



**TOWER HAMLETS COMMUNITY SAFETY  
PARTNERSHIP  
DOMESTIC HOMICIDE REVIEW  
Overview Report into the death of Salma  
January 2019**

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Associate Standing Together Against Domestic Abuse  
Date: September 2020**



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*“Peace be upon you for what you patiently endured.” (Ar-Ra’d:24).*

**Included as a dedication at the request of Salma’s family**

# 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 report examines agency responses and support given to Salma,<sup>1</sup> a resident of the London Borough of Tower Hamlets (hereafter ‘Tower Hamlets’) prior to the point of her death at her home. Salma was killed by her husband Omar.<sup>2</sup> She was found dead at home on a day in early January 2019, with fatal head and neck injuries. The London Ambulance Service (LAS) attended, as did police officers from the Metropolitan Police Service (MPS), but tragically Salma was pronounced dead at the scene.
- 1.1.3 Omar had left before the MPS arrived, but he presented himself to a South London Police Station the following morning. He was subsequently arrested and charged with murder. In July 2019 Omar was found guilty of murder and sentenced to life imprisonment with a minimum term of 19 years.
- 1.1.4 This DHR will consider agencies contact/involvement with Salma and/or Omar from the beginning of 2008 to the date of the homicide.
- 1.1.5 In addition to agency involvement, the DHR 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 DHR 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 of Salma for their loss and thanks them for their contributions and support for this process.

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<sup>1</sup> Not her real name.

<sup>2</sup> Not his real name.

## 1.2 Timescales

- 1.2.1 In accordance with the December 2016 '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*' (hereafter 'the statutory guidance'), the local Community Safety Partnership (CSP) – the Tower Hamlets CSP – commissioned this DHR. Having received notification from the MPS in early January 2019, a decision was made to conduct a DHR in consultation with CSP partners in February 2019 and confirmed in March 2019. Subsequently, the Home Office was notified of the decision in writing at the start of April 2019.
- 1.2.2 Standing Together Against Domestic Abuse (Standing Together) was commissioned to provide an Independent Chair (hereafter 'the chair') for this DHR in February 2019, with this beginning in April 2019 once the decision to conduct the DHR had been made. The completed report was handed to the Tower Hamlets CSP in September 2020. On the 24<sup>th</sup> November 2020, it was tabled at a meeting of the Tower Hamlets Community Safety Partnership and signed off, before being submitted to the Home Office Quality Assurance Panel on the 26<sup>th</sup> November 2020. In April 2021, the completed report was considered by the Home Office Quality Assurance Panel. In June 2021, the Tower Hamlets CSP received a letter from the Home Office Quality Assurance Panel approving the report for publication. The letter will be published alongside the completed report.
- 1.2.3 Home Office guidance states that a DHR 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 July 2019 to ensure agencies could attend, and with reference to the conclusion of the criminal justice process);
  - To allow the completion of the criminal trial (Omar was convicted in July 2019);
  - To meet with family and friends after the conclusion of the criminal trial, as well as allowing time for the family to feedback on the draft report (see 1.9); and
  - The Covid-19 pandemic (while the Review Panel was able to continue operating during this period, the availability of some members of the Review Panel and the transfer of meetings online extended the duration of the DHR).

### 1.3 Confidentiality

- 1.3.1 The findings of this DHR are confidential until approved for publication by the Home Office Quality Assurance Panel. In the interim, information has been available only to participating officers/professionals and their line managers.
- 1.3.2 This DHR has been anonymised in accordance with the statutory guidance. The specific date of the homicide and the sex of any children have been removed (with anonymity further enhanced by the children being referred to as Child A, B and C and identifying information about their primary schools being removed). Only the chair and Review Panel members are named.
- 1.3.3 The following pseudonyms have been used in this review to protect the identities of the victim, other parties, those of their family members, and the perpetrator:

Name	Relationship to Salma
Salma	n/a
Omar	Husband
Child A	Child
Child B	Child
Child C	Child
Samiha	Niece
Aneysa	Sister
Ahad	Nephew
Zoya	Cousin / Sister-in-law

- 1.3.4 The choice of pseudonyms used in this report were discussed with Salma's family. They asked the chair to choose pseudonyms, subject to their approval.

### 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 DHR process.

- 1.4.2 At the first meeting of the Review Panel, it was identified that the Protected Characteristic of Sex required specific consideration. This is because Salma was female, and Omar is male. An analysis of DHRs reveals gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators.<sup>3</sup>
- 1.4.3 The Review Panel also identified the following Protected Characteristics as requiring specific consideration:
- *Age* (there was a 16-year age gap between Salma and Omar);
  - *Race* (both Salma and Omar were of Bangladeshi origin); and
  - *Religion and belief* (both Salma and Omar are believed to have been of the Muslim faith).
- 1.4.4 Additionally, the following issues have also been identified as pertinent to this homicide:
- English as a second language and the use of translators (some agency records have highlighted that Salma and/or Omar may have had limited English); and
  - Immigration (both Salma and/or Omar were of Bangladeshi origin and had become naturalised British Citizens).
- 1.4.5 These issues are considered throughout this report and summarised in 5.4 below.

## 1.5 Terms of Reference

- 1.5.1 The full Terms of Reference are included at **Appendix 1**. This DHR 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.

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<sup>3</sup> "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 Standing Together 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.



- 1.5.2 The Review Panel was comprised of agencies from Tower Hamlets, as Salma and Omar were living in that area at the time of the homicide. Agencies were contacted as soon as possible to inform them of the DHR, invite their participation and to ask them to secure their records.
- 1.5.3 Additionally, at the start of the DHR, it was established that Salma and Omar had lived in another part of London, specifically the London Borough of Newham (hereafter 'Newham'). The CSP lead from that area was invited to join the Review Panel, as were specific agencies as required.
- 1.5.4 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from the beginning of 2008 to the date of the homicide. This date was chosen because Salma's first contact with agencies was in 2008, shortly after she arrived in the UK.
- 1.5.5 *Key Lines of Inquiry:* The Review Panel considered the statutory guidance and identified 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 Salma and/or Omar [and wider family];
  - 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 in domestic abuse issues;
  - Specific consideration to the following issues: English as a second language, the use of translators and Immigration; and
  - Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.
- 1.5.6 The Review Panel benefited from the involvement of two organisations that operate in Tower Hamlets, and which are commissioned to provide domestic abuse services, even though they had not been previously aware of the individuals involved:

- The Hestia Domestic Abuse Service, which holds the Black, Asian, Minority Ethnic and Refugee (BAMER) Refuge Contract;<sup>4</sup> and
- Victim Support, which holds the Independent Domestic Violence Advisor, (IDVA) contract.<sup>5</sup>

1.5.7 Additionally, the Review Panel is grateful for the participation of a representative from:

- The London Muslim Centre, who brought expertise particularly in relation to matters of race and faith;<sup>6</sup> and
- GamCare, who brought expertise in relation to problem gambling.<sup>7</sup>

## 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 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.”*

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<sup>4</sup> Hestia deliver services across London and the surrounding regions, including domestic abuse services. For more information, go to: <https://www.hestia.org/tower-hamlets>.

<sup>5</sup> Victim Support works with people affected by crime or traumatic events, including domestic abuse, For more information, go to: <https://www.victimsupport.org.uk/help-and-support/get-help/support-near-you/london/east-london>.

<sup>6</sup> The East London Mosque, which incorporates the London Muslim Centre and the Maryam Centre, offers a wide range of services including advice and counselling. For more information, go to: <https://www.eastlondonmosque.org.uk>.

<sup>7</sup> Provides information, advice and support for anyone affected by problem gambling. For more information, go to: <https://www.gamcare.org.uk>.

- 1.6.2 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.
- 1.6.3 This DHR has followed the statutory guidance issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004.
- 1.6.4 On notification of the homicide, agencies were asked to check for their involvement with any of the parties concerned and secure their records. As there was involvement with both Tower Hamlets, and the neighbouring London Borough of Newham, scoping was completed in both areas. A total of 33 agencies were contacted to check for involvement with the parties concerned with this DHR. Of these, three had only limited contact and submitted a Summary of Engagement only. However, 10 had more extensive contact and were asked to submit Individual Management Reviews (IMRs). A narrative chronology was also prepared.
- 1.6.5 *Independence and Quality of IMRs:* The IMRs were written by authors independent of case management or delivery of the service concerned. The IMRs received were for the most part comprehensive and enabled the Review Panel to analyse the contact with Salma, Omar, and their children, and to produce the learning for this DHR. In some IMRs, a lack of detail meant that further questions had to be sent to agencies. Additionally:
- Although the Primary School for Child B and C provided a Summary of Engagement that described their contact with Child B and C, as well as Salma and Omar, the Review panel decided not to request an IMR. This was because no concerns were identified during this contact nor were any disclosures made;
  - While the General Practice (GP) provided an IMR and chronology, this was focused on contact in 2018. The Review Panel made the decision not to request further information, reflecting the pressure on health services due to the Covid-19 pandemic; and
  - During the course of the DHR, a Named GP for Adult Safeguarding came into post, covering the CCGs in Waltham Forest, Newham, Tower Hamlets. The Review Panel agreed to note the value of having a Named GP, as this was a significant benefit to the DHR. The Named GP for Adult Safeguarding was able facilitate and resolve information requests with GPs (including in relation to the GP) and their input also ensured that the Review Panel was able to have insightful discussions in relation to learning for and from primary care.

- 1.6.6 Nine IMRs made recommendations of their own, and in some cases reported changes in practice and policies over time. These are described in the analysis (section 5).
- 1.6.7 *Documents Reviewed:* In addition to the above information, a number of other documents have been reviewed. These are referenced in this report.
- 1.6.8 *Interviews Undertaken:* The chair interviewed Samiha, the niece of Salma, during the course of this DHR. For more information, see 1.9 below.

## 1.7 Contributors to the Review

1.7.1 The following agencies were contacted, but recorded no involvement with the victim or perpetrator:

- Faith Regen Foundation<sup>8</sup>;
- Gamcare<sup>9</sup>
- Hestia - Domestic Abuse Service (Refuge)<sup>10</sup>;
- LAS;
- London Black Women's Project;
- London Borough of Tower Hamlets Safer Communities – Violence against Women and Girls (VAWG) and Hate Crime Team;
- London Muslim Centre<sup>11</sup>;
- Look Ahead - Domestic Abuse Service (Refuge);
- Newham Homelessness Prevention & Advice;
- Newham Public Health<sup>12</sup>;
- The Havens<sup>13</sup>;
- Tower Hamlets Adult Social Care;
- Tower Hamlets Children's Services - Youth Justice;

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<sup>8</sup> A multi-faith UK based regeneration charity, working to reduce social exclusion. For more information, go to: <https://thefrf.org/about-us/>.

<sup>9</sup> As noted in 1.5.7, invited to participate on the Review Panel.

<sup>10</sup> As noted in 1.5.6, invited to participate on the Review Panel.

<sup>11</sup> As noted in 1.5.7, invited to participate on the Review Panel.

<sup>12</sup> Commissions domestic abuse services in Newham.

<sup>13</sup> Specialist centres in London for people who have been raped or sexually assaulted. For more information, go to: <https://www.thehavens.org.uk>.

- Tower Hamlets Clinical Commissioning Group (CCG);
- Tower Hamlets Community Intervention Service<sup>14</sup>;
- Tower Hamlets Education Safeguarding Service;
- Tower Hamlets Safer Communities - Drug & Alcohol Action Team;
- Tower Hamlets Youth Service;
- Victim Support;<sup>15</sup> and
- Women's Health and Family Services<sup>16</sup>.

1.7.2 The following agencies made contributions to this DHR:

Agency	Contribution
Aanchal <sup>17</sup>	Summary of Engagement
Clarion Housing <sup>18</sup>	IMR and Chronology
Primary School for Child B and C	Summary of Engagement
East London NHS Foundation Trust <sup>19</sup> (ELFT)	IMR and Chronology
GP	IMR and Chronology
London Borough of Newham – Children's Social Care and Early Help Service	IMR and Chronology
London Borough of Tower Hamlets – Children's Social Care and Early Help Service	IMR and Chronology
Primary School for Child A	IMR and Chronology
London Borough of Tower Hamlets – Housing Options	IMR and Chronology
MPS	IMR and Chronology

<sup>14</sup> Provides support across a broad range of needs, such as unsuitable accommodation, substance abuse and mental health needs. For more information, go to: <https://www.lookahead.org.uk/our-services/our-service-map/services-accept-self-referrals/tower-hamlets-community-intervention-service/>.

<sup>15</sup> As noted in 1.5.6, invited to participate on the Review Panel.

<sup>16</sup> A community health charity focused on health and empowerment issues for disadvantaged women and their families more information, go to: <http://whfs.org.uk>.

<sup>17</sup> Aanchal operate in Redbridge and Newham and provide support and services to help women in the rescue, rehabilitation and rebuilding of their lives after the trauma of abuse. For more information, go to: <https://aanchal.org.uk>. Aanchal led the 'One Stop Shop', working with three other services commissioned by Newham until May 2019. Since June 2019, a single service has been commissioned from the Hestia Domestic Abuse Service.

<sup>18</sup> Clarion Housing is a housing association, managing 125,000 homes across 170 local authorities. For more information, go to: <https://www.myclarionhousing.com>.

<sup>19</sup> Provides mental health services in the City of London, Hackney, Newham and Tower Hamlets and, Bedfordshire and Luton. For more information, go to: <https://www.elft.nhs.uk/About-Us>.

The Royal London Hospital, part of Barts Health NHS Trust <sup>20</sup>	IMR and Chronology
Tower Hamlets GP Care Group <sup>21</sup> (THGPCG)	IMR and Chronology
Whittington Hospital, part of the Whittington Health NHS Trust <sup>22</sup>	Summary of Engagement

1.7.3 Additionally, information was also provided by:

- A high street bookmaker (relating to Omar’s gambling, see 4.4 below); and
- The Home Office (information concerning immigration and citizenship, see 2.2 below).

## 1.8 The Review Panel Members

1.8.1 The Review Panel members were:

Name	Job Title	Agency
Andrew Nowakowski	Tenancy Specialist Manager	Clarion Housing Group
Anna Davies	Named Midwife for Safeguarding Children & Gateway Team Manager	Barts Health NHS Trust
Beverley Williams	Specialist Crime Review Group (SCRG)	MPS
Caroline Fallan	Housing Management and Procurement Manager	Tower Hamlets Housing Options Service
Dinh Padicala	Associate Director for Adult safeguarding and Domestic Abuse	ELFT
Geraldine O'Donnell	Interim Service Manager, Safeguarding and Quality Assurance Service	Tower Hamlets Children’s Social Care and Early Help Service
Gurinder Lall	Named Professional for Safeguarding Children	ELFT

<sup>20</sup> Provides a range of range of clinical services to people in east London and beyond. For more information, go to: <https://www.bartshealth.nhs.uk>.

<sup>21</sup> The GP Care Group is a federation, a system that allows a group of general practices to come together as an organisation to share responsibility for delivering quality services to its local population. For more information, go to: <https://www.gpcaregroup.org/>.

<sup>22</sup> Provides hospital and community care services to 500,000 people living in Islington and Haringey as well as other London boroughs including Barnet, Enfield, Camden and Hackney

Helen Garratt	Director of Clinical Services	GamCare
Josephine Feeny	Operations Manager	Victim Support
Menara Ahmed	Senior VAWG and Hate Crime Manager	Tower Hamlets VAWG and Hate Crime Team
XXX XXX	Deputy Head Teacher/ Designated Safeguarding Lead	Child A's Primary School
Mags Groves	Senior Operational Lead- Community Mental Health Teams, Perinatal Service	ELFT
Dawn Henry	Early Help Partnership Coordinator	Newham Children's Social Care and Early Help Service
Richard Simmonds	Psychological Therapies Lead Tower Hamlets	Child and Adolescent Mental Health Services (CAMHS), ELFT
Robi Bibi	Senior Support Worker	Hestia - Domestic Abuse Service (Refuge)
Roisin Gavin	Safeguarding Coordinator	Barts Health NHS Trust
Ruth Walters	Director of Quality Assurance	THGPCG
Sarah Murphy	Joint Senior Strategic Safeguarding Adults Lead in Tower Hamlets	Tower Hamlets Adult Social Care / Tower Hamlets Clinical Commissioning Group (CCG)
Sharifa Chowdhury	Education Safeguarding Manager	Tower Hamlets Education Safeguarding Service
Sufia Alam	Maryam Centre Manager	London Muslim Centre

1.8.2 As noted in 1.5.7:

- The London Muslim Centre acted as a critical friend and provided comment and feedback on the report during drafting. The chair and Review Panel are grateful for their time and input. Their contribution is a reminder of the importance of being able to access local community expertise and knowledge in the course of a DHR; and
- GamCare provided expertise concerning problem gambling. During the DHR, GamCare shared that in their experience they are rarely

approached to contribute to DHRs, which seems indicative of the general lack of awareness of gambling-related harms and domestic violence and abuse. The Review Panel agreed to note Gamcare’s involvement in order to encourage other DHRs to consider seeking support with these matters.

- 1.8.3 Additionally, Aanchal was also invited to feedback on the report about their historical contact in this case.
- 1.8.4 *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.
- 1.8.5 The Review Panel met a total of four times, and the first meeting was on the 29<sup>th</sup> July 2019. There were further meetings on the 26<sup>th</sup> November 2019, the 27<sup>th</sup> March 2020 and the 24<sup>th</sup> June 2020. Thereafter, the Overview Report and Executive Summary were agreed electronically, with Review Panel members providing comment on a final draft and signing off the final report by email during August 2020.
- 1.8.6 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

- 1.9.1 From the outset, the Review Panel decided that it was important to take steps to involve the family, friends, work colleagues, neighbours and wider community.

### *Family*

<b>Name<sup>23</sup></b>	<b>Relationship to victim</b>	<b>Means of involvement</b>
Samiha	Niece	Agreed to share witness statement; interviewed
Aneysha	Sister	Chose not to be involved
Ahad	Nephew	Agreed to share witness statement
Zoya	Cousin / Sister-in-law	Agreed to share witness statement

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<sup>23</sup> Not their real names.



- 1.9.2 Once the decision to conduct the DHR had been confirmed in March 2019, the Tower Hamlets CSP notified Salma's sister (Aneysha) and niece (Samiha) of this decision in April 2019: a letter was sent via the MPS Family Liaison Officer (FLO), along with information on Advocacy After Fatal Domestic Abuse (AAFDA)<sup>24</sup>. In May 2019, the chair also wrote to Aneysha and Samiha, including additional information on the DHR process (the Home Office leaflet for families and further information on advocacy support). These letters were also sent via the MPS FLO. Letters were sent in English and were also translated.
- 1.9.3 It was subsequently confirmed that Samiha would be the point of contact for the family. With the assistance of the FLO, the chair was able to establish direct contact with Samiha towards the end of 2019. Samiha was being supported by the Victim Support Homicide Service (VSHS).<sup>25</sup> The chair and Samiha met in February 2019. A transcript of this meeting was produced, with this being approved by Samiha, and this information has been incorporated into this report (see 4.1 below for a summary).
- 1.9.4 Samiha was sent a draft copy of the Overview Report at the end of July 2020. In August 2020, Samiha and the chair spoke about the draft. Samiha said that the report addressed the issues she had wanted to see considered and that she felt satisfied with the contents and the way that Salma was represented. Samiha chose not to provide a pen portrait but instead asked that a dedication to Salma be included at the start of the Overview Report.
- 1.9.5 Samiha also facilitated contact with Ahad (Salma's nephew) and Zoya (Salma's Cousin / Sister-in-law), who agreed to share the witness statements they had provided to the MPS during the murder enquiry.
- 1.9.6 During the course of the DHR, consideration was given to engaging with Child A, B and C. Given their age, the Review Panel felt it was not appropriate to approach Child B and C. However, with the consent of their kinship carers, Child A was asked by their social worker whether they wanted to talk about the homicide. Child A did and the chair provided some questions to inform an initial discussion (see 1.11 for further information about support for the children in this case and 4.1 below for a summary of what Child A said). As part of this process, the chair also facilitated contact between Tower Hamlets Children's Social Care and a joint project run by AAFDA and AVA<sup>26</sup> called

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<sup>24</sup> AAFDA provide emotional, practical and specialist peer support to those left behind after domestic homicide. For or more information, go to: <https://aafda.org.uk>.

<sup>25</sup> 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>.

<sup>26</sup> AVA is a charity working to end gender-based violence and abuse. For more information, go to: <https://avaproject.org.uk>.

'When dad killed mum, children's voices in Domestic Homicide Reviews' to explore ongoing support for Child A.

*Friends, Work Colleagues, Neighbours and Wider Community*

- 1.9.7 Consideration was initially given to approaching friends, work colleagues, neighbours and wider community. However, it was not possible to identify any other contacts who could be approached.

## **1.10 Involvement of Perpetrator, Family, Friends, Work Colleagues, Neighbours and Wider Community**

*The Perpetrator and his Family, Friends, Work Colleagues, Neighbours and Wider Community*

- 1.10.1 Omar was approached in prison, with a letter being sent in English and also translated. No response was received. Omar's Prison Offender Manager was approached and confirmed that Omar did not want to participate.
- 1.10.2 As a result, there is no information directly from Omar in this DHR. Nor was it possible to identify any family or friends he might have suggested could be spoken to.
- 1.10.3 However, during the murder enquiry the MPS interviewed a member of staff at a high street bookmaker who had worked at a shop that Omar frequented. An approach was made via the MPS seeking their involvement in the DHR. Unfortunately, no response was received.

## **1.11 Parallel Reviews**

- 1.11.1 *Criminal trial:* Omar was charged with murder in January 2019. The trial was held in July 2019, where Omar provided a number of different explanations including claiming self-defence, loss of self-control and subsequently blamed third parties. These were not accepted by the Jury, and he was unanimously convicted.
- 1.11.2 The MPS Senior Investigation Officer (SIO) was invited to the first meeting of the Review Panel, but as the meeting occurred after the trial had concluded, it was agreed that it was not necessary for them to attend. The MPS SCRG representative instead provided a briefing to the Review Panel regarding the murder enquiry.
- 1.11.3 *The Coroner's Inquest:* The death of Salma was referred to the HM Coroner, and an inquest was opened and adjourned.

- 1.11.4 *Children*: There are no parallel reviews in relation to Child A, B or C. At the first Review Panel meeting, it was noted that the ongoing care of the children was beyond the remit of the DHR. However, it was agreed that a summary of the arrangements to date would be provided to assure the Review Panel that appropriate steps had been taken in relation to their care. The Review Panel were informed that after Salma's death, direct work was undertaken with the children by their social worker to try to explain their mother's death and their father's arrest using 'Story Boards'. Tower Hamlets also applied for and were granted an Interim Care Order<sup>27</sup> and the children were placed with their maternal aunt and her husband. The intention was to seek an SGO (Special Guardianship Order)<sup>28</sup> and for the children to remain in that placement, as well as to assess whether it is in the children's best interest for contact to take place with their father.
- 1.11.5 As the children are considered to be Children in Need, the Review Panel were reassured that a range of interventions had been put in place, including an allocated social worker and referrals for additional support if required (including to CAMHS and the Bereavement Counselling service).

While the Tower Hamlets CSP is not responsible for the care of Child A, B or C, it has a responsibility to liaise with the relevant Children's Social Care department to ensure that their wellbeing is considered in relation to the publication of this DHR.

**Recommendation 1: The Tower Hamlets CSP to satisfy itself that Child A, B and C (as well as their kinship carers) are offered support in relation to the publication of the DHR.**

**Recommendation 2: After publication of this DHR, the Tower Hamlets CSP to ensure that this report is attached to Child A, B and C's social care records. This is so that, if they wish to read the DHR when they are older, it will be available to them.**

***(In delivering these actions, Tower Hamlets CSP – as the commissioning body for this DHR – should satisfy itself that they have been completed, but it is expected that Tower Hamlets Children Social Care will be responsible for delivery).***

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<sup>27</sup> At the start of care proceedings, the council asks the family court to make a temporary court order, called an 'interim care order.

<sup>28</sup> A special guardianship order is an order appointing a person or persons to be a child's special guardian. The special guardian will have parental responsibility for the child.

## 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 Standing Together. James has received DHR Chair's training from Standing Together. He has chaired and authored ten 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 statutory, voluntary and community sector organisations.
- 1.12.2 Standing Together 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. Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 80 reviews.
- 1.12.3 *Independence:* James has no connection with the local area or any of the agencies involved, although he is concurrently chairing another DHR in the borough.

## 1.13 Dissemination

- 1.13.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the Tower Hamlets CSP for approval and thereafter will be sent to the Home Office for quality assurance.
- 1.13.2 Once agreed by the Home Office, the Executive Summary and Overview Report will be shared with the local VAWG Steering Group and Multi Agency Risk Assessment Conference (MARAC) partners, and also published. There will be a range of dissemination events to share learning.
- 1.13.3 The Executive Summary and Overview Report will also be shared with the CSP in Newham for dissemination to partners in that borough, as well as the Commissioner of the MPS and the Mayor's Office for Policing and Crime (MOPAC).
- 1.13.4 The recommendations will be owned by the CSP, with the Tower Hamlets VAWG, Domestic Abuse & Hate Crime Team being responsible for monitoring the recommendations and reporting on progress.

## 1.14 Previous case review learning locally

- 1.14.1 This is the eleventh DHR commissioned locally.
- 1.14.2 The Review Panel considered the learning and recommendations from other reviews in the analysis and the development of recommendations for this DHR. These have identified in particular issues of financial abuse, as well as learning for social housing providers. Both issues are relevant to this case and are discussed in the analysis. Published DHRs can be found at [https://www.towerhamlets.gov.uk/Ignl/community\\_and\\_living/community\\_safety\\_crime\\_preve/Domestic\\_Homicide\\_Reviews.aspx](https://www.towerhamlets.gov.uk/Ignl/community_and_living/community_safety_crime_preve/Domestic_Homicide_Reviews.aspx).

## 2. Background Information (The Facts)

### The Principle People Referred to in this report

Referred to in report as	Relationship to Salma	Age at time of Salma's death	Ethnic Origin	Faith	Immigration Status	Disability
Salma	n/a	31	Bangladeshi	Muslim	British Citizen	No
Omar	Husband	46	Bangladeshi	Muslim	British Citizen	No
Child A	Child	10	-	-	-	-
Child B	Child	5	-	-	-	-
Child C	Child	5	-	-	-	-
Samiha	Niece	-	-	-	-	-
Aneysha	Sister	-	-	-	-	-
Ahad	Nephew	-	-	-	-	-
Zoya	Cousin / Sister-in-law	-	-	-	-	-

### 2.1 The Homicide

2.1.1 *Homicide*: On a day in early January 2019, several family members received phone calls where they heard shouting and arguing between Salma and Omar. When Salma's nephew (Ahad) returned home in the afternoon, he found Salma lying on the kitchen floor, with fatal head and neck injuries. Ahad called the LAS and then a family member who he told "*Omar killed my aunt,*

*he cut her neck*". A LAS paramedic arrived and saw that Salma was not breathing. She was pronounced dead at the scene.

- 2.1.2 Omar had left the scene by the time police officers arrived but presented himself to a South London Police Station the following morning. He had a few injuries (superficial wounds to his hands and his lower leg, and some bruising to his body). He stated he had been a victim of domestic violence. During the subsequent murder enquiry, it could not be established if these were defensive injuries or whether they were injuries caused by himself during the attack on Salma. Having received no information to indicate that Omar had experienced any domestic abuse from Salma, the Review Panel has operated on the assumption that these were injuries caused when Omar killed Salma.
- 2.1.3 Having been identified, and given Salma's death, Omar was soon arrested. He was then charged with Salma's murder.
- 2.1.4 *Post Mortem*: A Post Mortem was conducted and gave the cause of death as multiple incised wounds to the head and neck. The pathologist noted evidence of a ferocious and sustained assault utilising extreme force. This meets the definition of 'overkill'. This is the term used to describe the use of gratuitous violence that goes further than that which is necessary to cause the victim's death.<sup>29</sup>
- 2.1.5 *Criminal trial outcome*: The criminal trial took place in July 2019. Omar provided a number of explanations including self-defence, loss of control, and then blaming third parties for Salma's murder. He was found guilty of murder by a unanimous verdict and sentenced to life imprisonment with a minimum term of 19 years.

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

- 2.2.1 *Background Information relating to the Victim*: At the time of her death, Salma was 31 years old. Salma was Asian and was originally from Bangladesh. Salma first came to the UK in 2008, before being granted leave to remain as the spouse of a settled person in 2010, then securing indefinite leave to remain in 2011. In 2014, Salma was naturalised as a British Citizen. Salma had no known disability and was of the Muslim faith.
- 2.2.2 *Background Information relating to the Perpetrator*: At the time of the homicide, Omar was 46 years old. Omar is Asian and was originally from Bangladesh. He had been granted indefinite leave to remain in 2001, having been sponsored by

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<sup>29</sup> Long, J., Harper, K., and Harvey, H. (2018) The Femicide Census 2017 Findings: Annual Report on UK Femicides 2017. Available at: <https://www.womensaid.org.uk/what-we-do/campaigning-and-influencing/femicide-census/> (Accessed: 22nd February 2020).

his first wife (who was British born).<sup>30</sup> He was subsequently naturalised as a British Citizen. Omar has no known disability and is of the Muslim faith.

- 2.2.3 *Synopsis of relationship with the Perpetrator:* Salma and Omar had an arranged marriage in Bangladesh in 2007. Child A was born in 2008, and shortly after they moved to the UK. Between 2008 and 2014 Salma and Child A lived with a family in Tower Hamlets, specifically Salma's older sister (Aneysha) and her family. Omar would visit regularly but did not live with the family as there was not enough space.
- 2.2.4 After the birth of Child B and C in 2014, Salma left her sister's property, as it had become overcrowded. Having approached the local council, they lived in emergency accommodation in Tower Hamlets for three months in 2014, before moving to temporary accommodation in Newham. They lived in this property for two and a half years, before being rehoused and having a six month stay in a second property, still in Newham, from January to June 2017. In July 2017 they secured permanent accommodation with Clarion Housing in a property in Tower Hamlets. This was initially a joint assured shorthold (starter) tenancy, before being converted into a 5-year fixed term assured shorthold tenancy in June 2018.
- 2.2.5 Salma did not work, although she had on occasion taken short term jobs in local shops.
- 2.2.6 Omar worked in the catering industry, usually working from the late afternoon into the night. For the first years of the relationship, before they secured their own home, he would stay in accommodation provided by employers. As a result, he spent substantial time away from home. Even when he lived with Salma in later years, Omar's work usually meant he would not get home until late.
- 2.2.7 *Members of the family and the household:* At the time of the homicide, Salma and Omar lived with their three children. Ahad (and his wife) had also been staying at the property.

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<sup>30</sup> The MPS had no record of any domestic abuse being reported in this relationship. The Review Panel agreed it would not be proportionate to explore this further.



## 3. Chronology

### 2008 – Living in Tower Hamlets

- 3.1.1 The first recorded contact with local services was in November 2008, when Salma and Child A were seen by a health visitor.<sup>31</sup> This was for a child assessment. No health concerns were identified, and the health visitor noted that there was a good bond between Salma and Child A. Salma was not asked about domestic abuse and her immigration status was not clarified. The records indicate that Salma was recorded as speaking Bengali (although, as will be discussed, she actually spoke Sylheti).<sup>32</sup> She was in the company of a female family member. It is unclear whether the female family member was used as an interpreter.

### 2010 – Living in Tower Hamlets

- 3.1.2 In November 2010, Salma did not attend with Child A for a development review with the health visitor. This was not followed up and there was no attempt to arrange a further appointment.
- 3.1.3 In December Salma and Omar applied to the Tower Hamlets Housing Register and were placed on the waiting list. At this point, only Child A had been born and their application indicated that they were living with Salma's sister (Aneysa) in one room of a 3-bedroom property. On the application form they had ticked to confirm that they required translation/interpretation services<sup>33</sup>. This application was subsequently cancelled by Tower Hamlets as further documentation was not supplied by Salma and Omar.

### 2011 – Living in Tower Hamlets

- 3.1.4 There was limited contact with services in this year, although in July 2011 the Royal London Hospital (part of the Barts Health NHS Trust) and the MPS had contact in relation to Child A following an accident. Subsequently, a health visitor had contact with Salma's family as a result of this incident. Child A was invited in for a follow up health assessment, weight check, and for advice. There is no record as to whether this was followed up or done.

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<sup>31</sup> At the start of the time period covered by this DHR, the health visiting service was provided by the then Tower Hamlets Primary Care Trust. The service was transferred to the Barts Health NHS Trust in 2011, before coming under the THGPCG from 2016. The information in this DHR is based on the THGPCG IMR and Chronology, which included a summary of contact by health visiting services through these organisational changes. Given this, reference is made generally to 'health visiting' until 2016 when this service was the responsibility of THGPCG.

<sup>32</sup> In the analysis the differences between Sylheti and Bengali are discussed, including implications for practice. In the chronology, information is reported as provided by agencies. That means, if an agency has reported that a staff member could speak Bengali and therefore converse with Salma, it is reported as such here.

<sup>33</sup> Omar ticked yes to the question 'can you read/write English' with Salma ticking 'No'. Both Salma and Omar ticked 'No' to the question 'Can you speak English'.

- 3.1.5 Barts Health NHS Trust also had contact with Omar and Salma for routine medical procedures, with no evidence identified to indicate that these were related to domestic violence and abuse.
- 3.1.6 The family were registered with the GP from this year. Most of this contact related to Child A, B and C for routine medical issues. There were no disclosures made or concerns noted about the family.

### **2013 – Living in Tower Hamlets**

- 3.1.7 In May 2013, Salma approached Tower Hamlets Housing Options again, saying she and Omar (and Child A) were still residing with her sister and there was not enough room. Salma attended three meetings in May. At the third meeting, she disclosed that she had regular fights with Omar about finances and referred to his gambling. Salma said that she did not want to be a joint tenant with Omar because of this: she made this request verbally and in writing. Salma also referred to Omar having “fights”. There were no further enquiries made in relation to these disclosures.
- 3.1.8 Salma had ongoing contact with Tower Hamlets Housing Options through to October. At these meetings, Salma was in the company of different family members. There is no record of interpreting services being used, and it is not clear if the accompanying family members were translating for Salma. However, the worker that Salma saw was a Bengali speaker so they may have been conversing directly with her. There was no contact with Omar.
- 3.1.9 On the 2<sup>nd</sup> October, Salma (again, accompanied by a family member) attended and was informed that the family would be assisted with temporary accommodation. In this appointment Salma is noted as stating that she wanted the application to be in her sole name because Omar had a gambling problem. Salma was frightened that this could pose a risk to any tenancy. As before, this does not appear to have been explored further. Salma did not take up the offer of temporary accommodation at this point, saying she wanted to consider her options further. There was no contact with Salma or Omar after this last meeting in 2013, although attempts were made to contact Salma or a family member using a council interpreter. These were unsuccessful.
- 3.1.10 In October, Barts Health NHS Trust also had contact with Salma for routine medical procedures, with no evidence identified to indicate that these were related to domestic violence and abuse.
- 3.1.11 In December, an antenatal assessment was booked with maternity services (part of the Barts Health NHS Trust). This related to Salma’s pregnancy with Child B and C. Salma was asked about domestic abuse and answered “no”. Salma was accompanied by a family member who interpreted for her.

**2014 – Living in Tower Hamlets, with a move to Newham in August**

- 3.1.12 In February 2014, Salma had further contact with maternity services. This contact continued through to March 2014. As with other earlier appointments, Salma was accompanied by a family member who interpreted for her.
- 3.1.13 That same month, Tower Hamlets Housing Options contacted Salma and advised her that she had been found 'not homeless' as there had been no further contact from her regarding her application.
- 3.1.14 In February, Barts Health NHS Trust also had contact with Salma for routine medical procedures, with no evidence identified to indicate that these were related to domestic violence and abuse.
- 3.1.15 On the 13<sup>th</sup> May Salma made a further approach to Tower Hamlets Housing Options for assistance. She said that she had not taken up the offer of assistance previously due to the distance from Child A's school and had opted to look for accommodation herself. However, Salma said she was expecting twins in July, which meant she could no longer continue staying with family. Salma was accompanied by a family member, who acted as an interpreter. Salma was not asked about previous disclosures relating to Omar's gambling or any other financial concerns.
- 3.1.16 On the 21<sup>st</sup> May, Salma and Omar both came to Tower Hamlets Housing Options to submit a formal application. The case officer noted the record of previous disclosures regarding Omar's gambling by Salma and her request that Omar was not included as a joint applicant because of this. As a result, Salma was interviewed separately with an interpreter. She confirmed she was happy for Omar to be a joint applicant for housing. This was accepted at face value with no exploration of her previous requests. After an assessment, Salma and Omar were offered emergency accommodation. They moved into this temporary accommodation towards the end of the month. This was located in Tower Hamlets.
- 3.1.17 Child B and C were born prematurely at the end May at the Whittington Hospital (part of Whittington Health NHS Trust). As a result, Whittington Hospital provided temporary accommodation. In due course, financial concerns were noted, with these arising because of travel expenses after Salma had been discharged but while the twins remained in hospital.
- 3.1.18 In May the health visiting service received a notification from maternity services about Child B and C. The information from Whittington Hospital included reference to the family's financial difficulties. There is no evidence of a Health Visitor attending hospital to visit Child B or Child C or for multidisciplinary meetings.

- 3.1.19 Between 21<sup>st</sup> May 2014 – 27<sup>th</sup> June 2014 Salma and Omar had contact in person and over the phone with Tower Hamlets Housing Options. There are no records to suggest that any disclosures about domestic abuse or other concerns were made. The case officer did note on 18<sup>th</sup> June that they had spoken to both Salma and Omar about Omar's history of gambling. Salma and Omar were told that they would both be responsible for any rent arrears that may be incurred as a result and therefore must ensure that the rent was paid. At this meeting, Salma and Omar were accompanied by a family member who provided translation.
- 3.1.20 The health visiting service conducted a home visit in early June. At this time Child B and C were still at Whittington Hospital. The health visitor was accompanied by a support worker who provided interpretation. Salma appeared to understand some English and to speak a little. The health visitor did not ask about domestic abuse because Omar was present. The financial issues reported by Whittington Hospital were not fully explored, although there was a discussion of other issues (for example, the family had not yet bought baby equipment). The health visitor also recorded that Salma and Omar had an older child (Child A).
- 3.1.21 At the end of June, Child B and C were seen at home by a health visitor. As in June, there was a discussion about Child A, although no further enquiries were made.
- 3.1.22 A planned visit in July was not completed, but there was one visit in that month, with further contact in August (for a 6-week development review) and then later in December. These all related to health visiting services and routine medical advice and monitoring. Salma was accompanied by a family member at these appointments who provided interpretation.
- 3.1.23 On the 3<sup>rd</sup> July, Tower Hamlets Housing Options wrote to Salma and Omar to confirm that the council had an accommodation duty to them, including rehousing them into permanent accommodation.
- 3.1.24 In August, Tower Hamlets Housing Options offered Salma and Omar a self-contained three-bedroom temporary property. This was accepted, and the family moved in. This was in Newham<sup>34</sup>. Subsequent contact was related to rent arrears and arrangements to pay these down.
- 3.1.25 In October, Tower Hamlets Housing Options had direct contact with Omar regarding rent arrears (this was a phone call, and it was conducted in English). An arrangement was reached regarding re-payment. In November a property inspection was completed. The property inspection form does not record who was present for the inspection, however no issues or concerns were reported.

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<sup>34</sup> The family would remain here until January 2017.

- 3.1.26 In December, Barts Health NHS Trust also had contact with Salma for routine medical procedures, with no evidence identified to indicate that these were related to domestic violence and abuse.

### **2015 – Living in Newham**

- 3.1.27 In May 2015, the health visiting service saw both Child B and Child C for an 8 – 12-month review. Salma was in the company of a family member who provided interpretation. The records note that both children were “*clean alert and appropriately dressed*”. Advice was given and there was also a referral made to a bi-lingual nutrition support worker.
- 3.1.28 In July, Tower Hamlets Housing Options sent a letter to Salma and Omar regarding the non-payment of rent. Arrears letters are sent out in English although the following statement is attached in several languages, including Bengali, stating: “*It is important that you understand the contents of this letter. If you require a further explanation and/or an interpretation facility, please contact the office shown overleaf as soon as possible.*”
- 3.1.29 That same month, Child A was discharged from the health visiting service. Their records were transferred to the school nursing service with no health needs or concerns being noted.<sup>35</sup>
- 3.1.30 In August, Tower Hamlets Housing Options had contact with Salma and Omar regarding rent arrears. An arrangement was reached regarding re-payment. There is no information recorded about whether this contact was in English.
- 3.1.31 That same month, Salma spoke with THGPCG’s bi-lingual nutrition support worker and received some advice around feeding.

### **2016 – Living in Newham**

- 3.1.32 In April the health visiting service (now provided by THGPCG) had contact with Child B and Child C at a clinic, and then in May tried (unsuccessfully) to conduct a 2-year review. A letter was sent by post, offering a further appointment. The letter was in English. There is no evidence in the record that there was a response to the letter or that any further contact was made.
- 3.1.33 On the 9<sup>th</sup> June, the MPS had its first contact relating to domestic abuse. Police officers were called to the home address by Ahad (Salma’s nephew). He told the operator that he was a neighbour, that every day Omar hit his wife (Salma) and that Omar was hitting her at the time of the call.
- 3.1.34 Police officers attended the home address. Neither Salma nor Omar appeared to speak English. Due to the language barrier Salma asked a family member to

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<sup>35</sup> At the time, this service was provided by Compass Wellbeing. THGPCG have managed the service since Sept 2018.

come and translate. Salma told police officers that Omar had a gambling issue and because of this they had a verbal argument; she had phoned Ahad and was upset that he had called police. No assault allegations were made by Salma, but she did say she was unhappy with the relationship and would be going to stay with her brother while she decided what to do.

3.1.35 Both Child B and C were noted as being in the property at the time (they were asleep on the sofa), although there is no mention of the whereabouts of Child A.

3.1.36 This contact was recorded as a non-crime domestic incident. A Domestic Abuse Stalking and Harassment (DASH) risk assessment<sup>36</sup> was completed. This recorded that Salma responded to four questions, specifically:

- Victim's perception of risk? – *"he tries to argue with me daily"*
- Escalation? – *"yes, it is happening most days the arguing"*
- Controlling and / or jealous behaviour? – *"yes, he does not like me talking to anyone else"*
- Use of / access to weapons or credible threats to kill? – *"in the past"*

3.1.37 The Initial Investigating Officer (IIO) graded the initial risk assessment as 'Medium'. However, because Salma had stated that she was going to take the children and stay with her brother, a supervisor subsequently regraded the risk as 'Standard'.

3.1.38 A Merlin PAC was not created by the IIO (one was subsequently created, see next paragraph).<sup>37</sup>

3.1.39 On the same day, the incident was reviewed by the Newham Community Safety Unit (CSU). An investigation strategy was created that included:

- Contact the victims, check welfare and ascertain the background issues/problems that they may wish to disclose. Offer personal safety advice ('target hardening'), offer victim support and referral to appropriate agencies (Aanchal) with the victim's consent
- Review the risk assessment
- Conduct 5-year history checks on all parties involved on all police indices

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<sup>36</sup> The DASH is a tool to provide a uniform understanding of risk across professions. There is a specific police version of the risk checklist, which is used by most police forces in England and Wales. For more information, go to: For <http://www.safelives.org.uk/practice-support/resources-identifying-risk-victims-face>.

<sup>37</sup> 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.

- Verify whether there are children [*this led to a Merlin PAC being created on the 20<sup>th</sup> June 2016*]
- Verify whether there are Court Orders, bail conditions etc in place

- 3.1.40 Subsequently, on the 10<sup>th</sup> June the Officer in the Case (OIC) spoke with Salma using Language Line<sup>38</sup>. Salma said that the incident was a verbal argument and that she had moved back into the home. The OIC discussed various support options and Salma agreed to a referral to domestic abuse service. As a result, a referral was made to Aanchal. The investigation was subsequently closed.
- 3.1.41 On the 10<sup>th</sup> June a case worker from Aanchal attempted to contact Salma on three occasions. Although the phone was answered, no one spoke. They contacted the referring police officer to ask if they had an alternative contact number and asked whether the perpetrator lived with the client. The case worker did not receive a reply from the police officer. They made a further three attempts to make contact, with the same outcome (i.e. the phone was answered, but no one spoke). The case worker closed the case and updated the referring police officer by email that they could not make contact with the client and asked them to get in touch if they required further support. However, as the case was closed to the MPS, this would not have been followed up unless Salma had made contact again.
- 3.1.42 On the 27<sup>th</sup> June, the MPS shared the Merlin PAC about this incident with the Newham Multi Agency Safeguarding Hub (MASH)<sup>39</sup>. As no allegations had been made, and no further police action had been taken, this was graded at 'Level 1' which led to no further action.<sup>40 41</sup>
- 3.1.43 In August, Barts Health NHS Trust also had contact with Omar for routine medical procedures, with no evidence identified to indicate that these were related to domestic violence and abuse.
- 3.1.44 On the 4<sup>th</sup> September, the MPS were called again by Ahad. He reported that Salma and Omar were fighting and arguing over money, and the operator could

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<sup>38</sup> Language Line is a UK language translation service agency that provides a wide range of interpreting, translation and localisation agency service. For more information, go to: <https://www.languageline.com/uk>.

<sup>39</sup> A MASH a single point of contact for all safeguarding referrals for children. MASH provides a delivery framework that enables partner agencies to work together to support and safeguard children by sharing and analysing information that is held about them. For more information on the Newham MASH, go to: <https://families.newham.gov.uk/kb5/newham/directory/family.page?familychannel=7>.

<sup>40</sup> This delay occurred because the IIO did not create a Merlin PAC (see 3.1.42). After this was identified by the CSU, a Merlin PAC was subsequently created on the 20<sup>th</sup> June and checks completed on the 22<sup>nd</sup> June. This should have been shared with the relevant children social department within 72 hours. There is no explanation as to why this was delayed.

<sup>41</sup> Further information on these thresholds is available in a guide to Newham's pathways to help and support, produced by the Newham Safeguarding Children Partnership. For more information, go to: <https://www.newhamscp.org.uk/wp-content/uploads/2020/02/Pathways-to-help-and-support-2020-21.pdf>.

hear the sound of a disturbance. When police officers attended, Ahad told them that he had been visiting and that the argument was over money and benefits for the children, but that there had not been a physical assault.

- 3.1.45 Police also spoke to Salma and Omar separately. A family member provided interpretation. Both Salma and Omar stated that there had been a verbal argument about money. Specifically, Salma said that they both received benefits and that Omar was demanding that she gave him hers, which she had refused to do, so he started to argue.
- 3.1.46 All three children were at the home address when police attended and were described as being seen by officers appearing to be happy and healthy.
- 3.1.47 This contact was recorded as a non-crime domestic incident. A DASH risk assessment was completed. It was graded as 'Standard' and it recorded that Salma responded yes to four questions, specifically:

- Victim's perception of risk? – *"we argue a lot it can be scary"*
- Escalation? – *"it happens every now and again"*
- Controlling and / or jealous behaviour? – *"yes, he's jealous"*
- Stalking and harassment? – *"just arguments"*

- 3.1.48 A Merlin PAC was also created and an investigation strategy, broadly similar to the previous strategy, was agreed. It was noted that the names given were different to the July incident, but the two incidents were nonetheless successfully linked.
- 3.1.49 On the 9<sup>th</sup> September, the MPS shared information with Newham's MASH about this incident. As no allegations had been made this was graded at 'Level 1' which led to no further action.
- 3.1.50 The investigation was reviewed by the Newham Community Safety Unit (CSU), but this review did not happen until the 19<sup>th</sup> September. It is unclear why there was a delay, but this led to an OIC being assigned to the investigation (a different police officer to the OIC for the earlier incident).
- 3.1.51 Ahad was spoken to again by the OIC and confirmed that Omar had been verbally abusive towards Salma. He also said that he thought that Salma would want to be referred to a support agency because she wanted to leave Omar.
- 3.1.52 After several attempts to contact Salma, the OIC was able to speak to Salma on the 22<sup>nd</sup> September using Language Line. Salma said that she was safe and that there had been no further incidents. Salma declined a referral to support



agencies but did say she would call the police if she experienced any further problems. The investigation was subsequently closed.

- 3.1.53 On the 29<sup>th</sup> October the MPS were called by Zoya (Salma's Cousin / Sister-in-law). She said that Salma had been fighting with her partner, that it had escalated, and he (Omar) had tried to hit Salma. She said that they were fighting over money because Omar gambled a lot and that he had left the property.
- 3.1.54 Police officers attended and spoke to Salma, with a family member providing interpretation. Salma confirmed that she was arguing with Omar due to his gambling problem, but that this had been a verbal argument only.
- 3.1.55 Zoya also told police officers that Salma had said that Omar had asked her for £3,000 from the children's benefits which she refused to give him. She said that she had called the MPS because, as Omar left, he said he would "*sort this out later*" and she was concerned that he would be physically violent towards Salma when he returned. Additionally, Salma stated that: she had a fear of escalation due to money problems; that Omar had a temper and that in the past he had hit her. In response to the question 'do they say or do things of a sexual nature that make you feel bad or that physically hurts you or someone else?', Salma replied "*yes he wakes me up sometimes and makes me have sex. If I refuse, he hits me*".
- 3.1.56 Police officers accessed Language Line in order to confirm the details of the allegations. Salma confirmed that Omar sometimes forced her to have sex with him, that it had been ongoing for the past two years and the last occasion was five days prior. As this was an allegation of a sexual offence, police officers at the Sapphire Unit <sup>42</sup> were contacted and a rape investigation commenced.
- 3.1.57 Salma and the children were taken by police officers to a place of safety (they went to stay with a family member who lived elsewhere in Newham).
- 3.1.58 A Merlin PAC was created, and a DASH risk assessment was completed. It was graded as 'High'.
- 3.1.59 When Omar returned to the address he was arrested and interviewed. He denied the allegations.
- 3.1.60 Later that evening, Salma was contacted by a Sexual Offence Investigation Technique (SOIT) officer<sup>43</sup>. This contact was some six hours after the report.<sup>44</sup>

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<sup>42</sup> An officer from the MPS team that specialise in the investigation of rape and sex assault cases.

<sup>43</sup> A SOIT officer acts as the main point of contact between a victim and the police during an investigation into a rape or a sexual assault.

<sup>44</sup> SOIT officers should make contact with the victim within 90 minutes of reporting the serious sexual assault and have face to face contact within three hours.

The reason for this delay appears to be related to information flow within the MPS, with the SOIT officer not being notified promptly.

- 3.1.61 The SOIT officer spoke to Salma, with a family member providing translation. In this conversation, there was some confusion about the timeframe for the most recent sexual assault: the SOIT officer understood that this had happened a month ago. As a result, the SOIT officer agreed that they would visit the next day and there was no discussion of a Haven referral (because the SOIT officer believed the most recent assault was outside the forensic window).<sup>45</sup>
- 3.1.62 On the same day (29<sup>th</sup> October), the MPS shared information with Newham Council's MASH about the allegations made by Salma. This was subsequently assessed at 'Level 2a', with the family to be offered 'Families First' (a targeted early help service provided by Newham Council's Children Early Help service).
- 3.1.63 On the 30<sup>th</sup> October, after being cautioned, Omar was released on police bail with conditions to live with his brother and not to contact Salma.
- 3.1.64 On the same day, Salma provided a Visually Recorded Interview (VRI) with the assistance of an interpreter. In addition to confirming the allegations of sexual assault, she disclosed that the last assault was five days ago, Salma said:

- That 5 days ago she and Omar had a fight about money. She also said that Omar would get very angry and physical and that they fought a lot
- That this happened once a month or once a fortnight and that sometimes Omar threatened her and said he was going to kill her
- That he "*fought her with anything*" [this appears to have been a reference to being beaten]
- That on the previous occasions that police officers had attended she had not been truthful about being subjected to physical abuse
- She did not tell anyone because of her culture and because she did not want her children to lose their father

- 3.1.65 Salma said that she wanted to divorce Omar, but that she needed some protection and a safe place to stay. She subsequently went to stay with a cousin.
- 3.1.66 Having clarified the timeframe for the most recent sexual assault in the VRI, the SOIT officer asked Salma if she would be willing to attend The Haven. She explained why it was important to attend within a timeframe close to the alleged assault, but Salma declined to visit on that day as she wanted to return to her

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<sup>45</sup> This refers to the timescale in which there is likely to be forensic evidence following an assault.

children. The SOIT officer attempted to contact Salma the following day, but she was unable to get in touch with Salma.<sup>46</sup>

- 3.1.67 At this point, the report was classified as a rape. There should also have been a secondary report for a non-crime domestic incident, reflecting the disclosures that Salma had made in the VRI. The SOIT officer noted that a domestic abuse report had not been created (because the investigation had been passed to the Sapphire Team who had treated it as a sexual assault). They made a request to the Newham CSU that a domestic abuse report be created [*this did not happen until the 19<sup>th</sup> December, see below*].
- 3.1.68 Given the concerns around domestic abuse, and the level of risk, a team leader made a supervisory note stating staff should not visit alone.
- 3.1.69 On the 2<sup>nd</sup> November, the OIC spoke with Salma (with Zoya acting as the point of contact), who said she was too scared to return to her home address. By this point a 'special schemes marker'<sup>47</sup> had been placed on the address, but Zoya said that the windows in Salma's house did not close properly and that she was afraid that Omar or anyone else might get inside. The OIC advised Zoya to tell Salma to get the windows repaired. Zoya also asked if contact with Salma could be through an interpreter, and she was assured this would be arranged. However, there is no record of this contact subsequently happening. An action was created on the CRIS system<sup>48</sup> by the OIC for the SOIT officer to contact Salma the next day but there is no record of contact being made.
- 3.1.70 The SOIT officer made three attempts to contact Salma in December 2016, but these were not successful.
- 3.1.71 On the 16<sup>th</sup> November the Families First coach sent a letter to Salma detailing a planned home visit for the 21<sup>st</sup> November (this had been triggered by the information shared by MPS as detailed above).
- 3.1.72 On the 21<sup>st</sup> November, when the Families First coach attended for the home visit, the family were not present. A calling card and phone message were left. This correspondence was in English.
- 3.1.73 On the 23<sup>rd</sup> November, Salma came to the Tower Hamlets Housing Options Team office and reported domestic abuse. She was accompanied by a family member who provided interpretation. Salma disclosed that Omar gambled, was violent towards her, and the sexual assault allegations that Salma had made to the MPS. She also told the housing officer she was not staying at the home address and intended to obtain a non-molestation order. As the family were accommodated in

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<sup>46</sup> As part of the DHR, The Havens confirmed that they did not have any contact with Salma.

<sup>47</sup> This is used by the MPS to highlight a particular address, with a person who is believed at risk.

<sup>48</sup> A computer system used by the MPS.

Newham, the housing officer completed a referral form to the Newham MASH. This stated:

- "...the perpetrator has a gambling [*sic*] habit and bets all his wages. He keeps asking the victim for money, as she is in receipt of child benefit and wtc [*sic*], and when she refuses as that is the only money she has, to pay gas, electric, water etc, and to feed and cloth [*sic*] the children, he gets angry and violent towards her. He has assaulted her when their twin[s] are in the house, but never in front of them"

- 3.1.74 The referral form also noted that "... *the victim advised he forces himself upon her when she refuses to have sex*".
- 3.1.75 It is unclear what happened with this referral. As will be discussed below, the housing officer did not subsequently receive a response until the 26<sup>th</sup> May 2017. It is also of note that the Housing Officer did not themselves follow up with Newham MASH.
- 3.1.76 The housing officer also made a referral to Aanchal. In response, it seems that Aanchal made contact with Salma who declined the offer of support and said a non-molestation order and occupation order was in place. Aanchal informed the Housing office of the outcome.<sup>49</sup>
- 3.1.77 On the 25<sup>th</sup> November, the previously attempted Families First home visit was completed, and the assessment started. The Families First coach was a Bengali speaker and as a result an interpreter was not used during this or subsequent meetings. During the assessment, Salma said that she and the children were staying with family and that Omar had not been in contact.
- 3.1.78 Salma told the Families First coach that:
- An injunction<sup>50</sup> was in place (this was accepted on face value and not checked);
  - She had been contacted by Aanchal, but they had spoken to her cousin and not her (this was never confirmed with Aanchal); and
  - Salma told the Families First coach that she felt unsafe at the home address as window locks were broken. She also said that an alarm that

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<sup>49</sup> Aanchal have a record of a referral from the Tower Hamlets Housing Options Team. However, this is dated in October 2016. The Review Panel has been unable to resolve this discrepancy.

<sup>50</sup> Presumably a reference to a non-molestation order.

had been promised by the Police has not been fitted (this does not appear to have been followed up with the MPS).<sup>51</sup>

3.1.79 The Families First coach:

- Committed to follow up the issues relating to the home address, as well as making contact with Assed Grove<sup>52</sup> to get an update regarding the windows. A message was left with Assed Grove, but no contact was made; and
- Made a referral to Aanchal.<sup>53</sup>

3.1.80 The record also noted that the family would benefit from attending a local children's centre (a later review in 2017 shows none of the children were registered with a children's centre so this action was not followed up / taken up).

3.1.81 On the 28<sup>th</sup> November, the Families First coach attempted to arrange a further visit but there was no response.

3.1.82 On the 30<sup>th</sup> November, THGPCG had contact with Salma when she attended the child health clinic (without Child B and C) for a healthy start application to be signed. The missed 2-year review (from April) was not discussed. There is no information in the records regarding translation in this contact.

3.1.83 On the 2<sup>nd</sup> December, the Families First coach attempted to chase up the Aanchal referral but had no response. They also contacted Assed Grove a second time but received no response. After this second attempt, there are no further entries made about this issue.

3.1.84 On the 8<sup>th</sup> December, the Families First coach asked for an update from Child A's Primary School about Child A. They were told their attendance was 87.5% and there were concerns about their behaviour. However, there is no record that any information was shared by the school concerning domestic violence within the family. The Families First coach also received a response from Aanchal, saying they could not locate Salma as a client because of ambiguities in names / dates of birth (there does not appear to have been any further action taken to address this).

3.1.85 On the same day, the Families First coach undertook a home visit. Salma was seen with all three children. There was a discussion about strategies that Salma could use around Child A's attendance and behaviour. Salma said she was

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<sup>51</sup> The MPS have no record that an alarm had been promised. It is possible this was the result of some confusion about the special schemes marker.

<sup>52</sup> Assed Grove was the housing management agency for the property.

<sup>53</sup> This is recorded as having been completed on the 2<sup>nd</sup> November 2016, which is before the case had been assigned to Families First. It has not been possible to confirm when the referral was made, however during this period the service was transitioning between to electronic record systems, which may mean this is a recording error.

receiving support from her family, had no contact with Omar and did not require additional support from Families First.

- 3.1.86 On the 20<sup>th</sup> December, the Families First coach had a discussion with their supervisor. It was agreed to close the case but to ask Child A's Primary School to address issues around attendance and behaviour and escalate any safeguarding concerns if those arose. At this point, it had not been confirmed whether Salma was receiving any support from Aanchal. A closing letter was sent to Salma on the same day (it has not been possible to confirm whether this letter was sent in English or translated), and the decision was communicated to Child A's Primary School. Although the correspondence with Child A's Primary School mentions that safeguarding concerns should be escalated it does not specifically mention the domestic abuse previously experienced by Salma.
- 3.1.87 A non-crime domestic report was created on the 19<sup>th</sup> December by the IIO, in response to the request from the SOIT at the start of November. However, in creating this, the IIO was unaware of the further allegations made during the VRI and so only recorded the initial disclosures made to attending police officers on the 29<sup>th</sup> October. When this report was reviewed, the supervisor at the Newham CSU commented that no offences were alleged or apparent (other than the serious sexual assault) and that the risk to Salma was being managed by Sapphire officers via the linked report. Efforts were made to contact Salma and a message was left but she did not respond, so the report was closed on the 31<sup>st</sup> December.

#### ***2017 – Living in Newham, with a move to Tower Hamlets in July***

- 3.1.88 On the 3<sup>rd</sup> January, the OIC created a summary of the VRI (which had not previously been completed), including details of the allegations that had been made during that interview. However, by this point the domestic abuse report had been closed a few days previously.
- 3.1.89 On the 13<sup>th</sup> January, Salma moved to alternative temporary accommodation, when the property she and the children were living in was returned to the landlord. The new property was still in Newham. (By this time, Omar had moved back in. Tower Hamlets Housing Options were aware of this at the time, as Salma and Omar attended a housing office together as part of this move. This information was not shared with any other agency and Newham Council Children Social Care would not become aware of this until May 2017).
- 3.1.90 The SOIT had attempted to contact Salma on three occasions in December 2016, and finally did so on the 9<sup>th</sup> January. Salma provided a statement saying that she wished to withdraw her support following discussion with her family and that she wanted to make a life with Omar and be happy. Although the SOIT officer believes that she would have used Language Line for this purpose (although

attending with an interpreter would have been best practice), there is no record of this.

- 3.1.91 The case was reviewed by the SOIT officer's supervisor on the 11<sup>th</sup> January. The supervisor felt that there was insufficient evidence to submit the case to the Crown Prosecution Service (CPS) for charging advice and so the investigation was submitted for closure.
- 3.1.92 Cases need to be reviewed by a Detective Inspector (DI) to be closed. Consequently, the case was reviewed by a DI on the 12<sup>th</sup> January and Omar's bail was extended until the 14<sup>th</sup> February. The DI requested that the supervising officer made a personal visit to ensure Salma had not been coerced into giving the withdrawal statement. They also asked that advice was sought regarding the CPS's position on a victimless prosecution under these circumstances.
- 3.1.93 In April, Barts Health NHS Trust also had contact with Omar for routine medical procedures, with no evidence identified to indicate that these were related to domestic violence and abuse.
- 3.1.94 The SOIT and their supervisor met with Salma on the 8<sup>th</sup> February. Salma was alone with two of the children, and Omar was at work. Via Language Line, Salma said that she had not been forced or encouraged to withdraw her allegation and again said she just wanted to move on with her life.
- 3.1.95 On the 10<sup>th</sup> February 2016, a decision was made by MPS to take no further action against Omar, with this being authorised by a DI.
- 3.1.96 On the 4<sup>th</sup> May, the referral that the housing officer in Tower Hamlets had made in November 2016 was assessed at the Newham MASH.<sup>54</sup> This was assessed at 'Level 1b', with the family to be offered 'Universal Early Help'.<sup>55</sup>
- 3.1.97 In response, on the 24<sup>th</sup> May the family were discussed at South Neighbourhood Action Meeting (NAM)<sup>56</sup>, reflecting the concerns around the level of risk and presenting needs. At the NAM, it was noted that the family were not registered at the local Children's Centre. It was agreed to contact Tower Hamlets Housing

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<sup>54</sup> It has not been possible to determine why such an extraordinary delay occurred. The Newham Children and Young People's Service representative noted that historical MASH practices may have accounted for this but, as the MASH practitioners at the time no longer worked for the authority, it has not been possible to establish what happened.

<sup>55</sup> This means a community or universal service (i.e. school, children's centre or health) would be identified to offer targeted support to a family and assess their strengths or needs. Given the ages of the children, the school or a local children's centre would have been identified to take the role of lead agency). As detailed below, it was subsequently agreed that Child A's Primary School would take the lead.

<sup>56</sup> A NAM is a multi-agency action, allocation and review meeting chaired by the Early Help Partnership Coordinator for that Integrated Neighbourhood area. It brings together a multi-agency group of professionals to discuss the presenting needs of a child or young person. The NAMs group will identify a lead agency and interventions to support the family using the Early Help Framework to meet the family's needs when judged to be best met at Level 1 or 2 Early Help. For more information, go to: [https://www.newhamscp.org.uk/wp-content/uploads/2018/01/20170214-04870-Strategy\\_A4-lores.pdf](https://www.newhamscp.org.uk/wp-content/uploads/2018/01/20170214-04870-Strategy_A4-lores.pdf).

Options (because there was a lack of clarity as to where the family lived, this was to establish whether Salma was still a resident of Tower Hamlets) and also try and establish whether Aanchal was working with the family.

- 3.1.98 On the 26<sup>th</sup> May, the Early Help coordinator in Newham contacted the Tower Hamlets housing officer by email to notify them that their referral had been triaged and early help would be provided. They asked for clarification as to the current home address (i.e. were the family living in Tower Hamlets or Newham); whether Aanchal had made contact with the family; and if there was any information about Child A's school.
- 3.1.99 On the 5<sup>th</sup> June, the Tower Hamlets housing officer responded, asking for either the full address or a reference number, so they could trace the case information. The Early Help coordinator provided this information by return.
- 3.1.100 On the 7<sup>th</sup> June, Salma and Omar were offered permanent accommodation in Tower Hamlets, with Tower Hamlets Housing Options nominating them to a property owned by Clarion Housing.
- 3.1.101 On the same day, the Early Help coordinator in Newham again followed up with the Tower Hamlets housing officer asking for a response to their email.
- 3.1.102 On the 8<sup>th</sup> June, the worker assigned an action from the NAM contacted Tower Hamlets Housing Options to confirm Salma's current address. They were provided with information on the current temporary accommodation (which was still in Newham), but also informed about the recent offer of permanent accommodation (which would be in Tower Hamlets).
- 3.1.103 Later that day, the NAM confirmed that Salma and her family were still resident in Newham but would be moving to Tower Hamlets. It was agreed that Child A's Primary School (who were included in email round up on the 12<sup>th</sup> June) would:
- Have the Family Support Worker (FSW) at Child A's Primary School make contact with Salma to establish the circumstances around housing and domestic abuse;
  - Start an Early Help Record if the family remained in Newham and make a referral to Aanchal for domestic abuse support (there is no record that this referral was made);
  - Make a referral to Tower Hamlets if it was clarified that the mother was rehoused in that borough; and
  - Establish whether Omar was still living at the home address.
- 3.1.104 During correspondence between professionals involved in the NAM, it was noted by Child A's Primary School that "... *parents have little to no English and getting in contact with them is becoming difficult*".



- 3.1.105 On the 22<sup>nd</sup> June, the Early Help coordinator received an update from Child A's Primary School confirming that Salma and her family were moving back to Tower Hamlets. As a result, requests were sent to the original referrer (the housing officer from Tower Hamlets Housing Options) to make a new referral to Tower Hamlets Children Services. The health visiting service was also contacted and asked to complete a 'transfer in' referral so that the family would have access to support in the Tower Hamlets.
- 3.1.106 On the 23<sup>rd</sup> June, Salma and Omar had a viewing a Clarion Housing property. Viewings on that day were coordinated so that at least one Clarion employee who was a Bengali speaker was on site to offer translation support.
- 3.1.107 At the point of the nomination being made by Tower Hamlets Housing Options, Clarion Housing was advised by the tenants that no household member was receiving support from any other organisation.
- 3.1.108 On the 28<sup>th</sup> of June, the Tower Hamlets housing officer responded to the query from the Early Help coordinator in Newham. They noted the referral that they had made in November 2016, something the housing officer identified in their response when they noted: "*Not sure how your internal system works or why it took so long to reach yourself*". In this exchange the housing officer noted that Omar had moved back into the family home in January 2017.
- 3.1.109 The housing officer agreed to make a referral to Tower Hamlets MASH. In making this referral, it appears that they simply forwarded a copy of the earlier Newham MASH referral instead of making a new referral.
- 3.1.110 Consequently, on the 29<sup>th</sup> June, Tower Hamlets MASH contacted the Early Help coordinator in Newham, following up the housing officer's referral. The Early Help coordinator responded on the same day, confirming the family had been discussed at the NAM. She noted that the family were going to be living in Tower Hamlets and '*the school will continue to monitor the family going forward*".
- 3.1.111 Salma and Omar accepted the offer, and their new joint assured shorthold (starter) tenancy began on the 3<sup>rd</sup> July. Salma, Omar and the three children were recorded as resident. As part of the tenancy sign-up process point of starting a new tenancy, Clarion Housing:
- Gathers a range of information (including about Next of Kin, contact information, etc);
  - Undertakes checks (e.g. Right to Rent Checks); and
  - Discusses support needs (e.g. this is via an advocacy form. In this case Salma and Omar did not request any support);

3.1.112 Additionally, staff explain contractual obligations, specifically in respect of paying rent and anti-social behaviour (i.e. how tenants are responsible for the behaviour of household members and visitors). As part of this process:

- There is no specific information provided in relation to domestic abuse; and
- The documents used are provided in English. However, prospective tenants can be provided with additional interpretation and/or translation services if required. In this case, Salma and Omar's Customer Accounts officer (rent officer) was a Bengali speaker so not additional provision was required.

3.1.113 After beginning their tenancy, between July and September there were 10 contacts (by phone or letter) with Salma and Omar, and the Customer Account Team. These related to rent arrears. It is of note that in these contacts it is rarely recorded with whom staff at Clarion Housing spoke. The underlying issue related to housing benefit, a claim for which had been submitted in August 2017.

3.1.114 On the 3<sup>rd</sup> July 2017, the school nurse service (at the time the service was provided by the London Borough of Newham) found that the NAM meeting minutes dated 22<sup>nd</sup> June 2017 noted domestic abuse by Omar toward Salma. They also noted that the family had moved to Tower Hamlets with the children.

3.1.115 On the 6<sup>th</sup> July, the NAM meeting reviewed the case:

- The health visiting service had no health records for Child A, while the original referrer (the housing officer from Tower Hamlets Housing Options) had confirmed that Omar had returned to the family home in January 2017;
- An Early Help Practitioner had completed a home visit with Salma, along with Beckton Primary School (this was on the 30<sup>th</sup> June). The Early Help Practitioner was a Bengali speaker, so no additional provision was made. Salma was described as having been "very open" during the meeting; and
- Salma also said there had been no further incidents and is recorded as having said she was happy to get support around domestic abuse and ensure a safety plan was in place. It is unclear whether this information was cross referenced with previous contact with Aanchal.

3.1.116 The outcome of the meeting was that the case was closed by NAM as the family had moved to Tower Hamlets. At case closure, there was reliance on Tower Hamlets Housing Options to make a referral and an assumption made that, having discussed the case with Tower Hamlets MASH, the family would receive ongoing support in Tower Hamlets).

- 3.1.117 On the 10<sup>th</sup> July, following an accident, Child A received treatment at a local emergency department. No concerns were identified, or disclosures made.
- 3.1.118 By the 3<sup>rd</sup> August 2018, the rent arrears had risen to around £900. As a result, a Notice of Seeking Possession<sup>57</sup> was sent to Salma and Omar.
- 3.1.119 On the 8<sup>th</sup> August, Salma and Omar were referred to Clarion Housing's internal Welfare Benefits Team. The referral was made by the Customer Accounts officer (rent officer), who had obtained consent from Omar. The intention was to provide tailored guidance and advice, focused on supporting a Housing Benefit claim. This led to a home visit on the 8<sup>th</sup> September by a welfare benefits advisor, with further communication with Omar by telephone and email. It is not clear whether the Welfare Benefits Advisor used an interpreter during these contacts.
- 3.1.120 On the 11<sup>th</sup> October, a 3-month tenancy review was conducted with Salma. The neighbourhood officer from Clarion Housing who carried out the home visit reported being able to communicate with Salma without requiring the assistance of a Bengali speaker and described Salma's ability to communicate in English as being "*sufficient*".<sup>58</sup> The property was assessed as being in a good condition. No anti-social behaviour or safeguarding concerns were observed. At this point, the rent arrears totalled just under £1,500. The neighbourhood officer met with Salma (Omar was not present) and a repayment plan was agreed as being in place, with this being followed up with a written agreement in January 2018.

#### **2018 – Living in Tower Hamlets**

- 3.1.121 On the 26<sup>th</sup> March 2018, a 9-month tenancy review was conducted with Salma. Omar was not present. The neighbourhood officer from Clarion Housing who carried out the home visit reported being able to communicate with Salma without requiring the assistance of a Bengali speaker and described Salma's ability to communicate in English as being "*sufficient*." The property was assessed as being in a good condition. No anti-social behaviour or safeguarding concerns were observed. The rent arrears were discussed and had been reduced to around £1,000.
- 3.1.122 In April, Barts Health NHS Trust also had contact with Omar for routine medical procedures, with no evidence identified to indicate that these were related to domestic violence and abuse.

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<sup>57</sup> This was in line with Clarion Housing's policy, whereby all accounts with over 4 weeks' rent owing are required to have a Notice of Possession served. A Notice of Possession can be used to evict tenants who had an assured shorthold tenancy. For more information, go to: <https://www.gov.uk/evicting-tenants/section-21-and-section-8-notice>.

<sup>58</sup> During the DHR process, it was clarified that the Neighbourhood Officer had been able to hold a straightforward conversation with Salma in English and that they would not have proceeded with a conversation about basic housing management issues otherwise.

- 3.1.123 In May 2018, Salma and Omar were placed on a transfer list by Clarion Housing, because they had applied to move to a larger home (given they had three children).
- 3.1.124 In June, the tenancy was converted into a 5-year fixed term Assured Shorthold Tenancy. By July 2018, the rent arrears had reduced to just under £500 and continued to fall, reaching £70 in September.
- 3.1.125 In August, Barts Health NHS Trust also had contact with Omar for routine medical procedures, with no evidence identified to indicate that these were related to domestic violence and abuse.
- 3.1.126 On the 10<sup>th</sup> August, Child A was seen by a health provider for routine medical issues.
- 3.1.127 On the 13<sup>th</sup> October Child A's Primary School made a referral for Child A to Newham MASH following concerns about their behaviour<sup>59</sup>. Child A's behaviour in school had been a concern since the start of the year, including verbal and physical altercations with other pupils.
- 3.1.128 The information in the referral described Child A's school attendance (which had deteriorated and was at 87%) and noted that Child A did not want to come to school, and their parents were finding it difficult to manage their behaviour. This included reports that Child A was often angry, would not listen to their parents and would attempt to hit their mother with a stick. In relation to the use of interpreters, the referral noted that Salma and Omar did not speak English. The referral did not address previous domestic abuse concerns, which Child A's Primary School were aware of given the family had previously been discussed at the NAM.
- 3.1.129 The school also noted that in their referral that CAMHS (provided by ELFT) were in the process of arranging family therapy and 1-1 support for Child A. (This appears to have been speculative, as the referral to CAMHS was not actually made by Child A's Primary School until November).
- 3.1.130 At the Newham MASH, no safeguarding concerns were identified. It is unclear why, as the referral stated that the family address was in Tower Hamlets, the Child A's Primary School were not advised to make a referral to the MASH there (as they would be when they made a further referral to Newham MASH in December). Instead, a decision was made to signpost to Newham's Early Help. This was because the case had been assessed as at the level of 'Universal Early Help (New Level 2)'. There was an expectation that, through Early Help, the following interventions would be put in place. At the time, practice in Newham

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<sup>59</sup> In the interests of proportionality and anonymity, the Review Panel felt it was not appropriate to include a detailed account about Child A's behaviour at school and felt this summary provided sufficient detail about the school's concerns.

would have meant that these actions were communicated to the Child A's Primary School to complete:

- Identify a Lead Professional to complete Early Help Assessment and hold regular Team Around the Child (TAC) meetings;<sup>60</sup>
- Identify appropriate parenting support for parents;
- Refer parents to an FSW to complete some direct interventions within the home around boundaries, parenting and routines, to also address school attendance;
- Refer to Children's Centre; and
- Refer to the school nurse/ encourage parents to attend GP for advice.

3.1.131 During the course of this decision, attempts were made to contact both parents (via telephone) but were not successful. This would have been in English in the first instance.

3.1.132 Child A's Primary School's referral to CAMHS (provided by ELFT) was received on the 2<sup>nd</sup> November (having been written on the 29<sup>th</sup> October 2018). Although the referral related to family therapy, it did not include any information about the referral the school had made to Newham Children's Social Care on the 13<sup>th</sup> October or the history of domestic abuse. The referral stated that Child A's parents do not speak English.

3.1.133 On the computer system used by CAMHS, there was one entry that referred to 'NAM'. This was the meeting in January where the family had been discussed as part of the Early Help offer. This entry, made previously by the school nurse, included information on the allegations of domestic abuse. However, these notes were cursory: the entry had been made on 3<sup>rd</sup> July 2017 stating they have "*perused minutes from NAM meeting... minutes indicate that there is DA towards mother and she has moved to Tower Hamlets with the children*".

3.1.134 On the 5<sup>th</sup> November, CAMHS attempted to make contact. Given the information in the referral that Salma and Omar did not speak English, a request was made internally for support from a cultural advocate worker and interpreter. Two attempts were made to call, although neither was successful. Subsequently, a first appointment letter was sent in English.

3.1.135 On the 19<sup>th</sup> November, Salma and Omar attended an initial appointment with CAMHS. Child A did not attend, because neither Salma nor Omar realised that they should have come to the session. An interpreter had not been arranged for

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<sup>60</sup> A Team Around the Child (TAC) is a multi-disciplinary team of practitioners established on a case-by-case basis to support a child, young person or family.

this appointment. It was noted that both parents had limited English, but it was agreed the session would go ahead and an interpreter would be invited to following sessions. The clinical notes suggest a detailed conversation with parents took place, albeit requiring follow-up with an interpreter.

- 3.1.136 At this initial CAMHS session, the issues identified in the referral were confirmed, with these including Child A's anger, the management of boundaries, and school attendance. Salma also confirmed that Child A would swear and shout at her. Salma and Omar reported that they did not argue and get on well.
- 3.1.137 CAMHS liaised with the school to get further information on Child A's presentation, with this discussion happening on the 22<sup>nd</sup> November. This included information about Child A's time in school, as well as possible causes of their behaviour including attachment issues since the birth of Child B and C. The school also confirmed that Child A was attending the school's self-esteem group. There was no discussion about the NAM meetings or the entry relating to domestic abuse.
- 3.1.138 At a second CAMHS session on the 27<sup>th</sup> November, Child A did not attend. An interpreter was used. The discussion focused on parenting styles, including what the CAMHS IMR describes as Omar's "*stricter approach*". CAMHS made efforts to engage with Child A, writing to them about attending (this letter was translated). This letter was given to Salma and Omar.
- 3.1.139 On the 3<sup>rd</sup> December a care plan was sent to Child A's family. This was in English. At this point Child A had not been seen by the CAMHS clinician. The main intervention in addition to sessions was a referral to a Non-Violent Resistance (NVR) parenting programme.<sup>61</sup> Child A did not attend this session and there is no evidence that, prior to the care plan, this had been discussed in supervision or at a Multi-Disciplinary Team (MDT) meeting.
- 3.1.140 On the 10<sup>th</sup> December, Salma and Omar attended a further CAMHS session. An interpreter was used. Parenting roles were again explored. The outcome of this meeting was a change from the NVR parenting programme to another intervention (either Incredible Years or the Parent Child Game).<sup>62</sup> CAMHS also decided a referral would also be made for Early Help and there was a plan to discuss an Early Help Hub referral with parents at the next meeting (this was due to be held on the 18<sup>th</sup> December).
- 3.1.141 On the 12<sup>th</sup> December, Child A's Primary School sent a further referral to the Newham MASH regarding concerns about Child A's behaviour in school. This

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<sup>61</sup> For more information, go to: <https://www.elft.nhs.uk/News/Empowering-The-Community---NVR-Training-in-Hackney->.

<sup>62</sup> These are other types of group-based programs to support parents and their children.

was after a meeting with Omar: information was translated by a member of staff that spoke the same language.

- 3.1.142 The referral related to Child A's behaviour in school but included background information as set out in the earlier referral to CAMHS. However, there was no reference to domestic abuse in the referral. It was confirmed the family were residing in Tower Hamlets and the school was asked to make a referral to that borough with their concerns about Child A.
- 3.1.143 On the 13<sup>th</sup> December, Child A's Primary School made a referral to the Tower Hamlets MASH. This repeated the information in the previous referral to Newham MASH. It included information on the family, including their address (which since July 2017 had been in Tower Hamlets). The Tower Hamlets Duty Social Worker then spoke with the school and CAMHS, although not with Newham Children Services, and then made a decision that the family would be referred to Early Help<sup>63</sup>. A Team Manager reviewed this decision and agreed with the recommendation.
- 3.1.144 On the 17<sup>th</sup> December Child A's Primary School contacted CAMHS with concerns about a fight between Child A and a relative at home.
- 3.1.145 The Tower Hamlets MASH contacted CAMHS on the 17<sup>th</sup> December, in response to the referral from Child A's Primary School. They asked for more information from the professionals who had been working with the family. As a result of this contact, CAMHS did not make the planned Early Help referral.
- 3.1.146 On 18<sup>th</sup> December 2018, a letter was received by the GP from CAMHS summarising their involvement with Child A.
- 3.1.147 Tower Hamlets Early Help was passed the referral by Tower Hamlets MASH on 18<sup>th</sup> December 2018. Unfortunately, the parents' consent had not been included in the original referral, and the MASH/Early Help Hub liaison worker attempted to obtain consent by telephoning the parents on a variety of numbers but was unsuccessful in making direct contact with either parent. A voice message was left on three telephone numbers. A letter was sent to the family address inviting the family to make contact with the Early Help Service. Practice at the time meant that voice mail messages left with parents/families are usually in English, unless it is explicitly stated that the family member needed an interpreter, when the message would be in the language of the family. In this case the message(s) left were in English.

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<sup>63</sup> The Early Help Hub works with families or young people who would like some extra support to deal with a difficult situation. For more information, go to [https://www.towerhamlets.gov.uk/ignl/health\\_social\\_care/children\\_and\\_family\\_care/Early\\_Help/Early\\_Help\\_Hub.aspx](https://www.towerhamlets.gov.uk/ignl/health_social_care/children_and_family_care/Early_Help/Early_Help_Hub.aspx)

- 3.1.148 On the 18<sup>th</sup> December, Salma and Omar came to a CAMHS session. They were both upset by the referral because they felt they had been coming to see CAMHS. There were further discussions about Child A's behaviour and strategies for managing this.
- 3.1.149 On the 19<sup>th</sup> December, Salma attended the GP and was seen for neck pain. No additional disclosures were made, or concerns identified, during this contact.

## 2019

- 3.1.150 In early January, the GP had contact with Child B and Child C as they were ill. Both Salma and Omar were present. There is nothing on the record to indicate that there was any discussion about Child A during this contact.
- 3.1.151 A few days later, Salma spoke with CAMHS. She reported that things had been a bit better, and Child A had been better behaved and she felt this was down to putting in boundaries and being more consistent.
- 3.1.152 A day before the homicide, at about 9.00am Ahad received a call from Salma who was upset and crying saying that Omar had lost £200 of her money gambling and that he had hit her.
- 3.1.153 On this same day Omar had £40 of credit for use on a Fixed Odds Betting Terminal (FOBT).<sup>64</sup> He subsequently lost this money. (More information about Omar's betting is described in section 4.4).
- 3.1.154 The next day, Ahad received a call from Salma in which she asked him to speak with Omar about the money he owed her. Ahad called Omar and told him that he was not happy about what he had done and how he was treating Salma. Omar spoke back in an aggressive manner, did not want to admit to any blame and ended the call abruptly.
- 3.1.155 During the day, other family members received calls where they heard shouting and arguing between Salma and Omar. At least two family members contacted Ahad as they were worried about Salma.
- 3.1.156 When Ahad returned home mid-afternoon, he found Salma's body in the kitchen, after she had been murdered by Omar.

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<sup>64</sup> Fixed odds betting terminals (FOBTs) are electronic machines, sited in betting shops, which contain a variety of games, including roulette. Each machine accepts bets for amounts up to a pre-set maximum and pays out according to fixed odds on the simulated outcomes of games.



## 4. Overview

### 4.1 Summary of Information from Family, Friends and Other Informal Networks

#### *Child A (Salma's oldest child)*

4.1.1 Child A explained that, before the homicide, it was “*good most of the time, but sometimes it was bad*”. Talking specifically about the relationship between their mother and father Child A explained it was “*bad, sometimes okay but sometimes not*”. Child A told a story about when their mother could not reach something on a top shelf and asked their father for some help. In response Child A said their father hit their mother without saying anything else. Child A also said that their father used to hit them. Child A said they felt powerless and unable to protect their mother but said that they would try to keep Child B and C safe.

#### *Samiha (Salma's niece)*

4.1.2 As described in 1.9, Samiha met with the chair. She described Salma as “... a really kind person, she had a tendency to put others first constantly”.

4.1.3 Salma had married Omar while she was still in Bangladesh. Noting the age difference, Samiha said that the marriage was arranged, but said that Salma: “*didn't have a choice though, she didn't want to get married she just had to, she was still in school and had to leave and become a housewife*”.<sup>65</sup>

4.1.4 Samiha said that Salma initially lived with her family (her mother is Aneysha, Salma's sister), living with them for a couple of years. Omar was not living with them at the time, because he was working elsewhere, but he would come and visit.

4.1.5 Salma soon “*realised he had a gambling problem, they used to argue a lot*”. Omar reportedly told Salma that he did not have any money to give her because he was sending it home to his family in Bangladesh, but she had bank statements which she had shown family, and which showed he was going to betting shops. Samiha said “...*if he lost money, he would come home angry and would start an argument and it would turn physical quickly – she felt like he just wanted to unleash his anger and frustration on something*”. While Salma sometimes worked informally in local shops, it was always short term, so she was dependent on Omar's income.

4.1.6 Samiha described Omar as controlling, preventing Salma from going to family gatherings. This was even when Omar was working away, so he was not there in

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<sup>65</sup> The Review Panel considered whether ideas of honour may have been relevant to Salma and Omar's experiences, including the murder itself. For a discussion, see section 5.1.

person to stop her going. Samiha was certain that Omar would hit Salma, having seen bruises on Salma at various times although Salma always claimed she had fallen. On at least one occasion when Samiha was young, she had overheard Omar attacking Salma in a neighbouring room (this was when Samiha was living with her family). She had gone into the room to see what was happening and saw Salma holding her neck and gasping for breath.

- 4.1.7 Although Salma would speak to her family, Samiha thought this was only when she “...*couldn't take it anymore*” and otherwise would not say anything. Samiha felt this would be the same if Salma spoke with services: “*She would have downplayed everything because she was scared, she would have to leave her kids and husband*”.
- 4.1.8 Samiha also said that Salma did not speak much English, although her family were supporting her as best they could to learn, encouraging her to go to different classes and groups. Samiha said that as a result “*her English was getting better...*”. There was also another benefit to the classes and groups because Salma was quite isolated. Samiha said that Salma: “... [did those] *classes with other women that had come from Bangladesh and [as a result] made some friends and they would help each other which was good*”. However, Omar reportedly did not like this.
- 4.1.9 Samiha talked about the support she and other family members tried to provide, including trying to talk to Salma about what was happening, encouraging her to get help and support and on occasions calling the MPS. But they found this difficult because Salma did not feel she could leave Omar. Samiha suggested that “*she [Salma] just saw it as how her life was meant to be*”.
- 4.1.10 Samiha knew that CAMHS had been involved with Child A because of their behaviour. However, she was clear as to the cause: “*I'm sure they were aware that [Salma] was having problems in the house because Child A used to hit [their] mum and [they] thought it was ok to abuse [their] mum. She expressed to them, I think, that the reason [they] hit her was because [they] saw [their] dad hit her*”.
- 4.1.11 Samiha also thought that Salma was scared of agency involvement, saying: “*She was very worried, her biggest concern was that the kids would be taken away*”. She felt that she would have got this idea from Omar, saying: “*he was all she knew*”.
- 4.1.12 Samiha was frustrated with the MPS response, talking about the different incidents, she felt it was “*ridiculous*” that the reports did not go somewhere. She described the MPS as “*walking away*” and wanted to know why they did not follow these up, in particular Salma's decision to move back in with Omar in January 2018.
- 4.1.13 Samiha also highlighted a concern about interpretation. She recalled seeing a recording of a police interview with Salma in the trial: “*when they played the*

*interview and the interpreter wasn't interpreting it correctly. They missed out things and interpreted it differently, so it wasn't what she meant. In Bengali there are so many dialects – you can't just get a general interpreter."*

- 4.1.14 Samiha was not sure what more they could have done but did feel that more information about help and support would be helpful. *"I mean who could we go to? Now I know there is helplines and stuff but back then I didn't".* She also pointed to the traditional beliefs that some members of the Bangladeshi community hold, and which reinforce the idea that men are superior to women, and which she felt influenced Salma and Omar.
- 4.1.15 She also expressed her sadness at Salma's death, saying: *"She had such high hopes for her children and won't see that which is sad. I wish we had more time with her".*

*Zoya (Salma's cousin / sister-in-law)*

- 4.1.16 As described in 1.9, Zoya agreed that the witness statement that she had provided to the MPS could be shared with the chair. In her witness statement, Zoya described how she and Salma had become close after Salma moved to the UK in 2008. Zoya said they talked most days and would often visit.
- 4.1.17 Zoya said she had attended Salma and Omar's marriage. She said this was an arranged marriage and not a love marriage.
- 4.1.18 Zoya also said that Salma was reluctant to go anywhere on her own and would become *"nervous"* if she had to go somewhere new. She would usually only go to school to drop off or pick up the children or go to the market.
- 4.1.19 Zoya also said that Salma's English was *"not very good"*, and she helped her to learn.
- 4.1.20 Zoya described Salma and Omar's relationship as having *"problems"*. Unlike Samiha, Zoya described Salma as being *"quite open about the arguments"*. However, she acknowledged that there were things that Salma told her that she did not tell other family members. Over time, Zoya also said that Salma started to be less open about arguments, but she said that Omar would *"...threaten to hit her and became more physical"*. Specifically, Salma told Samiha about assaults, including Omar grabbing her by the wrists and pulling her about. Salma said that Omar did not hit her but thought that *"...was only because he may then get found out if he left any visible marks"*.
- 4.1.21 Zoya said that, when she met him, Omar *"...gave the impression that he was a gentleman and a nice person who prayed five times a day"*. However, Zoya and other family members became aware that Omar had a gambling problem. She was aware of arguments between Salma and Omar over this, saying: *"often, when they argued, he would take it out on her and accuse her of swearing at him"*

*but she would say that she only swore because he had gambled the money away”.*

- 4.1.22 Zoya was aware that Omar had been arrested on one occasion, describing this as happening after a “*huge argument*”. Salma told her that Omar had grabbed her by the hair, dragged her into the bedroom and grabbed her by the chest. She said that Omar “*...really hurt her*”.<sup>66</sup>
- 4.1.23 After this incident, Zoya said that she told Salma that things could not continue as they were, including because of the impact on the children. Salma subsequently left Omar and moved out. While Salma’s family were encouraging her to stay away from Omar, Salma told Zoya that Omar and his family were contacting her to “*...give him another chance*”.
- 4.1.24 After reconciling, and moving to a new address in 2017, Zoya thought the relationship improved. Although there were “*minor arguments*”, she said that Omar “*... seemed much calmer and was behaving, probably because he didn’t want to be in a situation of being kicked out again*”.
- 4.1.25 Additionally, Zoya noted that Salma’s nephew Ahad had moved in with them. She was also aware that Child A was having some difficulties.
- 4.1.26 Zoya spoke to Salma the day before the homicide. During a call, Salma said that she had been arguing with Omar and this was to do with his gambling. Salma also said that she had given Omar her bank card, but he had not returned it. During this argument, Salma said that Omar had hit her.
- 4.1.27 Zoya felt an issue was that Omar did not have any family support, as his family (bar his ex-wife) were all in Bangladesh.

*Ahad (Salma’s nephew)*

- 4.1.28 As described in 1.9, Ahad agreed that the witness statement that he had provided to the MPS could be shared with the chair. Ahad had moved in with Salma and Omar (along with his wife) after his marriage. He said that Salma was “*very caring and kind towards me*”.
- 4.1.29 Ahad said that he was aware that Salma and Omar would argue about Omar’s gambling and money and that “*...sometimes he was violent towards her*”. While Ahad had never seen her be hit or any injuries, Salma would tell him that she had been hit and was in pain, although she would not discuss the incidents.
- 4.1.30 On the day before the homicide, Ahad received a call from Salma. She told him that Omar had hit her after she had challenged him about losing several hundred

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<sup>66</sup> Zoya said this incident was in 2014 or 2015, although her account of the incident matches the incident reported to the MPS in September 2016.

pounds when gambling. Ahad tried to speak with Omar about this but could not contact him.

- 4.1.31 On the day of the homicide, Ahad spoke with Omar and challenged him about his gambling and treatment of Salma. Omar reportedly responded “...*in an aggressive manner and did not want to admit his blame*”. Later that day, Ahad received a call from another family member in Bangladesh, who had been contacted by Salma saying that Omar was “*beating her*”. When Ahad returned to the property, he found Salma dead.

## 4.2 Summary of Information from Perpetrator

- 4.2.1 As detailed in 1.10, Omar declined to take part in the DHR.

## 4.3 Summary of Information known to the Agencies and Professionals involved

### *Salma*

- 4.3.1 Salma had contact with a range of different professionals. Within this contact, while the issues varied, a reoccurring feature was the extent to which professionals considered and responded to Salma’s limited English. This often meant that family members were (inappropriately) used as interpreters.
- 4.3.2 In relation to health providers, Salma accessed both maternity and health visiting services until 2016. In these contacts, health professionals had no concerns about her parenting. Broadly speaking, there were opportunities to ask about domestic abuse which were not taken because a third party was present, largely because health professionals often used family members as interpreters. However, in some contacts interpreters were used e.g. by Barts Health NHS Trust.
- 4.3.3 Throughout the timeframe covered by the DHR, Salma also had contact with her GP, albeit this was limited and related to specific health issues. This contact also related to health care for children A, B and C. Although family members were initially used as interpreters, after 2013 this was not required as Salma could speak directly with her GP.
- 4.3.4 In none of these contacts with health providers were concerns around domestic abuse identified, nor were any disclosures made. It is of particular note that the GP was unaware of latter disclosures around domestic violence and abuse or other issues. Broadly put, it appears that other agencies – mostly significantly Newham and later Tower Hamlets MASH – had not contacted or notified them of concerns. Given the GP had only limited contact with Salma, with no indicators of

domestic violence and abuse, being made aware of these concerns would have been essential to trigger a targeted enquiry.

- 4.3.5 Salma's contact with CAMHS (provided by ELFT) is summarised below.
- 4.3.6 In relation to housing providers, Salma had contact with Tower Hamlets Housing Options, principally in 2014 (when she was seeking accommodation) and in 2016 (in relation to her accommodation needs). In 2013, Salma first disclosed concerns about Omar's gambling and her concerns about any tenancy with him. In relation to the former, this was not responded to with any consistency by Tower Hamlets Housing Options, which focused on Salma and Omar's responsibility for rent payments, rather than exploring what help and support might be suitable. However, it is commendable that on one occasion a housing officer did speak to Salma alone about these issues, although they were not followed up again. In 2016, in relation to Salma's disclosure of domestic violence and abuse, while this triggered referrals by the housing officer, including to the Newham MASH, these were not followed up. Additionally, when Tower Hamlets later became aware that Omar had moved back in with Salma, they did not take steps to notify any other agencies.
- 4.3.7 Tower Hamlets Housing Options discharged their duty to Salma and Omar, by initially housing them in temporary accommodation from 2014 and then nominating them to permanent accommodation provided by Clarion Housing in 2017. However, they did not share information about Salma's disclosure – both of gambling concerns and domestic violence and abuse – when they made the nomination to Clarion Housing. This has led to the identification of a lack of guidance as to what information can be shared when nominations are made to a housing provider. Finally, like other services, Housing Options primarily relied on family interpreters.
- 4.3.8 Clarion Housing became landlords for Salma and Omar from 2017. It is commendable that, as part of the process for viewing properties, Clarion Housing took steps to ensure that staff on site could meet Salma and Omar's language requirements. During their subsequent interactions with Clarion Housing, most of the staff that Salma and Omar interacted with could also speak with them directly. However, there is still learning from Clarion Housing in relation to this issue. For example, Tenancy Sign-Up documents are in English.
- 4.3.9 More generally in relation to domestic violence and abuse, no disclosures were made to Clarion Housing by either Salma or Omar. Moreover, as noted above, Tower Hamlets Housing Options had not notified Clarion Housing of previous concerns. As a result, Clarion Housing would have been dependent on staff either identifying a concern or a disclosure by Salma. This has led to the identification of an absence of information in tenancy starter packs about domestic violence and abuse.

- 4.3.10 The MPS received three reports concerning Salma. In the first two incidents, in June and September 2016, Salma made significant disclosures about Omar's abusive behaviour. In October 2016, Salma made further disclosures, including an allegation of a sexual offence. In responding to the first two disclosures, there has been learning about how police officers risk assess, not least because in the June 2016 incident an assessment of 'Medium' risk was downgraded. This was because Salma said she was going to stay with a family member, but this was not revised when she returned home. In these contacts, police officers frequently used family as interpreters. This was most significant in October 2016, when this meant that the family were interpreting when Salma disclosed a sexual offence. In particular, this led to confusion about when this offence occurred which meant that an opportunity to refer Salma to The Haven was not initially considered. The October 2016 contact has also revealed issues with both record keeping, how domestic and sexual offence allegations are managed in parallel, as well as highlighting issues such as officer welfare.
- 4.3.11 Newham MASH received six referrals during the time the family resided in the borough. In assessing two referrals from the MPS in 2016, there was an over-reliance on police actions as determining the MASH's assessment. In essence, because the MPS had taken no further action, nor did the MASH. A third referral from the MPS in 2016 led to a referral to Early Help. Other referrals, from Tower Hamlet's in Housing Options in 2016 and then from Beckton Primary School in 2017, led to the same result. When Beckton Primary School made a final referral towards the end of 2018, they were advised to contact the Tower Hamlets MASH.
- 4.3.12 For both the MPS and Newham MASH, their contacts with Salma in 2016 could have been referred to MARAC. Arguably, the MPS should have made a referral based on 'professional judgement'. Additionally, the MPS and Newham MASH could have considered a referral to the local MARAC on the basis of 'potential escalation'. However, in this case, the local threshold would not have been met. This has highlighted issues with thresholds of the MARACs in both Newham and Tower Hamlets, which vary by both frequency and type of incident, and which are higher than the national guidance.
- 4.3.13 The various referrals to the MASH that led to Early Help referrals triggered a range of actions, including meetings with the family as well as consideration of referrals relating to domestic abuse and other measures around security in the home. However, partnership arrangements at the time do not appear to have been particularly robust, meaning many of the actions that were agreed do not seem to have been completed and/or there is a lack of clarity about outcomes.
- 4.3.14 Child A's Primary School also had contact in this case, relating to Child A. While the school provided support to Child A, including ultimately making a referral to CAMHS, as well as safeguarding referral(s), the focus was largely on their behaviour. As a result, concerns about domestic violence and abuse were not

considered, in particular in the referral to CAMHS. This would have been an opportunity to alert another service that was going to work closely with the family about the history of domestic violence and abuse and so potentially inform their interventions.

- 4.3.15 CAMHS received a referral for Child A in late 2018. This triggered an assessment and intervention, although this was delivered via Salma and Omar as Child A did not want to attend. While initial contact attempts included provision for interpretation, this was not consistently done in subsequent interactions, both in direct contact but also in writing. More generally, CAMHS did not consider domestic violence and abuse. This is perhaps understandable, given this was not highlighted in the referral from Child A's Primary School (or subsequent contact with the MASH in first Newham and then Tower Hamlets). However, there was one reference to domestic violence and abuse in the record, while the concerns about possible behaviour from Child A to Salma, as well as other issues (like reports of Omar's stricter parenting), could have triggered consideration. Moreover, the case handling in terms of supervision or case management appears limited; again, support from other colleagues may have drawn attention to the possibility of domestic violence and abuse.
- 4.3.16 Tower Hamlets Children's Social Care and Early Help Service had limited contact in this case, with some information in July 2017 (that did not trigger any further action), and a referral in December 2018. This was appropriately assessed, but reflecting the issues noted above, the focus of information shared by Child A's Primary School and CAMHS was Child A's behaviour and there was no information shared around domestic violence and abuse. If Tower Hamlets MASH had sought information from Newham, given it was aware that the children were attending school there, this would have provided an additional avenue through which this information could have been identified. Ultimately, the MASH signposted to Early Help although this had not progressed very far by the time of Selma's death.

#### *Omar*

- 4.3.17 Although Omar was in contact with some agencies, for example, Tower Hamlets Housing Options and Child A's Primary School, in some senses he is relatively absent. In part, this is because Omar did not participate in this DHR, which has limited the amount of information available about him and his experiences. However, it also reflects how the focus tended to be on either Salma and Omar jointly (e.g. as tenants when in contact with Tower Hamlets Housing Options or Clarion Housing) or on Child A (e.g. in relation to contact with Child A's Primary School or CAMHS).
- 4.3.18 The only agency that specifically had contact with Omar in relation to domestic violence and abuse was the MPS, in response to reports relating to his behaviour.



The MPS appear to have responded appropriately to Omar, including for example using bail conditions to remove him from the family home after the October 2016 sexual assault allegations. However, continuing the theme of Omar's relative absence, it is of note that the MPS focused its risk assessment on Salma's actions rather than his.

- 4.3.19 A final issue for Omar was his gambling. Relatively little information is known about this, but it is clear that Omar was regularly gambling, and this was a concern to Salma and her wider family. This is detailed below.

#### **4.4 Any other Relevant Facts or Information:**

- 4.4.1 A high street bookmaker where Omar had been reported as gambling was approached. They checked their records for contact with Omar and identified that he had used a credit card at betting shops operated by the company on four occasions between February 2018 and January 2019. The total sales on this credit card were for £255.
- 4.4.2 Customers can buy credit to spend on FOBT using a card or cash. The high street bookmaker noted that FOBT are located close together, so a customer could potentially use more than one machine at a time.
- 4.4.3 The last transaction was a day before the homicide, with Omar purchasing £40 on his credit card for use on a FOBT. Omar subsequently lost this money. In addition to this spending on his credit card, there is no way of knowing if Omar brought credit using cash, as records are not kept for cash transactions. Additionally, footage from the security camera is not available as this had been deleted in line with normal data retention practice.
- 4.4.4 GamCare were also approached and confirmed that neither Omar or Salma had approached them for help and support.

## 5. Analysis

### 5.1 Domestic Abuse/Violence

5.1.1 Taking into account the government definition above, information gathered by the MPS as part of the murder investigation, as well as provided by agencies and family, it is clear that Salma was the victim of domestic abuse by Omar, in addition to being killed at his hands.

5.1.2 Tragically, it will never be possible to know the full extent of Salma's experiences. However, as a minimum it appears Salma experienced the following:

- *Physical abuse*: Assaults by Omar, including strangulation and possibly the use of weapons (inferred when Salma told the SOIT officer in October 2016 that Omar "*fought her with anything*"). Child A also described an incident when Omar hit their mother;
- *Coercion, threats and intimidation*: The Review Panel does not have a full picture of Omar's behaviour in this context, although there are reports (including by Salma to police officers) that he had made threats to kill. Whatever means he used to coerce, threaten and intimate, these were clearly effective: it has been reported that Salma was isolated, in part because Omar did not want her to go out. Moreover, when Salma had moved out of the family home between October 2016 and January 2017, she was fearful of living there because she was worried that Omar would try and break in;
- *Emotional abuse and isolation*: The Review Panel does not have a full picture of Omar's behaviour in this context, although as regular arguments were reported to the police and noted by family, this is likely to have been a significant feature of the relationship. Salma herself told police officers in June 2016 that Omar "*does not like me talking to anyone else*";
- *Sexual abuse*: In her contact with the MPS in September 2016, Salma disclosed that Omar forced her to have sex with him and that that had been happening for the past two years. While it is unclear what Salma would have called this, and charges against Omar were ultimately dropped, it is important to note that as a minimum this would constitute sexual assault, if not rape;
- *Children and pregnancy*: It is unclear if or how the children were used by Omar to abuse Salma. However, it is of note that Salma's niece (Samiha) said that Salma was fearful that contact with services could lead to the loss of her children. Samiha thought Salma believed this based on what Omar had told her. Child A said they had been hit by Omar and also tried

to protect Child B and C. The impact on children of living in a household where domestic abuse is well known.<sup>67</sup> It is also possible that the concerns about Child A, as well as their reported behaviour towards Salma directly, were linked to their own experience of domestic abuse, with research showing how children can become abusive towards the non-abusive parent.<sup>68</sup> It also seems that Omar's economic abuse was linked to the children, on at least one occasion he is reported to have asked for the child benefit; and

- *Economic abuse*: Omar is reported to have either taken or demanded money, both to pay for his gambling and possibly also to send money to his family in Bangladesh. Based on the call outs to the MPS, and the account of family, Omar would respond to being challenged about finances with violence and abuse. There was also a broader impact on the family's finances. While the rent arrears in 2017 and 2018 appear to have been related to issues with housing benefit, and were paid down, financial issues were an ongoing concern. One example is after the birth of Child B and C in 2014, when the family had not yet bought baby equipment.

Additionally, Omar was known to gamble. While it is not possible to determine the extent of Omar's gambling, this was clearly of concern to Salma, who reported that Omar had taken money for this purpose and was worried about the impact on the family's finances (and tenancy). Salma's family also described arguments as a result of gambling. There is evidence of a link between gambling and relationship strain, as well as domestic abuse.<sup>69</sup> The issue of gambling is discussed below, specifically in relation to disclosures to agencies in 5.2, as well as more generally in 5.3.

5.1.3 It is therefore evident that Omar posed a significant risk to Salma prior to the homicide: all of these types of abuse are included in the DASH risk assessment checklist as examples of 'high risk' factors.<sup>70</sup>

5.1.4 Moreover, while the Review Panel cannot be sure what precipitated the murder of Salma, it noted that in addition to these factors:

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<sup>67</sup> James, E. (2020). *Not just Collateral Damage. The hidden impact of domestic abuse on children*. Available at [https://www.barnardos.org.uk/sites/default/files/uploads/%27Not%20just%20collateral%20damage%27%20Barnardo%27s%20Report\\_0.pdf](https://www.barnardos.org.uk/sites/default/files/uploads/%27Not%20just%20collateral%20damage%27%20Barnardo%27s%20Report_0.pdf) [Accessed 24 March 2020].

<sup>68</sup> CAADA (2014). *In plain sight: The evidence from children exposed to domestic abuse*. Available at: [https://safelives.org.uk/sites/default/files/resources/In\\_plain\\_sight\\_the\\_evidence\\_from\\_children\\_exposed\\_to\\_domestic\\_abuse.pdf](https://safelives.org.uk/sites/default/files/resources/In_plain_sight_the_evidence_from_children_exposed_to_domestic_abuse.pdf) [Accessed 24 March 2020].

<sup>69</sup> Roberts, A. et al. (2016) Gambling and violence in a nationally representative sample of UK men: Gambling and violence. *Addiction* 111(12), pp. 2196–2207.

<sup>70</sup> For more information on the DASH, go to: <http://www.safelives.org.uk/node/516>.

- There was an ongoing conflict over finances, precipitated by Omar’s behaviour. Experiencing economic abuse in the context of coercive control is associated with an increased risk of homicide,<sup>71</sup> with over a third of cases in one study of domestic homicide involving financial issues;<sup>72</sup> and
  - The Review Panel has not had any information to suggest that immediately before the homicide Salma intended to leave Omar, but it is relevant to note that at various points in the past Salma had left the family home (in July 2016) or was reported as wanting to end the relationship (something Ahad told police officers in September 2016) or said this herself (in October 2016). Separation, or even the possibility of it, is particularly relevant and is associated with significantly increased risk from a perpetrator.<sup>73</sup>
- 5.1.5 Clearly, the picture of domestic abuse presented here was not known to all agencies, nor known in full. However, different agencies knew about domestic abuse during their contact with Salma and Omar, as well as the children. This is discussed further in the analysis below.
- 5.1.6 It appears that Salma told different people different things at different times. This is evident in her disclosures to family members, with differences in what she told Zoya and Samiha. It is also apparent in her contact with professionals. Additionally, while Salma did at times talk about her concerns about Omar, including making disclosures of domestic violence and abuse, at other times she said and behaved as if everything was fine. The Review Panel noted this as an example of the challenges that victims of domestic violence and abuse can face in talking about their experiences, particularly when also trying to manage their safety. However, it is important to note that Salma did find ways to talk about what was happening to her. It is difficult to know what may have helped or hindered Salma in this regard, with issues potentially including her fear of Omar, or indeed services, as well as the challenge of the language barrier. These are explored in the remainder of the analysis.
- 5.1.7 Relevant to all these issues is how Salma’s experiences of abuse was affected by the cultural environment in which she lived and the cultural issues that could have

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<sup>71</sup> Websdale, N. (1999) *Understanding Domestic Homicide*. California, Northeastern University Press

<sup>72</sup> Home Office (2016). *Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews*. Available at [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf) (Accessed 24 March 2020).

<sup>73</sup> Long, J. and Harvey, H. (2020). *Annual Report on UK Femicides 2018*. Available at: <https://femicidescensus.org/wp-content/uploads/2020/02/Femicide-Census-Report-on-2018-Femicides-.pdf> [Accessed: 22nd February 2020].

impacted her ability to ask for help. This is also relevant to her accesses to help and support from her family and friends, as well as agencies.<sup>74</sup>

- 5.1.8 Salma was originally from Bangladesh. Although she had been naturalised as a British Citizen, she had limited English and was relatively isolated, bar support from her family. There is clear evidence that women from minoritized communities can face a range of barriers, including vulnerabilities to forms of abuse, as well as compounding affects like feelings of shame, language barriers and the impact of different cultural norms and expectations.<sup>75</sup>
- 5.1.9 There is clear evidence of the potential impact of specific cultural pressures and barriers for Salma. Illustrative of this was the information from Samiha, who both described Salma's marriage to Omar as "*arranged*" but also said that Salma did not have a choice in terms of whether she married or not. In the period examined by this DHR, such cultural expectations may have affected Salma in any number of ways. For example, in terms of whether she felt she had to remain in the relationship with Omar (this might explain, for example, why Omar was able to return to the family home in early 2017). As a result, the discussion in the following sections considers the impact of cultural attitudes and / or stereotypes.
- 5.1.10 In terms of agency responses, a key issue identified in this report relates to issues with language, in particular access to translators, with some agencies inappropriately using family members to provide translation. In Salma's case, while her family appear to have been supportive, accompanying her to appointments and encouraging her to seek help, it was nonetheless inappropriate to use family in this way. This is explored in relation to each agency where appropriate and then summarised in 5.3 below.
- 5.1.11 A further consideration is access to domestic abuse services with expertise in working with women from minoritised communities. In Salma's case, she was referred to Aanchal when she lived in Newham, although this did not lead to any specific support. Salma was never referred to a domestic abuse service while she was in Tower Hamlets, but the Review Panel has considered both community awareness and access to services in the borough. These issues are all discussed in the following section.
- 5.1.12 A final issue is that so-called honour-based violence may have been relevant. However, in the absence of information from Omar and given that no concerns

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<sup>74</sup> The Home Office Quality Assurance Panel suggested that more could have been done to consider the cultural environment in which Salma lived and the cultural issues that could have impacted her ability to ask for help. The follow text has been added to section 5.1 to bring together the Review Panel's discussions in relation to these issues.

<sup>75</sup> Gangoli, G., Bates, L. and Hester, M. (2020) What does justice mean to black and minority ethnic (BME) victims/survivors of gender-based violence? *Journal of Ethnic and Migration Studies* 46(15), pp. 3119–3135.

about so-called honour-based violence were identified by agencies at the time, it has not been possible to explore this further.

## 5.2 Analysis of Agency Involvement

5.2.1 Given the complexity of this case, the analysis is presented thematically, considering:

- Health providers;
- Children's Social Care and Early Help, Primary School;
- Housing; and
- The MPS.

5.2.2 For each agency, key issues are discussed, with what they knew about the family residence and their response to language barriers included in the narrative but also represented visually. While single agency recommendations are noted as appropriate in relation to family residence and language barriers, an overarching discussion of these issues across all agencies is included in section 5.3.

### Health providers

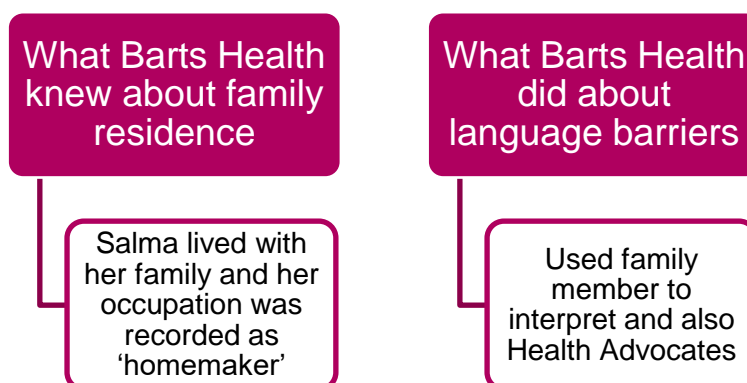
#### *Barts Health NHS Trust*

5.2.3 Salma was known to Barts Health NHS Trust from 2011-2014, including for midwifery and health visiting services. During the course of the DHR, this contact was reviewed and there were no disclosures or concerns identified relating to domestic violence and abuse.

5.2.4 In relation to her maternity care, in 2013 Salma was asked about domestic abuse and it was recorded that she answered in the negative. It was also recorded that she was accompanied by a family member who was translating. It not clear if Salma was asked about domestic abuse on her own.

5.2.5 Salma was seen regularly when she was pregnant with Child B and C, and subsequently after their birth and stay at hospital, with these interactions being clinically appropriate. It is recorded that Salma was accompanied to several appointments by her 'sister' and 'cousin'. As in the original booking appointment, it is reasonable to assume that these family members provided interpretation although in some contacts Health Advocates were used. There are no entries to suggest Salma ever attended with Omar.

- 5.2.6 Child B and C were subsequently delivered at Whittington Hospital.<sup>76</sup> Contact with Salma in relation to health visiting is summarised in analysis relating to THGPCG below.
- 5.2.7 Barts Health NHS Trust also had some contact with Omar (regarding an unrelated health condition). No concerns were identified.
- 5.2.8 Health Advocates is the term used to describe interpreters. While it is positive that Barts Health NHS Trust used Health Advocates in some contacts, this was not consistent with family members also being used. The presence and use of family members at appointments is an issue that has been identified for a number of agencies, including Barts Health, and this is therefore discussed in 5.3 below. However, in response to this learning, the Barts Health IMR made the following recommendation which was accepted by the Review Panel:
- “Health Advocates should be used for all pregnancy appointments, particularly the booking appointment”.*
- 5.2.9 The Review Panel also noted the information known to Barts Health NHS Trust about family residence and agency practice in relation to language barriers.



### THGPCG

- 5.2.10 As noted in the chronology, THGPCG were not responsible for the health visiting service until 2016, with this previously been provided by Tower Hamlets Primary Care Trust until 2011 and then by Barts Health NHS Trust until 2016. However, as THGPCG provided a summary of contact by health visiting services through these organisational changes, this is presented in the following section.
- 5.2.11 There is no evidence that health visiting services were aware of domestic abuse.

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<sup>76</sup> The Whittington Hospital provided a Summary of Engagement but was not asked for further information on the basis that information was known to either maternity or health visiting services, both of which were represented on the Review Panel.

5.2.12 As Child B and C were born prematurely, they should initially have been provided with an enhanced health visiting service (Universal Plus). This would have dictated increased visits, ensuring that all developmental reviews were offered, active follow up to ensure that they were completed, and use of an Enhanced Service Need Template. This could have provided further opportunities to ask about domestic violence and abuse. The children were not closed to the 0-5 service until they reached 5 years of age and were transferred to the 5-19 service.



5.2.13 However, there were missed opportunities for the health visiting service to have discussed domestic violence and abuse with Salma. There were good reasons why this issue was not explored, because Salma was always in the company of a family member (and, on one occasion, Omar). These are detailed in the table below. Additionally, even if Salma had been asked about domestic violence and abuse, this would have had to have been via a family member, as they were routinely used to provide interpretation rather than an interpreter.

Contact	Commentary
Movement in visit on 3 <sup>rd</sup> November 2008 (child's health needs assessment)	<p>No record of domestic violence and abuse being discussed. It is recorded that a family member was present and therefore asking about it would not have been appropriate.</p> <p>No record of a family needs assessment being undertaken. This could have explored her immigration (as she had just arrived in the UK), signposting to local services and an initial increased level of support by the Health Visiting team.</p> <p>In the absence of a further assessment, and no specific concerns about Child A, although not specifically recorded as such, the Health Visiting service only provided the family with a universal service.</p>
New Birth Visit on 10 <sup>th</sup> June 2014	<p>Domestic violence and abuse were not discussed as Omar was present.</p> <p>Possible financial difficulties were noted, no assessment of how these factors impacted on their relationship.</p>
Home visit on the 2 <sup>nd</sup> July 2014	This was another opportunity to ask about domestic violence and abuse, however it is noted that both parents and extended family were present.
Developmental reviews in August 2014 (6-week developmental review) and May 2015 (8-12-month developmental review).	These reviews are an opportunity for Health Visitors to ask about domestic abuse. On both occasions, Salma was with a family member.
Meetings at the child health clinic on 30 <sup>th</sup> July 2014, 13 <sup>th</sup> August 2014 and 10 <sup>th</sup> September 2014	On each occasion Salma is recorded as being accompanied by another family member (aunt/cousin/niece).

5.2.14 The health visiting service were aware of the three different addresses that the family lived at within Tower Hamlets whilst they were supporting them. They were however unaware that the family moved to Newham in 2014 prior to the twins six-week reviews. As a result, appointment letters continued to be sent to the family at a Tower Hamlets address (where they had been living with family). There is evidence that the family received at least one of these letters (the invite for the 8 – 12-month review on 11<sup>th</sup> May 2015). It is not known if they received the two appointments sent for the twins 2-year review on 26<sup>th</sup> May 2016 and 2nd June 2016.

5.2.15 The THGPCP made the following recommendations, which the Review Panel accepted:

*“Ensure that the current development of the organisational domestic abuse policy and on-going training additionally includes:*

- *The need to ask about Domestic Abuse at the initial contact with the Health Visiting Service (antenatal contact, new birth or movement in visit) and providing information about local domestic abuse services irrespective of the response.*
- *The need to ask to see women alone should partners/ family members/ friends be present at the initial visit.*
- *The need to record on EMIS<sup>77</sup> a plan should the above not be possible of how and when it can be asked at a future contact.*
- *The need to look for opportunities to ask about Domestic Abuse at all contacts (especially at key developmental reviews).*
- *Where potential predisposing factors to domestic abuse are identified there is an increased requirement to ask at every contact.*
- *The need to establish, prior to visits, whether an interpreter is required and if so ensure that one is booked and the inappropriateness of using a family member to interpret”.*

*“Ensure that the family health needs assessment includes, but is not limited to:*

- *Establishing immigration status*
- *Recording both parents’ religion*
- *Household finances*
- *Housing status*
- *Bonding / attachment and barriers to this.*

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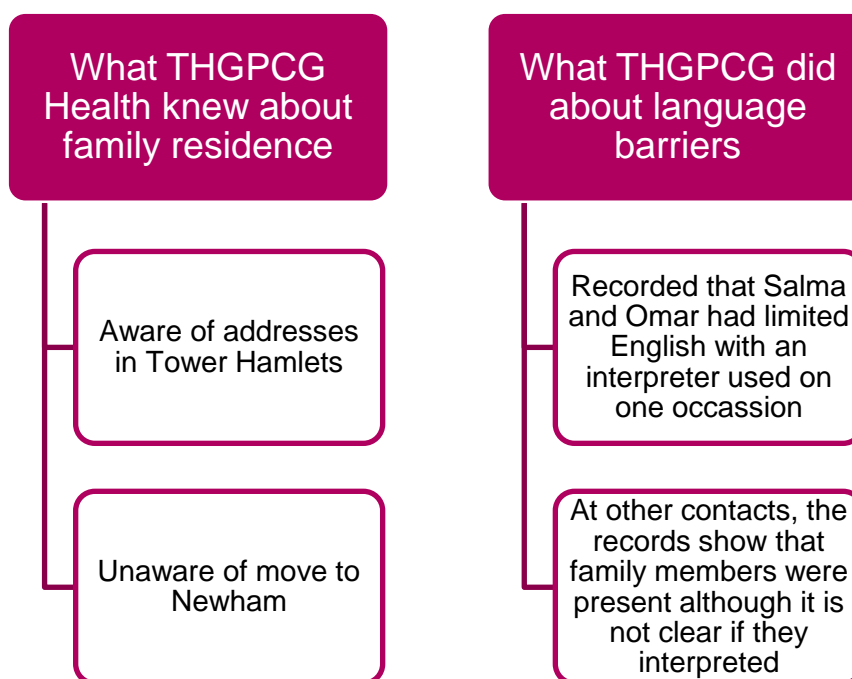
<sup>77</sup> A patient administration system.

- Knowledge of local specialist services as well as the local offer information.
- Assessment of the impact of the above on parental relationships and parenting”.

“Ensure that that it is clearly stated in policy or standard operating procedure (SOP) and staff to be reminded of:

- The need to verify address and contact details at every time the family are seen and EMIS record updated accordingly.
- The need to establish at initial contact whether an interpreter is required and to ensure that only organisationally approved, interpreters are used at planned contacts.
- The need to initially offer a universal plus Health Visiting service following premature delivery and consideration of support via the MECSH programme.
- The expected response to a potential non accidental injury, even if there are no obvious visible injuries”.

5.2.16 The Review Panel also noted the information known to THGPCG about family residence and agency practice in relation to language barriers:



GP

5.2.17 Salma was registered with the practice from 2011. Between then and 2013, Salma was regularly accompanied by a family member who translated for her. Since 2013, she was seen by a regular GP who spoke the same language therefore limiting the need for an interpreter.

- 5.2.18 Salma and Omar (and Child A, B and C) had various contact with the practice between 2017 and 2019. Most of these contacts were for routine medical issues and there were no documented concerns by the practice.
- 5.2.19 Salma had experienced upper back pain since 2012, had also complained of neck and shoulder pain in 2016, and was last seen at the practice on 19<sup>th</sup> December 2017 regarding neck pain. In response to a question asking for clarification about their IMR, the practice confirmed that there was no evidence of trauma associated with these health issue, with routine medical practice identifying possible contributing factors and providing appropriate interventions. As a result, no concerns were identified, while no disclosures were made by Salma.
- 5.2.20 The Review Panel considered whether it would have been appropriate for enquiries about Salma's home life to have been undertaken, including for example the opportunity for targeted enquiring about domestic abuse. In response to a question asking for clarification about the IMR, the practice reported that no information was disclosed by Salma relating to her home life. The practice also noted that in the year prior to Salma's death she had only been seen once by a GP in 2017, and twice in 2016 for neck pain. As a result, the Review Panel accepted that there were no reasons to undertake targeted enquiry. However, the Review Panel considered best practice responses in a GP setting, such as the IRIS project. IRIS is a specialist domestic violence and abuse (DVA) training, support and referral programme for GPs that has been positively evaluated in a randomised controlled trial<sup>78</sup>. In this case, the Review Panel felt that a recommendation was not necessary as, in Tower Hamlets, IRIS is funded by Public Health and the CCG to work with all GPs across the borough and is provided by Victim Support.
- 5.2.21 Omar had some contact in relation to specific health issues and there were no documented concerns by the practice.
- 5.2.22 On 18<sup>th</sup> December 2018, a letter was received from CAMHS summarising their involvement, including the reasons for the referral and Child A's reluctance to engage with CAMHS, However, there were no opportunities to discuss this with Child A, who was not seen at the practice before the homicide.
- 5.2.23 There was contact with Salma and Omar when both Child B and C were seen by a GP in relation to an illness in early January 2019. The Review Panel considered whether this contact could have been an opportunity to discuss the CAMHS referral with Omar and Salma. Clearly, the focus would have been on Child B and C and their care. However, this would have been an opportunity to have a discussion with the Salma and Omar in response to the notification from CAMHS. It also illustrates why, as discussed above, if CAMHS had considered contacting the wider

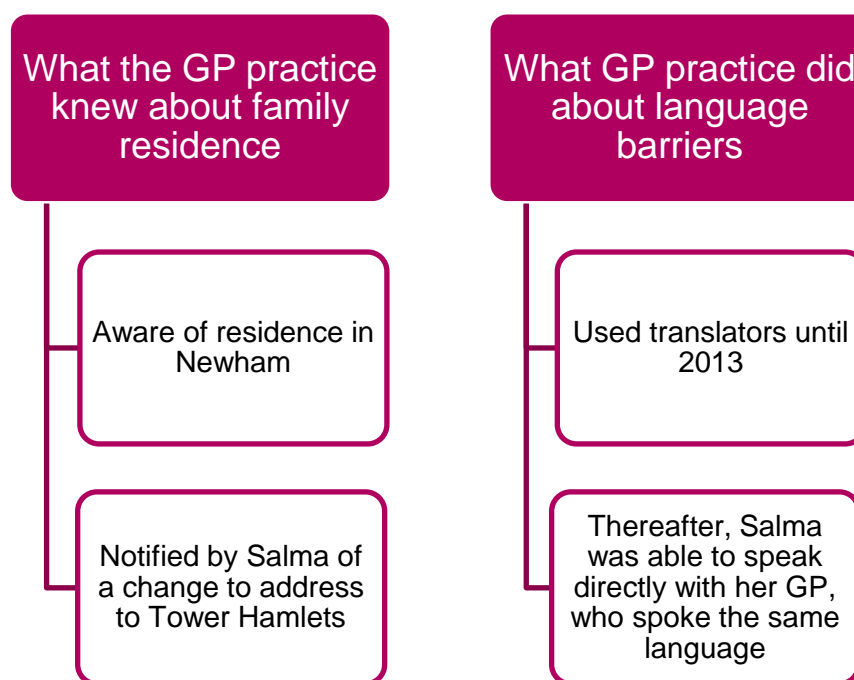
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<sup>78</sup> For more information, go to: <https://irisi.org/iris/about-the-iris-programme/>.

professional network in order to help establish contact with Child A, the GP may have been an importance route to consider.

5.2.24 The practice IMR noted that “*there appeared to be no concerns raised by, Health Visitors, Nursery Nurses and or social services*”. Indeed, the practice appears to have been unaware of the information shared by agencies, e.g. in 2016 or 2018.

5.2.25 The Review Panel also noted the information known to the practice about family residence and agency practice in relation to language barriers:



#### CAMHS – ELFT

5.2.26 CAMHS received a referral from Beckton Primary School in November 2018. This primarily related to concerns about Child A’s behaviour in school and at home. It did not specifically address domestic abuse. By the 19<sup>th</sup> November, Salma and Omar had attended a first appointment.

5.2.27 However, Child A was never seen by CAMHS. This is because they declined to come to sessions. In CAMHS this would normally be understood as ‘was not brought’ by a parent or carer as opposed to ‘did not attend’. This is not unusual: The Review Panel were informed that CAMHS routinely offer work with families and parents without young people being present. This is often the case if a young person chooses not to attend, which is not uncommon when there are concerns around challenging behaviour and conduct problems, or where parents are engaging with a therapeutic parenting intervention.

- 5.2.28 To try and engage with Child A, a translated letter was sent to them, care of Salma and Omar. The Review Panel felt that while a letter may be useful, it should be a supplement to other ways of engaging a child or young person. Taking a more proactive approach would have also been consistent with the CAMHS's own guidance, which is that the professional network should be contacted in order to ensure that all risks are understood and then any actions can be taken. In this case, that would have involved speaking to Child A's Primary School, the Newham Council Children Services or the GP.
- 5.2.29 ELFT has guidance around the risk of assessment that recommends that for a child presenting with violence and aggression there is an assessment of past and current individual/family history of violence. While information was sought from the school, this related primarily to Child's A's behaviour. Domestic abuse concerns had not been shared by the school and this does not appear to have specifically explored, nor was the reference to the NAM meeting followed up (for example, by contacting Newham Council Children Services directly).
- 5.2.30 A positive aspect of CAMHS contact is that the frequency and number of appointments offered were more than would usually be expected for a child that has not been seen. It is not clear why the family were seen in this way, it may have been because the end of year holidays was approaching, a response to the difficulties in engaging them, or an undocumented safeguarding concern. Although this is positive, it would not be unreasonable to expect the professional involved to have recorded a rationale.
- 5.2.31 Furthermore, it does not appear that domestic abuse in the family as a whole was considered. This includes both Child A's experience of domestic abuse in the family home, as well as risk towards Salma and the behaviour of Omar. In particular, it does not appear that the possibility of Child to Parent Violence (CPV) was explicitly considered<sup>79</sup>. This would have been appropriate given the reported violence towards Salma. However, in suggesting the consideration of CPV would have been appropriate, the Review Panel felt that it was important to note this as a possibility and without inappropriately labelling Child A. Critically, considering such a possibility may have led to an exploration of the underlying cause of Child A's behaviour, including domestic violence and abuse in the family home, as well as the recognition that Omar had a "*stricter*" parenting style. However, as domestic abuse concerns had not been shared or disclosed, it is perhaps understandable that this was not immediately explored but it should have been considered.
- 5.2.32 Despite these challenges, while Child A's case was allocated to a team following initial referral it does not appear the case was discussed in MDT or supervision

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<sup>79</sup> Home Office. (2013) Information guide: Adolescent to parent violence and abuse (APVA). Available [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/732573/APVA.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/732573/APVA.pdf) (Accessed: 22nd February 2020).

following assessment. It is not clear from the records whether Child A was allocated to a particular team/pathway or whether an MDT discussion took place following allocation. If this had happened, it may have supported the professional involved in making decisions at these early stages, especially when thinking about past records relating to domestic abuse (although this was a single, scant entry as noted in the chronology), Child A's attendance and (in December) the referral made by the school to the Newham MASH.

- 5.2.33 The following recommendations were made in the CAMHS IMR, which were accepted by the Review Panel:

*"MDT discussions are recorded routinely in clinical records. the CAMHS clinical team leads to review systems to ensure that the outcome of MDT discussions in cases where the parents are reporting that their child is refusing to attend and has never been seen, are included in and inform the action plan".*

*"Tower Hamlets CAMHS leadership team to remind staff of their duties of documenting clinical supervision case discussions on to RIO".*

*"Tower Hamlets CAMHS to continue to communicate care plans verbally and by letter copied to GP directly following families attendance at assessment clinics"*

*"Tower Hamlets CAMHS leadership team to ensure that ELFT Guidelines from risk of violence assessment (appendix 4) are circulated and then made readily available to staff via the intranet".*

*"Tower Hamlets CAMHS clinical leadership to ensure that all staff are aware that in all new assessments, there is a record that past RIO records have been reviewed and relevant action plans taken into account, based on the review of notes".*

*"Tower Hamlets CAMHS to consider routinely checking for past or current involvement with social services at point of referral".*

*"If there is a past history of Social services involvement, for clinical team lead to remind staff on obtaining consent from parents to obtain information relating to Social Services involvement".*

*"Tower Hamlets CAMHS staff to be refreshed on and recirculate NICE guidelines on Conduct Disorders and to consider providing assessment guidance to clinicians for children and adolescents presenting with violence or aggression".*

*"Tower Hamlets CAMHS to consider implementing a pathway for young people presenting with violence or aggression and/or those that are hard to engage, as illustrated by the City and Hackney Conduct and Outreach pathway".*

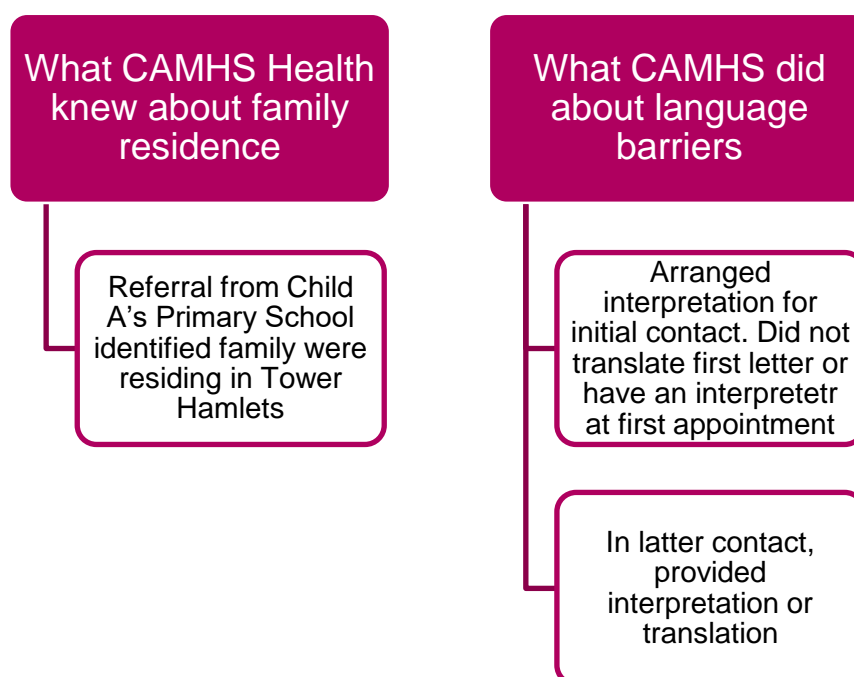
*"Tower Hamlets CAMHS to review systems to ensure that MDT meetings and clinical supervision discussions are clearly recorded in the clinical records".*

*“Tower Hamlets CAMHS to review systems to ensure that interpreting services are booked routinely for initial assessment if referral states that the clients cannot speak English. Giving the patient the option to refuse if not needed”.*

*“Tower Hamlets CAMHS to ensure clinicians are aware of the systems for accessing telephone interpreting services if face to face interpreter is not possible”.*

*“There are clear supervision structures for Tower Hamlets CAMHS clinicians involved in the assessment, management and safeguarding of young people presenting with violence and aggression. Clinical team leads to ensure that clinical discussions in supervision are clearly documented”.*

*“Tower Hamlets CAMHS clinicians are able to access safeguarding and clinical training relating to domestic abuse from a variety of sources. Clinical supervisors to ensure that CAMHS staff are aware of the range of training available”.*



5.2.34

The Review Panel also noted the information known to CAMHS about family residence and agency practice in relation to language barriers:

## Housing

### *Tower Hamlets Housing Options*

5.2.35 In one sense, Tower Hamlets Housing Options discharged their duty to Salma (and Omar), first through temporary accommodation after an approach in 2014, and finalising nominating them to a permanent tenancy provided by Clarion Housing in 2017.

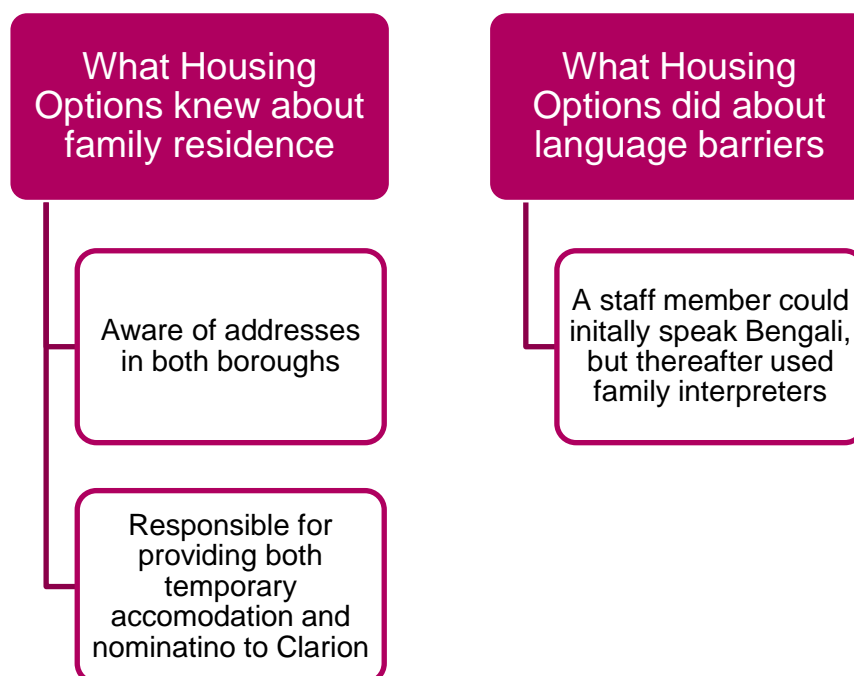


- 5.2.36 However, despite being told by Salma that she had concerns about Omar's gambling, no action was taken to understand her concerns. Although this was not an explicit disclosure of domestic abuse, these were opportunities to explore Salma's concerns about Omar's behaviour, identify economic abuse, and potentially offer earlier signposting and assistance to the family.
- 5.2.37 Additionally, when Salma said she was happy with a joint tenancy in May 2014 this was accepted at face value, despite her having requested on a number of occasions before this that it did not happen. Although it was good practice to speak with Salma separately to explore this with her, the discrepancy between what Salma said and her previous concerns was not considered further. This was compounded by subsequent contact between May and June when Salma and Omar were reminded of their joint responsibility towards the rent and their family, instead of gambling. While this may be factually accurate, it treated Salma and Omar as jointly responsible despite professionals knowing that Salma was concerned about Omar's gambling. This could also have been a barrier to Salma seeking help subsequently and may also have affected her understanding of what agencies would consider as domestic abuse. Additionally, this was a missed opportunity to explore a referral to specialist gambling support for Salma, irrespective of whether Omar was willing to receive help. However, it is worth noting that Salma did feel able to report domestic abuse in 2016.
- 5.2.38 As a result, the Tower Hamlets Housing Options made the following recommendation, which the Review Panel accepted.
- "Clients that disclose any difficulties within a family setting or with partners are interviewed further in an appropriate way to ascertain if there is a need for signposting and/or referrals for assistance."*
- 5.2.39 When Salma made a disclosure in November 2016, the housing officer completed a number of referrals. However, no follow up was made to confirm the outcome of these referrals. This is particularly striking for two reasons:
- Firstly, the referral in November 2016 did not trigger contact with Newham Council Children Social Care until May 2017. When they did not receive a response, the housing officer should have followed up, given the concerns that had been identified around domestic abuse; and
  - Second, it appears that Aanchal informed the housing officer that Salma had declined support. This outcome would have been a further reason to follow up with Newham Council Children Social Care.
- 5.2.40 As a result, the Tower Hamlets Housing Options made the following recommendation, which the Review Panel accepted

*“Referrals made to other professionals in the context of domestic violence and/or safeguarding are followed up to establish what, if any, further action is required from the referring agency.”*

- 5.2.41 It is also of note that when the housing officer was advised by the Newham Council Early Help coordinator to make a referral to Tower Hamlets MASH in June 2017, they did not make a new referral, instead re-using the referral completed for Newham. The Review Panel noted that ideally the appropriate (that is, a new) referral form should have been completed. However, this should not have prevented Tower Hamlets MASH from responding.
- 5.2.42 More significantly, when Salma and Omar were moved into new temporary accommodation in January 2017, Tower Hamlets Housing Options were aware that they had reconciled when they attended the office to sign the paperwork for a new property they had been allocated. At this point it would have been best practice to speak to Salma on her own through an interpreter to determine whether she was in agreement with the reconciliation, however, this did not happen. Contact should also have been made with Newham Council Children Services to follow up on the referral made in November 2016 and to discuss whether Newham were aware of the current situation. Despite Salma’s report in November 2016, no actions were taken to share this information, although in May 2017 when there was contact with Newham Children Social Care via the Early Help coordinator, it was noted that Omar had moved back into the property.
- 5.2.43 The Review Panel has not made a specific recommendation in response to this issue. First, there is an ongoing programme of work around domestic violence and abuse that is discussed below. Second, this is linked to the broader theme of communication between agencies which has been identified during this DHR. This is discussed further in 5.3 below.
- 5.2.44 When Tower Hamlets Housing Options made a nomination to Clarion Housing, they did not share any information about possible risks in the relationship, including the disclosures made by Salma. Recommendations have been made to address this issue, and they are detailed in the discussion of Clarion Housing’s response below.
- 5.2.45 In relation to Tower Hamlets Housing Options, since 2018 there has been a programme of training for new and experienced staff in many areas connected with their work including domestic abuse. This has been in conjunction with the borough’s VAWG Team, who have co-located a member of staff once a week.
- 5.2.46 The Review Panel were informed that housing staff attend a one-day domestic abuse awareness training course which covers the different forms of abuse including financial abuse. Several members of staff have also undertaken further training as VAWG Champions. No formal evaluation has yet been undertaken but informal feedback indicates these measures have raised awareness of domestic abuse among other staff.

- 5.2.47 The borough also has a range of additional domestic abuse courses, including a half day course on ‘domestic abuse disclosures and how to respond’. The intention is that all Housing Options front line staff will attend this course over the next 12 months. Additionally, there is a Domestic Abuse Housing Protocol for their staff (this has not been reviewed as part of the DHR).
- 5.2.48 In 2019 Tower Hamlets Housing Options took the decision to apply for Domestic Abuse Housing Alliance (DAHA) accreditation.<sup>80</sup> This process involves the service scrutinising policies, procedures, case management, training and partnership working. This process has started, with a steering group having been established. The Covid-19 pandemic has had some impact on the timeline for this programme. However, the borough has additionally secured funds for two Housing based IDVAs and a Floating Support Worker who will work with clients placed in temporary accommodation outside the borough who are impacted by domestic abuse. The Review Panel commended the decision to seek DAHA accreditation.



- 5.2.49 The Review Panel also noted the information known to Tower Hamlets Housing Options about family residence and agency practice in relation to language barriers:

### *Clarion Housing*

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<sup>80</sup> DAHA partnership between three agencies: housing associations Peabody (London) and Gentoo (Sunderland), and London-based charity Standing Together Against Domestic Violence. DAHA have established an accreditation standard to provide a UK benchmark for how housing providers should respond to domestic abuse in the UK. For more information, go to: <https://www.dahalliance.org.uk>.

- 5.2.50 Clarion Housing first had contact with Salma and Omar in June 2017, when they came to a viewing of a property which they had been offered by way of a nomination to permanent accommodation by Tower Hamlets Housing Options. Salma and Omar accepted the property and their joint tenancy started on the 3<sup>rd</sup> July 2017.
- 5.2.51 When it received Salma and Omar’s tenancy nomination from Tower Hamlets, Clarion was not notified of any agency concerns, in particular the information that was known to Tower Hamlets Housing Options. As a result, it was not aware of either concerns about Omar’s gambling, or domestic abuse including the disclosures made in November 2016. The sharing of this information would have potentially enabled Clarion Housing to consider the best way to respond, including whether to offer and deliver enhanced tenancy sustainment services, or to seek information from other agencies. As a minimum, it might have meant that housing officers were aware of potential concerns.

Clarion Housing made the following recommendation in its IMR, specifically *“that sharing of recent and wider safeguarding concerns with registered providers of social housing at the tenancy nomination stage would be relevant to its housing management function”*. The Review Panel discussed this. It welcomed this recommendation: information sharing is an important part of the multi-agency response and, in this case, being made aware of these safeguarding concerns may have enabled Clarion Housing to provide targeted support to Salma. In any information sharing process, the Review Panel recognised this would require consistent guidance to ensure such sharing is lawful and proportionate. While Clarion Housing made an IMR recommendation, the Review Panel agreed that this was more appropriately a multi-agency concern.

The Review Panel considered making a recommendation but were informed that another DHR has already identified learning relating to this issue. The other DHR (as yet unpublished but concerning ‘Zahra’) recommended that:

*“Housing Options to review the information contained on nominations to Registered Providers of social housing that include reference to previous safeguarding concerns and/or interventions that can serve to inform and result in the provision of internal tenancy sustainment measures at the start of a tenancy”*.

As a result, the Review Panel agreed not to make a recommendation on this issue locally but felt that this raised important national learning.

**Recommendation 3: The Ministry of Housing, Communities and Local Government (MHCLG) to review the learning from this case and issue**

**appropriate guidance nationally to ensure housing providers can be informed of safeguarding concerns at the tenancy nomination stage.**

- 5.2.52 As Clarion Housing had not been informed of any concerns, staff were therefore dependent on relevant information being shared by Salma and Omar or identifying safeguarding concerns during their interactions with them. This highlights the importance of both initial contact with new tenants and then subsequent interactions.
- 5.2.53 During the sign-up process for the new tenancy, information is collected from tenants, checks are undertaken, and staff also explain the tenant's contractual obligations. Additionally, this is an opportunity to ask tenants about any support needs and also discuss issues like Anti-Social Behaviour. However, there is no information provided to new tenants about domestic abuse (including what it is, as well as the help and support that is available) as part of this process.

Domestic abuse is everyone's business. By routinely providing information on domestic abuse, more victims/survivors will be in a position to identify their experiences and may feel about making a disclosure and seek help.

**Recommendation 4: Clarion Housing to review its new tenancy starter information to include information on domestic violence and abuse.**

- 5.2.54 In their subsequent contact with Salma and Omar over rent arrears, Clarion Housing issued a Notice of Seeking Possession on the 3<sup>rd</sup> August 2017. This is standard practice where there are rent arrears, however it was accompanied with a referral to an internal Welfare Benefits team to support Salma and Omar to manage the arrears. This intervention was successful and, having secured Housing Benefits payments, over the following year the arrears were largely paid off and no further action was taken.
- 5.2.55 All Social Housing providers are required to adhere to a Pre-Action Protocol in respect of possession claims for rent arrears.<sup>81</sup> Clarion Housing uses an internal checklist for compliance against the Pre-Action Protocol. This is included as **Appendix 3**. In both cases, there is a reference to 'vulnerability', but no explicit consideration is given to domestic violence and abuse.

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<sup>81</sup> This protocol applies to residential possession claims in England and Wales brought by social landlords (such as local authorities and housing associations). For more information, go to: <https://www.justice.gov.uk/courts/procedure-rules/civil/protocol/pre-action-protocol-for-possession-claims-by-social-landlords>.

Domestic abuse is everyone's business. Ensuring that domestic abuse is recognised in procedure and policy will assist staff in considering domestic abuse and, where appropriate, providing information to victims/survivors, thereby creating potential opportunities to disclose.

**Recommendation 5: Clarion Housing to review its internal checklist for compliance against the Pre-Action protocol to explicitly address domestic violence and abuse.**

**Recommendation 6: The Ministry of Justice to consider the learning from this case and review and / or issue appropriate guidance nationally to ensure consideration of domestic violence and abuse in the Pre-Action Protocol.**

- 5.2.56 There is a good evidence base that, in addition to the human cost, there are costs to housing providers because of domestic abuse. These can include costs relating to housing damage, property management and enforcement. This can also include the cost of evictions.<sup>82</sup> It is therefore vital that housing providers have a robust response to domestic violence and abuse.
- 5.2.57 Clarion Housing reported that since November 2019, a new Customer Relationship Management (CRM) system has been in place. This means all Customer Accounts Specialists are required to enquire if a resident considers themselves to be vulnerable. The questions asked will vary depending on the nature of the contact. For example, during a home visit, an assessment is made on the condition/upkeep of the property and if there are any safeguarding concerns (i.e. signs of self-neglect). In these circumstances, residents would be asked, "*Do you feel like you might be at risk of harm from other people?*" and if they feel safe at their home.
- 5.2.58 If any indication of a vulnerability is provided, Clarion's Customer Accounts Specialists automatically refer the customer to Clarion's internal Tenancy Sustainment Team. (The staff are also trained to raise an internal alert in the event that a safeguarding concern is identified). Under this new way of working, Tenancy Sustainment teams are required to ask mandatory questions regarding the tenant's vulnerability, which lead to specific questions around whether the tenant is being subjected to domestic abuse.
- 5.2.59 Clarion staff receive mandatory safeguarding training. A new domestic abuse training module is being designed and will be rolled out to customer facing teams

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<sup>82</sup> Safelives (2017) *Safe at home: Homelessness and domestic abuse*. [Online]. Available at: [https://safelives.org.uk/sites/default/files/resources/Safe\\_at\\_home\\_Spotlight\\_web.pdf](https://safelives.org.uk/sites/default/files/resources/Safe_at_home_Spotlight_web.pdf) (Accessed: 22nd February 2020).

during 2020/21. Clarion Housing also has a Domestic Abuse Policy (although this was not reviewed as part of the DHR).

- 5.2.60 As part of the DHR, the Review Panel sought information from Clarion Housing as to the number of disclosures of domestic violence and abuse that had been made since this new process was introduced. Between the roll out of the new CRM in November 2019 and June 2020, Clarion Housing confirmed that 414 disclosures have been made nationally (Clarion Housing's stock includes 125,000 homes across over 170 local authorities), of which 10 were in its Tower Hamlets housing stock (from almost 6,000 homes). While these disclosures are positive, and the Review Panel recognised that this is a relatively new process, it noted that the level of reporting in Tower Hamlets is less than the national average when considered against the volume of disclosures between November 2019-June 2020.
- 5.2.61 Clarion Housing has begun reviewing and internally benchmarking itself against the DAHA accreditation standards. This work has included an initial GAP analysis<sup>83</sup> against the DAHA accreditation standards. This was completed in October 2018, and it was agreed that Clarion Housing would immediately sign up to the 'Make A Stand' Pledge. The pledge was launched by the Chartered Institute of Housing and was designed to be a commitment to support people experiencing domestic abuse. By signing the pledge, organisations committed to achieving the following: having a domestic abuse policy; making information available about national domestic abuse support services so it is easily accessible for residents and staff; having a policy to support members of staff who may be experiencing domestic abuse; and appointing a champion at a senior level in the organisation to own the domestic abuse agenda.<sup>84</sup> There was a small delay in ensuring policy changes were implemented (specifically, having a policy to support members of staff who may be experiencing domestic abuse) with pledge commitments being met in February 2019.
- 5.2.62 The GAP analysis has been regularly refreshed since that point, most recently in May 2020. This has fed into a range of activities, including those described above, which the Review Panel felt was positive.
- 5.2.63 The Review Panel acknowledges that there was no direct opportunity for Clarion to have identified or responded to domestic abuse in this case, because it was unaware of the concerns about domestic abuse as this information was not shared by Tower Hamlets Housing Options and no disclosures were made by Salma. Additionally, the Review Panel acknowledge the ongoing work around domestic abuse. However, it felt that in light of the issues identified here that it was essential that further work was prioritised.

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<sup>83</sup> A GAP analysis involves the comparison of actual performance with potential or desired performance.

<sup>84</sup> For more information, go to: <http://www.cih.org/resources/PDF/1Makeastand%20pledge%20FINAL.pdf>.

- 5.2.64 Additionally, this is the second DHR locally that has identified learning relating to Clarion Housing. The other DHR concerning 'Zahra' is as yet unpublished, but it identified issues in relation to the accumulation of rent arrears and also discussed the use of the Pre-Action Checklist (although it identified good practice by Clarion, albeit while also noting areas for further development). To reflect the learning in that DHR, a recommendation was made for all social housing providers:

*"In reference to rent arrears management, Registered Providers of Social Housing should consider the 'Whole Housing Toolkit' and Domestic Abuse Housing Alliance (DAHA) accreditation to improve their responses to victims of domestic abuse, in particular to highlight possible indicators of financial/domestic abuse and improve awareness of the support available"*

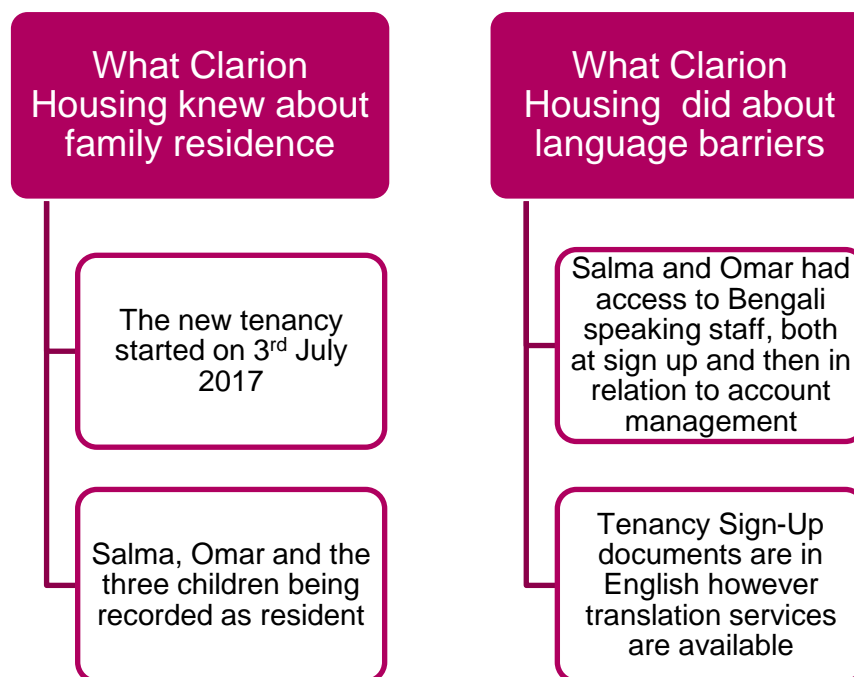
- 5.2.65 Given this general recommendation that has been made for housing providers, the Review Panel restricted its consideration to Clarion Housing alone, given its involvement in this case. The Review Panel was unclear why Clarion Housing would use DAHA's standards to conduct internal benchmarking but would not then seek to secure accreditation given DAHA is currently the only national accreditation framework for housing providers. As part of this discussion, the Clarion Housing representative explained that, based on the above GAP analysis, Clarion Housing has decided to defer a decision about whether to seek DAHA accreditation until the conclusion of restructure during 2020/21. Additionally, while the DAHA accreditation standard has helped the organisation develop its work in this area, a key challenge is applying the accreditation framework to an organisation of Clarion Housing's size. The Review Panel felt that, while this was clearly an issue that will need to be worked through by both Clarion Housing and DAHA and a recommendation as a result be made.

It is important that housing providers have a robust response to domestic violence and abuse and participating in a national accreditation framework will help deliver this. If there are barriers to the current accreditation framework, these should be addressed.

**Recommendation 7: Clarion Housing to work with DAHA to address its concerns around the current accreditation framework in order to assist its decision in relation to accreditation at the conclusion of its restructure during 2020/21.**

- 5.2.66 The Review Panel also noted the information known to Clarion Housing about family residence and agency practice in relation to language barriers:





Children’s Social Care and Early Help

*Newham Children’s Social Care and Early Help Service - MASH*

- 5.2.67 There were six referrals to Newham MASH during the time that the family resided within the borough.
- 5.2.68 The first two contacts (triggered by police incidents) led to no further action:

Contact	Commentary
The first MASH referral was made by the MPS, following an incident on the 9 <sup>th</sup> June 2016. As Salma insisted this was an argument, and made no allegations, no further action was taken by the MPS. The MASH graded this as ‘level 1’ as a result of the absence of allegations or police action (i.e. ‘Blue’).	This decision appears problematic. When talking to police officers, Salma had disclosed daily and escalating arguments, controlling behaviour and the past use of weapons.
The second MASH referral was made by the MPS, following an incident on the 9 <sup>th</sup> September 2016. Again, the MASH graded this as ‘level 1’ in the absence of allegations (i.e. ‘Blue’).	This decision appears problematic. When talking to police officers, Salma had disclosed being scared as a result of arguments (although she said they happened less often than during her contact with the MPS in June, saying they were “ <i>every now and again</i> ”) and that Omar was jealous.

- 5.2.69 In both cases, it appears that the MASH focused on an assessment of the actions of the MPS (whether a crime was recorded, or action taken) rather than considering the substantive information in the referral.
- 5.2.70 The third contact, triggered by an MPS referral following the incident on the 29<sup>th</sup> October 2016, led to an Early Help referral as it was assessed as 'Level 2a' ('Green'). However, Salma's disclosures (of abuse, including sexual assault) should have been considered more fully even though these were later retracted. The service's IMR suggested the family's vulnerability in relation to domestic violence may have been overlooked (for example, as a result of cultural and gender factors, temporary separation from Omar, language barriers, Salma minimising the seriousness of incidents, and withdrawing her consent for support and prosecution of the perpetrator).
- 5.2.71 Critically, regardless of the decisions taken in the MASH, this was the third incident in less than six months. Therefore, a MARAC referral could have been considered (something that has also been identified for the MPS and which is discussed further below).
- 5.2.72 Newham Council Children Services were asked to consider this referral again as part of the DHR. It identified:
- Only a manager's comment / rationale about the incident and brief reason for progressing the case to Families First is available; and
  - There is no record of a risk assessment.
- 5.2.73 As part of the DHR, Newham Council Children Services were asked to consider this referral again as part of the DHR. Depending on the outcome of a risk assessment, this could have led to a higher risk assessment, i.e. 'level 3' ('Amber') and therefore a statutory intervention.
- 5.2.74 The fourth contact, triggered by a referral from Tower Hamlets Housing Options, on the 23<sup>rd</sup> November 2016 does not appear to have led to timely action, given there was no contact with the referrer until May 2017. It has not been possible to establish why this delay occurred. When it was finally considered, it was assessed as 'Level 1b' (Green), with the family to be offered 'Universal Early Help' (a targeted early help provided by universal/community agencies).
- 5.2.75 As part of the DHR, Newham Council Children Services were asked to consider this referral again as part of the DHR. Again, there was no record of a risk assessment and current practice would have required this, including contact with Salma and other agencies. Depending on the outcome of this risk assessment, this could have led to a higher risk assessment, i.e. 'level 3' ('Amber') and therefore a statutory intervention. It was noted that there was a high chance that this threshold would have been met based on the information available.

- 5.2.76 The fifth contact, triggered by a referral from the Child A's Primary School on the 13<sup>th</sup> October 2017, was also assessed as 'level 2' (Green) and signposted to Early Help. Depending on the findings, this case could have progressed to statutory intervention.
- 5.2.77 It is unclear why, given the family were residing in Tower Hamlets at this point, this was not referred to Tower Hamlet MASH.
- 5.2.78 The sixth contact, in December 2018, a referral from the Child A's Primary School, was not assessed. This was because it was confirmed that Salma and Omar were resident in Tower Hamlets and Child A's Primary School was advised to make a MASH referral there.
- 5.2.79 The Newham Children's Social Care and Early Help Service identified a number of recommendations, which are detailed below. Additionally, assurances were provided as to current practice. Specifically, this would include a risk assessment, including an attempt to speak with Salma (including undertaking a DASH RIC) or other agencies, as well as an exploration of Salma's decision to move to a safe place (including her capacity to sustain this).

*Newham Children's Social Care and Early Help Service – Early Help*

- 5.2.80 Referrals to the Newham MASH on 29<sup>th</sup> October 2016 and 13<sup>th</sup> October 2017 led to onward referrals to Early Help.
- 5.2.81 In 2016, the Families First coach first met with Salma on the 25<sup>th</sup> November. The Families First coach made attempts to liaise with the school, domestic abuse support services, and family members. However, there are a number of issues with this contact:
- While the Families First coach made attempts to contact the housing management agency on two occasions, Salma's concern about the security of her home in October 2016 were never resolved;
  - The referral to specialist domestic abuse services (provided at the time by Aanchal) was never completed. This included confirming whether Aanchal had indeed spoken with Salma's cousin and addressing the confusion with Aanchal over client details;
  - Salma's statement that an injunction was in place was accepted at face value (this was not explored. No agency has any evidence that an injunction was indeed in place. At the time, Omar was on bail, and it is possible that Salma had confused these two different things); and
  - No support was offered to Omar in regard to his gambling addiction and abuse.
- 5.2.82 When the case was closed on 20<sup>th</sup> December, responsibility for monitoring issues around attendance and behaviour and escalating any safeguarding concerns was passed to Child A's Primary School. Although the correspondence with Child A's

Primary School mentions that safeguarding concerns should be escalated it does not specifically mention the domestic abuse previously experienced by Salma.

5.2.83 In 2017, in addition to being referred to Families First, the family were discussed at the Neighbourhood Action Meeting (NAM). While this meant that a number of agencies were involved, there were gaps in determining whether key actions agreed at the NAM had been completed. It is possible that actions may have been conducted by agencies but not recorded or shared between professionals in a timely manner, or alternatively were not completed at all. Most problematically:

- It is unclear what actions were taken around domestic abuse. For example, on the 8th June 2017, it was agreed at the NAM that Child A's Primary School would make a referral to Aanchal. It is unclear if this happened; and
- On the 6<sup>th</sup> July 2017, when the NAM discussed the outcome of a home visit, Salma was reported as saying that there had been no more incidents and she was happy to get support. However, it does not appear that this information was cross referred with previous issues with referral to / engagement with Aanchal.

5.2.84 Once it was confirmed the family were moving to Tower Hamlets, the case was closed to NAM in July 2017 after it was ascertained the family were residing or were about to move to Tower Hamlets. However, it does not appear a referral was ever made, with a reliance instead on the original referrer (Tower Hamlets Housing Options) doing this, and the assumption that having discussed the case with Tower Hamlets MASH the family would receive ongoing support in Tower Hamlets.

5.2.85 The NAM ceased operating back in July 2019 and the Early Help Support Co-ordination Panel (EHSCP) was developed and introduced in its place, commencing in January 2020. The panel consists of representatives from across service areas such as children's social care, 0-19 community health, early help, behaviour and attendance service, school nursing, police, domestic violence support services, substance misuse, 0-25 disabilities team, children's centres and housing. The purpose of this panel is to be responsible for ensuring the co-ordination of services to families engaged under universal services where one of the following applies:

- More targeted support is required with input from other agencies;
- Progress with the family is 'stuck' and multi-agency input and advice is required;
- There is an identified need but no obvious lead agency; and

They will ensure that families have access to the right support, from the right service at the right time to prevent escalation in need and entry to statutory services.

5.2.86 Schools and partner agencies have the opportunity to present families that they have concerns about to receive support and further guidance around an appropriate lead agency. This EHSCP is reported to enable greater partnership

involvement and representation from a range of agencies, including specialist domestic abuse services. This reduces information lag and allows for a more responsive service.

- 5.2.87 The Newham Children's Social Care and Early Help IMR made the following recommendations, which the Review Panel accepted:

*"SafeLives Risk Assessment should be completed routinely in domestic violence cases and consideration taken of types of abuse outlined in the Power and Control Wheel".*

*"Training in these tools, general training in Domestic Abuse and MARAC refresher training should be provided for Practitioners".*

*"Risk assessments should clearly identify triggers which would indicate a change in the level of risk and the assessment should be reviewed at these points. Evidence clearly indicates relationship breakdown, reconciliation, pregnancy and major life events such as bereavements as trigger points, but assessments should be individual to each case".*

*"Practitioners working with families where domestic abuse is a factor should ensure they take into consideration any support that could be offered to the perpetrator to address contributing factors such as substance misuse, worklessness and gambling however it should be taken into account that perpetrator work in relation to violence itself is specialist and may require referral to a specialist agency".*

*"Interpreters/Translators should complete domestic abuse awareness training".*

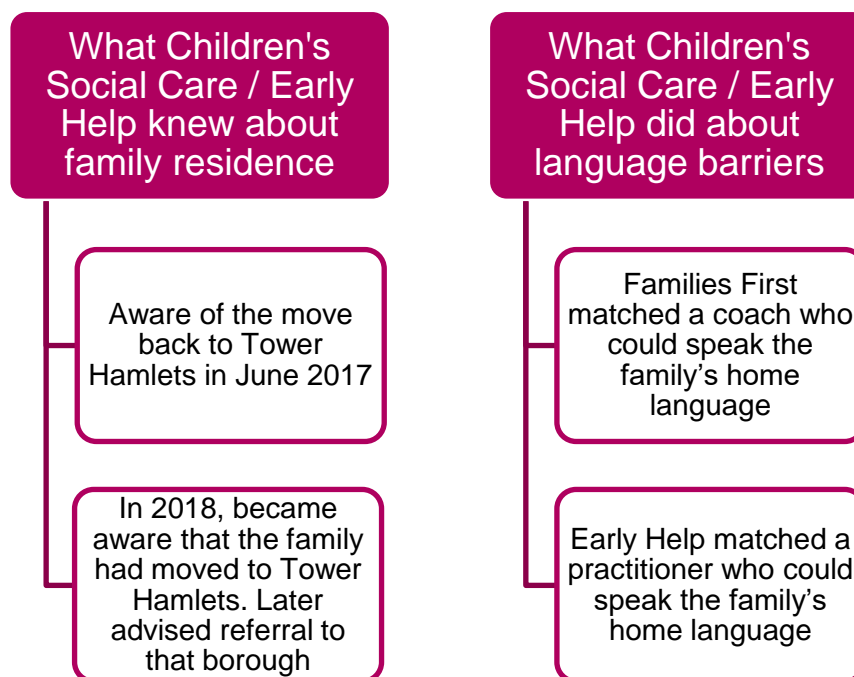
*"Referrals should be made to Domestic Violence Support Services at the point of contact with the local authority or other agencies (already in place)".*

*"System Connectivity should be explored and there should be more information sharing between Local Authorities and Commissioned Providers (i.e. Hestia) so that we know if DV services are actively working with a family".*

*"Consideration should be given to reviewing Information Sharing Protocols in the light of this IMR".*

*"Protocols for information sharing when families relocate out of borough should be reviewed and / or developed".*

- 5.2.88 The Review Panel also noted the information known to Newham Children's Social Care and Early Help about family residence and agency practice in relation to language barriers:



#### *Tower Hamlets Children Social Care - MASH*

- 5.2.89 Tower Hamlets Children Social Care had no direct contact with Salma or Omar.
- 5.2.90 In July 2017, Tower Hamlets MASH were made aware that the family had moved back to Tower Hamlets. However, this was as a result of communication between agencies and not a formal referral. As a result, it does not appear any action was taken.
- 5.2.91 The Tower Hamlets MASH also received a single referral from Beckton Primary School on the 13<sup>th</sup> December 2018. This was assessed promptly. However, in the referral there was no reference to domestic abuse, with the case information focusing on Child A's behaviour in school. When the Duty Social Worker spoke to Beckton Primary School and CAMHS, this was also the focus of the discussion and the history of domestic abuse was not flagged (the former was aware of this, the latter were not).
- 5.2.92 Checks were not completed with Newham Council Children Services. The Review Panel discussed whether Tower Hamlets should have done so. The Tower Hamlets Children Social Care representative acknowledged that contact with Newham CSC should have happened at the point the referral in December 2018. However, it was noted that the school referral did not include any information to suggest that the family had resided in Newham previously and therefore the officer who undertook the checks with the school (and CAMHS), might not have considered it necessary to do this as none of the contact with school or CAMHS indicated that the family had resided elsewhere. Nonetheless, the Tower Hamlets Children Social Care IMR

reported that if the referral had led to an assessment, then a housing check would have been completed, on the basis that the family were living in Tower Hamlets, but the child was attending school in Newham.

5.2.93 The Review Panel considered whether to make a recommendation on this issue but decided not to, on the basis that the checks with Newham Council Children Services should have happened and a key issue was the lack of information about domestic violence and abuse and / or the issue of cross border moves. These issues reflect the broader learning from this DHR and are discussed in 5.3 below.

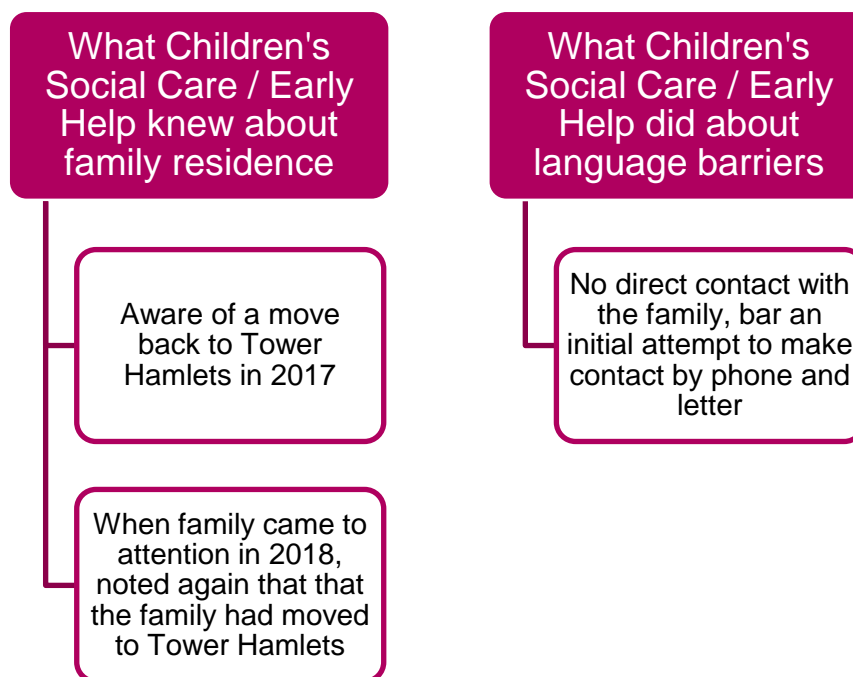
5.2.94 The Tower Hamlets Children Social Care IMR states that the MASH decision to signpost to Early Help was proportionate and appropriate. However, it noted that because of the nature of the referral (Beckton Primary School had not included whether either Salma or Omar had consented to the referral), consent was required. As a result, the IMR made the following recommendation, which was accepted by the Review Panel:

*“For consideration to be given to how consent is gained from families when a referral is being made (to whatever service) for a broad range of services, including CSC, to be offered to them”.*

5.2.95 Early Help tried to make contact with the parents to seek their consent for the referral to their service, trying both phone calls and then a letter. These were in English.

5.2.96 In Tower Hamlets the LSCB (Local Safeguarding Children’s Board) which is presently transitioning to THSCP (Tower Hamlets Safeguarding Children’s Partnership) will be fully operational by March 2020. The LSCB has previously issued domestic abuse guidance, and this is being reviewed and updated following a Domestic Abuse Summit in November 2019. This is positive, although the content has not been revised as part of this DHR.

5.2.97 The Review Panel also noted the information known to Tower Hamlets Children’s Social Care and Early Help about family residence and agency practice in relation to language barriers:



#### *Child A's Primary School*

5.2.98 Child A's Primary School had had contact with Salma and Omar, although this was most regularly with Omar. The school reported having a good relationship with both and following the meetings that took place at school with the parents, (in house) interpreters were used for all appointments.

5.2.99 There was communication between Child A's Primary School and Early Help in 2016 and 2017. It is unclear whether some of the actions that were agreed via the NAM – which were assigned to the school – were completed. No recommendations are made here, as the issues with the NAM have been discussed above.

5.2.100 Additionally, North Becton Primary School had contacted CAMHS, Newham MASH and, toward the end of 2018, with Tower Hamlets MASH.

5.2.101 Broadly, this communication was appropriate and related to concerns about Child A. However, the Review Panel has identified two issues:

- First, there was a lack of clarity about domestic abuse concerns, with the focus on Child A's behaviour;
- Second, when raising safeguarding concerns, the school approached the borough in which it operated (Newham) rather than the borough where the family were resident (Tower Hamlets), until directed to refer to the latter by the former.

5.2.102 In response, Child A's Primary School made the following recommendations, which will help it develop staff awareness of domestic violence and abuse and ensure that there is a continued focus on healthy relationship in a school setting. These were accepted by the Review Panel:

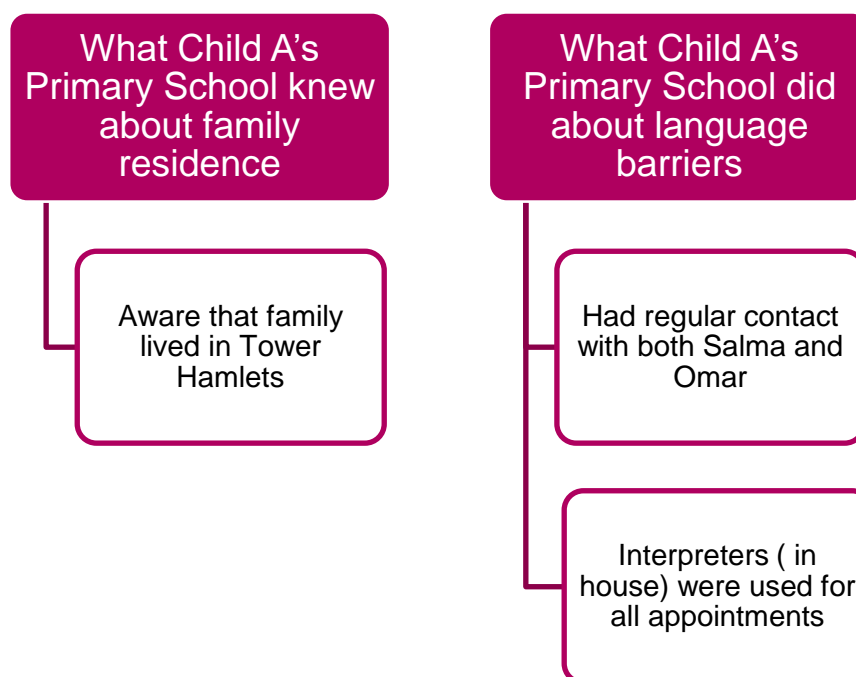


*Children to understand what a positive relationship looks like through P4C/PHSCE and Bounce back days or Headstart Champions sessions”.*

*“Safeguarding team to attend training on Domestic Violence”.*

*“Safeguarding team to provide training for the all staff members in relations to Domestic Violence”*

5.2.103 The Review Panel have not made any further recommendation in response to these issues because they are an example of the issues with the broader theme of communication between agencies which has been identified in this DHR.<sup>85</sup> This is disused further in 5.3 below.



5.2.104

The Review Panel also noted the information known to Child A's Primary School about family residence and agency practice in relation to language barriers:

### *MPS*

5.2.105 The MPS were aware of three reports of domestic abuse, in June, September and October 2016. The Review Panel discussed this contact in relation to the response to the identification of domestic abuse and identified a number of issues.

5.2.106 The first issue relates to the incidents in June and September 2016.

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<sup>85</sup> The Home Office Quality Assurance Panel suggested that the DHR should consider Operation Encompass. However, as this programme started in Newham in January 2019, the Review Panel felt it was out of scope to consider this further.

- 5.2.107 In the June incident, although Salma had disclosed arguments, controlling behaviour and the past use of weapons, she did not make any allegations. As a result, the investigation was closed. In response to her disclosures, IIO graded the initial risk assessment as 'medium'. However, because Salma had stated that she was going to take the children and stay with her brother, a supervisor subsequently regraded the risk as 'standard'. Yet, when Salma was spoken to the next day (when the investigation was reviewed by the Newham CSU) she reported she had moved back home.
- 5.2.108 The Review Panel felt that the decision to downgrade the IIO's risk assessment to standard was problematic. This assumed that (a) Salma would remain with her brother and (b) only took account of Salma's actions and did not consider what Omar might do in response.
- 5.2.109 It is concerning that an action by a victim to remove themselves to a place of safety (in this case, to stay with a family member) could be interpreted as a reason for the overall risk assessment being downgraded particularly when, as was evident in this case, that action is only short term.
- 5.2.110 What is even more problematic is that during the course of the investigation police officers became aware that Salma had returned to the family home. If the MPS is to allow that the assessment of risk is dynamic, thereby allowing risk levels to be downgraded, this also implies it should have a similar approach to the potential increase in risk. In this case, Salma's return home should have triggered a re-assessment of the risk.
- 5.2.111 Similarly, in the September incident, although Salma said it had been an argument, she again made significant disclosures (she said she was scared as a result of arguments, although she said they happened less often than during her contact with the MPS in June, saying they were "*every now and again*") and that Omar was jealous. This incident was rated as standard risk.
- 5.2.112 Research has identified that police officers can focus on physical violence at the expense of other behaviours, including coercion and control, or patterns of behaviour.<sup>86</sup> While taken alone these individual incidents may not have been sufficient to identify coercion and control (which may have been relevant, given an offence of coercive control had been introduced in law in December 2015), this is an important reflection in relation to the nature of risk assessment.
- 5.2.113 This is also relevant in considering the third incident in October, by which time the level of violence and abuse in the relationship had become starkly apparent. If this should have triggered a referral to the local MARAC is explored further below.

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<sup>86</sup> Myhill, A., & Hohl, K. (2019). The "Golden Thread": Coercive Control and Risk Assessment for Domestic Violence. *Journal of Interpersonal Violence*, 34(21–22), 4477–4497.

- 5.2.114 The MPS's current policy includes the review of risk by a supervisor prior to closure and this should include the consideration of changes in circumstances (for example, it states: "*Review all investigations prior to closure for missed opportunities for detections and to ensure that victim safety matters have been addressed*").

It is important that risk is contextualised, taking account of both a victim's and a perpetrator's actions over time.

**Recommendation 8: The MPS to remind police officers of the importance of reviewing the risk of domestic abuse cases when changes to circumstances occur to order to identify, as illustrated in this case, the possibility of increased risk.**

- 5.2.115 The second issue relates to the October 2016 incident. When Salma made detailed disclosures during the VRI, the SOIT officer should have created new reports documenting fully the further allegations in line with National Crime Reporting Standards. This was not a deliberate omission but a mistaken assumption that a separate domestic abuse report had been completed by the IIO at the time of the incident. When the SOIT officer identified that no domestic abuse report had been made, they attempted to rectify this by making a request to the IIO to complete a report. However, this was not done until December 2016. In short, the recording was not timely.
- 5.2.116 Taken together, the result was a disconnect between the domestic abuse and sexual assault elements of the same report, as well as a lack of communication between the Sapphire Team and the Newham CSU. This meant that Salma's report was not considered in the round. For example, when the CSU reviewed the report, they were unaware that Salma had made further assault allegations and had stated that she had not been truthful with the police when they attended incidents in June and September 2016. The Newham CSU also assumed that the Sapphire Team were managing all the risks, which was not the case. Conversely, there was a missed opportunity for the SOIT officer to contact the CSU directly and highlight the physical abuse which had not been correctly reported or investigated.
- 5.2.117 Moreover, because Salma had said she had not been truthful about the June and September 2016 incidents, the MPS IMR noted that both investigations should have been updated, reopened and further investigated.
- 5.2.118 In response to this, the MPS IMR included the following recommendation, which was accepted by the Review Panel:

*“It is recommended that North East Basic Command Unit (BCU) Senior Leadership Team (SLT) remind all staff of the requirements of the National Crime Reporting Standards, with regards to prompt reporting of the allegations of crime”.*

5.2.119 In preparing the MPS IMR, the IMR author interviewed the SOIT officer and their supervisor. This interview highlighted a number of issues:

- The SOIT officer had supported in excess of 60 victims during two and a half years in post;
- At times they had become frustrated with the criminal justice system and the way in which some victims were treated by the courts. At times they felt as if they could not always switch off their emotions;
- They remember discussing a Haven referral with Salma, and attempting to contact her, but could not be sure these were always documented. They expected any errors to be picked up in supervision;
- That they tended to record their activities in their SOIT log, rather than the CRIS system that other officers (such as the Newham CSU) would have accessed.

5.2.120 Given these reflections, the Review Panel felt further consideration was appropriate both in terms of staff welfare and also recording.

5.2.121 Regarding *welfare*, the SOIT officer’s supervisor confirmed that towards the end of the police officer’s time as a SOIT they were suffering what they referred to as compassion fatigue and as a result, they had relocated to a different role.

5.2.122 It is of course not possible for the Review Panel to connect the issues identified in this case directly to the broader issue of the welfare of the SOIT officer concerned. However, as described above, the workload and impact of working with sexual offences provides a context that is potentially relevant to the response to Salma.

5.2.123 Consequently, the Review Panel sought assurances from the MPS relating to SOIT officer welfare. The Review Panel was informed that a new Safeguarding Model was put in place in February 2019, with each BCU having a strategic SOIT coordinator and 4 SOIT coordinators. To support SOIT officers:

- There is a clear role profile for SOIT coordinators;
- A SOIT focus group has been introduced, with this being held monthly with SOIT Coordinators and SOIT offices from each BCU – where current issues can be discussed. The intention is that these meetings are a safe confidential environment to discuss officers’ feelings or concerns, as well as enabling networking with peers. Concerns can then be raised via the coordinators protecting the identity of the officer if required; and

- SOIT officers will be getting regular mandatory one to one counselling through Occupational Health.

- 5.2.124 While the Review Panel felt this is positive, it asked about the current workload. While the SOIT officer in this case was working in June 2016, the underlying issues remain. In March 2020, SOIT teams were 25% below strength due to sickness, maternity, or stress related absences. This is clearly concerning.
- 5.2.125 The issue of support for staff has been identified elsewhere, including the Independent Review into 'The Investigation and Prosecution of Rape in London' by Rt Hon Dame Elish Angiolini.<sup>87</sup> The Review Panel was assured that issue of capacity is of concern and is being monitored by the MPS's Continuous Policing Improvement Command (CPIC). Given this, the Review Panel decided not to make an additional recommendation but did agree to note its discussion in full to draw attention to this issue.
- 5.2.126 Regarding *recording*, the SOIT officer's supervisor confirmed that the reflections the SOIT officer provided were consistent with working practice and that generally the officer had been good at keeping records up to date.
- 5.2.127 The Review Panel sought assurance about recording practice. It was informed that there is an expectation that SOIT officers maintain a log of contact with a victim and that early communication is encouraged between the SOIT and investigating officer as it is vital that pertinent information is shared at the earliest opportunity. There is also an expectation that information/evidence must usually be recorded on CRIS, unless it is inappropriate to do so (in which case, there should be a cross reference from CRIS to the log).
- 5.2.128 As a result, the Review Panel agreed with the Police representatives view that if existing policy is adhered to it should ensure that all relevant and important information is recorded on the CRIS report and/or brought to the attention of the investigating officer. In this case, it is relevant to note that this did happen, albeit it was delayed. As a result, the Review Panel felt that while this is learning that is a reminder of the importance of accurate and timely recording, no recommendation was made.
- 5.2.129 The third issue was the review of the sexual assault allegation in January 2017 when the reviewing DI included an instruction to seek advice from the CPS regarding an evidence-based prosecution<sup>88</sup> even though Salma had withdrawn her support. This was not followed through. The MPS IMR noted that the supervisor's view (that a prosecution without the support of the victim would not have been

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<sup>87</sup> To access this report, and the joint response from the MPS and CPS, go to: <https://www.cps.gov.uk/publication/report-independent-review-investigation-and-prosecution-rape-london-rt-hon-dame-elish>.

<sup>88</sup> This is a case that does not rely on the support of the victim, meaning the case relies on forensic evidence and / or the testimony of witnesses.

likely) may have been accurate, but his decision-making process was not documented in a review or closing report. During the period under review the policy to refer all such cases to CPS RASSO (Rape and Serious Sexual Offences) Unit via the Case Overview and Preparation System (COPA) for Early Investigative Advice (EIA) was not common practice. It was normal for a police supervisor to assess if a case met the threshold test.

5.2.130 The Review Panel were informed that since 2018 the pathway for the referral of allegations of rape and penetrative sexual offences during the initial stages of the investigation has improved. This has encouraged a more stringent supervision process and ensures that a lawyer is allocated to the case and a thorough action plan is prepared where relevant. If this incident had occurred now, the case would be sent to CPS RASSO as an EIA file and a lawyer would be asked to provide assistance on specific questions such as type and parameters of third-party material, value of forensic examination as well as other evidential opportunities.

5.2.131 The MPS IMR made the following recommendation in response, which was accepted by the Review Panel:

*“It is recommended that North East BCU SLT ensure that all supervisors of rape and penetrative sexual offences are aware of and give due consideration to obtaining Early Investigative Advice from CPS RASSO and that this is documented as part of the investigation strategy”.*

5.2.132 The fourth issue relates to whether Salma could have been referred to the local Multi-Agency Risk Assessment Conference (MARAC).

5.2.133 The national guidance from SafeLives identifies the referral criteria for MARACs. This guidance is included in full in **Appendix 2**.

5.2.134 The key referral criteria in this scenario are either ‘professional judgement’ or ‘potential escalation’. This is because, while all of the incidents when the MPS had contact with Salma were ‘non crime domestics’, and none were assessed as high risk, these could potentially trigger a referral to the local MARAC using either of these criteria.

5.2.135 Yet, at conclusion of the rape investigation in January 2017 there was no mention of a MARAC referral being considered by the SOIT, their supervisor or the reviewing DI.

5.2.136 However, in relation to ‘professional judgement’, the MPS IMR noted the following could have justified a MARAC referral on this basis given:

- Salma being the victim of domestic rape;
- She had disclosed being beaten on a regular basis;
- She was of Bangladeshi origin, spoke very little English and had no support other than family; and

- Omar had threatened to kill her in the past, and they had recently been through a separation.

5.2.137 The MPS IMR made the following recommendation in response, which was accepted by the Review Panel:

*‘It is recommended that North Eastern BCU SLT remind all Safeguarding Officers of the MARAC referral pathway, when this should be considered and how to document the decision process and rationale’*

*“It is recommended that North Eastern BCU SLT monitor and supervise Domestic Abuse closing reports to ensure there is an understanding and compliance with MPS and Local Authority Guidelines for MARAC referral.”*

5.2.138 There is another referral route to the MARAC that police officers could have used, which is ‘potential escalation’. This was not considered by the MPS IMR author; however, it was discussed by the Review Panel. This is also relevant to Newham Council’s Children’s Social Care and Early Help Service given it received three notifications from the MPS between June and October 2016.

5.2.139 The national guidance puts the threshold for potential escalation at three domestic abuse ‘events’ in a 12-month period. It is important to note that these events are not defined specifically but could include reports to Accident and Emergency (A&E) departments, the police or a housing provider for repairs.

5.2.140 With this in mind, regardless of how the October 2016 incident had been recorded or progressed, based on the national guidance, Salma would have met the threshold for referral to the local MARAC by either the MPS or Newham MASH.

5.2.141 However, in contrast to the national guidance, the Newham MARAC threshold is set at either three or more domestic abuse crimes or six or more domestic non crimes being reported to the police.<sup>89</sup> That would have meant Salma would not have been referred to the MARAC.

5.2.142 Reflecting on if a similar set of circumstances had occurred in Tower Hamlets, the Tower Hamlets MARAC threshold is different again: it is six domestic abuse incidents in the past 12 months (which have been reported to any agency / professional).<sup>90</sup>

5.2.143 The Review Panel discussed this issue at some length. It recognised that there are challenges with MARAC thresholds, particularly for MARACs where there is a high volume of cases. At the same time, the Review Panel was concerned that setting thresholds for escalation at a high level could mean that some victims were not

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<sup>89</sup> For more information on the Newham MARAC, go to: <https://www.newham.gov.uk/health-adult-social-care/domestic-violence-support/4?documentId=147&categoryId=20148>.

<sup>90</sup> For more information on the Tower Hamlets MARAC, go to: [https://www.towerhamlets.gov.uk/ignl/community\\_and\\_living/community\\_safety\\_\\_crime\\_preve/domestic\\_violence/marac.aspx](https://www.towerhamlets.gov.uk/ignl/community_and_living/community_safety__crime_preve/domestic_violence/marac.aspx).

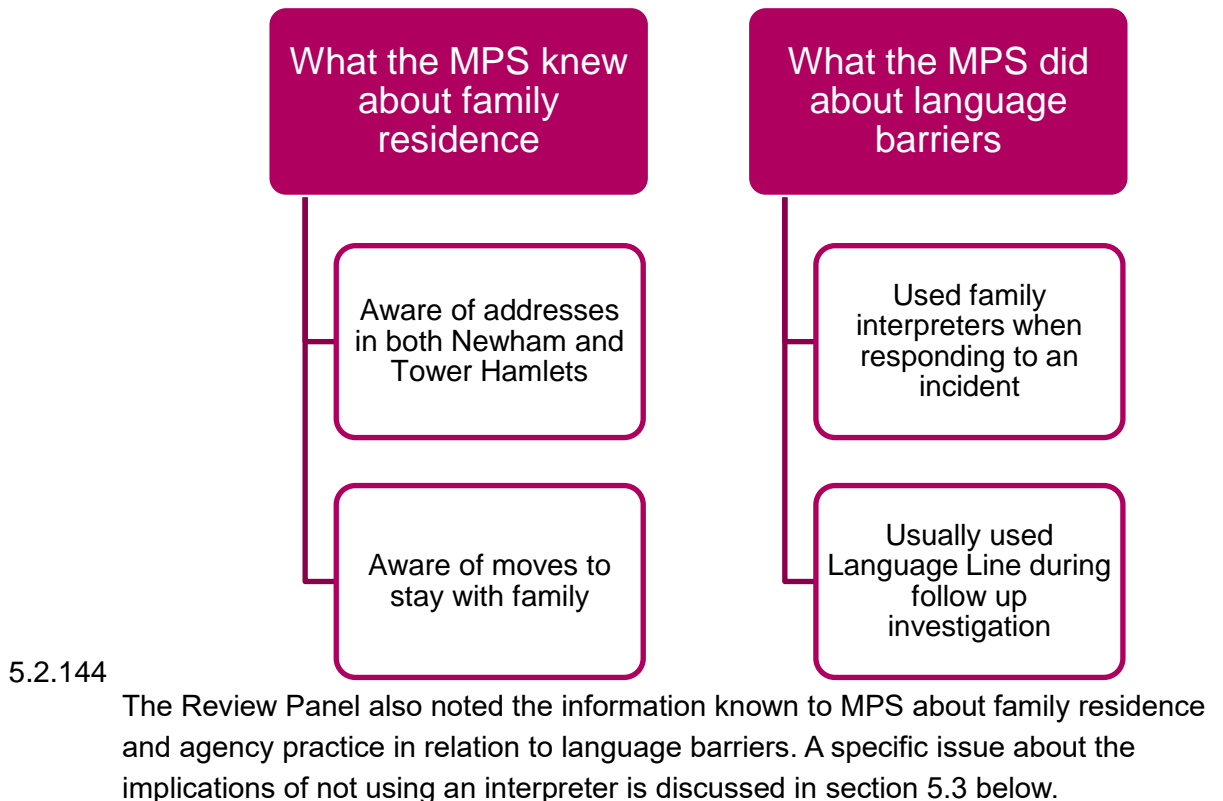
referred to MARAC, while having variation between boroughs may lead to confusion. Considering Newham and Tower Hamlets respective escalation criteria as an example, there is variation both in terms of frequency (three or six) but also types of contact (crimes, non-crime or incidents).

To be referred to MARAC, high risk victims of domestic abuse need to be identified. One of the referral routes to MARAC is 'potential escalation'. However, inconsistencies about the level and definition of escalation thresholds may cause confusion and / or prevent victims being identified.

**Recommendation 9: Newham CSP to review its local MARAC threshold against the national guidance.**

**Recommendation 10: Tower Hamlets CSP to review its local MARAC threshold against the national guidance.**

**Recommendation 11: MOPAC to work with boroughs to conduct a review of MARAC thresholds in London.**





### 5.3 Responding to the Terms of Reference

5.3.1 The following section responds to the lines of enquiry as set out in the Terms of Reference.

5.3.2 The Review Panel considered making recommendations in response to several of these areas, but given the learning relates to multiple agencies, the Review Panel felt recommendation were unlikely to be helpful. However, the learning from this DHR should be shared to encourage reflection in relation to the following themes.

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

**The co-operation between different agencies involved with Salma and / or Omar [and wider family];**

5.3.3 For each agency that had contact with Salma, Omar or the children, internal and external communication and cooperation have been explored above. Taken together, broadly, several themes have emerged.

5.3.4 First, communication between agencies was often extensive but sometimes had little effect. In general, that seems to have been due to an overreliance on email, rather than direct conversations between agencies. More immediate communication may have enabled clarification of issues including whether a referral had been made or taken up (e.g. referrals to Aanchal), or indeed the family's residence (e.g. between Newham Children's Social Care and Early Help Service and Tower Hamlet's Housing Options).

5.3.5 Additionally, to some extent, communication was sometimes along the lines of 'fire and forget', with referrals being made but not followed up (particularly to Aanchal) or outstanding queries abandoned when responses were not received (e.g. when Aanchal informed the MPS after the incident in June 2016 that they had not been able to contact Salma; in relation to attempts to fix the door to Salma's house later in the year, which was never resolved by Newham Early Help; and following the referral by Tower Hamlets Housing Options to Newham in November 2016). At other contacts assumptions were made (e.g. when the case was closed to Newham NAM in July 2017, there was a reliance on Tower Hamlets Housing Options to make a referral and an assumption made that, having discussed the case with Tower Hamlets MASH, the family would receive ongoing support in Tower Hamlets).

5.3.6 Conversely, some agencies do not seem to have been notified at all, including the GP.

5.3.7 Second, in Newham, agency responses were to provide individual and parenting interventions to manage Child A's behaviour (i.e. the school offered social skills and early mental health intervention, Families First discussed parenting strategies

with Salma and CAMHS focused on their behaviour) without a deeper consideration of what may have been occurring within the family home.

- 5.3.8 Different information and recording systems used by health, education, social care and external agencies also limited the ability of agencies to triangulate what interventions, referrals or support were offered to the family whilst they resided within Newham. Meanwhile, the known history of domestic abuse was not always shared between agencies (e.g. initially to Child A's Primary School in 2016, then later by Child A's Primary School or the Newham MASH to CAMHS in 2018).
- 5.3.9 Third, there were different opportunities to identify that the family had moved between Newham and Tower Hamlets. As represented visually for each agency, what was known varied considerably and was the cause of confusion. The Review Panel felt that, while the issue of residence was important, the underlying factor was the communication between agencies. This meant that the issue of residence often went unresolved contributing to an inconsistent response.
- 5.3.10 The Review Panel noted that some of this learning is not new – it has been a feature of multiple different reviews into serious incidents and homicides involving adults as well as children.

**The opportunity for agencies to identify and assess domestic abuse risk;**

- 5.3.11 Apart from the DASH risk assessment completed by the MPS, no other agencies appear to have completed any assessment of domestic abuse risk. The disclosures made to different agencies are discussed above, but this could have triggered more robust consideration of the risks to Salma, as well as her needs and those of the children. Additionally, as noted below, Omar was often largely 'absent' from view, with consideration of key issues – including his gambling as disclosed by Salma – going unaddressed. Finally, there was evidence of agencies (in particular, Newham MASH) relying on the actions of other agencies as a proxy for their own assessment. This is not acceptable given each agency should take responsibility for its own response.

**Agency responses to any identification of domestic abuse issues;**

- 5.3.12 The reality of Salma's experience of domestic abuse was not grasped by most agencies who were aware of it. As discussed above, both the MPS and Newham Children Services could have responded more robustly to the three incidents in succession between June and October 2016.
- 5.3.13 Meanwhile, in 2017, things were taken for granted – including Salma saying that an injunction was in place (there is no evidence that it was) or that she would take up support.
- 5.3.14 Moreover, in 2018, the focus on Child A's behaviour appears to have occluded consideration of domestic abuse (either the possibility of CPV from Child A to Salma, or domestic abuse from Omar). In conversations with Child A's school, it

was clear that there were some safeguarding concerns and vulnerabilities that were being displayed. However, agencies did not recognise Child A's behaviour and mental health difficulties as occurring within a wider family context where domestic abuse was an apparent and ongoing feature. Additionally, historical information (from 2016) was not shared. For example, Child A's Primary School did not include this information in their referral to CAMHS or highlight their wider safeguarding concerns.

**Organisations' access to specialist domestic abuse agencies;**

- 5.3.15 This case has illustrated some significant challenges in referral pathways to specialist domestic abuse services in place at the time in Newham (pathways in Tower Hamlets have not been considered, as no referrals were ever made to services in the borough).
- 5.3.16 The initial contact was in June 2016. This was after a referral was made to Aanchal by the MPS on the 10<sup>th</sup> June. The referral was initially graded as 'Medium' by the MPS but had been downgraded to 'Standard'. Aanchal's guidance at the time for medium or low risk cases was to make three calls within five working days, on three separate occasions and times of the day and, if unable to make contact, to update the referrer after five working days. On this occasion Aanchal made six attempts to contact Salma over several days. The Review Panel noted this as an example of good practice, given it exceeded the policy requirements at the time.
- 5.3.17 Aanchal also attempted to contact the referring police officer to ask if they had an alternative contact number and determine whether the perpetrator lived with Salma. The case worker did not receive a reply from the officer. After further contact attempts, the case worker closed the case and updated the MPS that they could not establish contact and asked the police officer to get in touch if they required further support. However, as the case was closed to the MPS, this would not have been followed up unless Salma had made contact again. This issue has been discussed in the more general discussion of inter-agency communication above.
- 5.3.18 Later in 2016, the referral pathway did not function:
- On the 23<sup>rd</sup> November Tower Hamlets Housing Options made a referral to Aanchal (it appears that this was followed up, with Salma declining an offer of support and Aanchal then notifying the housing officer. However, this did not trigger any further consideration by Housing Options);
  - On the 25<sup>th</sup> November, Salma told the Families First coach that she had been contacted by Aanchal, but they had spoken to her cousin and not her (Aanchal have no record of this contact);

- On the 2<sup>nd</sup> December, the Families First coach made a telephone call to Aanchal to follow up the referral for Salma (the case records indicate there was no response received); and
  - On the 8<sup>th</sup> December, The Families First coach received a response from Aanchal, saying they could not locate Salma as a client because of ambiguities in names / dates of birth (it does not appear this was resolved).
- 5.3.19 The Review Panel has faced considerable difficulties in confirming the outcome of the referrals to and response by Aanchal. While records are available for the June 2016 contacts, it has not been possible to identify records relating to all but one of the November 2016 contacts.<sup>91</sup>
- 5.3.20 Taken together, the Review Panel felt that these issues highlighted challenges with the referral pathway in 2016. At that time, Newham commissioned four different providers to deliver community-based support across the borough – this was collectively known as the ‘One Stop Shop’. The gatekeeper for the service was Aanchal.
- 5.3.21 In this case, multiple referrals to Aanchal do not appear to have consistently triggered contact with Salma. Clearly there was a practical issue, in that there were ambiguities in names/dates of birth (this was something the DHR identified as well, with two different dates of birth being recorded by agencies). Additionally, for whatever reason, Aanchal could not always be contacted or did not respond promptly, while in other cases referring agencies did not always follow up with Aanchal or, having been told by Aanchal about the outcome, did not then consider if they should take further steps.
- 5.3.22 Conversely, there is also evidence of good practice, including multiple attempts by Aanchal to engage with Salma in June 2016.
- 5.3.23 The issue with inter-agency communication has been discussed above, leaving the question of the effectiveness of the referral routes to the ‘One Stop Shop’ (and in particular Aanchal’s role) to be considered.
- 5.3.24 In response to this question, the Review Panel were informed that domestic abuse services in Newham have since been recommissioned. As part of the recommissioning process, one issue that was identified was that having four different providers had created some confusion over the referral route into support.

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<sup>91</sup> Aanchal are no longer commissioned to provide this service and does not have access to the client database and could only provide information on the June 2016 contact and information about the referral by Tower Hamlets Housing Options in either October or November 2016. Consequently, the Newham Public Health representative, who commissions domestic abuse services in the borough, undertook to search the client database. They were unable to identify any records relating to the other November 2016 contacts.

5.3.25 A new service, delivered by Hestia Housing and Support, has been operational in the borough since 1<sup>st</sup> June 2019. The new service offers a single referral route and has also included co-location so that IDVAs and floating support workers are working alongside social workers, the police and health services.

5.3.26 The Review Panel felt this addressed the learning identified in this DHR, although in reaching this determination it was agreed to note that this does not mean the Review Panel has formed a view on either the overall practice by Aanchal and other partners in 2016, commissioning arrangements, or indeed the current practice of Hestia.

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

5.3.27 Where appropriate, agencies have been asked to provide information on their policies, procedures and training. This is discussed in relation to individual agency contact.

**Specific consideration to the following issues: English as a second language, the use of translators and Immigration;**

5.3.28 There is one contact that is of particular note in relation to the use of interpreters, with this being Salma's disclosure of a sexual assault to police officers in October 2018. When Salma first disclosed sexual assault to response officers, Language Line was used, and the most recent assault was understood to have been five days prior. When Salma subsequently spoke with the SOIT officer, who used a family member to translate, this was misunderstood as being a month prior. It was later confirmed this was 5 days prior in the subsequent VRI with an interpreter. As a result, no consideration was given to making a Haven referral on the day of the report. When this was raised by the SOIT officer the next day, after the VRI, Salma did not feel able to go and this does not appear to have been discussed again.

5.3.29 The MPS IMR made the following recommendation in response, which was accepted by the Review Panel:

*"Consideration is being given for an MPS wide campaign to promote the use of Language Line and increase awareness of diversity to all officers Pan London with the use of the MPS intranet system".*

5.3.30 More broadly, there were issues in relation to translation for a number of agencies, as described above and represented visually for each agency. Broadly speaking, a number of agencies used family members as interpreters and, in some cases, Salma appears to have been accompanied to appointments by family members for this purpose. However, it is not appropriate to use family members to provide interpretation, particular in the case of domestic violence. This can clearly cause discomfort to the victim and their family member, and in

some cases could be a potential risk (although in this case, this was not an issue: the individuals that provided interpretation were all members of Salma's family and appear to have done their best to support her).

- 5.3.31 This is an important issue in Tower Hamlets. The 2011 Census identifies at least 90 different languages (or groups of languages) being used in the borough. Data from the 2019 School Census shows that pupils are exposed to 168 languages other than English.
- 5.3.32 In this case, Salma's family spoke Sylheti. Unfortunately, Sylheti is often simply described as 'Bengali'. Reflecting this, the 2011 Census data does not distinguish between Sylheti and Bengali and instead groups them together. In Tower Hamlets, English and Bengali are the two most commonly used languages: two thirds (66%) of residents use English as their main language and 18% use Bengali (which includes Sylheti and Chatgaya).<sup>92</sup>
- 5.3.33 The potential for miscommunication is evident. Salma's niece (Samiha) highlighted this when commenting on the video of an MPS interview she observed at court. Referring to the translator, she said: "*They missed out things and interpreted it differently, so it wasn't what she meant. In Bengali there are so many dialects – you can't just get a general interpreter*". This is also apparent in agency records: as discussed in agency contact, when assurances were provided to the Review Panel that interpreters were not required, this was often because a staff member was described as speaking Bengali.

Ensuring victims are supported to communicate safely with professionals is critical if they are to be able to access help and support. It is important that differences between languages are recognised.

**Recommendation 12: Tower Hamlets to run a learning event with local agencies around the use of translation and take action to assure itself that:**

- All agencies have robust policies and procedures in place
- That family members are not used as translators
- There is easy access to appropriately trained professional translation, including provision for Sylheti were required.

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<sup>92</sup> More information on the local profile is available at:  
[https://www.towerhamlets.gov.uk/ignl/community\\_and\\_living/borough\\_statistics/Borough\\_profile.aspx](https://www.towerhamlets.gov.uk/ignl/community_and_living/borough_statistics/Borough_profile.aspx).

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

- 5.3.34 Given Salma's limited contact with services overall, the Review Panel has struggled to identify what might have helped and hindered access to support.
- 5.3.35 Salma was a Muslim and from Bangladesh. Although the Review Panel were mindful of immigration, both Salam and Omar had become British Citizens. There is limited information available to the Review Panel on the impact of these issues directly, although accounts by Salma's family have identified some of the impact of cultural expectations in Salma's life, including around her marriage. She was also isolated, both because of her limited English (the response to which is discussed above) but also because Omar was controlling.
- 5.3.36 What is apparent is that Salma's contact with services was often triggered by her family. For example, contact with the MPS came about as a result of calls made by family members. This reflects the information from family members, who described their attempts to support Salma. The Review Panel could not identify what, if any, specific advice, and support was available to family members around how they could help and support Salma. It is important to note, however, that family contact with services was some years ago.
- 5.3.37 The Review Panel therefore felt it helpful to consider what is currently available locally to raise awareness of domestic violence and abuse, both to victims and their families, as this may have benefitted either Salma or her family. The borough has a VAWG strategy, which was most recently refreshed in 2019. It has three priorities:
- Support and protection for victims;
  - Bringing offenders to justice; and
  - Educating communities and challenging gender-based discrimination (misogyny).<sup>93</sup>
- 5.3.38 There is a range of activity in the borough including training, outreach, awareness raising material. This is targeted based on the needs of local populations and materials are produced in community languages. This includes training and outreach in Sylheti, as well as work with faith groups like the London Muslim Centre/East London Mosque. As part of this activity, there has been specific activities relating to the role of bystanders, including both families, but also friends and community members.<sup>94</sup>

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<sup>93</sup> For more information, go to:  
[https://www.towerhamlets.gov.uk/lgnl/community\\_and\\_living/community\\_safety\\_\\_crime\\_preve/domestic\\_violence/vawg/vawg.aspx](https://www.towerhamlets.gov.uk/lgnl/community_and_living/community_safety__crime_preve/domestic_violence/vawg/vawg.aspx).

<sup>94</sup> The Home Office Quality Assurance Panel suggested that the DHR should make a recommendation around information for family and friends. The Review Panel felt this was unnecessary given the work that was already going on in the borough.

- 5.3.39 The Review Panel felt this was positive. It was also reassured by evidence that local services are accessible. The borough has an IDVA service (provided by Victim Support). From April 2016 to December 2019, client data shows that the largest ethnic group accessing the service were self-identified as Asian. The second highest ethnic group were White British. A change in Victim Support's recording system this year enabled Victim Support to be more specific in their breakdown. This has identified that victims from the Bangladeshi community are the third highest ethnic group worked with by Victim Support in the borough. Given this, the Review Panel felt no further recommendations were required.
- 5.3.40 The Review Panel also felt it was important to consider the learning in this case around economic abuse, particularly given the evidence of Omar's gambling.
- 5.3.41 With regard to economic abuse more generally, although this is a developing area of work, there is ongoing programme of work in the borough:
- Economic abuse is included as a topic in existing domestic abuse training, with a specific economic abuse webinar and half day training session currently been developed; and
  - Staff at the Poplar Jobcentre received domestic abuse training in November 2019 and the council has an agreement with the Department of Work and Pensions to co-locate an IDVA within the team.
- 5.3.42 Given this work, the Review Panel felt a recommendation on economic abuse was unnecessary.
- 5.3.43 However, the Review Panel also felt it was important to consider the learning in this case around gambling. This DHR has not identified any opportunity to intervene directly with Omar, given the relatively limited information about his contact with betting shops locally (as detailed in 4.4), although it has noted the significance of Omar's apparent gambling problem in this case (as summarised in 5.1).
- 5.3.44 As a result, the Review Panel felt it was useful to consider what, if any, role gambling premises can play. Having consulted with Tower Hamlet Council's Head of Environmental Health and Trading Standards, the Review Panel were informed that there were 80 gambling premises in Tower Hamlets in December 2019.
- 5.3.45 The Review Panel sought to identify to what extent domestic violence and abuse was recognised in this area and was informed:
- A new Gambling Policy was introduced in December 2019, which explicitly references domestic violence as a harm associated with gambling;<sup>95</sup> and

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<sup>95</sup> For more information, go to: <https://democracy.towerhamlets.gov.uk/documents/s158448/9.1d%20Appendix%20-%20Statement.Gambling.Policy.2019-2022formattedv1.pdf>.



- Gambling premises staff are trained to identify problem gambling and issues associated with it such as domestic violence and abuse. This training is provided by the employers although it is not monitored by Tower Hamlets Council.

5.3.46 Given this, the Review Panel has not made a recommendation but did agree to encourage the Tower Hamlets Council to ensure that existing information on the local training offer and services for victim/survivors and perpetrators regarding domestic violence and abuse (and other forms of VAWG) is routinely circulated to gambling premises.

5.3.47 The Review Panel also considered the broader learning in relation to gambling, specifically the missed opportunity to address this when Salma disclosed her concerns (e.g. Tower Hamlets Housing Options in 2013, as well as the MPS in 2016). The Review Panel felt it was important to ensure that all professionals are able to identify and respond to such disclosures, including considering signposting or referral into gambling specialist support, for both the person affected by gambling and family members. Given the feedback from GamCare about the general lack of awareness of gambling related harms and domestic violence and abuse, it was agreed it was important to make a recommendation on this issue to ensure its significance is recognised

Professionals should be able to identify gambling related harms and the links to domestic violence and abuse and respond appropriately.

**Recommendation 13: Tower Hamlets CSP to ensure that gambling is addressed in its economic abuse work programme.**

## 5.4 Equality and Diversity

- 5.4.1 At the outset of this DHR, the Review Panel identified the following protected characteristics of Salma and Omar as requiring specific consideration for this case; *Age, Race, Religion and Belief and Sex*.
- 5.4.2 *Age*: Although age was not identified by the Review Panel as having a particular impact in this case, Salma was in her early thirties at the time of her death. A Home Office analysis of DHRs<sup>96</sup> found that among both women and men the highest proportion of domestic homicides was among those aged 30 to 50. It is also of note that there was a 16-year age gap between Salma and Omar; some research suggests that a large gap can be a risk factor.<sup>97</sup>
- 5.4.3 *Race*: Both Salma and Omar were of Bangladeshi origin. Related to this:
- While Salma and /or Omar were of Bangladeshi origin, both had become naturalised British Citizens; and
  - For Salma and Omar, English was a second language, and this necessitated the use of translators.
- 5.4.4 Consequently, the Review Panel felt that Salma's experiences were directly or indirectly affected by race, immigration and cultural issues, specifically expectations around her relationship, while issues with language (including access to translators) affected some agency engagement. Additionally, both Salma and Omar may have experienced discrimination that is unknown to the Review Panel.
- 5.4.5 *Religion or belief*: Both Salma and Omar were Muslims. The Review Panel has not identified any information that either Salma or Omar's experiences were directly affected by their faith. However, as with the discussion concerning race, faith may have been a factor more generally.
- 5.4.6 *Sex*: As noted in 1.4.2, domestic homicide is gendered with the majority of victims in both intimate partner and familial homicides being females and males representing the majority of perpetrators.
- 5.4.7 Although *Pregnancy and Maternity* was not strictly relevant, as Child B and C had been born in 2014, the Review Panel has explored contact with health services in this context.
- 5.4.8 Taken together, an intersectional perspective draws attention to these different aspects of Salma's lived experiences and how these may have affected her.

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<sup>96</sup> Home Office. (2016) Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews. Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf) [Accessed 24 March 2020].

<sup>97</sup> Garcia, L., C. Soria, and E.L. Hurwitz. (2017) Homicides and Intimate Partner Violence: A Literature Review. *Trauma, Violence, and Abuse* 8(4), pp. 370–383.

- 5.4.9 For Salma, it appears that the impacts of cultural expectations, and perhaps her faith, as well as her relative isolation due to her limited English, may have been important. Indeed, these issues may have been a barrier to Salma's ability to access help and support. However, the same time, it is clear that her family were a source of support, including offering both emotional and practical support.
- 5.4.10 Given the limited information on Omar, particularly as he did not participate in the DHR, it is not possible to consider his experiences more generally.
- 5.4.11 No information was presented that raised any issues regarding other Protected Characteristics, including; *Disability; Gender Reassignment; Marriage and Civil Partnership; Sexual Orientation*.

## 6. Conclusions and Lessons to be Learnt

### 6.1 Conclusions (key issues during this DHR)

- 6.1.1 Salma was a much-loved sister and aunt. She was also the mother of three children, who now face growing up without their mother as a result of Omar's actions. The Review Panel extends its sympathy to the family and friends of Salma.
- 6.1.2 The Review Panel has sought to try and understand Salma's lived experiences and consider the issues she faced in order to try and understand the circumstances of the homicide and identify relevant learning. In this endeavour, the Review Panel has been aided to a great extent by help from family members and extends its thanks to all those who have participated in this DHR.
- 6.1.3 Omar is solely responsible for Salma's murder. Nonetheless, there has been significant learning identified during this DHR, 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 The learning in this DHR relates to several key areas. First, *interpretation and translation*: While agencies did make some efforts to provide interpretation and translation this was inconsistent. Instead, agencies often relied on family members. This is not appropriate. Additionally, this DHR has highlighted that simply collapsing Sylheti into Bengali is unhelpful, given there are distinct differences which may present barriers to communication, yet many agencies and professionals do not appear to be aware of these differences. Recommendations have been made to address these issues.
- 6.2.2 Second, *interagency communication*: There were examples of good interagency working, including an awareness of the importance of sharing information or making referrals where necessary. However, all too often communication took the form of 'fire and forget', with agencies failing to follow up correspondence, or enquire about outcomes, or respond promptly. There was also a reliance on indirect communication (particularly email) rather than speaking directly to another professional, which may have more readily resolved the issues causing confusion or concern.

- 6.2.3 Third, *cross border working*: During the timeframe covered by this DHR, Salma, Omar and their family had been residents in both Tower Hamlets and Newham. It is important to note one fact: this was not their choice. They had come to live in Newham as a result of being placed in temporary accommodation there by Tower Hamlets Housing Options. Even after returning to Tower Hamlets, the children continued to access schools in Tower Hamlets and other services there also worked with the family. This caused considerable confusion, affecting decisions both on what services were offered but also meaning agencies did not always have a complete picture of the family's risks and needs. This was exacerbated by the issues with interagency communication as summarised above, but also on occasion the failure of agencies to undertake enquiries with their counterparts in neighbouring boroughs (this is most pertinent to Tower Hamlets MASH). Additionally, this meant there were occasions when concerns either went unresolved (e.g. when Salma raised the security of the property in 2016), or the outcome of referrals were unclear (e.g. to the local specialist domestic abuse services, at that time provided by Aanchal).
- 6.2.4 Individual agencies have made recommendations in relation to both interagency communication and cross border working. While it is impossible to say what the effect of resolving these issues may have been, the importance of prompt and clear communication, as well as the speedy resolution of areas of confusion, is important learning from this DHR.
- 6.2.5 Fourth, *responses to domestic violence and abuse*: despite Salma's fears for her children, as well as isolation and challenges given her limited English and potentially the impact of cultural norms and expectations, she did disclose her experiences of domestic violence and abuse, usually with the support of her family. The responses to these disclosures were mixed, with examples of risk being downgraded or not recognised. Critically, the issues identified around interagency communication above meant there were multiple attempts to refer Salma to Aanchal without success. While Salma would have needed to take up any offer, it clearly did not help that these attempts were disjointed and that agencies were often unaware that referrals had not been successful so could not consider what if anything else they could do to support Salma. Other areas of learning include issues around risk identification and assessment, not least referral to the MARAC; as well as the response to other issues in this context like gambling; and policy and practice that would encourage agencies to raise awareness of and identify domestic violence and abuse. Individual agencies have made recommendations in response to these issues, while multi agency recommendations have also been made.
- 6.2.6 Finally, when Early Help, and later CAMHS, worked with the family, domestic violence and abuse was either not consistently responded to or was not the

focus of intervention. Instead, concern about Child A's behaviour took centre stage. While this is understandable in so far as this was the presenting issue for many agencies, there could and should have been a consideration as to the context (and possible cause) of Child A's behaviour. This would have enabled agencies to consider how to either support Salma or begin to address Omar's behaviour. Sadly, this did not happen. Individual agency recommendations have been made in response to this learning, but this is important learning that should remind all agencies of the importance of professional curiosity and a wide-angled lens to assessment.

- 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. This is relevant to agencies both individually and collectively. Tower Hamlets was able to share information on its strategy and action plan, which will provide a basis on which to feed in learning from this DHR and to continue to develop local processes, systems and partnership working. The Review Panel hopes that this work will be underpinned by a recognition that the response to domestic violence is a shared responsibility as it is everybody's business to make the future safer for others.

## 7. Recommendations

### 7.1 Single Agency Recommendations

7.1.1 The following single agency recommendations were made by the agencies in their IMRs. They are described in section 5 following the analysis of contact by each agency and are also presented collectively in **Appendix 4**. These are as follows:

#### *Barts Health*

7.1.2 “Health Advocates should be used for all pregnancy appointments, particularly the booking appointment”.

#### *CAMHS (provided by ELFT)*

7.1.3 “MDT discussions are recorded routinely in clinical records. TH CAMHS clinical team leads to review systems to ensure that the outcome of MDT discussions in cases where the parents are reporting that their child is refusing to attend and has never been seen, are included in and inform the action plan”.

7.1.4 “Tower Hamlets CAMHS leadership team to remind staff of their duties of documenting clinical supervision case discussions on to RIO”.

7.1.5 “Tower Hamlets CAMHS to continue to communicate care plans verbally and by letter copied to GP directly following families attendance at assessment clinics”

7.1.6 “Tower Hamlets CAMHS leadership team to ensure that ELFT Guidelines from risk of violence assessment (appendix 4) are circulated and then made readily available to staff via the intranet”.

7.1.7 “Tower Hamlets CAMHS clinical leadership to ensure that all staff are aware that in all new assessments, there is a record that past RIO records have been reviewed and relevant action plans taken into account, based on the review of notes”.

7.1.8 “Tower Hamlets CAMHS to consider routinely checking for past or current involvement with social services at point of referral”.

7.1.9 “If there is a past history of social services involvement, for clinical team lead to remind staff on obtaining consent from parents to obtain information relating to Social Services involvement”.

7.1.10 “Tower Hamlets CAMHS staff to be refreshed on and recirculate NICE guidelines on Conduct Disorders and to consider providing assessment guidance to clinicians for children and adolescents presenting with violence or aggression”.

- 7.1.11 “Tower Hamlets CAMHS to consider implementing a pathway for young people presenting with violence or aggression and/or those that are hard to engage, as illustrated by the City and Hackney Conduct and Outreach pathway”.
- 7.1.12 “Tower Hamlets CAMHS to review systems to ensure that MDT meetings and clinical supervision discussions are clearly recorded in the clinical records”.
- 7.1.13 “Tower Hamlets CAMHS to review systems to ensure that interpreting services are booked routinely for initial assessment if referral states that the clients cannot speak English. Giving the patient the option to refuse if not needed”.
- 7.1.14 “Tower Hamlets CAMHS to ensure clinicians are aware of the systems for accessing telephone interpreting services if face to face interpreter is not possible”.
- 7.1.15 “There are clear supervision structures for Tower Hamlets CAMHS clinicians involved in the assessment, management and safeguarding of young people presenting with violence and aggression. Clinical team leads to ensure that clinical discussions in supervision are clearly documented”.
- 7.1.16 “Tower Hamlets CAMHS clinicians are able to access safeguarding and clinical training relating to domestic abuse from a variety of sources. Clinical supervisors to ensure that CAMHS staff are aware of the range of training available”.

#### *Clarion Housing*

- 7.1.17 “The sharing of recent and wider safeguarding concerns with registered providers of social housing at the tenancy nomination stage would be relevant to its housing management function”

#### *Newham Children’s Social Care and Early Help*

- 7.1.18 SafeLives Risk Assessment should be completed routinely in domestic violence cases and consideration taken of types of abuse outlined in the Power and Control Wheel”.
- 7.1.19 “Training in these tools, general training in Domestic Abuse and MARAC refresher training should be provided for Practitioners”.
- 7.1.20 “Risk assessments should clearly identify triggers which would indicate a change in the level of risk and the assessment should be reviewed at these points. Evidence clearly indicates relationship breakdown, reconciliation, pregnancy and major life events such as bereavements as trigger points, but assessments should be individual to each case”.
- 7.1.21 “Practitioners working with families where domestic abuse is a factor should ensure they take into consideration any support that could be offered to the perpetrator to address contributing factors such as substance misuse, worklessness and gambling however it should be taken into account that



perpetrator work in relation to violence itself is specialist and may require referral to a specialist agency”.

- 7.1.22 “Interpreters/Translators should complete domestic abuse awareness training”.
- 7.1.23 “Referrals should be made to Domestic Violence Support Services at the point of contact with the local authority or other agencies (already in place)”.
- 7.1.24 “System Connectivity should be explored and there should be more information sharing between Local Authorities and Commissioned Providers (i.e. Hestia) so that we know if DV services are actively working with a family”.
- 7.1.25 “Consideration should be given to reviewing Information Sharing Protocols in the light of this IMR”.
- 7.1.26 “Protocols for information sharing when families relocate out of borough should be reviewed and / or developed”.

#### *MPS*

- 7.1.27 “It is recommended that North East BCU SLT remind all front-line officers and Safeguarding investigators of the importance of Language Line / Interpreting services when reporting and investigating allegations of domestic abuse”.
- 7.1.28 “It is recommended that North East BCU SLT remind all Safeguarding Officers of the MARAC referral pathway, when this should be considered and how to document the decision process and rationale”.
- 7.1.29 “It is recommended that North East BCU SLT monitor and supervise Domestic Abuse closing reports to ensure there is an understanding and compliance with MPS and Local Authority Guidelines for MARAC referral”.
- 7.1.30 “It is recommended that North East BCU SLT remind all staff of the requirements of the National Crime Reporting Standards, with regards to prompt reporting of the allegations of crime”.
- 7.1.31 “It is recommended that North East BCU SLT ensure that all supervisors of rape and penetrative sexual offences are aware of and give due consideration to obtaining EIA from CPS RASSO and that this is documented as part of the investigation strategy”.

#### *Child A’s Primary School*

- 7.1.32 “Children to understand what a positive relationship looks like through P4C/PHSCE and Bounce back days or Headstart Champions sessions”.
- 7.1.33 “Safeguarding team to attend training on Domestic Violence”.
- 7.1.34 “Safeguarding team to provide training for the all staff members in relation to Domestic Violence”.

*THGPCG*

- 7.1.35 “To ensure that the current development of the organisational domestic abuse policy and on-going training additionally includes:
- The need to ask about Domestic Abuse at the initial contact with the Health Visiting Service (antenatal contact, new birth or movement in visit) and providing information about local domestic abuse services irrespective of the response.
  - The need to ask to see a woman alone should partners/ family members/ friends be present at the initial visit.
  - The need to record on EMIS a plan should the above not be possible of how and when it can be asked at a future contact.
  - The need to look for opportunities to ask about Domestic Abuse at all contacts (especially at key developmental reviews).
  - Where potential predisposing factors to domestic abuse are identified there is an increased requirement to ask at every contact.
  - The need to establish, prior to visits, whether an interpreter is required and if so ensure that one is booked and the inappropriateness of using a family member to interpret”.
- 7.1.36 “To ensure that the family health needs assessment includes, but is not limited to:
- Establishing immigration status
  - Recording both parents’ religion
  - Household finances
  - Housing status
  - Bonding / attachment and barriers to this.
  - Knowledge of local specialist services as well as the local offer information.
  - Assessment of the impact of the above on parental relationships and parenting”.
- 7.1.37 “To ensure that that it is clearly stated in policy or standard operating procedure (SOP) and staff to be reminded of:
- The need to verify address and contact details at every time the family are seen and EMIS record updated accordingly.
  - The need to establish at initial contact whether an interpreter is required and to ensure that only organisationally approved, interpreters are used at planned contacts.

- The need to initially offer a universal plus Health Visiting service following premature delivery and consideration of support via the MECOSH programme.
- The expected response to a potential non accidental injury, even if there are no obvious visible injuries”.

*Tower Hamlets - Children’s Social Care and Early Help*

7.1.38 “For consideration to be given to how consent is gained from families, when a referral is being made (to whatever service) for a broad range of services, including CSC, to be offered to them”.

*Tower Hamlets – Housing Options*

7.1.39 “Clients that disclose any difficulties within a family setting or with partners are interviewed further in an appropriate way to ascertain if there is a need for sign posting and/or referrals for assistance.”

7.1.40 “Referrals made to other professionals in the context of domestic violence and/or safeguarding are followed up to establish what, if any, further action is required from the referring agency.”

## 7.2 Multi Agency Recommendations

7.2.1 The Review Panel has made the following recommendations as part of the DHR. These are described in section 5 as part of the analysis and are also presented collectively in **Appendix 5**.

7.2.2 These recommendations should be acted on through the development of an action plan, with progress reported on to the CSP within six months of the review being approved.

7.2.3 **Recommendation 1:** The Tower Hamlets CSP to satisfy itself that Child A, B and C (as well as their kinship carers) are offered support in relation to the publication of the DHR.

7.2.4 **Recommendation 2:** After publication of this DHR, the Tower Hamlets CSP to ensure that this report is attached to Child A, B and C’s social care records. This is so that, if they wish to read the DHR when they are older, it will be available to them.

7.2.5 **Recommendation 3:** The Ministry of Housing, Communities and Local Government (MHCLG) to review the learning from this case and issue appropriate guidance nationally to ensure housing providers can be informed of safeguarding concerns at the tenancy nomination stage.

7.2.6 **Recommendation 4:** Clarion Housing to review its new tenancy starter information to include information on domestic violence and abuse.

- 7.2.7 **Recommendation 5:** Clarion Housing to review its internal checklist for compliance against the Pre-Action protocol to explicitly address domestic violence and abuse.
- 7.2.8 **Recommendation 6:** The Ministry of Justice to consider the learning from this case and review and / or issue appropriate guidance nationally to ensure consideration of domestic violence and abuse in the Pre-Action Protocol.
- 7.2.9 Recommendation 7: Clarion Housing to work with DAHA to address its concerns around the current accreditation framework in order to assist its decision in relation to accreditation at the conclusion of its restructure during 2020/21.
- 7.2.10 Recommendation 8: The MPS to remind police officers of the importance of reviewing the risk of domestic abuse cases when changes to circumstances occur to order to identify, as illustrated in this case, the possibility of increased risk.
- 7.2.11 **Recommendation 9:** Newham CSP to review its local MARAC threshold against the national guidance.
- 7.2.12 **Recommendation 10:** Tower Hamlets CSP to review its local MARAC threshold against the national guidance.
- 7.2.13 **Recommendation 11:** MOPAC to work with boroughs to conduct a review of MARAC thresholds in London.
- 7.2.14 **Recommendation 12:** Tower Hamlets to run a learning event with local agencies around the use of translation and take action to assure itself that:
- All agencies have robust policies and procedures in place
  - That family members are not used as translators
  - There is easy access to appropriately trained professional translation, including provision for Sylheti were required.
- 7.2.15 **Recommendation 13:** Tower Hamlets CSP to ensure that gambling is addressed in its economic abuse work programme.

# Appendix 1: Domestic Homicide Review Terms of Reference

This Domestic Homicide Review (DHR) is being completed to consider agency involvement with Salma and Omar following the death of Salma in January 2019. 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:
  - Salma and Omar during the relevant period of time from the beginning of 2008 to the date of the homicide (inclusive).
  - Child A, B and C (from their birth to the date of the homicide (inclusive)).
  - Given this extended timeframe, agencies must provide a complete chronology but may summarize agency involvement within the Individual Management Review (IMR) 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 Review Panel, Independent Chair and the London Borough of Tower Hamlets (LBTH) Community Safety Partnership (CSP)

8. *The Independent Chair of the DHR will:*
  - a) Chair the Domestic Homicide Review 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 their agency at the panel: Review 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 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 LBTH CSP
- j) Implement your agency's actions from the Overview Report Action Plan.

**LBTH CSP:**

- 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 Standing Together Agree publication date and method of dissemination for the Executive Summary and Overview Report.
- d) Notify the family, Review Panel and Standing Together of publication.

**The London Borough of Newham CSP:**

- a) Be an associated CSP, with responsibility for supporting the DHR process.
- b) Nominate a Single Point of Contact to be a member of the Review Panel.
- c) Facilitate the engagement of other Review Panel members from Newham as appropriate.
- d) Support the translation of any recommendations from Overview Report into a SMART Action Plan where they relate to Newham and takes responsibility for progressing these.

**Definitions: Domestic Violence and Coercive Control**

10. The Overview Report will make reference to the term 'domestic violence and abuse' 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**

11. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both Salma and the Omar (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).
12. The Review Panel identified the following protected characteristics of Salma and of Omar as requiring specific consideration in this case:
  - Age (there was a 16-year age gap between Salma and Omar)
  - Race (both Salma and Omar were of Bangladeshi origin)
  - Religion and belief (both Salma and Omar are believed to have been of the Muslim faith)
  - Sex (Salma was female, Omar is male)
13. The following issues have also been identified as particularly pertinent to this homicide:
  - English as a second language and the use of translators (some agency records have highlighted that Salma and / or Omar may have had limited English)
  - Immigration (both Salma and /or Omar were of Bangladeshi origin and both had become naturalised British Citizens)
14. Consideration has been 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.*” At the outset of the review, there is no evidence that either Salma and / or Omar would have met this definition.
15. *Expertise:* The Review Panel will therefore invite a local community and / or faith representative to the panel as an expert/advisory panel member to the chair to ensure they are providing appropriate consideration to the identified characteristics and to help understand crucial aspects of the homicide.
16. The Independent Chair will make the link with relevant interested parties outside the main statutory agencies as required.
17. The Review Panel agrees it is important to have an intersectional framework to review Salma and Omar 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.

## **Membership**

18. 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.
19. The following agencies are to be on the Review Panel:
- a) Barts Health NHS Trust
  - b) Clarion Housing
  - c) Primary School for Child B and C<sup>98</sup>
  - d) East London NHS Foundation Trust (ELFT)
  - e) GP
  - f) GP Care Group (Health Visiting / School Health)
  - a) Hestia Domestic Abuse Service (which holds a Black, Asian, Minority Ethnic and Refugee (BAMER) Refugee Contract)
  - g) LBTH Children Social Care Services (including summary of post homicide and care)
  - h) LBTH Education and Partnerships
  - i) LBTH Housing Options
  - j) LBTH Safer Communities - Drug & Alcohol Action Team
  - k) LBTH VAWG, Domestic Abuse & Hate Crime Team
  - l) Metropolitan Police Service (MPS)
  - m) Tower Hamlets Clinical Commissioning Group / LBTH Adult Social Care
  - n) Victim Support.
20. Salma/Omar had previously lived in another local authority area the London Borough of Newham. The following agencies will be invited to contribute to the review:
- a) London Borough of Newham Adult Social Care (Public Health Commissioner who is the lead commissioner for domestic abuse services)
  - b) London Borough of Newham Early Help Services / Children Social Care
  - c) North Becton Primary School (in relation to eldest child, Child A).
21. As set out in paragraph 15, the London Muslim Centre will contribute to the review as a faith and community expert representative.

### **Collating evidence**

22. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted and secure all relevant records.
23. Chronologies and Individual Management Review (IMRs) will be completed by the following agencies:
- a) Barts Health NHS Trust
  - b) Clarion Housing
  - c) Primary School for Child B and C (in relation to the youngest children, Child B and C)
  - d) East London NHS Foundation Trust (CAMHS contact in relation to eldest child, Child A)
  - e) GP
  - f) GP Care Group (Health Visiting / School Health)
  - g) LBTH Children Social Care Services (including summary of post homicide and care)
  - h) LBTH Housing Options
  - i) MPS

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<sup>98</sup> Although the Primary School for Child B and C provided information, it did not attend the Review Panel. Subsequently, Child A's Primary School was also identified and did attend the Review Panel.



24. Additionally, the following agencies from Newham will provide IMRs:
  - a) London Borough of Newham Early Help Services / Children Social Care
  - b) Child A's Primary School (in relation to eldest child, Child A)
25. Further agencies may be asked to completed chronologies and IMRs if their involvement with Salma and Omar becomes apparent through the information received as part of the review.
26. Each IMR will:
  - o Set out the facts of their involvement with Salma and/or Omar;
  - o Critically analyse the service they provided in line with the specific terms of reference;
  - o Identify any recommendations for practice or policy in relation to their agency;
  - o Consider issues of agency activity in other areas and review the impact in this specific case.
27. 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 Salma and Omar in contact with their agency.

### **Key Lines of Inquiry**

28. In order to critically analyse the incident and the agencies' responses to Salma and/or Omar, 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 Salma and/or Omar
  - c) Analyse the co-operation between different involved with Child A, B and C (generally, but with particular reference to any concerns around domestic violence and abuse) and any other family members where relevant
  - d) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
  - e) Analyse agency responses to any identification of domestic abuse issues.
  - f) Analyse organisations' access to specialist domestic abuse agencies.
  - g) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
  - h) Specific consideration to the following issues:
    - English as a second language
    - Immigration
  - i) 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**

29. 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 LBTH CSP on their action plans within six months of the review being completed.

30. LBTH CSP 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.

### Media handling

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

### Confidentiality

33. 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.
34. 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.

### Disclosure

35. 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.
36. The sharing of information by agencies in relation to their contact with the victim and/or the 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:
    - The review team should be informed about the existence of information relevant to an inquiry in all cases; and
    - 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)

## Appendix 2: Marac Referral Criteria - Definitions from SafeLives<sup>99</sup>

### Visible High Risk

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This is an assessment based on actuarial data, involving the use of risk indicators to assess the probability of serious harm or homicide. For domestic abuse cases, the number or 'yes' answers on the DASH usually determines the level of risk.

SafeLives recommends that 14 'yes' answers on the Dash should result in a referral to Marac. However, completing the DASH is not a simple 'tick box' exercise and, even where there is a lower number of ticks, professional judgement should be used to inform the overall assessment of risk. In addition, professional judgement should not be used to 'downgrade' an actuarial risk assessment.

### Professional Judgement

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Professional judgement involves an assessment of dangerousness based on an individual practitioner's consideration of a situation but will naturally use the information from the DASH checklist to inform this judgement. However, in addition to using the DASH it is crucial that professionals use their full range of knowledge to make an assessment; this knowledge will usually be gained through experience, reflection and deliberation. This form of assessment relies heavily on the skill and experience of the practitioner in order to make an informed decision of likely risk.

In domestic abuse settings, professional judgement will be informed by the practitioner's knowledge of domestic abuse and its manifestations.

Referrals to Marac can be made based solely on professional judgement. However, it is the practitioner's responsibility to articulate what their concerns are and the reasons for the referral.

### Potential Escalation

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The potential for escalation can be assessed by looking at the frequency and/or severity of abuse.

It is common practice for services to determine there is a potential for serious harm or homicide when three domestic abuse events have been identified in a 12-month period. For example, three attendances at A&E, three police call outs or three calls to make housing repairs. This should alert professionals to the need to consider a referral to Marac.

### Repeat Referral

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SafeLives defines a 'repeat' as ANY instance of abuse between the same victim and perpetrator(s), within 12 months of the last referral to Marac.

The individual act of abuse does not need to be 'criminal', violent or threatening but should be viewed within the context of a pattern of coercive and controlling behaviour.

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<sup>99</sup> Safelives (2018) *MARAC Referral Criteria*. Available at:

[http://www.safelives.org.uk/sites/default/files/resources/Marac%20Referral%20Criteria%20-%20Definitions\\_.doc](http://www.safelives.org.uk/sites/default/files/resources/Marac%20Referral%20Criteria%20-%20Definitions_.doc) (Accessed: 22nd February 2020)

Some events that might be considered a 'repeat' incident may include, but are not limited to:

Unwanted direct or indirect contact from the perpetrator and/or their friends or family  
A breach of police or court bail conditions

A breach of any civil court order between the victim and perpetrator

These events could be disclosed to any service or agency including, but not exclusive to, health care practitioners (including mental health), domestic abuse specialists, police, substance misuse services, housing providers etc.

## Appendix 3: Clarion Housing Check List for Compliance with the Pre-Action Protocol

1. Was the tenant contacted as soon as reasonably possible when the account fell into arrears, to discuss the cause of the arrears, tenants financial circumstances, entitlement to HB and re payment of arrears.
2. Have copies of all letters/documents sent to the tenant from NOSP stage onwards been sent to each joint tenant separately.
3. Have we previously tried to make an arrangement with the tenant for an affordable sum to be paid off the arrears?
4. If any arrangements were made, were we clear about any time limits for payments to be made.
5. Have rent statements been sent regularly or a one off statement sent if requested.
6. Are we aware that the tenant has difficulty in reading and/or understanding the info given/letters sent etc? If so, have we taken reasonable steps to ensure that the info has been appropriately communicated in ways that the tenant can understand?
7. Vulnerability;
  - a) Is the tenant aged under 18 years old?
  - b) Are we aware that the tenant is particularly vulnerable?
  - c) Do we have any doubts that the tenant has the mental capacity to defend possession proceedings?
  - d) Are there any issues arising under the Disability Discrimination Act?

If the answer is YES to any of the above, was this included in the court application and did we ask the court to consider appointing a 'litigation friend' to represent the tenant in court.

8. If the tenant meets the appropriate criteria, have we arranged for the arrears to be paid by the Dept for Works and Pensions from the tenants other benefits?
9. Housing Benefit Applications - Have we assisted the tenant in applying for HB?
10. Housing Benefit Entitlement
  - a) can the tenant demonstrate that he/she has provided the local authority with all the evidence required to process their claim
  - b) Can the tenant demonstrate/provide that there is reasonable expectation of eligibility for housing?
  - c) Has paid other sums due not covered by housing benefit?

If the answer is YES to the above, court proceedings should not be taken unless in exceptional circumstances

11. Have we made effort to obtain info form Housing Benefits as to progress with the claim/entitlement?
12. Have we offered assistance/advice on other benefits entitlements, debt counselling etc or signposted the tenant to appropriate advice agencies if service not provided in house?
13. Did we try and make contact with the tenant prior to commencing court proceedings, to discuss e.g. cause of arrears; repayment options, benefits entitlements etc?
14. If we previously held off court proceedings base upon an arrangement made after service of NOSP and the tenant defaulted on the ARR, did we warn the tenant of our intention to take court action and give clear timescale to be brought back in line?
15. Can we show that we have made every effort to resolve the matter before taking court action? E.g. Have we suggested the tenant seeks advice from other sources e.g. CAB. If appropriate have we been willing to allow agencies to negotiate with us on behalf of the tenant and willing to agree reasonable arrangements for payments?
16. At least 10 days prior to the hearing have we provided;
  - a) An up to date statement
  - b) Disclosed to the tenant our knowledge of their housing benefit position
17. Have we informed the tenant of the date, time and place of the hearing when known and advised the tenant to attend as their home is at risk?
18. Has the tenant complied with an arrangement made to pay off arrears, after court action already commenced? If so then we should agree to POSTPONE court proceedings as long as the arrangement is kept to.

(If tenant fails to maintain payments we should advise of our intention to bring proceedings, giving the tenant a date for payment to be brought up to date before doing so)

## Appendix 4: Single Agency Recommendations and Template Action Plan

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
<b>Barts Health</b>						
Health Advocates should be used for all pregnancy appointments, particularly the booking appointment	<i>Local</i>	<p>Ensure health advocates are used for all pregnancy appointments.</p> <p>Ensure workers identify any interpreting needs from the outset.</p> <p>Ensure all midwives have access to on site health advocates and language line.</p> <p>Update the Antenatal Care Guideline to include instruction to midwives to use interpreters for appointments.</p>	<i>Barts Health</i>	<p>Inform staff of need to use health advocates and interpreting services.</p> <p>Antenatal Care Guidelines to be updated to incorporate recommendation.</p>	<i>December 2020</i>	<p><i>December 2020</i></p> <p><i>Improved system in place to enable improved support for pregnant women with language barriers</i></p>



<b>CAMHS (provided by ELFT)</b>	<b>Scope of recommendation</b>	<b>Action to take</b>	<b>Lead Agency</b>	<b>Key milestones in enacting the recommendation</b>	<b>Target Date</b>	<b>Date of Completion and Outcome</b>
MDT discussions are recorded routinely in clinical records. TH CAMHS clinical team leads to review systems to ensure that the outcome of MDT discussions in cases where the parents are reporting that their child is refusing to attend and has never been seen, are included in and inform the action plan	<i>All CAMHS MDT's</i>	All CAMHS MDT clinical discussions are routinely recorded on Rio including risks, safeguarding, rag rating and care planning.  Include plan for engagement and multi-agency communication if non-attendance.	<i>CAMHS</i>	Continue to review the established practice within all MDT's and audit accordingly.	<i>April 2020</i>	<i>April 2020</i>  <i>Improved recording process in place to enable improved care planning</i>
Tower Hamlets CAMHS leadership team to remind staff of their duties of documenting clinical supervision case discussions on to RIO	<i>All CAMHS clinical staff</i>	All case discussions in supervision are recorded routinely on Rio clinical record.	<i>CAMHS</i>	Policy reiterated verbally and in writing to all clinicians, clinical supervisors and line managers in accordance with ELFT supervision policy.	<i>October 2020</i> <i>DHR presented at whole staff meeting and established supervision policies reiterated in this context</i>	<i>October 2020</i>  <i>Improved recording process in place to enable improved care planning</i>
Tower Hamlets CAMHS to continue to communicate care plans verbally and by letter copied to GP directly following families	<i>CAMHS</i>	CAMHS standards now ensure there is both written and verbal communication of assessment and care	<i>CAMHS</i>	Adherence to ELFT CAMHS paperwork standards regularly audited and managed for	<i>Line management is monthly. Audit of paperwork</i>	<i>April 2020</i>  <i>Improved recording process in place</i>

attendance at assessment clinics		plans within two weeks of initial contact and a comprehensive written summary within 8 weeks. This is audited for compliance regularly.		individual clinicians in line management supervision.	<i>standards occurs every six months.</i>	<i>to enable improved care planning</i>
Tower Hamlets CAMHS leadership team to ensure that ELFT Guidelines from risk of violence assessment (appendix 4) are circulated and then made readily available to staff via the intranet	<i>All CAMHS clinical staff</i>	At the 4 designated SIR staff meetings per year, ELFT risk of violence guidelines to be shared with written follow-up to all staff.  Upload of the policy on local and Trust wide intranet.	<i>CAMHS</i>	Next designated SIR whole staff meeting.	<i>November 2020</i>	<i>November 2020</i>  <i>Improved awareness for staff on risk assessments to ensure improved safeguarding</i>
Tower Hamlets CAMHS clinical leadership to ensure that all staff are aware that in all new assessments, there is a record that past RIO records have been reviewed and relevant action plans taken into account, based on the review of notes	<i>All CAMHS clinical staff</i>	Support clinical team leads and clinical supervisors to ensure this practice is adhered to routinely when assessing new cases.  Review of previous notes to be documented in new assessment record including all known referrals and previous safeguarding concerns.	<i>CAMHS</i>	Update of line management policy April 2020.  Reiteration of policy for clinical team leads and all clinical staff at SIR whole staff meeting November 2020.	<i>November 2020</i>	<i>November 2020</i>  <i>Improved awareness for staff on risk assessments to ensure improved safeguarding</i>

<p>Tower Hamlets CAMHS to consider routinely checking for past or current involvement with social services at point of referral</p>	<p><i>Triage and Duty Team</i></p>	<p>Review the possibility of sharing all accepted referrals regularly with social care in order to see if there is current or previous involvement. Options include having regular referral data shared with social care or shared access to data systems across agencies.</p>	<p><i>CAMHS and CSC</i></p>	<p>Once we agree an adequate and safe data sharing process with CSC partners.</p>	<p><i>January 2020</i></p>	<p><i>January 2020</i>  <i>Improved awareness for staff on risk assessments to ensure improved safeguarding</i></p>
<p>Tower Hamlets CAMHS clinicians are able to access safeguarding and clinical training relating to domestic abuse from a variety of sources. Clinical supervisors to ensure that CAMHS staff are aware of the range of training available</p>	<p><i>All CAMHS clinical staff</i></p>	<p>Mandatory requirement for all CAMHS clinical staff to attend domestic abuse training.</p>	<p><i>CAMHS</i></p>	<p>Ensuring monthly and annual compliance with training objectives for whole staff team.</p>	<p><i>Ongoing</i></p>	<p><i>January 2020 and ongoing training available</i>  <i>Improved staff awareness and training on domestic abuse to ensure DV disclosures are responded to effectively</i></p>
<p>Tower Hamlets CAMHS staff to be refreshed on and recirculate NICE guidelines on Conduct Disorders and to consider providing assessment guidance to</p>	<p><i>All CAMHS staff and CAMHS specialist Conduct Pathway</i></p>	<p>CAMHS Conduct team to lead a refresher session on Nice guidelines and locally developed approaches for assessment and</p>	<p><i>CAMHS</i></p>	<p>Refresher session organised for December 2020.</p>	<p><i>December 2020</i></p>	<p><i>December 2020</i>  <i>Improved staff awareness and training on NICE guidelines to</i></p>

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clinicians for children and adolescents presenting with violence or aggression		<p>intervention for Conduct problems.</p> <p>Audit to be designed and carried out to ensure compliance with Nice guidelines and quality standards with respect to YP presenting with Conduct issues.</p>		<p>Audit planned for April 2021.</p>	<p><i>April 2021</i></p>	<p><i>ensure compliance</i></p>
Tower Hamlets CAMHS to consider implementing a pathway for young people presenting with violence or aggression and/or those that are hard to engage, as illustrated by the City and Hackney Conduct and Outreach pathway		<p>Conduct Pathway and dedicated MDT established in Tower Hamlets CAMHS since 2016 with ongoing development of individual and group offer.</p> <p>Increase outreach capacity for this client group.</p>	<p><i>CAMHS</i></p>	<p>Development of NVR parenting offer which is now accessible remotely.</p> <p>Regulate emotions boxing and music groups established.</p> <p>Implementation of advanced outreach team by April 2020.</p>	<p><i>April 2020</i></p>	<p><i>April 2020</i></p> <p><i>Improved pathway for young people presenting with violence or aggression</i></p>
Tower Hamlets CAMHS to review systems to ensure that MDT meetings and clinical supervision discussions are clearly recorded in the clinical records	<p><i>Refer to above</i></p>	<p>Conduct Pathway and dedicated MDT established in Tower Hamlets CAMHS since 2016 with ongoing development of individual and group</p>	<p><i>CAMHS</i></p>	<p>Development of NVR parenting offer which is now accessible remotely.</p> <p>Regulate emotions</p>	<p><i>April 2020</i></p>	<p><i>April 2020</i></p> <p><i>Improved pathway for young people presenting with violence or</i></p>

		offer.  Increase outreach capacity for this client group.		boxing and music groups established.  Implementation of advanced outreach team by April 2020.		<i>aggression</i>
Tower Hamlets CAMHS to review systems to ensure that interpreting services are booked routinely for initial assessment if referral states that the clients cannot speak English. Giving the patient the option to refuse if not needed	<i>All CAMHS staff</i>	Duty and triage teams now routinely screen referrals, contact referrers and families in order to organise the best possible interpreting service or cultural advocacy as required.  Consideration to be given to cultural advocacy representation in all triage referral discussion meetings.	<i>CAMHS</i>	Establishment of regular cultural advocacy in triage referral meetings, supported by our local equality agenda.	<i>December 2020</i>	<i>December 2020</i>  <i>Improved system in place for interpreting ensuring non English-speaking clients are able to effectively communicate needs</i>
Tower Hamlets CAMHS to ensure clinicians are aware of the systems for accessing telephone interpreting services if face to face interpreter is not possible	<i>All CAMHS staff</i>	Reiterate the policy for admin to support clinicians in arranging telephone interpreting services as cited in local established policy.	<i>CAMHS</i>	To be discussed at whole staff meeting in October or November and shared in writing with whole staff team including admin.	<i>November 2020</i>	<i>November 2020</i>  <i>Improved system in place for interpreting ensuring non English-speaking clients are able to effectively communicate needs</i>

<p>There are clear supervision structures for Tower Hamlets CAMHS clinicians involved in the assessment, management and safeguarding of young people presenting with violence and aggression. Clinical team leads to ensure that clinical discussions in supervision are clearly documented</p>	<p><i>All CAMHS staff and CAMHS specialist Conduct Pathway</i></p>	<p>CAMHS Conduct team to lead a refresher session on Nice guidelines and locally developed approaches for assessment and intervention for Conduct problems.</p> <p>Audit to be designed and carried out to ensure compliance with Nice guidelines and quality standards with respect to YP presenting with Conduct issues.</p>	<p><i>CAMHS</i></p>	<p>Refresher session organised for December 2020.</p> <p>Audit planned for April 2021.</p>	<p><i>December 2020</i></p> <p><i>April 2021</i></p>	<p><i>December 2020</i></p> <p><i>Improved staff awareness and training on NICE guidelines to ensure compliance</i></p>
<p>Tower Hamlets CAMHS clinicians are able to access safeguarding and clinical training relating to domestic abuse from a variety of sources. Clinical supervisors to ensure that CAMHS staff are aware of the range of training available</p>	<p><i>All CAMHS clinical staff</i></p>	<p>Mandatory requirement for all CAMHS clinical staff to attend domestic abuse training.</p>	<p><i>CAMHS</i></p>	<p>Ensuring monthly and annual compliance with training objectives for whole staff team.</p>	<p><i>Ongoing</i></p>	<p><i>Improved staff awareness and training on domestic abuse to ensure DV disclosures are responded to effectively</i></p>

Housing	Scope of recommendation	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
The sharing of recent and wider safeguarding concerns with registered providers of social housing at the tenancy nomination stage would be relevant to its housing management function”	<i>Local</i>	To ensure nomination form is reviewed to ensure support and safeguarding information is captured for use by housing association partners	LBTH HO/LBTH Common Housing Register Partners	Engage with registered housing providers in Tower Hamlets and review the housing nomination form. Common Housing Registered partners to agree revised form to ensure safeguarding and support needs adequately and sensitively captured.	31 March 2021	<i>March 2021</i>  <i>Improved system in place to enable more effective information sharing for DA cases.</i>

Newham Children’s Social Care and Early Help	Scope of recommendation	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
SafeLives Risk Assessment should be completed routinely in domestic violence cases and consideration taken of types	<i>LBN Social Care and Early Help</i>	All practitioners to receive training on how to use SL Risk Assessment and score appropriately.	Early Help Service	This will be delivered as part of the NewDAY domestic abuse innovation transitional offer	<i>30<sup>th</sup> November 2020 – 30<sup>th</sup> July 2021</i>	<i>July 2021</i>  <i>Improved training and awareness around risk assessments and</i>

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of abuse outlined in the Power and Control Wheel.		All practitioners to complete a Safelives Risk Assessment as part of the Early Help Assessment in domestic abuse cases.		across Children's Services training, consultation and specialist supervision.		<i>earlier intervention of DA clients</i>
Training in these tools, general training in Domestic Abuse and MARAC refresher training should be provided for Practitioners	<i>LBN Children's Social Care and Early Help, Designated safeguarding leads and interpreter service</i>	All practitioners to undertake MARAC training to understand purpose, threshold and referral pathway.  All practitioners to be able to identify domestic abuse, risk assess and identify high risks cases that require MARAC involvement.	Early Help Service and NewDAY transitional programme manager	Schools and community early help agencies have received domestic abuse awareness training Further specialist training as 1. above is timetabled	<i>March 2019</i>  <i>31<sup>st</sup> March 2021</i>	<i>March 2019</i>  <i>Improved training and awareness around risk assessments and earlier intervention of DA clients</i>
Risk assessments should clearly identify triggers which would indicate a change in the level of risk and the assessment should be reviewed at these points. Evidence clearly indicates relationship breakdown, reconciliation, pregnancy and major life events such as bereavements as trigger points, but assessments	<i>Early Help</i>	To support the development of skills and confidence of practitioners in working effectively with men who are alleged to have been violent within their family relationships in order to compile the best assessments of family need.	NewDAY innovation programme manager	Develop a referral pathway to specialist providers such as CGL, Adfam, Troubled Families Employment Advisors, Newham Workplace is available.	<i>30<sup>th</sup> November 2020</i>	<i>November 2020</i>  <i>Improved training and awareness around risk assessments and earlier intervention of DA clients</i>



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should be individual to each case		.	Lead officer – Working with Men	Skill up staff using the Working with Men workshop sessions and toolkit.	20 <sup>th</sup> October 2020 - 31 <sup>st</sup> March 2021	
Practitioners working with families where domestic abuse is a factor should ensure they take into consideration any support that could be offered to the perpetrator to address contributing factors such as substance misuse, worklessness and gambling however it should be taken into account that perpetrator work in relation to violence itself is specialist and may require referral to a specialist agency	<i>LBN Early Help</i>	Develop links with local specialist support services and refer to as appropriate.  Utilise the in-house 'Caring Dads' group intervention programme for men who have abused, neglected, or exposed their children to domestic violence.	NewDAY innovation programme manager  Lead officer – Working with Men	Develop a referral pathway to specialist providers such as CGL, Adfam, Troubled Families Employment Advisors, Newham Workplace is available.  To skill up the staff using the Working with Men workshop sessions and the toolkit.	30 <sup>th</sup> November 2020  20 <sup>th</sup> October 2020 - 31 <sup>st</sup> March 2021	November 2020  <i>Improved training and awareness around risk assessments and earlier intervention of DA clients</i>
Interpreters/Translators should complete domestic abuse awareness training	<i>LB Language Shop</i>	Domestic abuse awareness training to be provided to our commissioned translation and interpreting service.	NewDAY transitional programme/Safe lives	Use interpreters in systemic approaches when working with domestic abuse to test the model.  Wider role out of domestic abuse	November 2019  January 2021	November 2019  <i>Improved training and awareness around risk assessments and earlier intervention of DA clients where</i>

			Newham Social Care Academy	awareness training to interpreting service.  Research project with University of East London to better understand the interpreting experience.	November 2020 – June 2021	<i>English is a second language</i>
Referrals should be made to Domestic Violence Support Services at the point of contact with the local authority or other agencies (already in place)	<i>LBN Newham MASH</i>	MASH and EHH practitioners to routinely refer contacts to Domestic Violence Support Services when consent has been obtained.	MASH and EHH	Hestia, our commissioned domestic violence service is routinely notified of all DV MASH contact at point of contact.	<i>In place</i>	<i>Complete and ongoing</i>  <i>Hestia contract in place and DA clients are referred, supported and staff awareness in place for raised awareness of signposting</i>
System Connectivity should be explored and there should be more information sharing between Local Authorities and Commissioned Providers (i.e. Hestia) so that we know if DV services are actively working with a family	<i>LBN Newham MASH and Early Help</i>	Risk assessment, threshold decision making and information sharing protocols to be strengthened.	MASH/EHH/ Multi-agency partnership	An additional question has been added to Newham MASH portal requesting that the parent consents to agency checks to determine appropriate intervention for a	<i>August 2020</i>	<i>August 2020</i>  <i>Improved information sharing protocols to ensure better risk management</i>

				<p>family.</p> <p>NAM replaced with a weekly Early Help Support Co-ordination Panel (EHSCP) with improved panel membership to strengthen the sharing of information.</p> <p>Improved system connectivity and information sharing between social care system (Azeus) and schools' safeguard system through hub.</p> <p>Operation Encompass has been in operation since January 2019 with 95% school sign up.</p> <p>Support to Designated Safeguarding</p>	<p><i>In place</i></p> <p><i>In place</i></p> <p><i>In place</i></p> <p><i>In place</i></p>	
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				Leads by specialist DV teachers.  Hestia (commissioned DV service) acknowledges receipt of referral, informs practitioner of named Case Worker and work undertaken.	<i>In place</i>	
Consideration should be given to reviewing Information Sharing Protocols in the light of this IMR	<i>LBN Newham Early Help/Brighter Futures</i>	Take recommendation to MASH Board and consider reviewing Information Sharing Protocol.	Head of Service MASH. Assessment, EDT, NRPF	MASH Board leadership to ensure review.	<i>March 2021</i>	<i>March 2021</i>  <i>ISA reviewed and improved ISA in place</i>
Protocols for information sharing when families relocate out of borough should be reviewed and / or developed	<i>LBN Newham Early Help/Brighter Futures</i>	Take recommendation to MASH Board and consider reviewing Information Sharing Protocol.	Head of Service MASH. Assessment, EDT, NRPF	MASH Board leadership to ensure review.	<i>March 2021</i>	<i>March 2021</i>  <i>ISA reviewed and improved ISA in place</i>



		and to provide contact details should assistance be required in creating a referral.		actions complete.		<i>and risk management partnerships</i>
It is recommended that North East BCU SLT monitor and supervise Domestic Abuse closing reports to ensure there is an understanding and compliance with MPS and Local Authority Guidelines for MARAC referral	<i>Local BCU</i>	All Safeguarding Domestic Abuse Strand Detective Inspectors to be instructed to ensure that the Domestic Abuse Strand Detective Sergeants complete a closing report and document consideration for or referral to MARAC.	MPS North East (NE) Area Basic Command Unit (BCU)	Quarterly recommendations meetings held at BCU Commander Level to ensure governance and actions complete.	<i>February 2020</i>	<i>February 2020</i>  <i>Improved monitoring of DA cases to ensure compliance of good practice.</i>
It is recommended that North East BCU SLT remind all staff of the requirements of the National Crime Reporting Standards, with regards to prompt reporting of the allegations of crime	<i>Local BCU</i>	Safeguarding Domestic Abuse Strand Detective Inspector to attend Emergency Response Policing Teams (ERPT) parades for each leave line and give a briefing to all frontline officers around Domestic Abuse/ Violence.	MPS North East (NE) Area Basic Command Unit (BCU)	Quarterly recommendations meetings held at BCU Commander Level to ensure governance and actions complete.	<i>February 2020</i>	<i>February 2020</i>  <i>Improved safeguarding processes and awareness of staff</i>

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<p>It is recommended that North East BCU SLT ensure that all supervisors of rape and penetrative sexual offences are aware of and give due consideration to obtaining EIA from CPS RASSO and that this is documented as part of the investigation strategy</p>	<p><i>Local BCU</i></p>	<p>Safeguarding Sapphire Strand Detective Inspectors to be instructed to remind all Sapphire Strand Detective Sergeants to document consideration of Early Investigative Advice within the decision pages of crime reports.</p>	<p>MPS North East (NE) Area Basic Command Unit (BCU)</p>	<p>Quarterly recommendations meetings held at BCU Commander Level to ensure governance and actions complete.</p>	<p><i>February 2020</i></p>	<p><i>February 2020</i></p> <p><i>Improved staff awareness in place re: sexual offences considerations</i></p>
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<p><b>North Beckton Primary School</b></p>	<p>Scope of recommendation</p>	<p>Action to take</p>	<p>Lead Agency</p>	<p>Key milestones in enacting the recommendation</p>	<p>Target Date</p>	<p>Date of Completion and Outcome</p>
<p>Children to understand what a positive relationship looks like through P4C/PHSCE and Bounce back days or Headstart Champions sessions</p>	<p><i>Local</i></p>	<p>Deliver: P4C/Time for Us lessons Bounce back days Head start sessions</p> <p>NSPCC days</p>	<p>NBP School</p>	<p>September 2019-2020 &amp; 2020-2021 for all year groups</p> <p>October 2017 &amp; October 2020</p>	<p><i>All pupils to receive training between 2019-2021</i></p>	<p><i>All pupils to receive the training by 2019/2020</i></p> <p><i>Training is having an impact on how to keep themselves safe and positive relationships, developing positive friendship, resilience, assertiveness, and</i></p>

						<i>reading body language</i>
Safeguarding team to attend training on Domestic Violence training	<i>Local</i>	Domestic Abuse and Child Protection training to be offered.	Designated Safeguarding Leads	The DSL learnt about the impact of domestic abuse on adult victims and their children, why domestic abuse is a safeguarding issue for children and the routes for help and protection.  DSL was able to offer additional resources that were available in the local area.	<i>September 2019</i>  <i>September – December 2020</i>	<i>September 2019</i>  <i>Improved staff awareness on safeguarding re: DA cases</i>
Safeguarding team to provide training for the all staff members in relations to Domestic Violence	<i>Local</i>	Coordinate safeguarding training for staff.	NBP School	Liaise with Safeguarding Team  Coordinate and arrange staff training dates	<i>Staff to be trained by September 2020</i>	<i>September 2020</i> <i>Increased staff are aware of the impact of domestic abuse on adult victims and their children, why domestic abuse is</i>



						<i>a safeguarding issue for children and the routes for help and protection.</i>
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<b>THGPCG</b>	<b>Scope of recommendation</b>	<b>Action to take</b>	<b>Lead Agency</b>	<b>Key milestones in enacting the recommendation</b>	<b>Target Date</b>	<b>Date of Completion and Outcome</b>
<p>To ensure that the current development of the organisational domestic abuse policy and on-going training additionally includes:</p> <ul style="list-style-type: none"> <li>• The need to ask about Domestic Abuse at the initial contact with the Health Visiting Service (antenatal contact, new birth or movement in visit) and providing information about local domestic abuse services irrespective of the response.</li> <li>• The need to ask to see woman alone should partners/ family members/ friends be present at the initial visit.</li> <li>• The need to record on EMIS a plan should the above not be possible of how and when it can be asked at a future contact.</li> <li>• The need to look for opportunities to ask about Domestic Abuse at all</li> </ul>		DHR Overview and recommendations to be cascaded to all 0-19 staff.	Named Nurse for Safeguarding Children	DHR Overview and recommendations cascaded to all 0-19 staff as a practice reminder on 11.12.2019 within the 0-19 Forum.	<i>December 2019</i>	<p><i>December 2019</i></p> <p><i>Improved DA Policy</i></p> <p><i>Increased staff training on DA and improved DA practice around DA disclosures</i></p>

<p>contacts (especially at key developmental reviews).</p> <ul style="list-style-type: none"><li>• Where potential predisposing factors to domestic abuse are identified there is an increased requirement to ask at every contact.</li><li>• The need to establish, prior to visits, whether an interpreter is required and if so ensure that one is booked and the inappropriateness of using a family member to interpret</li></ul>						
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<p>To ensure that the family health needs assessment includes, but is not limited to:</p> <ul style="list-style-type: none"> <li>• Establishing immigration status</li> <li>• Recording both parents' religion</li> <li>• Household finances</li> <li>• Housing status</li> <li>• Bonding / attachment and barriers to this.</li> <li>• Knowledge of local specialist services as well as the local offer information.</li> <li>• Assessment of the impact of the above on parental relationships and parenting</li> </ul>		<p>Support for staff in undertaking routine enquiry within video contacts.</p> <p>Domestic abuse enquiry questions to be added to the EMIS template for all core health visiting contacts to enable compliance monitoring. Establishing the need for interpreters prior to key contact visits to be added to the workflow of the EMIS Admin Team.</p> <p>Domestic Abuse Policy to be written and approved via the Safeguarding Sub-Committee; Quality, Safety &amp; Governance sub-committee and the</p>	<p>Named Nurse for Safeguarding Children/ Domestic Abuse Coordinator</p> <p>Health Visiting Clinical Leads/ CHIS Co-Ordinator</p> <p>Domestic Abuse Coordinator</p> <p>Health Visiting Clinical Leads</p>	<p>Domestic abuse guidance for use in video contacts cascaded to 0-19 staff on 20.04.2020.</p> <p>Webinar sessions scheduled with the Health Visiting Service to explore barriers to asking during video contacts and to support staff in overcoming these on 29.10.2020 and 09.11.2020.</p> <p>Draft templates created 12.10.2020</p>	<p><i>April 2020</i></p> <p><i>November 2020</i></p> <p><i>November 2020</i></p> <p><i>November 2020</i></p>	<p><i>April 2020 and November 2020</i></p> <p><i>Improved DA processes and staff training including DA Policy and recording system enhanced.</i></p>
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		<p>THGPCG Board.</p> <p>Domestic Abuse Policy cascaded to all staff.</p> <p>Task and Finish Group to be convened to update the Family Health Needs Assessment.</p> <p>FHNA EMIS Template to be updated.</p> <p>Cascade updated template to Health Visitors via Locality / Team Meetings.</p>	<p>Health Visiting Clinical Leads</p> <p>Health Visiting Clinical Leads</p>		<p><i>December 2020</i></p> <p><i>November 2020</i></p> <p><i>November 2020</i></p> <p><i>December 2020</i></p>	
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<p>To ensure that that it is clearly stated in policy or standard operating procedure (SOP) and staff to be reminded of:</p> <ul style="list-style-type: none"> <li>• The need to verify address and contact details at every time the family are seen and EMIS record updated accordingly.</li> <li>• The need to establish at initial contact whether an interpreter is required and to ensure that only organisationally approved, interpreters are used at planned contacts.</li> <li>• The need to initially offer a universal plus Health Visiting service following premature delivery and consideration of support via the MECSH programme.</li> </ul> <p>The expected response to a potential non accidental injury, even if there are no obvious visible injuries”.</p>		<p>DHR Overview and recommendations to be cascaded to all 0-19 staff.</p> <p>Establishing the need for interpreters prior to key contact visits to be added to the workflow of the EMIS Admin Team.</p> <p>Expected response to a potential non-accidental injury to be included in the revised Safeguarding Children Policy</p>	<p>Named Nurse for Safeguarding Children</p> <p>CHIS Co-Ordinator</p> <p>Named Nurse for Safeguarding Children</p>	<p>DHR Overview and recommendations cascaded to all 0-19 staff as a practice reminder on 11.12.2019 within the 0-19 Forum.</p>	<p><i>December 2019</i></p> <p><i>November 2020</i></p> <p><i>December 2020</i></p>	<p><i>December 2020</i></p> <p><i>Improved DA systems and processes to ensure improved responses to DA.</i></p>
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Tower Hamlets - Children's Social Care and Early Help	Scope of recommendation	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
For consideration to be given to how consent is gained from families, when a referral is being made (to whatever service) for a broad range of services, including CSC, to be offered to them	<i>Local</i>	Update the privacy documentation to reference statutory and non-statutory types of support for the family.	LBTH CSC and Early Help	Privacy documentation updated by December 2020.  Awareness raised across the service of updated procedure by December 2020	<i>December 2020</i>	<i>December 2020</i>  <i>Increased awareness of privacy/consent procedures and processes.</i>

Tower Hamlets – Housing Options	Scope of recommendation	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Clients that disclose any difficulties within a family setting or with partners are interviewed further in an appropriate way to ascertain if there is a need for sign posting and/or referrals for assistance	<i>Local</i>	Ensure staff training and awareness of how to signpost victims effectively.	LBTH HOST	Arrange training for staff through VAWG Team.  LBTH Host Staff to familiarise self with LBTH DV Protocol.  Increased staff capacity to	<i>December 2020</i>	<i>December 2020</i>  <i>Increased staff capacity, training on DA to ensure victims are supported and signposted effectively.</i>

				<p>support and signpost victims effectively.</p> <p>Increased referrals to IDVAs from HOST.</p>		
<p>Referrals made to other professionals in the context of domestic violence and/or safeguarding are followed up to establish what, if any, further action is required from the referring agency</p>	<p><i>Local</i></p>	<p>Ensure staff training and awareness of how to signpost victims effectively.</p> <p>Commission funding of Housing IDVA and ensure co-location.</p>	<p>LBTH HOST</p>	<p>Arrange training for staff through VAWG Team.</p> <p>LBTH Host Staff to familiarise self with LBTH DV Protocol.</p> <p>Commission Housing IDVA.</p> <p>Housing IDVA Induction and introduction with all HOST staff.</p> <p>Increased referrals to IDVAs from</p>	<p><i>December 2020</i></p>	<p><i>December 2020</i></p> <p><i>Increased specialist support to victims through Housing IDVA.</i></p> <p><i>August 2020. Specialist DV and housing support funding secured will ensure victims are supported at point of disclosure.</i></p> <p><i>January 2021</i></p>

				HOST. LBTH HOST staff to work closely with Housing IDVA.		
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## Appendix 5: Multi Agency Recommendations and Template Action Plan

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
<b>Recommendation 1:</b> The Tower Hamlets CSP to satisfy itself that Child A, B and C (as well as their kinship carers) are offered support in relation to the publication of the DHR	<i>Local</i>	The social work team have been linked to Advocacy After Fatal Domestic Abuse (AAFDA) who specialise in guiding families through Inquiries including Domestic Homicide Reviews. The social work team will review and provide support, for Child A and B as well as their carers, as identified and agreed.	LBTH CSC	<p>Liaise with AAFDA to ascertain support structure.</p> <p>Identify named CSC Lead to be a single point of contact upon publication.</p> <p>Provide support with final DHR report to the children.</p>	<i>Upon sign off from Home Office. Date TBC</i>	<p><i>September 2021</i></p> <p><i>Children offered support further to publication</i></p>
<b>Recommendation 2:</b> After publication of this DHR, the Tower Hamlets CSP to ensure that this report is attached to Child A, B and C's social care records. This is so	<i>Local</i>	Identify named CSC contact to ensure report is attached to records and support is available to them.	LBTH CSC	Named CSC contact to attach final report to social care records	<i>Upon sign off from Home Office. Date TBC</i>	<p><i>September 2020</i></p> <p><i>Improved social care</i></p>

that, if they wish to read the DHR when they are older, it will be available to them						<i>records in relation to children</i>
<b>Recommendation 3:</b> The Ministry of Housing, Communities and Local Government (MHCLG) to review the learning from this case and issue appropriate guidance nationally to ensure housing providers can be informed of safeguarding concerns at the tenancy nomination stage	<i>National</i>	MHCLG to be sent final report to consider recommendation	LBTH VAWG Team/ MHCLG  MHCLG	VAWG Team to send final report to MHCLG.  MHCLG to review learning from case and feedback outcomes of recommendation consideration.	<i>July 2021</i>	<i>July 2021</i>  <i>Report sent to MHCLG for consideration</i>
<b>Recommendation 4:</b> Clarion Housing to review its new tenancy starter information to include information on domestic violence and abuse	<i>National, across all Clarion Housing stock</i>	To provide information on domestic violence/abuse during the starter tenancy process.	Clarion Housing	Senior management have agreed that operationally it would not be practical to discuss domestic abuse during this specific customer contact (i.e. the tenancy sign up process). Alternatively, the customer support team will contact the resident to complete a 'welcome call', 6 weeks after the tenancy begins. This will include all new tenants being specifically asked if	<i>March 2021</i>	<i>March 2021</i>  <i>Improved system to enable earlier identification of DA and support during starter tenancy processes</i>

				<p>they have experienced any form of domestic abuse. This mirrors the NHS Make Every Contact Count (MECC) model.</p> <p>Discuss how to implement this process nationally.</p>	<p><i>October 2020</i></p>	
<p><b>Recommendation 5:</b> Clarion Housing to review its internal checklist for compliance against the Pre-Action protocol to explicitly address domestic violence and abuse</p>	<p><i>National, across all Clarion Housing stock</i></p>	<p>Clarion to review and amend its rent arrears procedure to ensure that residents in arrears are specifically asked if they have experienced domestic abuse (including financial abuse).</p>	<p>Clarion Housing</p>	<p>The pre-action protocol is a form provided by the court and is not within Clarion's power to change (and as such Recommendations 5 and 6 are interdependent).</p> <p>Amend Clarion's national rent arrears procedure to ask resident if there are any elements of financial abuse occurring and maintain clear records of these conversations.</p> <p>Learning from the NHS Make Every Contact Count (MECC) model,</p>	<p><i>March 2021</i></p> <p><i>October 2020</i></p>	<p>December 2020</p> <p>Implementation of improved DA processes around rent arrears and Customer Accounts Team have increased understanding and around financial abuse.</p> <p>(The pre-action protocol is a document prepared by</p>

				Clarion's Head of Customer Accounts and Head of Specialist Services will review and mirror the implementation of the MECC model within Clarion's Customer Accounts service provision. This review will include the implementation of a fail-safe mechanism to ensure that in the case of joint tenants, both tenants will be contacted separately about domestic abuse.		the Ministry of Justice, so local changes could not be made. done
<b>Recommendation 6:</b> The Ministry of Justice (MOJ) to consider the learning from this case and review and / or issue appropriate guidance nationally to ensure consideration of domestic violence and abuse in the Pre-Action Protocol	<i>National</i>	MOJ to be sent final copy of DHR for learning to be considered. MOJ to feedback outcome of consideration of Pre-Action Protocol.	VAWG Team/MOJ	VAWG Team send MOJ final copy of DHR.  MOJ to consider recommendation of Pre-Action Protocol.	<i>June 2021 Home Office signed off DHR.</i>  <i>July 2021 final copy sent to MOJ</i>	<i>July 2021 Report sent to MOJ for consideration</i>
<b>Recommendation 7:</b> Clarion Housing to work with DAHA to address its concerns around the current accreditation framework in	<i>The action will impact nationally on all Clarion Housing stock</i>	Clarion to work with DAHA coordinators and other larger Registered	Clarion Housing	Clarion Housing is actively working with DAHA coordinators and other large housing	<i>March 2021</i>	<i>May 2021 DAHA accreditation</i>

<p>order to assist its decision in relation to accreditation at the conclusion of its restructure during 2020/21</p>		<p>Providers of Social Housing to inform its decision-making process regarding DAHA accreditation.</p>		<p>associations who are either starting their DAHA accreditation journey or have recently obtained the accreditation to assist Clarion in informing its decision making regarding whether it seeks DAHA accreditation.</p> <p>Clarion have reviewed the DAHA requirements and following a GAP analysis have made subsequent changes to our training and working practices.</p>		<p><i>being considered by Clarion and ensurance that staff are compliant with high level DA service to residents and staff.</i></p>
<p><b>Recommendation 8:</b> The MPS to remind police officers of the importance of reviewing the risk of domestic abuse cases when changes to circumstances occur to order to identify, as illustrated in this case, the possibility of increased risk</p>	<p><i>MPS</i></p>	<p>Safeguarding Domestic Abuse Strand Detective Inspector to attend Emergency Response Policing Teams (ERPT) parades for each leave line and give a briefing to all frontline officers around Domestic</p>	<p>North East (NE) Area Basic Command Unit (BCU)</p> <p>MPS Specialist Crime Review Group (SCRG)</p>	<p>Quarterly recommendations meetings held at BCU Commander Level to ensure governance and actions complete.</p> <p>First draft of overview report. MPS current policy around dynamic risk assessment in cases of domestic</p>	<p>February 2020</p> <p>July 2020</p> <p>December 2020</p>	<p><i>February 2020</i></p> <p><i>Increased staff awareness of risk management of DA reports</i></p> <p><i>Reviewed and improved DA Policy</i></p>

		<p>Abuse and Domestic Violence.</p> <p>Review current MPS Domestic Abuse policy and Toolkits to ensure suitability and robustness of risk assessment guidance.</p> <p>Review the outcome of other MPS DHR's within a similar time frame to identify compliance of current MPS policy and identify</p>	<p>MPS Specialist Crime Review Group (SCRG)</p>	<p>abuse considered to be adequate and readily accessible to all officers.</p>		<p><i>Recommendations grid complete and published by Specialist Crime Review Group (SCRG).</i></p> <p><i>July 2020 MPS wide recommendations included within the OV report.</i></p> <p><i>Consideration for Service Level agreement</i></p>
<p><b>Recommendation 9:</b> Newham CSP to review its local MARAC threshold against the national guidance</p>	<p><i>The scope will cover the functioning of the Newham MARAC</i></p>	<p>Officers will liaise with colleagues in Safelives and request a review of the Newham MARAC to take place that will include reviewing current thresholds</p>	<p>Newham</p>	<p>Officers will liaise with Safelives and agree a review and audit.</p> <p>The audit will be carried out by Safelives. Discussion of findings and action plan agreed.</p>	<p><i>December 2021 to be completed</i></p>	<p><i>Currently being reviewed by DA Commissioner, Safe Lives and Newham Chair</i></p>

<p><b>Recommendation 10:</b> Tower Hamlets CSP to review its local MARAC threshold against the national guidance</p>	<p><i>Local</i></p>	<p>and practice. Review of MARAC processes through consultation with MARAC Steering Group partners and benchmarking.</p>	<p>MPS/LBTH</p>	<p>Consult with London boroughs on their processes/threshold, MARAC Steering Group partners and Safelives recommendations.</p> <p>Analysis of findings and recommendations put forward for agreement.</p> <p>Implementation of agreed recommendations including reducing threshold.</p>	<p><i>June 2020</i></p> <p><i>July 2020</i></p> <p><i>August 2020</i></p>	<p><i>September 2020 MARAC review complete and local MARAC threshold reduced to mirror national guidance.</i></p> <p><i>Further improvement made to MARAC processes including increasing frequency of MARACs and number of cases discussed.</i></p> <p><i>Improved safeguarding processes in place and increased</i></p>
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						<i>number of survivors/ families safeguarded.</i>
<b>Recommendation 11:</b> MOPAC to work with boroughs to conduct a review of MARAC thresholds in London	<i>Although it is not for MOPAC to determine and mandate thresholds on a borough level – MOPAC will raise this to be reviewed at the London Framework sub-group.</i>	MOPAC will raise this to be reviewed at the London Framework sub-group. MOPAC will also be conducting a Pan London review of efficacy of MARACs in early 2021.	MOPAC, Met	Sub-group to discuss as an agenda item. Publish of review ITT.	<i>August 2021</i>	<i>Recommendation forwarded for consideration.  MOPAC commissioned STADA to conduct review whereby findings will provide insight end of December 2021</i>
<b>Recommendation 12:</b> Tower Hamlets to run a learning event with local agencies around the use of translation and take action to assure itself that: <ul style="list-style-type: none"> <li>• All agencies have robust policies and procedures in place</li> <li>• That family members are not used as translators</li> </ul>	<i>Local</i>	Revise, publish and circulate Councils Interpreting, Translation and Transcription Policy.  Run a learning event across VAWG Steering Group partnership around the use of translation	LBTH CSP	Revise Councils Policy.  Develop training for partners around use of translation.	<i>November 2020</i>  <i>October 2020</i>	<i>Complete. March 2021  Increased training, awareness and support for professionals and non English speaking</i>



<p>• There is easy access appropriately trained professional translation, including provision Sylheti were required</p>		<p>for domestic abuse victims.</p> <p>Ensure agencies are aware of appropriate policies in use of translators.</p> <p>All LBTH VAWG training includes information on best practice use of interpreters and translation services.</p> <p>IRISi training includes information on best practice use of interpreters and translation services.</p> <p>VAWG Steering Group members take action to review their interpreter /translation policy.</p>	<p>Solace</p> <p>LBTH CSP</p>	<p>Deliver training to partners to raise awareness of need for appropriate translation and interpreting.</p> <p>CSC to continue delivery of training around “Working with Bangladeshi Families”</p>	<p>March 2021</p> <p>Ongoing</p> <p>October 2020</p> <p>December 2020</p> <p>November 2020</p>	<p>victims of abuse.</p> <p>All VAWG training attendees and GP practices signed up to IRISi are informed of best practice for using interpreters/translation services and encouraged to refresh their memory on their own policies. Also advised to create/update policy/procedures if not currently active.</p> <p>All VAWG Steering Group agencies review their interpreter/</p>
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		'Translation, Interpretation and Transcription' policy promoted internally to LBTH staff.			December 2020	translation policy and share with staff to remind them. LBTH Council staff will know how to access guidelines on best practice in using interpreters and transcribers.
<b>Recommendation 13:</b> Tower Hamlets CSP to ensure that gambling is addressed in its economic abuse work programme.	<i>Local</i>	Further develop economic abuse work programme  Ensure gambling is addressed in domestic abuse training.  Include Gamcare as a form of support for perpetrators in the	LBTH VAWG Team	Identify funding for economic abuse IDVA  Commission economic abuse IDVA service in partnership with Tackling Poverty Team and DWP.  Enhance training offer around economic abuse to raise awareness of gambling related harm, links with domestic abuse.  Partnership working with Gamcare including	February 2020  July 2020  October 2020  November 2020	Complete December 2020  Increased training, awareness and support of gambling and economic abuse  Perpetrators/ professionals searching for support will consider gambling as a

		VAWG Directory.		joint training and presentation to VAWG Steering Group.		<i>concern they could be addressing. 4 economic abuse training sessions offered to professionals working with Tower Hamlets residents.</i>
				Partnership working with Licensing Team to ensure Licensing Policy includes gambling related harm, domestic abuse and encourages training and awareness.	<i>December 2020</i>	
				Online VAWG Directory is published on LBTH Council website.	<i>September 2020</i>	<i>IRISi include Gamcare as support option in IRISi GP resources.</i>
		Specific economic abuse training will be offered as part of the rolling VAWG training calendar.		Multi-agency attendees at the Economic Abuse training.	<i>March 2021 2020</i>	
				GPs accept training from IRISi.	<i>March 2021</i>	

## Appendix 6: Glossary

<b>A&amp;E</b>	Accident and Emergency
<b>BAMER</b>	Black, Asian, Minority Ethnic and Refugee
<b>BCU</b>	(MPS) Basic Command Unit
<b>CAMHS</b>	Child and Adolescent Mental Health Service
<b>CPIC</b>	(MPS) Continuous Policing Improvement Command
<b>COPA</b>	Case Overview and Preparation System
<b>CCG</b>	Clinical Commissioning Group
<b>CCR</b>	Coordinated Community Response
<b>CPS</b>	Crown Prosecution Service
<b>CPV</b>	Child to Parent Violence
<b>CRIS</b>	(MPS) Crime Recording and Information System
<b>CRM</b>	Customer Relationship Management
<b>CSP</b>	Community Safety Partnership
<b>CSU</b>	(MPS) Community Safety Unit
<b>DAHA</b>	Domestic Abuse Housing Alliance
<b>DASH</b>	Domestic Abuse Stalking and Harassment
<b>DHR</b>	Domestic Homicide Review
<b>DI</b>	[MPS] Detective Inspector
<b>EIA</b>	Early Investigative Advice
<b>EHSCP</b>	Early Help Support Co-ordination Panel
<b>ELFT</b>	East London NHS Foundation Trust
<b>FSW</b>	Family Support Worker
<b>FLO</b>	(MPS) Family Liaison Officer
<b>FOBT</b>	Fixed Odds Betting Terminal
<b>GP</b>	General Practice
<b>IDVA</b>	Independent Domestic Violence Advisor
<b>IMR</b>	Individual Management Review
<b>IIO</b>	(MPS) Initial Investigating Officer
<b>LAS</b>	London Ambulance Service
<b>LSCB</b>	Local Safeguarding Children Board
<b>MARAC</b>	Multi Agency Risk Assessment Conference
<b>MASH</b>	Multi Agency Safeguarding Hub
<b>MHCLG</b>	Ministry of Housing, Communities and Local Government
<b>MDT</b>	Multi-Disciplinary Team
<b>MERLIN PAC</b>	(MPS) report completed by police officer when they encounter a child in circumstances that cause a concern
<b>MOPAC</b>	Mayor's Office for Policing and Crime
<b>MPS</b>	Metropolitan Police Service
<b>NAM</b>	Neighbourhood Action Meeting
<b>NVR</b>	Non-Violent Resistance
<b>OIC</b>	(MPS) Officer in the Case
<b>RASSO</b>	Rape and Serious Sexual Offences
<b>SCRG</b>	(MPS) Specialist Crime Review Group
<b>SIO</b>	(MPS) Senior Investigating Officer
<b>SLT</b>	Senior Leadership Team
<b>SOIT</b>	Sexual Offence Investigation Technique

<b>TAC</b>	Team Around the Child
<b>THGPCG</b>	Tower Hamlets General Practice (GP) Care Group
<b>THSCP</b>	Tower Hamlets Safeguarding Children's Partnership
<b>VAWG</b>	Violence against Women and Girls
<b>VRI</b>	Visually Recorded Interview
<b>VSHS</b>	Victim Support Homicide Service