FLO) and subsequently with the Victim Support Homicide Service and / or Advocacy After Fatal Domestic Abuse (AAFDA) as appropriate.
35. Razvan will be invited to participate in the review, following the completion of the criminal trial.
36. Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.
37. The Review Panel discussed involvement of other informal networks of the Elena / Razvan and agreed that the chair will seek engagement with informal networks (including neighbours, friends and community networks).

Media handling

38. Any enquiries from the media and family should be forwarded to the Safer Brent Partnership who will liaise with the chair. Panel members are asked not to comment if requested. The Safer Brent Partnership will make no comment apart from stating that a review is underway and will report in due course.
39. The Safer Brent Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

40. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material

that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

41. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.
42. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Documents will be password protected.
43. If an agency representative does not have a secure email address, then their non-secure address can be used but all confidential information must be sent in a password protected attachment. The password used must be sent in a separate email. Please use the password provided to you by the Standing Together team. They should be reminded that they should remove the password and only share appropriate information to appropriate front line staff in line with the DHR Confidentiality Statement and the specific Terms of Reference.
44. If you are sending password protected document to a non-secure email address it must be a recognisable work email address for the professional receiving information. Information from DHR should not be sent to a gmail / hotmail or other personal email account unless in rare cases when it has been verified as the work address for an individual or charity.
45. No confidential content should be in the body of an email to a non-secure email account. That includes names, DOBs and address of any subjects discussed at DHR.

Disclosure

46. Disclosure of facts or sensitive information will be managed and appropriately so that problems do not arise. The review process will seek to complete its work in a timely fashion in order to safeguard others.
47. The sharing of information by agencies in relation to their contact with the victim and/or the [alleged] perpetrator is guided by the following:
    a) The Data Protection Act 1998 governs the protection of personal data of living persons and places obligations on public authorities to follow ‘data protection principles’: The 2016 Home Office Multi-Agency Guidance for the Conduct of DHRs (Guidance) outlines data protection issues in relation to DHRs(Par 98). It recognises they tend to emerge in relation to access to records, for example medical records. It states ‘data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims of domestic abuse for the purposes of a DHR should not normally pose difficulty – this applies to all records relating to the deceased, including those held by solicitors and counsellors’.
    b) Data Protection Act and Living Persons: The Guidance notes that in the case of a living person, for example the perpetrator, the obligations do apply. However, it further advises in Par 99 that the Department of Health encourages clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:
        i) The review team should be informed about the existence of information relevant to an inquiry in all cases; and

ii) The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or partial redaction of record content.

c) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).

d) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:
   i) It is needed to prevent serious crime
   ii) there is a public interest (e.g. prevention of crime, protection of vulnerable persons)

48. During the police criminal investigation, the police are bound by law to ensure that there is fair disclosure of material that may be relevant to an investigation and which does not form part of the prosecution case. Any material gathered in this DHR process could be subject to disclosure to the defence, if it is considered to undermine the prosecution case or assisting the case for the accused.
49. The chair will discuss the issues of disclosure in this case with the police Disclosure Officer.
50. The chair, police and CPS will be minded to consider the confidentiality of material at all times and to balance that with the interests of justice.

Appendix 2: Single Agency Recommendations and Action Plan

Brent CYP						
Recommendation	Scope of Recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Awareness raising with multi-agency partners that referrals to the Brent Family Front Door should be as complete as possible (a correct address and contact details are needed to progress referrals).						

LNWHT						
Recommendation	Scope of Recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Establish a standardised screening tool for use by Emergency Department clinicians in patients presenting to the Emergency Department routine enquiry will identify those experiencing domestic violence, with a particular focus on those that have not presented as a result of suspicious injuries or after a disclosure of domestic violence.						
Ensure training to Emergency Department clinicians (doctors and nurses including bank/agency/locum staff) on use of the tool and actions to be taken if the patient is screened positive, with training to be repeated at regular intervals.						
Aim to implement this screening tool within the next 3 months and regularly audit its use, with training adapted to the results of this audit.						
ED staff to be reminded of the importance of mini booking that it is essential in all un-booked pregnant women wherever they attend in the Trust and a referral to maternity should be made.						
ED staff to familiarise themselves with the 'Non-Obstetric Emergency Care: Guideline for the Care and Management of Maternity Admission to the Emergency Department.						

Adult patients should be seen alone during their attendance in hospital if there is a safeguarding concern.						
Staff to be reminded of the importance of completing documentation appropriately.						
Develop an online platform for child safeguarding referrals that will enable clinicians from the Trust to complete a single form with information regarding their concerns that can be shared with different professionals (depending on the case) from Social Care, the Trust's PMLS team, the Trust's Safeguarding Midwife, the Trust's IDVA, the Adult Psychiatric Liaison Service, the Children's and Adolescent Mental Health (CAMHS) team and local Substance Misuse teams. This will reduce the number of different forms clinicians need to complete for a single patient, reducing time away from direct clinical care and produce a simpler system which will be easier to train staff members on then the current very complex system.						
The online platform will also enable a robust method for the PMLS to identify all Child Safeguarding referrals sent from the ED (as well as the rest of the Trust) to ensure they are appropriately actioned, information shared as required and establish a clear governance structure for these cases.						

WDP						
Recommendation	Scope of Recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Independent Domestic Violence Advisor (IDVA) worker – It has been identified that a specialist Domestic Violence Practitioner would be beneficial within the service. A Criminal Justice Practitioner has been identified to complete the IDVA qualification to commence in their specialised role.						
Review of Safeguarding Standard Operating Procedure (SOP) – The local Safeguarding SOP has recently been developed and expanded. It now directs staff to ensure they scan all referrals made to safeguarding (children and adults) onto the case management system. They also need to follow up the outcome once the referral has been made before being able to discharge the service user.						
Audit of procedures and guidance compliance – The organisation will be undertaking an internal audit aimed at ensuring local compliance with organisational policy and procedure within an agreed timeframe are taking place.						
Risk management – A guidance tool on how to write a comprehensive risk management plan has been developed, discussed and distributed amongst staff. We will be developing a workshop for staff on how to identify and assess risk, and then write an						

effective risk management plan.						
Case notes – A case note format and guidance has been devised and implemented. Staff have been advised on when and how to document case notes correctly and efficiently through a workshop that was mandatory for all staff to attend. The template has been shared to all staff, and it will be included in any new staffs' induction, so the good practice continues.						

Appendix 3: DHR Recommendations and Action Plan

Recommendation	Scope of Recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Recommendation 1: The Home Office to review funding arrangements for the provision of specialist and expert advocacy for the families of victims who reside outside of the UK.						
Recommendation 2: The Safer Brent Partnership to review the local training offer to ensure all front-line practitioners have a good awareness of the barriers and support options for a person with NRPF.						
Recommendation 3: The Home Office to ensure that there is consistent access to immigration and/or benefits advice, support and pathways out of destitution, for EEA nationals who are victims of domestic violence and abuse but have NRPF.						
Recommendation 4: The Safer Brent Partnership to work with the Brent LSCB and Safeguarding Adults Board (SAB) to ensure all front-line practitioners are aware of the signs and indicators of Modern-Day Slavery as well as the NRM.						
Recommendation 5: WDP to work with its commissioners to ensure that female offenders can access a female member of staff as part of unscheduled 'drop ins'.						
Recommendation 6: The Brent LSCB to undertake a case audit to explore the issues identified in this case (relating to the undertaking of a Pre-Birth Assessment and identification of domestic valence risk) and identify any actions required to improve						

performance.						
Recommendation 7: Brent CYP to ensure that mandatory domestic abuse training is undertaken by all staff to ensure they are familiar with indicators of domestic abuse, as well as the need to speak to people separately.						
Recommendation 8: The Safer Brent Partnership to develop a comprehensive engagement and communications strategy. This should identify the actions the partnership will take to deliver both a sustained awareness raising campaign and community outreach (including developing resources to meet the needs of Eastern European communities and ensuring access to interpretation where appropriate).						
Recommendation 9: The Safer Brent Partnership to scope the requirement for specialist provision for Eastern European communities in the borough**.**						
Recommendation 10: The Safer Brent Partnership to work with neighbouring boroughs such as Barnet and Harrow, and MOPAC, to develop sustainable specialist provision for Eastern European communities at a regional level.						
Recommendation 11: The Safer Brent Partnership to review its existing strategy and action plans in relation to domestic abuse, to explicitly identify the actions it will take to ensure that the needs of Eastern European victims are met, including ensuring: • Staff can access single and multi-agency training, so they have appropriate skills and knowledge						

• There are robust pathways in place locally. • This recommendation should be implemented in consultation with the Brent LSCB and SAB.						
Recommendation 12: The Brent LSCB to review the learning identified in the case and develop an interim policy and procedure to ensure that no case is closed by health or children's social are without consideration of safety netting options.						
Recommendation 13: The Brent LSCB to escalate the learning identified in this case to the national Serious Case Review Panel for consideration.						

Appendix 4: Glossary

AAFDA	Advocacy After Fatal Domestic Abuse
BFFD	(Brent Council CYP) Brent Family Front Door
CCG	(Brent) Clinical Commissioning Group
CAIT	(MPS) Child Abuse Investigation Team
CNWLT	Central and North West London NHS Foundation Trust
CPS	Crown Prosecution Service
CYP	(Brent Council) Children and Young People
DHR	Domestic Homicide Review
ECG	Electrocardiogram
EEA	European Economic Area
EU	European Union
FLO	(MPS) Family Liaison Officer
GP	General Practitioner
HIDVA	Health Independent Domestic Violence Advisor
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
ICPC	Initial Child Protection Conference
LAS	London Ambulance Service
L&D	Liaison & Diversion
LSCB	Local Safeguarding Children Board
LAS	London Ambulance Service
LNWHT	London North West Healthcare University NHS Trust
MASH	Multi Agency Safeguarding Hub
MBRRACE	Mothers and Babies: reducing risk through audits and confidential enquiries across the UK
MERLIN PAC	Completed by police officers when they encounter a child in circumstances that cause concern
MOPAC	Mayor's Office for Policing and Crime
MPS	Metropolitan Police Service
NRF	National Referral Mechanism
NPS	National Probation Service
NRPF	No Resource to Public Funds
NRM	National Referral Mechanism
OCG	Organised Crime Group
PMLS	(LNWHT) Paediatric and Maternity Liaison Service
SAB	Safeguarding Adults Board
SCR	Serious Case Review
SCRG	(MPS) Specialist Crime Review Group
SI	Serious Incident
SIO	(MPS) Senior Investigating Officer
STADV	Standing Together Against Domestic Violence
SEA	Surviving Economic Abuse
UK	United Kingdom
UKVI	UK Visas & Immigration
WDP	Westminster Drug Project