Final Version for Publication

TOWER HAMLETS COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the homicide of CJ

February 2014

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Associate Standing Together Against Domestic Violence

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Contents

1. Introduction

1.1 Outline of the Incident

1.1.1 In February 2014 police were called to a block of flats in the London Borough of Tower Hamlets. On arrival, the police officers found CJ lying on the floor outside her flat, her teenage son GN was crouching over her with his hand inside her chest and holding a pair of scissors. The officers arrested GN. An ambulance attended the scene and found that CJ had serious head injuries and chest wounds. She was pronounced dead at the scene.

1.1.2 **Criminal prosecution**: GN later appeared before the Central Criminal Court charged with his mother's murder. He was found not guilty of murder by virtue of insanity and sentenced to a hospital order.

1.1.3 The Panel would like to express its sympathy to the family of CJ for their loss.

1.2 The Review Process

1.2.1 This review was commissioned by the London Borough of Tower Hamlets Community Safety Partnership (CSP). The initial meeting was held on 28th May 2014 to establish the scope of the review and there have been six subsequent meetings of the Domestic Homicide Review (DHR) panel.

1.2.2 DHRs were established under Section 9 (3), Domestic Violence, Crime and Victims Act 2004 and are conducted in accordance with Home Office guidance.

1.2.3 The purpose of this and every DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply those lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.2.4 This review process does not take the place of the criminal or coroners courts proceedings nor does it take the form of any disciplinary process.

1.3 Terms of Reference

1.3.1 The full Terms of Reference are included in **Appendix 1**. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

1.3.2 The Review Panel were asked to review all contact from 1st January 2012 up to the date of the homicide. Agencies were asked to summarise any contact they had with CJ or GN prior to that date. Those agencies who had contact with CJ or GN were required to complete Individual Management Reviews (IMRs) for submission to the panel.

1.3.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. There have been delays in the process. The initial delay was caused through the complexities of the contact between the family and Children's Social Care (CSC). This required extensive work to catalogue and analyse the contact. The panel also felt it important to include the perpetrator in the review process and allow him to provide his viewpoint. This was particularly pertinent as the wider family did not know GN was suffering from severe mental illness at the time of the homicide. It took a long period for GN to be considered well enough to be interviewed. The interview with GN was considered to be a valuable part of the process.

1.4 Parallel and Related Processes

1.4.1 Two agencies conducted reviews parallel to this DHR: East London Foundation Trust's (ELFT) mental health services and London Borough of Tower Hamlets CSC.

1.4.2 **ELFT Review:** The ELFT service Tower Hamlets Child and Adolescent Mental Health Services (CAMHS) provided care to the perpetrator GN and to CJ's other two youngest children, her son HB and daughter MK. Therefore, ELFT conducted two internal management reviews. One review examined the care provided to the perpetrator GN prior to the death of his mother. The second review considered the care provided to HB and MK.

1.4.3 The ELFT reviews used the methodology of Root Cause Analysis according to the model devised by the National Patient Safety Agency.[1] The reviews examined the care provided by ELFT. All aspects of patient care over the time-period defined by the scope of the review were examined, the reviewers identifying any notable or good practice as well as any care or service delivery problems. Where care or service delivery issues were identified, the reviewers attempted to understand the underlying reasons for the difficulties. Finally, the reviewers attempted to consider any root causes for the incident and whether it was predictable or preventable by the actions of ELFT staff. Recommendations were made together with associated action plans to ensure that auditable outcomes could be achieved, GN was one subject of the review.

1.4.4 **Tower Hamlets CSC**: CSC conducted a thematic review on behalf of Tower Hamlets Safeguarding Children Board. The review considered the cases of six children concerned in cases of serious violence across the borough. GN was one of those children. The cases examined did not all involve inter-familial violence. The thematic review will use material gathered for the CSC IMR to consider the wider thematic review. It is the intention of that review to report and explore issues that fall outside the scope of this DHR's Terms of Reference.

1.5 Panel Membership

1.5.1 The panel consisted of representatives from the following agencies: -

- Barts Health
- Circle Housing Old Ford
- City Gateway School
- East London Foundation Trust – mental health services
- Lifeline – substance misuse services
- London Borough of Tower Hamlets Children's Social Care
- London Borough of Tower Hamlets Community Safety Team
- London Borough of Tower Hamlets Domestic Violence and Hate Crime Team

[1] http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

- London Borough of Tower Hamlets Safeguarding Adults
- London Borough of Tower Hamlets Youth and Community Services
- London Borough of Tower Hamlets Youth Offending Services
- Metropolitan Police Service – Specialist Crime Review Group and Tower Hamlets Borough Police
- National Probation Service, London Probation Area
- NHS England
- NSPCC
- Peacocks Gym
- Tower Hamlets Clinical Commissioning Group
- Victim Support
- Standing Together Against Domestic Violence Domestic Homicide Review Team – chair and minutes
- Full details of panel members are recorded in **Appendix 2**

1.6 Independent Chair

1.6.1 The Independent Chair of the DHR is Mark Yexley, an associate of Standing Together Against Domestic Violence (STADV), an organisation dedicated to developing and delivering a coordinated response to domestic abuse through multi-agency partnerships. Mark has received training from the then Chief Executive of Standing Together, Anthony Wills. Mark is an ex-Detective Chief Inspector in the Metropolitan Police Service with 32 years' experience of dealing with sexual violence and domestic abuse. Mark retired from the MPS in 2011. He was the head of service-wide strategic and tactical intelligence units combating domestic violence offenders, head of cold case rape investigation unit and partnership head for sexual violence in London. He was also a member of the Metropolitan Police Authority Domestic and Sexual Violence Board and Mayor for London Violence Against Women Group. Mark was a member of the Department of Health National Support Team and London lead on National ACPO and HMIC Reference Groups. Since retiring from the police service he has been employed as a lay chair for NHS Health Education Services in London, Kent, Surrey and Sussex. This work involves independent review of NHS

services for foundation doctors, specialty grades and pharmacy services. He currently lectures at Middlesex University on the Forensic Psychology MSc course. Mark has no connection with the London Borough of Tower Hamlets or any of the agencies involved in this case.

1.7 Methodology

1.7.1 The approach adopted was to seek IMRs from all organisations and agencies that had contact with GN or CJ. This also included contact with CJ's children residing with her during the period under review, her son HB and daughter CJ. CJ had children over the age of eighteen and they are not subject the IMR process. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved.

1.7.2 **Agencies Who Reviewed Files and Had No Contact:**

The following agencies were members of the panel. They had no involvement with CJ or GN and had no information for IMRs.

- London Borough of Tower Hamlets Safeguarding Adults
- National Probation Service
- NHS England
- Victim Support

1.7.3 **IMRs:**

All IMRs included chronologies of each agency's contacts with the victim and/or perpetrator over the Terms of Reference time period of 1st January 2012 to the date of the homicide.

Overall, the IMRs provided were comprehensive and the analysis supported the findings. Following comments, questions and suggestions some IMRs were redrafted and once complete were comprehensive and high quality. IMRs were received from:

- Barts Health
- Circle Housing Old Ford
- City Gateway School
- Tower Hamlets Clinical Commissioning Group

- East London Foundation Trust – mental health services
- Lifeline – substance misuse services
- London Borough of Tower Hamlets Children's Social Care
- London Borough of Tower Hamlets Community Safety Team
- London Borough of Tower Hamlets Domestic Violence and Hate Crime Team
- London Borough of Tower Hamlets Youth and Community Services
- London Borough of Tower Hamlets Youth Offending Services
- Metropolitan Police Service – Specialist Crime Review Group
- NSPCC
- Peacocks Gym

Agency members not directly involved with the victim, perpetrator or any family members, undertook the IMRs.

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

1.8 Contact with Family and Friends

1.8.1 The panel appreciates the value that families can bring to reviews. In this case an initial approach was made to the family through the police Family Liaison Officer. The responsibility for contact with the police had been taken by CJ's eldest son HB. The response from the family, through the police case officer, was that they did not want any contact with the panel or involvement with the DHR process. It was also noted that the victim's eldest son was acting as a liaison point with the criminal justice agencies. The behaviour of the eldest son, and the control he appeared to exert over the family, was a key element of concern in the review. It was decided that the panel would not be complicit in supporting the power in that relationship.

1.8.2 The panel decided to make direct contact with the victim's mother and inform her of the process. The Chair sent a translated letter to the victim's mother. There was no response to letters sent to the CJ's mother. The police were unable to provide contact details for other family members. At the time of writing CSC are

attempting contact with another family member and in order to facilitate contact with the DHR chair.

1.8.3 There were no friends of the victim known to the panel members.

1.9 Contact with Perpetrator:

1.9.1 A key element of this process was to consider the views of the perpetrator, GN. At the criminal hearing GN was found not to be criminally culpable for the homicide due to the condition of his mental health at the time of the incident. GN had never been interviewed by the police and his only account of the homicide had been obtained as part of mental health reviews. The DHR process was delayed for some time to allow treatment of the perpetrator and to consider whether he would ever be stable enough to be interviewed by non-clinical persons. The chair worked with ELFT and GN's consultant psychiatrist to ensure that GN was fit to be interviewed. The chair was eventually given permission to interview GN in May 2015. That interview was considered to be a valuable part of this review.

1.10 Equalities

1.10.1 The nine protected characteristics as defined by the Equality Act of 2010 have all been considered for conducting this review. They are; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. The victim in this case was a widowed Bangladeshi woman of the Islamic faith. Communication with the victim's mother has been through letters translated to Bengali.

1.10.2 Consideration has also been given to disability in relation to the mental health of the perpetrator. The perpetrator was also considered as a young person, being fifteen years old at the time of the attack. During the review period the perpetrator was held within a secure NHS mental health facility. The chair has liaised with clinical staff during this process. The perpetrator's consultant psychiatrist was present during the chair's interview. The chair would like to express his gratitude to NHS Mental Health professionals and ELFT clinicians on the panel for their support in ensuring that the perpetrator understood the purpose of the DHR process and for facilitating the interview. The Panel considered all the protected characteristics when analysing the facts of this case.

2. The Facts

2.1 CJ's Background

2.1.1 CJ was born in 1970 and was forty-three years old at the time of her death. She was born in Bangladesh and lived in the UK before marrying in Bangladesh. She spoke the Sylheti dialect and had limited proficiency in English. Her husband always remained in Bangladesh. The couple had six children, two boys and four girls: -

- LP: Daughter born in 1987 – twenty-six years old at the time of her mother's death. Married and living in the West Midlands with her husband.
- TW: Daughter born in 1990 – twenty-two years old at the time of her mother's death. Married and living in the West Midlands with her husband.
- RF: Daughter born in 1993 - twenty years old at the time of her mother's death. Married and living in the West Midlands with her husband.
- HB: Son born in 1996 – seventeen years old at the time of his mother's death;
- GN: Son born in 1998 – fifteen years old at the time of his mother's death; and
- MK: Daughter born in 2000 – thirteen years old at the time of her mother's death.
- It is believed by the panel that the children all shared the same father, although their surnames are different.

2.1.2 It is believed that CJ's three eldest daughters and her two sons were born outside the UK. The two eldest daughters, LP and TW, had marriages arranged at the age of fourteen years to men in the UK. CJ came to the UK in 2000 and gave birth to her youngest child, her daughter MK. When CJ came to the UK her two sons, HB and GN, remained in Bangladesh. They lived with their father in Bangladesh and moved to the UK in 2006. CJ's husband remained in Bangladesh and he died as the result of a heart attack some months after the boys had moved to the UK.

2.1.3 At the time of her death CJ lived with her children in a three-bedroom rented flat managed by Circle Housing Old Ford (CHOF). The flat was on the eleventh floor of a block.

2.1.4 CJ's main contact with statutory agencies was through her parental role. There is no record of CJ being referred to Adult Safeguarding or Mental Health Services. There is no record of CJ being in employment.

2.2 Death of CJ

2.2.1 In February 2012, the Metropolitan Police Service (MPS) were called to CJ's home. Neighbours had seen GN attacking his mother with a hammer and scissors shouting 'you killed my dad'. When the police arrived they found CJ lying on the floor of the lobby outside her flat. Her son GN was crouching over her with his hand inside her chest. He was also holding a pair of scissors. GN was arrested and struggled violently with the officers. The London Ambulance Service (LAS) attended the scene and found that CJ had serious injuries to her head and chest. She was pronounced dead at the scene. A homicide investigation was commenced by the MPS.

2.2.2 GN was detained by the police. During his detention he was examined by the Mental Health Crisis Team. He was found fit to be detained, but he was not fit to be interviewed. GN was never interviewed by police. In February 2014 GN was charged with the murder of his mother. He was remanded in custody and mental health assessments were undertaken.

2.2.3 A post mortem examination was conducted and the cause of death was determined to be due to head and chest injuries. There were severe blunt head injuries and there were sharp injuries and stab wounds to the chest, heart and lungs

2.3 GN Sentencing

2.3.1 In September 2014 GN appeared before the Central Criminal Court indicted with the murder of his mother. Legal argument took place on GN's culpability due to his mental health.

2.3.2 GN was found not guilty of murder by virtue of insanity. He was sentenced to a hospital order under s. 37 Mental Health Act 1983 with restrictions imposed under s. 41 Mental Health Act 1983.

2.4 The Perpetrator GN

2.4.1 The perpetrator GN was born in Bangladesh in 1998. He was fifteen years old at the time of the homicide. He lived in Bangladesh until he was seven years old with his father, brother and an older sister. GN has stated that his mother left him when he was five years old to come to the UK to give birth to her daughter MK. GN later described his older sister as being the maternal figure in his life. In 2006 GN moved to the UK to live with his mother, leaving his father in Bangladesh. His father died about six months after GN arrived in the UK. When he first arrived in the United Kingdom GN lived with his grandmother, mother and siblings in East London. CJ later moved with her children their own flat. GN spent a period of time in foster care between March and July 2013. This move was with GN's agreement. GN was living outside Tower Hamlets but was still looked after by Tower Hamlets CSC. GN was known to have had a girlfriend during the review period. His girlfriend was also a teenager in the care of a neighbouring local authority. At the time of his mother's death he was living with his mother and younger sister MK. His older brother HB had lived at home with his mother for a large part of the period covered by this review.

2.4.2 GN attended a number of educational establishments in the East London area. These have included a Pupil Referral Unit (PRU), local authority and independent education providers. Details of GN's contact and attendance at school is recorded in the relevant sections of this report. It should be noted that on admission to hospital after his arrest GN was assessed as having a low IQ and was described as having a learning disability by psychiatrists.

2.4.3 GN was never medically fit to be interviewed during the criminal proceedings and he has never given a public account of his actions. GN was subject of a number of psychiatric assessments between his arrest and final disposal of the case at court. These assessments concluded that he had an abnormality of mental functioning at the time of the killing. This means he is considered not to know the nature and quality of his acts. He was also diagnosed to be suffering from a mental psychosis believing his mother was a witch. There was considered opinion from his assessments that GN had previously suffered from conduct disorder. Given the complexities of GNs mental health condition, it was some time before he was fit to be interviewed by non-clinical persons.

2.4.4 During the DHR process the chair liaised with mental health services to establish whether GN would be stable enough to be interviewed and whether he would

agree to contribute to the DHR process. In May 2015 GN's consultant psychiatrist considered him fit to be interviewed and GN was willing to meet the Chair of the Review.

2.4.5 The chair interviewed GN in the presence of his doctor at a secure mental health facility.

2.4.6 During the interview GN said that he moved to the UK in 2006 and before that lived with his father in Bangladesh. He was about eight or nine years old when he left his father and his father died shortly after from a heart attack. He described his father's death as causing 'stress and hurtful'. GN said that he had then lived with his mum, brother and little sister at home. They had lived at the current family home since he was twelve to thirteen years old. The family had previously lived at another address in Tower Hamlets with his maternal grandmother. GN said he had spent six to seven months away from home in foster care, in Newham and Croydon.

2.4.7 He said that he lived in a peaceful home, but sometimes argued with his mother. They would argue about personal hygiene and his tidiness. He could not remember arguing with his brother. He spoke with his mother in Bengali at home, as his mother only spoke a bit of English. He could not name any personal friends of his mother, she got on well with friends from the job centre and his grandmother. He recounted how police were called to his home once to deal with an argument between him and his mother. He admitted throwing a pillow at her face in anger. She had wanted him to see a new born nephew in Birmingham and he was unable to leave London as he had a court date pending. He said that when the police came to the house he left and stayed with his grandmother and then at a friend's house. He did not mention any other friction and home and denied any problems with his brother, HB.

2.4.8 GN discussed his dealings with the police, saying he had been wearing a tag for three years on and off. He had been in trouble for robbery, theft and public order.

2.4.9 GN's drug use was discussed. He said that he smoked cannabis three to four times a week. He said that people at school and his social workers would not have been aware of his drug use. GN said that he was once offered help for his use of 'legal highs' when he met with CAMHS. He felt that he did not need help.

2.4.10 He described his education, stating that he went to school for four years and then got moved to a PRU. The PRU believed he was better off at college and he

went to City Gateway for a year. He was 'kicked out' of City Gateway for being aggressive towards staff. He then went to Peacocks Gym and finished his Tec there. He enjoyed being at Peacocks Gym and had no problems with attendance.

2.4.11 He reported no other health problems, apart from his mental health. He attended CAMHS (the psychiatrist present in interview confirmed that GN only attended CAMHS twice).

2.4.12 GN was asked if there was anything in his childhood that was traumatic. He said '…I did not have no mum at my side…She was not there for me when I was young'. He stated that no other person had been violent towards him at home.

2.4.13 GN recounted the day of his mother's death. He said that he was feeling ill and hearing voices in his head. He said that he had thought that his mother had killed his father. He said that he told friends that his mum had killed his dad and he was so angry. He said he went to his flat and smashed the door and accused his mother of killing his father. He then head-butted his mother and chased her with a hammer. He said that if his little sister were at home at the time she could have been hurt.

2.4.14 He said that he had experienced hearing voices a couple of days before. He said that he was seeing ghost figures and hearing voices. He did not tell professionals everything 'because they might think I'm mental'. He said that he had told social services and they had informed CAMHS. He said that this was about two weeks to a month before his mother's death.

2.4.15 GN was asked if there was anything that could have been done to stop him or help him. He said that CAMHS could have told his brother about his mental health and his brother could have looked after him. He would have deferred to his brother as his mother did not speak English.

2.5 Metropolitan Police Service

2.5.1 The MPS had a number of contacts with CJ's family over the years. The contact came through dealings with Tower Hamlets Borough Police and their neighbourhood officers and the Child Abuse Investigation Team (CAIT). Incidents of domestic abuse in London are investigated by Community Safety Units (CSU).

2.5.2 There were two incidents of note on police records that were before the timespan set in the Terms of Reference.

2.5.3 **9th December 2011:** An argument took place in the presence of an Outreach Worker who was at the family home. HB became aggressive towards his mother when she did not want his girlfriend to stay at the flat. The officers completed a Form 124D Domestic Violence report, Crime Report Information System (CRIS or Crime Report) and Child Coming to Notice report (MERLIN). The risk assessment was graded as 'standard'.

2.5.4 **10th December 2011:** MK phoned the police and said that HB had slapped and kicked their mother and he had also assaulted MK and his sister RF. Police attended the flat and saw CJ and her two daughters. They all declined to assist the police or make statements. HB was seen by a police officer and he admitted hitting his mother saying 'Why is that wrong?'. HB was arrested for causing a breach of the peace. He was later released after police consulted with his mother. A MERLIN report was completed and shared with partner agencies. This incident did not fall within the Home Office definition of Domestic Abuse due to HB's age and the CSU were not notified.

2.5.5 A search of MPS systems showed that there were ninety-six records of police contact in connection with CJ and her family between 1st January 2012 and her death. GN is mentioned in eighty-nine of these records. The police IMR revealed:

- Six MERLIN reports
- Seven CRIS reports where GN is shown as a suspect for offences including robbery, drugs, assault and threatening behaviour
- Three CRIS reports where GN is victim of robbery or assault
- Twenty-eight records of being stopped and searched or intelligence reports
- Sixteen records of breach of bail conditions
- Six records of breaching Anti-Social Behaviour Orders (ASBO)
- Twenty-three other records from CAIT or Social Services referrals or updates

2.5.6 The panel considered the entire chronology of police contact with the family. This section of the report will focus on the significant incidents known to the police.

2.5.7 **3rd January 2012:** HB reported his brother as a missing person stating that he went to a New Year's Eve party and had not returned. GN eventually returned

home on 5th January 2012, stating that he had stayed with friends. He was seen by the police, found to be in good health and no further action was taken.

2.5.8 **8th January 2012:** GN phoned the police stating that he was unhappy and wanted to be put in care. Police saw GN and his mother at home. HB was also present and acted as an interpreter for his mother. GN said that his mother was always going on at him. GN said that he had anger and sometimes felt like hitting his mother. GN felt that being in care would give him some independence. The officers explained that this would not be the case. CJ said she was happy for GN to stay at home. A MERLIN report was completed.

2.5.9 **17th January 2012:** GN was arrested for theft and assault. He had stolen alcohol from a supermarket and then armed himself with a belt and threatened security staff. GN was charged. He later appeared at East London Juvenile Court on 8th March 2012 where he pleaded guilty to theft, affray and possessing an offensive weapon. He was sentenced to a six-month parenting order and a six-month referral order.

2.5.10 Whilst GN was on bail for the theft he committed an attempted robbery.

25 February 2012: GN was one of a group of eight youths who went into a fast food shop and provoked an argument with customers. GN and another then followed customers outside and tried to steal a woman's phone. The woman's boyfriend intervened and GN ran away. GN was later arrested and charged. He was convicted of attempted robbery and on 28 June 2012 he was sentenced to a Youth Rehabilitation Order, four-month curfew with electronic tag, six-month programme requirement, costs of £150 and a three year ASBO. After GN breached this order his sentenced was varied on 30th August 2012 to Youth Rehabilitation Order and a Curfew.

2.5.11 **9th March 2012:** CJ phoned police and said that her son had left their home after an argument when he refused to go to bed. During the call to police CJ said that her son had been hitting and hurting her. Police searched the area and could not find GN. He eventually returned home at 5am. He was seen by the police and a MERLIN report was completed. The report noted that CJ was not concerned for GN's welfare or whereabouts. There was no record of a CRIS report being created and the call record states 'The circumstances of the incident do not amount to a notifiable crime'. There was no explanation to cover the comments made by CJ when she called police.

2.5.12 **22nd March 2012:** GN attended Bow Police Station with his mother to sign an Acceptable Behaviour Contract (RFC) concerning anti-social behaviour by a group of youths on estates in Tower Hamlets. This was in response to complaints of youths smoking cannabis, drinking and causing damage. GN was identified as being involved on three or more occasions. A MERLIN report was completed.

2.5.13 **12th April 2012:** GN was amongst a group of ten youths who attacked a thirty-year-old man and attempted to steal his rucksack. GN was charged on 14th April 2012. He was kept in custody until 16th April 2012 when he pleaded guilty at East London Juvenile Court. He was remanded to local authority care and his sentence was later combined with the one imposed for the attempted robbery committed on 25th February 2012.

2.5.14 **13th April 2012:** The National Society for the Prevention of Cruelty to Children (NSPCC) contacted police as they had been informed by GN's sister MK that he had been missing for two days. The NSPCC were informed that GN had been in custody for the past two days and his mother had acted as his appropriate adult at the police station. The family address had also been searched by police officers on 12th April 2012.

2.5.15 **7th July 2012:** GN was seen in the street in company with a youth, in breach of his ASBO. He was arrested. It was noted that GN appeared to regard his ASBO as a status symbol. CSC and Youth Offending Team (YOT) were informed by MERLIN report. GN was detained to appear before East London Juvenile Court on 9th July 2012 when he was sentence to a six-month conditional discharge.

2.5.16 **11th July 2012**: the MPS CAIT team at Stratford were notified by the Tower Hamlets CSC Assessment and Intervention Team (AIT) concerning a disclosure made by MK at school. It was reported that HB had struck GN causing a nose bleed. MK also expressed fears that she would be subject to an arranged marriage. Police liaised with CSC and it was agreed that an Initial Child Protection Conference (IPCC) would be held on 18th July 2012. A CRIS was created and the assault on GN was not pursued by him.

2.5.17 **16th July 2012**: A CRIS report was opened to record the involvement of police in the Child Protection (CP) conference. It was recorded as 'Child Care Issues – Specified Investigation'. There were numerous updates on this report until closure in May 2014.

2.5.18 **7th August 2012:** GN reported being robbed at knifepoint in a local park. GN said the suspects came from a local school. The matter was investigated but GN declined to make a statement or assist in identifying the suspects. A MERLIN form was completed.

2.5.19 **25th August 2012:** GN was arrested for breach in his ASBO, through association with another youth. He was charged and detained until 25th August 2012. He was later sentenced for this along with his outstanding robbery matters on 30th August 2012.

2.5.20 **22nd October 2012:** MPS were called to the family home by an anonymous caller who heard shouting and swearing. Police attended and spoke to a male at the house. The TV was found to be on at a high volume.

2.5.21 **21st December 2012:** The CAIT CRIS record was updated to state that GN and MK were to remain subject to a Child Protection Plan (CPP) and there was no action required from the police.

2.5.22 **31st December 2012:** GN was arrested for breaching his ASBO, being in the company of a person he was barred from associating with. He was taken to Bethnal Green Police Station and detained to appear at East London Juvenile Court on 2nd January 2013. He was later bailed from court to reappear on 13th February 2013. On that date he was given a Youth Rehabilitation Order, a twenty-four-hour Reparation Activity Requirement and a three-month curfew with an electronic tag. Police monitored GN by checking his address on fourteen occasions until 12th February 2013. He was found to be home on all but one occasion, and no action was taken.

2.5.23 **6th February 2013:** The CAIT CRIS record was updated to show that the CSC were monitoring the family and supporting the situation. They would trigger an early intervention if risk of significant harm develops.

2.5.24 **5th March 2013:** CAIT were notified by CSC that GN had reported an assault by HB. GN had told his key worker at college that HB had slapped him after an argument in the local park. A further fight took place at the family home and GN refused to go home and was staying with a school friend. It was jointly agreed with CSC that the matter would be raised at a CP review due on 6th March 2013. Police spoke to both brothers. HB denied hitting his brother, stating that they argued over GN's school attendance. GN refused to support the allegation and it

was closed by police on 8th March 2013. It was noted that CJ had agreed for GN to go to a short term foster placement.

2.5.25 **23rd April 2013:** GN and three other youths went to a former friend's house. During the visit GN was alleged to have threatened to stab the former friend and his family. Police arrested GN on 25th April 2013. He was in the company of a person barred from association by ASBO. GN denied making the threats. He was charged with threatening behaviour and breach of ASBO. GN was bailed to East London Juvenile Court on 26th April 2013. He was eventually sentenced to a Supervision Requirement and Youth Rehabilitation Order until 22nd May 2014. He was also given an Activity Requirement for two days and a four-month curfew with an electronic tag. A MERLIN report was completed.

2.5.26 **3rd May 2013:** GN's foster carer reported him missing after he had left that day and had not come back for his 8:00pm curfew. A missing person report was being completed when GN returned to the foster placement. He was arrested for breach of bail and detained for court the next day, when he was bailed again. A MERLIN report was completed.

2.5.27 **8th May 2013:** GN was stopped by police in Stratford High Street. He was again associating in breach of his ASBO. He was arrested. He was remanded in custody until 10th May 2013 where he received a twelve-month Rehabilitation Order, three-month curfew, twenty-four-day Activity Requirement and Supervision Requirement. There was a further arrest for breach of ASBO when GN was with a group behaving in a rowdy manner on a local estate on 13th May 2013. The case was discontinued due to incorrect wording of the charge.

2.5.28 **22nd May 2013 – 19th July 2013:** The Serco tagging company reported GN breaching his conditions on thirteen occasions. On some occasions he was detained for court. On one occasion he was at the mosque and on another he was at hospital with an injured arm. The police IMR established that there were inconsistencies in the recording of the conditions of tagging on the Police National Computer (PNC). This resulted in the order not being effectively enforced on all occasions as officers had insufficient information to justify an arrest.

2.5.29 **12th July 2013:** The CAIT file was updated on the Review Child Protection Conference (RCPC). It was recorded that there was no change in CJ's parenting and it placed MK in a vulnerable position. MK was considered to be in need of

care and protection. GN was already in foster care and being reviewed under looked after children procedures. It was decided that GN should no longer be subject to a CPP.

2.5.30 **16th – 21st July 2013:** GN was reported by his foster carer to be breaching his curfew on four occasions. He often returned home at 1:00am. The details of the curfew order could not be found on the PNC. Police reported this to Serco. Serco contacted the court concerned without response.

2.5.31 **21st July 2013:** GN was reported missing when he failed to return one evening. He was eventually found by police at his family home on 25th July 2013. GN was with his mother and they both wanted GN to stay. Police liaised with CSC and it was established that as GN was in voluntary care, he could stay with his mother if she agreed.

2.5.32 **1st August 2013:** GN was found by police, on a local estate, with a group of youths smoking cannabis. He was found in possession of an oyster card, in another's name. He was charged with possession of cannabis and fraud in relation to the misuse of the card. There is no record of any custody referral to substance misuse services. GN was bailed and eventually given an absolute discharge on both matters on 5th September 2013.

2.5.33 **19th August 2013:** Tower Hamlets CSC made a referral to CAIT concerning risks around GN and also CJ's parenting skills. The information came from a strategy meeting on GN's ex-girlfriend. Hackney CSC had informed Tower Hamlets CSC that it was believed that GN was dealing in cocaine and storing the drugs at his ex-girlfriend's foster carer's home. It was also reported that CJ had made abusive calls to the ex-girlfriend delegating her parental responsibilities for GN to her. There were also concerns that GN was exposing his ex-girlfriend to sexual exploitation by gang members. CAIT conducted intelligence checks and shared with partners on a MERLIN report on 21st August 2013. CAIT passed the intelligence on the drugs matter to Hackney Borough Police and Hackney CSC were to contact local police too.

2.5.34 **9th November 2013:** GN was arrested for breaching his ASBO through association. He was found to be in possession of a stolen mobile phone. The phone was stolen when three youths attacked a woman knocking her to the ground and kicking her. GN was charged with the breach of ASBO and bailed whilst the robbery was investigated. He was later identified as being one of the

robbers and charged on 12th December 2013. On 19th December 2013 GN pleaded guilty. He was sentenced to a six-month Youth Rehabilitation Order with a supervision requirement. He was also sentenced to a three-day programme requirement for violent offenders. This was varied on 30th January 2014 to an eighteen-month rehabilitation order with Intensive Supervision and Surveillance Programme (ISSP). There was also a sixteen-week curfew with an electronic tag, a ninety-one-day Activity Requirement and three-day programme.

2.5.35 **29th December 2013:** At 3:37pm CJ phoned police to report that she had had an argument with her son GN. CJ had wanted the family to go to Birmingham. GN had refused to go, and he would have been in breach of his curfew. The police operator initially tried to speak to CJ via a Bengali interpreter on 'Language Line'. They were told that a Sylheti interpreter was required. At that point MK came on the phone and told the operator that her mother had been assaulted and was 'bleeding from the hands' and had been 'hit with a hoover' by her brother GN. CJ was heard in the background asking for an interpreter.

2.5.36 The police recorded that this was not a domestic incident as one party was only fifteen years old. It was recorded that no assault had taken place and CJ was not bleeding. The incident was described as a verbal dispute and one party wished the other to leave the address. The police officer completed a MERLIN report and GN left the address. A CRIS report was not completed. At 10:11pm CJ phoned police and told police that GN had come home, but she would not let him in as she found him hard to deal with. Police attended the address, with the agreement of GN and CJ, they took GN to his grandmother's house. A further MERLIN report was completed.

2.5.37 The original Computer Aided Dispatch (CAD) message did not record that an assault did not take place. A CRIS report should have been completed at this stage. The MERLIN reports were noted by the Public Protection Desk (PPD); they did not forward the reports to CSC. The Police IMR notes that this was the only occasion when the MERLIN report was not shared.

2.5.38 **20th January 2014** the CAIT file on Child Protection noted the result of a review on MK. MK was noted to have shown positive changes. HB was discussed in relation to his sister's care. MK was to remain subject to a CP plan and GN was to be brought back on 24th January 2014 for an Initial Child Protection Conference (ICPC) due to his criminal behaviour placing him and his family at risk and not consenting to undergo a foster placement.

2.5.39 **27th January 2014:** GN was arrested by Tower Hamlets officers for breaching his ASBO through association. It was noted on his custody record that GN was under the influence of cannabis on his detention. He was asked in the Risk Assessment what he took, GN answered 'Zoot'. He was detained overnight to allow him to recover from the effects of cannabis.

A review of GN's custody records makes no reference to any mental health problems. During this last period of detention, he was seen by a custody nurse who advised the effects of the drugs would wear off naturally. In his past dealings with police he was always described as being calm and cooperative. During the detention of the 27th to 28th January 2014 GN became aggressive for no apparent reason when talking to a detention officer. He faced officers in an aggressive stance and had to be forcibly put in a cell. He then began kicking at the cell door and shouting. GN's mother attended the police station to act as appropriate adult. GN then later said that he felt anxious and wanted to see the nurse. He told the nurse that his head was 'vibrating'. The nurse told him he was suffering from a panic attack and told him to slow his breathing. Attempts were made to find secure non-police accommodation without success. GN was later heard to be crying in his cell. The detention officers continued to check on GN every thirty minutes without noting any incidents. There is no reference to referring GN to substance misuse services.

GN was charged with breaching his ASBO.

2.5.40 **29th January 2014:** GN appeared in custody at East London Juvenile Court on 29th January 2014, he was bailed to 30th January 2014 when he was sentenced for this matter and the robbery from November 2013.

2.5.41 **6th February 2014:** GN phoned police to report that he had been robbed of his phone by a gang of local boys. The police attended and GN varied his account of the robbery several times and said that he did not want to take the matter further. GN reported that he had been punched and kicked by his assailants. When it was noted that he had no injuries, GN said he had been punched softly. A MERLIN report and CRIS report were completed. This was the last known contact with GN before his arrest for murder.

2.5.42 **11th February 2014:** The CAIT record of CP concerns noted a result from a RCPC concerning CJ and her family held on 24th January 2014. Concerns were noted for GN's criminal behaviour, recent violent behaviour towards his mother

on 29th December 2013, possibility of a custodial sentence on 30th January 2013, GN's poor engagement with services, historic emotional neglect of GN by CJ contributing to his behaviour, recent concerns for his mental health and gang association. It was agreed that GN be subject to CPP under category of emotional abuse. A review was set for 9th April 2014.

2.5.43 **February 2014**: GN was arrested in the act of killing his mother.

2.6 East London Foundation Trust (ELFT) - mental health GN

2.6.1 There is no record of the victim, CJ, accessing or being referred to ELFT mental health services. Family contact with mental health services came through referrals to the Tower Hamlets CAMHS.

2.6.2 Tower Hamlets CAMHS assesses and treats children and young people with mental health problems and their families. The teams include psychiatrists, psychologists, family therapists and community mental health nurses trained to work with the patient group.

2.6.3 Both GN and HB were first referred to CAMHS in 2010. GN was referred via his GP from school as he had used a compass to cut the skin on his forearm. He had attended A&E. He denied any problems at home. HB was referred at the same time due to concerns about his weight loss. Neither attended the agreed appointment and then they failed to make new appointments. The case was closed by CAMHS.

2.6.4 **24th January 2013:** This victim's youngest daughter, MK, was referred to CAMHS by her CSC social worker. The referral stated that MK was on a Child Protection Plan after physical and emotional abuse from her older brother, HB, and limited protection and support from her mother, CJ. MK was also reported as feeling sad without understanding why.

2.6.5 **30th January 2013:** CAHMS requested further information from CSC. An email reply came from duty social worker, stating that MK was living under the control of her sixteen-year-old brother. CSC described her as fragile and living with one brother who is an offender and another who is fifteen and is expecting a child with his girlfriend. CSC found MK to be confused as to her identity and expectations in the family. CSC describe her mother as widowed and a glamourous non-traditional woman often out of the home with her personal life. They state MK was being told to wear a headscarf by her brother, although she

does not wish to wear one and her mother does not wear a headscarf. MK was described as "feeling vulnerable".

2.6.6 MK's case was allocated to the CAMHS care co-ordinator. MK was offered an appointment on 18th February 2013 and failed to attend. Her social worker was emailed. MK failed to attend a further appointment on 28th February 2013. The care coordinator attended a professional's meeting at MK's school on 6th March 2013. The meeting discussed the behaviour of the brothers exerting authority over MK. A further appointment was offered to MK on 29thd March 2013 and she did not attend. A further attempt was made to meet MK at home on 12th April 2013. CJ told the care coordinator that the meeting was cancelled and she was refused entry. The care coordinator noted in May 2013 that CJ was failing to bring MK to appointments.

2.6.7 **4th April 2013**: GN was referred to CAMHS by his social worker. The referral resulted from a recent review. The referral stated that GN had been on a CP plan since August 2012. He had been accommodated since 7th March 2013 following a report of physical abuse by his older brother. GN was reported to have an offending history that included stabbing and a history of alcohol misuse. He reported anger management issues. The referral also included information on GN's detention in April 2012 for robbery.

2.6.8 **15th April 2013:** HB was referred to CAMHS by his social worker. The referral describes HB as a sixteen-year-old who has perpetrated domestic violence towards his younger siblings and mother. He resented his mother bringing him to the UK whilst his father was terminally ill. He had since taken on the father's role in the home. HB had recently married his nineteen-year-old girlfriend and they had a baby on 1st April 2013. The baby was subject to care proceedings.

2.6.9 **17th April 2013:** The case was discussed in CAMHS meeting and they asked CSC to clarify what was required of CAMHS and how it related to other agencies. On 19th April 2013 CSC emailed CAMHS and stated that GN was a troubled person struggling with emotions, anger, the loss of his father and attachment to his mother. CAMHS were asked to assist HB in managing his issues of loss/separation and anger. They were also asked to consider the issue of identity which he used to justify his violent controlling response to his siblings and mother. CAMHS family therapist and CSC social worker spoke on the phone and discussed GN. GN was in a short term placement in Lewisham to keep him safe from HB. It was planned for HB to move out of the family home soon. The

social worker sought individual work with GN and he was to be seen with foster parent. HB had not engaged previously with the social worker and it was hoped he would now because of the care proceedings for his child.

2.6.10 **20th May 2013:** CAMHS child psychologist met GN with his foster father for an initial assessment. The notes record: "Mr GN is at present highly defended and cannot contemplate having the need (for therapy). However, he may benefit from encouraging the development of a therapeutic experience".

2.6.11 **23rd May 2013:** The CAMHS care co-ordinator met MK at school. She completed an assessment and risk assessment form. The care plan included helping to explore her feelings and having a family meeting to explore issues. The CAMHS risk assessment identified current risk as emotional abuse from HB. Her protective factors included: having a good friend, being able to talk to mother and GN being very supportive.

2.6.12 HB was offered a CAMHS appointment with the family therapist on 28th May 2013. He did not attend. He was offered a new appointment for 14th June 2013. After not attending, he was also offered a further appointment for 25th June 2013. HB attended the appointment. After the meeting the therapist emailed HB's social worker to say that HB perceived all his difficulties with the family to be in the past and he was focussed on his partner and new baby. The email asked the social worker if they 'shared this formulation'. The social worker replied on 4th July 2013 that HB's past difficulties may be impacting on his current behaviour.

2.6.13 **9th July 2014:** The care co-ordinator met with MK. MK described things as being better at home. HB had calmed down and wanted custody of his baby. MK misses GN, who is in foster care in Newham.

2.6.14 **10th July 2013:** The CAMHS care co-ordinator for GN wrote to a CP conference due that day. They recommended working on engagement with CAMHS, getting him to develop awareness of his psychological needs, and a therapeutic relationship.

2.6.15 **14th August 2013:** The family therapist and care co-ordinator then liaised with CSC to arrange a family appointment, to include GN. GN would be able to attend with an approved adult. On 13th August 2013 the family therapist received an email from CSC social worker that GN had returned to his mother, against the care plan of the local authority. The family meeting took place and the CAMHS workers met with CJ, HB, GN and MK. It was reported that HB was leaving it to

his mother to discipline his siblings and focusing himself on his family responsibility. CJ said that GN was not taking much notice of her boundary setting, but was not shouting. There were concerns over GN's associates outside the home. It was agreed that GN would be offered a CAMHS appointment. MK would be seen by her CAMHS worker at school. HB was not reporting any problems. A further family meeting would be arranged for October 2013. A letter was sent to the GP updating them on CAMHS work with the family.

2.6.16 **9th September 2013:** CAMHS care co-ordinator attended a CP review meeting at the family home. The outcomes of the meeting included references to: care proceedings for GN and MK, possible placement of MK with her grandmother, two non-familial sexual allegations made by MK, and GN supplying drugs in gangs.

2.6.17 **13th September 2013:** The family therapist and psychotherapist met with CJ and GN at home. It was reported that GN was more settled and it was good to be home with his mother. He valued his work with YOT worker. He spoke of feeling angry and differentiating it from losing control. GN also spoke of having to give up his dog because his mother was scared of dogs. He no longer had a girlfriend. At the time he had been excluded from college and was spending a lot of time sleeping. GN did not want individual work. He was given the offer of contacting CAMHS directly in the future or through his YOT worker.

2.6.18 **26th October 2013**: The CAMHS care co-ordinator met with MK. She was happy to stay with her grandmother but not permanently. There was an expression that MK needed her mother to show more emotional warmth. It was agreed that a bi-lingual worker would tell CJ this.

2.6.19 **1st November 2012:** There was a meeting at home with care co-ordinator of HB and GN. HB reported being stressed with the care proceedings of his daughter. MK wanted more dialogue with her mother. GN's case file with CAMHS was closed on 9th November 2013.

2.6.20 **18th December 2012:** CAMHS records note a CP conference where MK continued to be subject to a plan for physical and emotional abuse. It was reported that there had been positive changes since the last meeting and no violence. MK still had problems with school attendance. It was noted that the continued criminal behaviour of GN was placing his family at risk.

2.6.21 **9th January 2014:** There was an emergency referral of GN to CAMHS by the social worker. He was assessed by the family therapist and a trainee psychiatrist. The mother of GN's friend had become concerned about GN's behaviour changing two days before and believed he needed an assessment of his mental health. It was reported that on New Year's Eve GN had an argument with his mother over a trip to Birmingham. GN became angry and smashed the vacuum cleaner. Police were called to the home and GN stayed with a friend and his mother as a temporary measure. At his friend's mothers home, he smoked cannabis and talked of black magic and so she made the emergency referral to CAMHS. GN described himself in the assessment as having two parts to him, one part good and one bad. He also described three years of hearing voices and sounds in his head. On more detailed examination of GN, it was decided that he did not appear to be suffering from true hallucinations or delusional ideas. It appeared his problems had got worse in January after a severe argument with his mother and heavy cannabis use. The CAMHS assessors wished to request neurological assessment or a brain scan. The risk assessment was determined as low to self and others. The plan was for GN to be reviewed the following week and the family therapist would liaise with GN's social worker. The trainee psychiatrist later discussed GN with his consultant and a plan for review was agreed.

2.6.22 **10th January 2014:** The following day MK had a meeting with her care co-ordinator. MK was worried about her mother who was concerned about GN and his activities and involvement with the police.

2.6.23 **15th January 2014:** The care coordinator noted that MK was worried about her mother's benefits being cut. She was less worried because HB was not at home, he had work in Norwich. MK was spending more quality time with her mother.

2.6.24 **16th January 2014:** GN's case was discussed in the CAMHS Multi-Disciplinary Team (MDT) meeting. A referral to neurology and a second psychiatric assessment was agreed.

2.6.25 **17th January 2014**: GN had a second appointment with the family therapist and trainee psychiatrist. GN only stayed for ten minutes as his girlfriend was due to visit him from West London. He said that things had been ok. He denied hearing voices or paranoid thoughts. He believed that he may be possessed by a ghost. He was using less cannabis. He denied having any physical problems. He felt there was no need for treatment and would not go for a neurological review. He

agreed to see the family therapist again. He said he sees shadows or his shadow as a double. He also said he could see into the sun. He was assessed to be low risk to self or others with no suicidal ideation or thoughts to harm others. It was decided that the family therapist would review in three weeks. If it was considered necessary, they would invite GN to see the psychiatrist for a fuller assessment and possible exploration of an organic cause to his problems.

2.6.26 **23rd January 2014:** GN was discussed at the CAMHS MDT meeting. It was agreed that the family therapist was to continue with the case, the care co-ordinator would monitor mental state or concerns and recommend a psychiatric review. The trainee psychiatrist had a supervision meeting with their consultant. The trainee was due to leave in February 2014. The MDT plan for GN was agreed.

2.6.27 **24th January 2014:** The care co-ordinator, who dealt with MK, represented CAMHS at a CP Conference on GN. GN was present and his mother was absent. At this point details of GN's emergency admission had not been recorded on the RiO (electronic patient record) database. The trainee psychiatrist and family therapist were unable to attend the meeting and it does not appear that the care co-ordinator was briefed on the latest position with GN. GN's dealings with the police were mentioned. GN expressed concern about hearing voices and trouble sleeping due to nightmares since December 2013. There was also report of the recent incident where he had hit his mother on 29th December 2013. GN said his relationship with his mother had been improving. The conference decided that GN should be subject of a CP plan for emotional abuse.

2.6.28 **4th February 2014**: the social worker's assessment of GN was sent as the formal referral to CAMHS.

2.6.29 **4th February 2014:** The family therapist emailed the YOT worker to state they would continue to monitor GN's wellbeing 'for the time being'.

2.6.30 **February 2014:** The next contact with CAMHS was a request for a Mental Health Act assessment on GN who had been arrested for the murder of his mother.

2.7 Barts Health NHS Trust

2.7.1 The acute services had no contact with CJ and HB and limited contact with GN and his sister MK. The notable incidents of contact are outlined below:

2.7.2 The contact with GN was at the Royal London Hospital and falls outside the time scale set in the Terms of Reference. The only incident of note was in April 2011 when GN was brought to the Emergency Department (ED) by HB. GN had come home stumbling and unsteady on his feet. GN was admitted and his mother stayed with him overnight. A social services referral was made. GN also had unexplained marks on his left arm. GN also made comment that his father had passed away four years before.

2.7.3 **2nd November 2012:** CJ's daughter MK was seen at the ED complaining of body pain. She was discharged without follow up.

2.7.4 **28th March 2013:** CJ's daughter MK was seen at the ED with abdominal pain and overdose of Tranexamic acid tablets (prescribed for heavy periods). She was admitted overnight for observation and referred to CAMHS.

2.7.5 **7th November 2013:** MK was seen as an outpatient for a gynaecology appointment. She was referred for weight management and a follow up after three months.

2.8 GP

2.8.1 **29th October 2010:** CJ and GN registered at the St Stephens Health Centre. They both had very limited contact during the period under review.

2.8.2 **12th September 2011:** GN consulted with a GP and the notes of the consultation mention that an assault was reported. There is no further information available within the notes and the GP concerned no longer works at the practice.

2.8.3 **21st February 2013:** the practice was alerted to concerns for the family in a letter from social services and was advised that counselling may be helpful for the family. Telephone contact with CJ was unsuccessful and a letter was sent. The GP practice appreciate that CJ may not have understood the letter, written in English. On 22nd April 2013 CJ attended the practice for an unrelated issue. The letter and consideration of counselling was not mentioned during this consultation.

2.8.4 **27th June 2013:** GN transferred to another practice. GN moved to his new GP Upton Lane Medical Centre, Newham when he was in foster care of the local authority. He only had one appointment with the GP on 1st July 2013. He registered and informed the practice that he smoked cannabis. It appears that GN may have enquired about sexual health. Full details of the consultation are not clear and the doctor who saw GN is not currently in the UK. GP notes show that on 19th June 2013 GN attended ED and he was referred to the GP. On 6th July 2013 GN attended ED but left before he was seen. There is no other record of GN visiting the GP and no record of his care being transferred back to St. Stephens.

2.8.5 **18th December 2013:** The St Stephens practice GP received a letter concerning CJ's daughter, MK, remaining on a Child Protection Plan. GP records do not show any earlier notification concerning Child Protection Procedures.

2.9 Education – GN

2.9.1 City Gateway School is an alternative education provider for fourteen to nineteen year olds. GN came to the school with concerns from his previous school of his behaviour, poor attendance and punctuality. GN started at City Gateway School on 10th September 2012 at the start of Key Stage 4 education. He was allocated retention workers and targeted support workers and the school safeguarding team supported them. The school made early contact with CSC and YOT to coordinate the work being done with GN.

2.9.2 **5th March 2013:** GN's social worker came to the school following GN being assaulted by this brother HB. GN was placed in foster care in Lewisham and YOTs arranged transport for him to continue to attend City Gateway. Shortly after this GN became subject of bail conditions that required him not to associate with a fellow student at the school. GN was moved to a temporary site, under City Gateway, although he did return and meet with the restricted student.

2.9.3 **21st May 2013:** GN was raised as a possible perpetrator with the Sexual Exploitation Task Group. This followed an incident where he was overheard being extremely aggressive, abusive and threatening to his girlfriend over the telephone. His social worker was notified by the school. Attitudes towards women and girls were discussed with GN during mentoring sessions.

2.9.4 **4th July 2013:** GN was involved in a behavioural incident and this was the second case where he had been threatening and abusive towards a female

member of staff. Due to his behaviour and the difficulties in managing his bail conditions, it was decided to move GN to a new education provider. The targeted support team became involved together with the school safeguarding team. GN did not engage with any visits to potential new placements.

2.9.5 At the start of Autumn term 2013 GN was still at City Gateway. There had been a suggestion that he may have been moving to Birmingham, but this did not take place. City Gateway continued to seek alternative placements. GN had expressed a preference to attend Peacock's Gym and a start date was arranged for 4th November 2013. GN's move was facilitated by his targeted support workers and they continued to call and message him during his start at the new school. They also liaised with Peacocks Gym to monitor his attendance.

2.9.6 Peacocks Gym works in partnership with the local authority to provide an academy programme to deliver 'education through sport' to young people aged fourteen to nineteen. The academy works to divert young people away from gangs and crime. GN stayed at Peacocks Gym for a relatively short period.

2.9.7 During the period that GN attended Peacocks Gym he continued to receive support and contact from City Gateway. City Gateway staff attended meetings to consider GN's welfare.

2.9.8 **12th November 2013:** There was an incident at the Gym during lunchtime. GN was talking to two female members of staff and asked them for a light, addressing them as 'sister'. The students thought this funny and started laughing. GN then lost his temper and started shouting and swearing. He later apologised.

2.9.9 **11th December 2013:** City Gateway attended a Troubled Families Data Sharing meeting as there were concerns that GN and/or his girlfriend were possibly being exploited by an older female. The school safeguarding team updated the sexual exploitation task group with this information.

2.9.10 **8th January 2014:** The City Gateway Targeted Support Team received an email from GN's social worker informing them that GN had been involved in an altercation with his mother as she was about to go to Birmingham. His mother had asked GN to leave and this resulted in him staying with a friend and his mother. The support team worker tried to contact the friend's mother and eventually spoke to her on 13th January 2014. The woman who GN was staying with was very concerned about his mental health. She had taken GN to CAMHS.

The mother also mentioned that locally people were claiming that GN was possessed. On 14th January 2014 the school confirmed with GN's social worker that she was aware of the events reported. The social worker asked GN to be supported at a CAMHS meeting on the 17th January 2014 and that the school were represented at a conference meeting on 24th January 2014.

2.9.11 **17th January 2014:** The City Gateway safeguarding lead took GN to his CAMHS appointment where he met with the family therapist. It was agreed that the therapist would conduct a home visit in three weeks. After this meeting GN's attendance at Peacocks Gym deteriorated. His City Gateway targeted support worker found it difficult to contact GN. GN had no phone and was rarely at home. City Gateway staff attended the meeting on 24th January 2014 with GN. City Gateway also emailed Peacocks Gym to arrange a meeting with GN and his mother to improve his attendance. GN was given a new court order on 30th January 2014 and his attendance improved. Targeted Support continued to support GN.

2.9.12 **3rd February 2014**: Peacocks Gym staff met with GN. The aim was to discuss re-engagement to education. He was asked if he understood what was being asked of him concerning attendance, GN answered "If Allah tells me no then I will not". GN was reminded that if he did not follow directions he would be breaching the terms of his court orders.

2.9.13 **6th February 2014:** GN arrived late at Peacocks Gym. During a gym session he was seen to be coughing uncontrollably. He was seen by staff and asked if he had been smoking cannabis, he denied this and said he was smoking stuff he bought from the shops in Stratford. GN was spitting and he was given a bucket. He then vomited in the bucket. The Gym staff tried phoning CJ but there was no answer. GN was allowed to go home and was accompanied to the station at 2:00pm. On 7th February 2014 GN phoned the Gym and reported sick. He also thanked the member of staff for cleaning his face the previous day. There were no other incidents of note until GN was arrested for his mother's homicide.

2.10 Children's Social Care (CSC) and Youth Offending Service (YOS)

2.10.1 CSC in Tower Hamlets has five distinct service areas within it. These are:

The Multiagency Safeguarding Hub and the Assessment and Intervention Service (first point of contact);

Family Support and Protection (longer term social work intervention for children on CPPs and Children in Need);

Children Looked After (including the Leaving Care Service) and the Children with Disabilities Service;

Children's Planning and Review Service;

The YOS;

The Family Intervention Service; and

Children's Resources (including adoption, fostering and residential care).

2.10.2 During the review process the CSC lead commissioned a review of the combined work of these teams within Tower Hamlets. The CSC IMR does not provide a summary of involvement before the detailed review period starting on 1st January 2012. The CSC management decided to review in a thematic way rather than in a chronological examination of contact over the review period. There is a chronological account of the three months leading up to CJ's death. This section will bring together the key events identified in the CSC IMR in a chronological order and will detail specific dates where appropriate.

2.10.3 Working Together to Safeguard Children March 2015 clearly identifies the responsibility of CSC to undertake an assessment of risk if there is a likelihood that a child or young person may have suffered significant harm. This responsibility is clearly outlined in the Children Act 1989 that is the primary legislation that governs the work of CSC. It is reiterated in The Pan London Child Protection Procedures.

2.10.4 After the Munro review of child protection in 2011, London Borough of Tower Hamlets CSC developed a risk assessment model that enabled social workers to consider a range of factors pertinent to the safety of children in Tower Hamlets. The child protection process has series of checks and balances and is subject to independent scrutiny by the Child Protection Reviewing Service that acts to ensure quality standards, regularly update and review risk assessments and

provide independent scrutiny of all assessments and plans within the child protection process.

2.10.5 The Tower Hamlets YOS uses the "Asset' structured assessment tool in the management of young offenders. Asset is used by all YOTs in England. The system aims to look at a young person's offence to identify factors that may contribute to criminal behaviour. These can range from lack of educational attainment to mental health problems. Asset is also used for measuring changes in needs and risk of offending over time.

2.10.6 **8th March 2012:** The YOS first became involved with the family when GN was made subject of a Referral Order on this date for the offences of theft and affray at a supermarket. The YOS report came to the Referral Order Panel in April 2012. When interviewed for the report, GN described his family history. He admitted that he could get angry very quickly. It was acknowledged in the report that GN would not adhere to boundaries set and was a "law unto himself". GN stated that he and his mother would 'fight and argue all the time' and he would smash things in frustration. His mother shouting at him would make him angrier. Reference was made to GN's father and if anyone spoke of his father it would make him angry. CJ was also interviewed and told YOS that GN would become verbally abusive and destroy things in the house. It was assessed that GN had 'loss… bereavement and attachment issues' and it was recommended that a CAMHS referral was in the plan.

2.10.7 The YOS IMR makes no reference to addressing risks to CJ from GN.

2.10.8 CSC The Family Intervention Project (FIP) provides services to disadvantaged families. The focus is to reduce anti-social behaviour; they provide early help to chaotic families.

2.10.9 **12th June 2012:** The FIP worker contacted the Muslim Children's Safeguarding Coordinator. They reported that HB had told them that he overheard his mother discussing black magic with his eldest sister and trying to establish the name of his girlfriend's mother. CJ was blaming the girlfriend for making HB 'bad' and wanted to split them up. HB reports that his mother did not care for him concerning his health or education and would not give him house keys. In considering GN, he was noted to have been involved with a negative peer group. It was reported that HB stated that his mother particularly disliked GN. The

advice was for HB to speak with his imam and the FIP worker should underline that black magic is a myth to alleviate his fears.

2.10.10 **12th July 2012:** GN had contact with CSC. At the meeting GN was giggling and it was suspected he had been smoking 'weed'. GN told his social worker that he had to go home to change his clothes before the meeting, this led to suspicion that he had been smoking cannabis.

2.10.11 **18th July 2013:** An Initial Child Protection Conference was held to consider GN. The meeting was informed that HB had slapped his brother and their mother had tried to intervene. There was considered to be a likelihood of repetition of violence. GN and HB appeared to be imposing rules on their sister MK. At home MK was being pressured by HB to wear a headscarf and was threatened with having her hair cut off. The conference decided that MK would be subject to a CPP. This was due to physical abuse by her older brother and emotional abuse from lack of parental boundaries. GN was also subject to a CPP due to physical abuse by his brother and emotional abuse from lack of parental boundaries. HB was seen as in need due to anger management and his role in the family. CJ was present at the meeting and was referred to a parenting course, she said it would be her fourth. The aim of the plan was to strengthen CJ's parenting role and stop the threats of violence from HB, to improve the quality CJ's relationship with her children and to explore with GN alternatives to offending. The case was allocated to a social worker who retained responsibility for the period subject to this DHR review.

2.10.12 **25th July 2012**: The CP social worker recorded "Positively there is a high professional oversight within this case and the subject children appear to be working openly with the social worker".

2.10.13 **7th August 2012**: CSC social worker recorded a home visit to CJ, GN was not present. CJ was having difficulties accepting the need to have CP intervention. CJ did not want to engage and the view was that her involvement in her children's lives was minimal. There was a significant lack of attachment shown towards her son GN. There was concern expressed by the social worker whether the birth certificate produced for GN was genuine and whether CJ was the mother of the children.

2.10.14 **21st August 2012:** A YOS report to CSC recorded that on 22nd July 2012 GN was assaulted by another group of boys. The report author states that this

affected GN emotionally and he was spending less time on the streets. His risk of reoffending remained medium however, his risk of harm was assessed as being low. A YOS report on 26th August 2012 records twelve breaches by GN between 8th July 2012 and 26th August 2012.

2.10.15 **29th August 2012:** A YOS contact records GN saying he was brought up in an environment where he had to stand up for himself and not show weakness.

2.10.16 **4th September 2014**: The CSC social worker had their first meeting with GN. GN reported that things at home had improved. There have been no incidents. GN regarded HB as the 'man of the house' and his decisions overrode their mother.

2.10.17 **10th September 2012:** A core group meeting was held by CSC concerning GN starting at City Gateway College. The school explained they were concerned that HB had been reading and responding to school mail concerning GN. The school had restricted which members of staff would write to CJ. All group members agreed that the children should remain subject to CPP.

2.10.18 **18th September 2012:** In a further YOS meeting with CJ and GN CJ was challenged on her parenting abilities. CJ became verbally aggressive. CJ was asked what education establishment her son attended and she did not know. GN cited this response as evidence that his mother did not care or support him and he needed to support himself.

2.10.19 **26th September 2012:** A CP conference was held. In a YOT report to the CP Review, GN was noted to be complying with court orders but was taking lots of time and effort from the YOTs team. However, the time spent by YOTs was not considered disproportionate for the case. It was considered that there was no encouragement or support from his mother and as a result GN was drawn to his peer group as an alternative support network. There was still an outstanding educational assessment due from a psychologist. The conference decided that GN and MK were to remain subjects to CPPs. CJ was asked to call the police if HB becomes aggressive or violent. She would call CSC if she could not manage to control her children.

2.10.20 **18th October 2012:** CSC conducted a CP visit and spoke with GN. He had an in depth conversation about family history. He considered his mother a stranger and there was no pre-existing relationship. His big sister was positive towards him and treated him well. He said that he would never hurt his older sister 'but he

would hurt his mother because he does not care for her'. There is no record of a risk assessment being conducted at CSC.

2.10.21 **5th March 2013:** GN disclosed to City Gateway that he had been assaulted by his brother. GN's social worker was called to the college. GN stated that he was in a park with his girlfriend when HB approached him, slapped his face and told him to go home. On returning home HB and GN became involved in a fight resulting in GN being scratched on the head. HB punched and hit GN. GN fought back and believed that his brother went to the kitchen to get a knife. CJ tried to intervene and suggested that GN leave. GN told his social worker he wanted to stay with friends. His social worker suggested that because GN was on a tag that HB should leave. GN was insistent that he would stay with a friend even though he was on a tag. CSC made a referral to police. There is no record of a risk assessment on the safety of CJ or MK.

2.10.22 **6th March 2013:** A CP conference was held. It was concluded that GN and MK remain on a CPP. The social worker attempted to persuade GN to return home. GN said that he would stay on the streets or go back to prison rather than go home and then stormed out of the meeting. CAIT officers met GN with the social worker and GN decided not to provide a statement to the police on the assault of 5th March 2012. On 7th March 2013 an agreement was reached that GN would be temporarily fostered in Lewisham.

2.10.23 **14th March 2013:** The Family Intervention Project Service Manager emailed the YOS and CSC social worker. The email addressed the 'statutory workers' and stated "In the context of whole family work and considering the risk issues in this family across the board, I would be grateful if one of the teams working with the family could complete a DASH (Domestic Abuse, Stalking and Honour Based Violence) risk assessment and raise this family for consideration at MAPPA (MARAC)'. There were concerns that there was not a family safety plan that considered the pressure on the family. On 15th March 2013 the social worker replied that they were trying to contain the case and it appeared to be progressing. The social worker outlined a leave period and suggested that someone else complete the DASH. The social worker also requested guidance on the DASH process.

2.10.24 **3rd April 2013:** A CSC visit took place with GN. He was reported to be happy and settled in his foster arrangement. He wished to return home after his brother left and he thought he may leave soon.

2.10.25 **4th April 2013:** The CSC file records a referral to CAMHS for GN. The referral stated "Mr GN has an offending history which includes a stabbing and a history of alcohol misuse. He reports anger management issues. Recent LAC review recommended CAMHS referral. The referral contains the current social work assessment and the information of the referral to Social Care from YOT on 20.04.12 when Mr GN was remanded to Oakhill STC (Secure Training Centre) having pleaded guilty to attempted robbery". The DHR panel noted that in relation to the stabbing, GN was involved in a group that perpetrated a stabbing and the act was not committed by him.

2.10.26 **8th April 2013:** CSC referred GN to Positive Futures. Positive Futures was a Home Office funded project to reduce youth crime and anti-social behaviour. The CSC referral outlined the history of police involvement and offending history. A risk assessment considered GN's short temper and struggle with anger management. He has an aggressive response to not getting his own way. He had been known to 'lose it' with staff and young people.

2.10.27 **9th April 2013:** The CSC social worker completed a DASH risk assessment with GN. The report detailed disclosure of physical abuse by HB on GN. It outlined how HB was believed to go to the kitchen to arm himself with a knife and how CJ intervened. The report was being made on the advice of Troubled Families. Emails were exchanged with the Domestic Violence and Hate Crime Team. It was established that GN reported that HB had previously hurt his mother and MK.

2.10.28 **11th April 2013:** CSC were informed by the Domestic Violence and Hate Crime Team that the matter should be referred to Lewisham as the victim now lives there.

2.10.29 **12th April 2013:** Troubled Families team emailed Domestic Violence and Hate Crime Team. They requested the matter was managed at Tower Hamlets MARAC as the victim was only temporarily out of Borough, all of his support agencies are in Tower Hamlets, the perpetrator was in Tower Hamlets and the violence was taking place there. The response from the Domestic Violence and Hate Crime Team was 'It is MARAC procedure that a case is to be discussed in the borough where the victim is residing. This is to ensure current risks are identified and appropriate safety planning is completed'. Troubled Families replied that as there was no risk to GN in Lewisham, the referral would not be made. The MARAC coordinator suggested that the case be reconsidered when

GN returns to Tower Hamlets. It was agreed that CSC hold the referral and would pass the referral on when GN returns home.

2.10.30 **12th April 2013:** The social worker emailed the Domestic Violence and Hate Crime Team stating she had just returned from sick leave. She outlined that there was a younger sister at home but there had been no Domestic Violence towards her since July 2012. On 15th April 2013 there were emails between the social worker and MARAC coordinator. It was reported that, similar to GN, MK was also subject to HB's controlling behaviour and excessive discipline. The MARAC referral form templates were emailed to the social worker to complete.

2.10.31 **17th April 2013:** YOS conducted a home visit to GN at his foster carer and found GN to be refusing to go to college and verbally aggressive to the YOS staff. On 22nd April 2013 the foster carer told the social worker, by phone, that GN was angry and slamming doors at home. The social worker spoke with GN. GN was angry that he did not get his birthday money from CSC. GN used obscene language towards the female social worker and hung up the phone. On 25th April 2013 the social worker spoke to GN on the phone again. GN was unhappy with his travel card not being paid for. GN was verbally abusive towards his social worker using obscene language and making threats.

2.10.32 **26th April 2013:** GN left his Lewisham foster placement due to being arrested. His social worker attended Bethnal Green Police Station to deal with his arrest. He was charged with three offences. YOS recorded that GN was remanded in custody on 29th April 2013.

2.10.33 **14th May 2013:** A YOS Asset risk assessment plan determined GN's level of risk of harm to others as 'medium'. The assessor stated 'GN has grown up within an environment of physical abuse where he has been the victim of neglect by his mother which may have had an effect on his cognitive processes. Given all this GN may view violence as a way of dealing with conflict either in the community or in a domestic partnership'. At this point GN was in a remand foster placement in Newham. The plan was that this placement would be for a period of six months dependent on his behaviour. GN had recently been arrested for smoking cannabis.

2.10.34 **22nd May 2013:** A statutory local authority care report was completed on GN. It was noted that GN spoke to his girlfriend on the phone at night. He had been heard to swear, be verbally abusive and threatening towards her. He openly

discussed that he was using legal highs. A CSC care plan of 29th May 2013 states that the overall aim was to return GN home. The concerns were largely with his brother, who may be moving out. It was hoped to place GN in education in Newham but GN was refusing to comply. The local authority care plan of 30th May 2013 recommended the social worker to refer GN to Lifeline substance misuse services.

2.10.35 During the period of GN's foster placement in Newham, YOS at Tower Hamlets moved his management to Newham YOS. GN challenged this and stated he wanted to remain with Tower Hamlets. He was informed that the management from Newham was compulsory.

2.10.36 **14th June 2013:** There was a conference between GN, his social worker, Tower Hamlets YOS and City Gateway. GN had said that he wanted to move back home after Eid and he had reconciled differences with his brother. GN had also broken up with his girlfriend.

2.10.37 GN was referred to Lifeline by his social worker on 21st June 2013. It is believed this was as a result of the CPP set three weeks earlier.

2.10.38 **4th July 2013:** CSC received an email from his Retention Worker at City Gateway concerning GN's behaviour. He had threatened staff and threatened to hit people with a snooker cue. GN also made sexually abusive remarks to staff. The college were to consider permanently excluding GN. On 8th July 2013 GN was excluded for five days. On 11th July 2013 it was decided that GN should not return to City Gateway.

2.10.39 **10th July 2013:** A CP review conference decided that GN did not need to be on a CPP as he was outside the borough. It was decided that if he were to return to the family home whilst HB was there, then the meeting should be reconvened.

2.10.40 **11th July 2013:** A CSC statutory foster placement visit took place. There were concerns recorded on GN's schooling, substance misuse and relationship with his girlfriend. GN was reported to have phoned his girlfriend in the early hours of the morning and his calls were so loud and aggressive that the neighbours called the police. The carers were concerned at GN's lack of respect for women. When the social worker questioned his use of legal highs GN became abusive using obscene language. GN's girlfriend's social worker, from Hackney CSC, made contact with her to discuss her relationship.

2.10.41 **19th July 2013:** CSC received a phone call from Hackney CSC. They stated that GN was currently in Southend. He had visited his girlfriend, who was with a foster carer. When alone with his girlfriend GN had become abusive, his girlfriend was distressed. The Hackney CSC were advised to ask the foster carer to call the police if GN behaved in a threatening manner. Hackney CSC phoned again to ask if GN was still on a tag, as he was found in his girlfriend's bedroom half clothed with his girlfriend shouting 'no no'.

2.10.42 **21st July 2013:** GN was reported missing by his foster carer. The foster carer believed that GN had returned home. GN phoned CSC the next day to state that he had returned home. On 23rd July 2013 CSC noted that GN was at home and the risks were high because of all three children being at home.

2.10.43 **25th July 2013:** YOS received a call from GN's social worker. She was seeking legal advice. CJ was concerned that GN had returned but did not want to ask him to leave. On 29th July 2013 CSC confirmed that GN was at home against the terms of his care plan. On 30th July 2013 YOS recorded that GN was to be referred by CSC to substance misuse worker and CAMHS. CSC also requested work with Outreach. CSC have an Assertive Outreach team to provide additional support.

2.10.44 **2nd August 2013:** The Troubled Families Team Data Manager emailed CSC reminding them of the recommendation that a MARAC referral should be made when GN was at home with HB.

2.10.45 **7th August 2013:** There were a range of emails between Hackney and Tower Hamlets CSC. Discussing the need to set up a meeting to manage the 'highly abusive relationship' between GN and his girlfriend.

2.10.46 **7th August 2013:** GN's new Newham YOS worker phoned GN to make initial contact. GN was described as being flippant on the phone and told the YOS worker to speak to his social worker. GN refused to attend meetings with YOS and told them he was going to Birmingham, in contravention of his curfew.

2.10.47 **15th August 2013:** Legal advice on the position on GN's local authority care was provided. It was advised that the threshold criteria for care proceedings had been reached, however it may not be in GN's best interests for there to be court proceedings at that stage. CSC should continue to work with the family without placing the matter before the courts.

2.10.48 **15th August 2013:** A CSC strategy meeting was held between Hackney and Tower Hamlets to discuss GN's relationship with his girlfriend. GN was seen as harassing his girlfriend, who was on a placement in Southend. She was believed to have held money for GN when he dealt cocaine. There were concerns about the way that GN views women. It was reported that CJ and MK had also been in contact with the girlfriend putting pressure on her to continue a relationship with GN. The meeting noted that there was no evidence of GN being violent to other women and no concerns on his attitudes to women in general. CAIT were contacted and advised that Hackney Police should be informed of criminal allegations.

2.10.49 **18th August 2013:** Hackney CSC contacted Tower Hamlets CSC on 18th August 2013 to inform them that CJ had contacted GN's girlfriend. CJ had told the girlfriend to manage GN's behaviour, delegating her parental responsibility.

2.10.50 **23rd August 2013:** The CSC case manager gave an overview of GN. They noted a lack of boundaries within the family. GN admitted the daily use of cannabis. He was seen as paying 'lip service' to the YOS. He was assessed as being a medium risk of harm and in regard to his own vulnerability was assessed as being medium as well.

2.10.51 **29th August 2013:** There were emails between the Troubled Families Data Manager and CSC. It was suggested by Troubled Families that CSC were struggling to obtain information on GN's gang association. It was noted that police intelligence had been checked and there was no confirmed gang membership. In relation to the MARAC, there had not been any recent domestic violence and CSC had not thought to refer. This was followed up with a further email on 30th August 2013 from Troubled Families stating that the last domestic violence was in February and March 2013. It was suggested to be on the safe side to use more agencies to get better outcomes.

2.10.52 **5th September 2013:** Hackney CSC informed Tower Hamlets that GN was still harassing his girlfriend via Facebook. The social worker was concerned that speaking to GN could increase harassment.

2.10.53 **9th September 2013:** CSC had a meeting with CJ about their concerns for GN and MK. She was told that her parenting was not strong enough and GN was beyond her control. CJ said he was fine at home and she did not know what he got up to outside home. GN then joined the meeting. He had an injury under his

eye and refused to say how it was caused. He said that his gang was his 'Bow family'. A section 20 care plan was put to GN. He said that he did not wish to move away from London and did not want Asian carers but was agreeable to the plan. This meeting was followed up with emails between YOS and CSC suggesting that GN would be best placed outside London.

2.10.54 **16th September 2013:** YOS contacted CSC to report on education. GN preferred to return to his original mainstream school and was convinced that he could cope with this. It was considered that the more realistic option was moving to a PRU. GN gave a preference for Tommy Flowers PRU. It was decided that City Gateway would take responsibility for any move.

2.10.55 **19th September 2013**: GN met with the YOS case manager. A move to Birmingham was discussed. He spoke about his brother being in Birmingham. GN was asked about his phone being taken from him in a recent theft. The worker had the impression that GN knew his assailants but would not say. The possibility of a curfew was discussed with GN. A further meeting was held on 24th September 2013 where the move to Birmingham was discussed. YOS risk assessed GN as being of 'medium' vulnerability. A Pakistani foster carer was identified in Birmingham.

2.10.56 The situation concerning GN's placement had not been resolved by October 2013.

2.10.57 **7th October 2013:** It was noted by YOS that his education provider should not be arranged until it was known where GN would be living. CSC stated the placement could take weeks or months.

2.10.58 **14th October 2013:** A professionals meeting was held in order for all social workers involved to consider the case. GN had then started at Tommy Flowers PRU. There was scepticism on whether the Birmingham placement would be successful. The Family Intervention Service would work directly with GN and MK. A further meeting was planned to discuss how all professionals should work in an integrated manner.

2.10.59 **17th October 2013:** GN was seen by YOS. GN informed YOS of how he had been 'thrown out' of City Gateway for using a weapon against a teacher. He said he was cutting down on cannabis use but still drinking. He said things were fine at home.

2.10.60 **22nd October 2013:** CSC records noted that the social worker had recently met with the family. GN was attending Tommy Flowers PRU and he no longer agreed with plan to place him in care. It was deemed that GN and MK reached the threshold for entry to care and the entry to care panel would be updated. CJ was considered to have no insight into her inadequacies and no motivation to make changes to provide a safe home for MK and GN. CJ was said to engage with professionals on a 'superficial level'.

2.10.61 **1st November 2013:** The family were allocated to a FIP worker under the Troubled Families agenda. The family were identified as a 'London Borough of Tower Hamlets Troubled Family'. They would be discussed at the monthly Data Sharing Group (DSG).

2.10.62 **15th November 2013:** The FIP worker conducted a home visit to see the family. The key discussion was on employment for CJ and obtaining benefits. GN was present and said that he was enjoying being at Peacocks Gym.

2.10.63 **25th November 2013:** FIP worker contacted CJ by phone. CJ reported that her benefits had been stopped and will resume on 30th November. A home visit was arranged in the hope of helping her with housing benefits.

2.10.64 **9th December 2013:** GN had a meeting with YOS. The aim of the session was to internalise strategies to avoid and minimise conflict with others at home and within the community. GN's previous conflict with his mother and brother was discussed. He was asked to consider how strategies could be used to de-escalate the situation. GN said he would hold his hand tightly when stressed. It was discussed how arguments could escalate into aggression and violence. GN said he walked away and his brother was no longer trying to discipline him. GN said that he was able to identify ways of avoiding conflict and had matured. GN considered it to be a positive session.

2.10.65 **13th December 2013:** CSC contacted GN. He asked about child benefit money and that he wanted it from his mother. GN seemed frustrated and said that his mother never did anything for him. He said that he does not love her and she had failed as a mother. He said that 'she can't give love'. GN said he 'went mad' at his mother the previous day. He said that he did not want to live at home but did not want to live in care.

2.10.66 **16th December 2013:** A CSC Young Persons Plan was completed. It was noted that GN felt his family no longer needed the support of CSC. He did not fully

accept the risks from his brother. GN reported that there was no bond or attachment between him and his mother and was keen to move out as soon as he could. CJ was reported to have offered little comment about the plan or process, she was of the view that HB was no longer a threat to her younger children. On 17th December 2013 GN contacted his social worker to say that he had sorted his differences with his mother. He appreciated that he was in the wrong but they are ok now.

2.10.67 **18th December 2013:** CSC had a strategy discussion and decided to hold an ICPC on 24th January 2014 on GN. It was considered that GN continued to suffer significant harm to his emotional, social and educational development. It was considered by CSC that GN continued to engage in criminality and this was due to his mother not having the parental capacity to manage his behaviour.

2.10.68 **28th December 2013:** YOS recorded that GN assaulted his mother in relation to an argument about him remaining in London.

2.10.69 **29th December 2013:** the FIP worker contacted CJ. She was unable to speak without an interpreter. HB later called the FIP worker to state that his brother was outside making disturbances. HB stated that the police had been called the previous day when GN had assaulted his mother. The worker went to the family home but GN had left when they arrived. CJ later stated that she did not want GN at home. She also reported problems with benefits. The FIP worker confirmed an appointment with her to support her obtaining employment.

2.10.70 **31st December 2013:** The FIP worker met with GN. They also met a friend who was hosting GN. The friend's mother agreed to look after GN whilst CJ was away. The friend's mother was happy to accept subsistence money whilst GN was staying with her. There was further contact with the friend's mother on 4th January 2014. She informed GN's social worker that CJ had thrown GN out and she needed some financial support to help keep GN. GN was reported to be fine, well behaved and no problem. CJ was believed to be in Birmingham until 7th January 2014.

2.10.71 **6th January 2014:** CSC received a phone call from HB stating he was living in Norwich. He had been told by his mother that GN had 'beat her up'. On 7th January 2014 CSC considered that HB moving out would reduce the stress and conflict.

2.10.72 **7th January 2014:** There was a meeting between YOS and social worker. The argument between GN and CJ was discussed. GN did not fully acknowledge the assault, whilst CJ has informed the social worker that she was hit by GN. GN gave an account that he had argued with his mother over staying at home whilst she went to Birmingham. CJ was shouting at him. After this his mother was vacuuming in the morning whilst he was asleep which made him 'mad'. GN got up and became intimidating and went up to his mother's face shouting and threw the hoover. GN expressed great anger towards his mother saying that he could 'have murdered her'. Having said that he still wanted to return home. A call was made by a Bengali speaking member of CSC to CJ. She confirmed she was returning to London on 9th January 2014. A home visit was arranged to coincide with the return. CJ would decide if she would allow GN home when she got back.

2.10.73 The FIP contacted the housing officer for CJ and confirmed that her benefits had been paid. There were still concerns over mounting rent arrears. The FIP worker expressed concern to GN's social worker that his mother did not understand what was going with her housing situation. At this point her housing officer was considering giving notice of seeking possession.

2.10.74 **9th January 2014:** The FIP noted a professionals meeting expressing concerns for CJ. Her financial situation was considered as very concerning, as her benefits had stopped and she would not be paid until the end of the month. CJ had failed to comply with the requirements of looking for work to qualify for Job Seekers Allowance. CJ's command of English was limited and she was not computer literate. CJ had been referred to a Job Centre worker seconded to Troubled Families.

2.10.75 **9th January 2014**: CAMHS contacted the CSC social worker. The assessment of GN was that he was stable but struggling emotionally. It was felt that GN's drug use is contributing to his mental health condition.

2.10.76 In a Troubled Families Review it was noted that GN and CJ were angry towards each other. The trauma of the aggressive incident with his mother appeared to have impacted on GN's mental health. GN's friend's mother was prepared to keep him a while longer but was concerned about GN's mental health. She has raised her concerns with GN's social worker and considered taking GN to CAMHS. The social worker was to make a referral to CAMHS.

2.10.77 The CSC social worker met with CJ where she recounted the incident before New Year involving the vacuum cleaner. She said that GN had broken the vacuum cleaner pipe, pushed her and threatened her. The social worker expressed concerns that this was not a good time for GN to return home.

2.10.78 **10th January 2014:** GN's friend's mother contacted CSC to say that the CAMHS assessment had been completed. It was suggested that CAMHS were thinking of giving GN medication after his next appointment. CSC contacted GN and he said he would be going home that night. It was suggested that there should be mediation between GN and his mother supported with a written agreement.

2.10.79 **10th January 2014:** A professionals meeting was held and included CJ and GN. The CSC social worker reminded the meeting that GN had little stability. It was agreed that CAMHS would explore the recent altercation between mother and GN. YOS informed the meeting that GN had recently pleaded guilty to robbing a lone female. CSC proposed a return home with a written agreement. The professionals agreed this. CJ became frustrated during the meeting. She stated that if GN did not stick to the rules, at sixteen years old she would 'tell him to leave and die'. It was pointed out that such comments were not appropriate. The agreement between mother and son was eventually made.

2.10.80 **14th January 2014:** A management oversight meeting was held with the CSC social worker. The social worker felt that the situation may last a while but was not sustainable. It was also felt that YOT were not doing what they should. It is not known if this is with reference to the mugging of a lone female. An ICPC was due the following week.

2.10.81 **17th January 2014:** The FIP team held a meeting between CJ and the housing officer. The FIP team considered the housing officer uncooperative and adjusted CJ's current payments from £26.80 to £25. It had been arranged for CJ to meet a Job Centre worker after the meeting. It was considered that CJ made excuses and eventually refused to attend the meeting. It was thought that CJ did not appreciate the graveness of her housing situation.

2.10.82 **17th January 2014:** YOS made contact with CAMHS. There were no immediate concerns regarding GN presenting with psychotic symptoms. On 20th January 2014 YOS formally referred GN to CAMHS. It was on the basis of GN's emotional difficulties associated with his chaotic upbringing and relationship difficulties with his mother.

2.10.83 **21st January 2014:** YOS met with GN to conduct a Restorative Justice Assessment concerning the robbery of a lone female. He said the attack was initiated by his friend. He appreciated that the woman was vulnerable but his desire to get an iPhone from her trumped his issues with targeting a woman. He said he was drawn to the excitement of the robbery. He later felt remorse for his actions.

2.10.84 **22nd January 2014:** CSC Framework review for understanding families stated that GN's circumstances had continued to deteriorate and he presented a risk to himself as being beyond parental control. GN's circumstances were considered as 'bleak'. Concerns were recorded on his mental health with reports of him hearing voices and seeing shadows and faces. It was noted that GN was engaging with CAMHS. It was recorded that HB was still at home. There was reflection on when GN was asked if he would hurt his older sister he said 'No' however when asked if he would ever hit his mother he replied 'I dunno'. It was considered that GN had sought support for what was missing in his relationship with his mother from gang affiliation. The family were considered to have a good network of professional support. It was considered that GN's emotional and mental health were key at that stage. It was recommended that GN was made subject of a CPP.

2.10.85 **24th January 2014:** CJ was called by CSC to remind her of the CP conference on GN that day. She said that she would not attend because she had a job centre appointment. She was asked to attend after the appointment and she declined.

2.10.86 The CP conference took place in the absence of CJ. GN did attend. GN said that he was trying to make better effort with his mother. He did not know if she was worried about him hitting her again. It was considered that many agencies were working with GN but no agency had been successful in fully engaging him. It was noted that GN had been hearing voices. The meeting noted that the CAMHS worker was on leave at the time but due to conduct a home visit in two weeks. CJ was reported as being reluctant to engage with CAMHS. YOS were considering a robust community sentence for the upcoming court hearing. There were concerns expressed that CJ would not have the capacity to help GN complete his court order and that GN would be set up to fail. GN pointed out to the meeting that his mother should have been at the meeting and it was like he

was the ‘adult at present’. The meeting agreed that GN should be made subject to a CPP under the category of emotional abuse.

2.10.87 After the meeting YOS had a further meeting with GN. One aspect of the meeting was to minimise conflict with others. The situation with his mother and the recent incident with the vacuum cleaner was discussed. He said that he did not want to be told to leave the living room whilst his mother was vacuuming. He was asked to consider how his mother felt. GN said that his mother did not care for him and had never shown any love. Ways of avoiding conflict were discussed by GN. GN considered walking away and not using an aggressive tone. Acceptable behaviour was also discussed.

2.10.88 **28th January 2014:** CSC received a request from police to provide secure accommodation for GN as he was in custody for breach of an ASBO. The only available accommodation was in Durham. It was decided to keep GN in police custody. The next day CJ contacted FIP with concerns that GN’s arrest would affect her tenancy.

2.10.89 **30th January 2014:** GN appeared at Stratford Youth Court for the offence of robbery. A YOS report used the Asset system to inform the court of a proposed sentence. His risk of re-offending was considered as being ‘medium’ and his vulnerability was viewed to be ‘high’. The YOS report advised the court ‘GN’s risk of harm is high and this relates to his pattern of robbery offences and historical aggression within education and close relationships; as highlighted by his recent violence at the family home. Despite this, there is no evidence to suggest that he presents an imminent risk of serious harm to others’. CJ was not at court and had to be called by the FIP worker. CJ did not arrive at the court until the verdict was being given. CSC case notes record that that GN was sentenced to a Youth Referral Order and he was required to remain at home on a tag.

2.10.90 **30th January 2014:** YOS considered risk of harm. It was decided that ‘harm is not imminent’. The report stated ‘There has been no re-occurrence of harmful behaviour over the past twelve months’. It was recorded that no immediate action was required. It was not established by the IMR author if this was a new entry or an update to an earlier report.

2.10.91 **4th February 2014:** YOS gave a formal warning to GN due to him missing his Intense Supervision and Surveillance meeting that day.

2.10.92 Later that day the YOS Victim Worker conducted a home visit. CJ was present with GN. CJ watched TV throughout the meeting. GN said that he had missed his appointment because he was stressed with CAMHS stuff. He said he was feeling down and lacked motivation. It was considered that GN may have been 'stoned' he had red eyes and switched between thoughtful silence and giggling. GN stated that he wanted to participate in a film project. MK explained this to CJ and she signed the paperwork to support her son. This was followed up with further contact with GN the next day.

2.10.93 **5th February 2014:** YOS telephoned CAMHS to discuss supporting GN's emotional wellbeing. It was suggested that some CAMHS appointments could be with YOT, if GN failed to attend CAMHS.

2.10.94 **6th February 2014:** A meeting was arranged by FIP for the housing officer to discuss Anti-Social Behaviour with CJ. CJ was not at home. FIP contacted the social worker to re-schedule the meeting for the following week.

2.10.95 **7th February 2014:** YOS records show that GN did not attend Peacocks Gym as he was feeling unwell. GN was seen by YOS at home on 8th February 2014. GN said he had had a good week and attended all YOS appointments. GN then failed to attend Peacocks Gym on 9th and 10th February 2014. GN was sent a formal warning by YOS for breaching his curfew between 8th and 10th February 2014.

2.10.96 **11th February 2014:** FIP confirmed a meeting with CJ at home for the following day. The meeting was to discuss anti-social behaviour of GN and a threat of Notice Seeking Possession of her home. An interpreter was arranged for the meeting.

2.10.97 **11th February 2014:** GN failed to attend his YOS appointment. A compliance/breach meeting was set for the following day with CSC.

2.10.98 **February 2014:** The FIP worker attend CJ's home. When they arrived the police were present. Also present outside the block was the social worker and housing officer. They then found the interpreter who was distressed and said she had just found a boy stabbing a woman on the eleventh floor. The FIP worker and social worker introduced themselves to the police to establish if the stabbing was at the address where they were visiting. They went up in the lift to the eleventh floor and saw a woman they believed to be CJ lying outside her door and the police arresting a male.

2.11 National Society for the Prevention of Cruelty to Children (NSPCC)

2.11.1 The NSPCC is a national children's charity providing direct services to children and families focussed on safeguarding and protecting children and young persons. The NSPCC works in partnership with local statutory agencies on safeguarding matters. The NSPCC were providing a service in East London called Street Matters. This was a sexual exploitation service focusing on the Bengali community, dealing with self-referrals and statutory agencies.

2.11.2 In 2011 CJ's youngest daughter MK was referred to Street Matters by her school for matters of sexual exploitation. She was twelve years old at the time and the perpetrator was from outside the family. During her dealings with Street Matters MK indicated that she was scared of her mother and brothers. When CJ was spoken to by NSPCC she said that she was disgusted by the exploitation situation and that her daughter had brought shame on the whole family. She was noted as having little insight into her daughter's view and did not show concern. It was agreed that MK would meet with the NSPCC at school for sessions. At this time, it was noted on the NSPCC file that GN had presented to A & E having consumed excess alcohol.

2.11.3 On her initial assessment MK gave a family history and explained that her two eldest sisters had arranged marriages. Her sister RF was living at home in 2011 and had a boyfriend and expected a 'love marriage'. MK expected that her brothers would arrange a marriage for her. She said her brothers were protective of her and would beat up any boyfriend that she had. She said that her brothers hit her and her mother was more likely to shout at her.

2.11.4 **29th November 2011:** HB was also referred to Street Matters. He was aged fifteen at the time and there were concerns that he was involved in a sexual relationship with a woman aged eighteen. The referral came from a social worker at the Tower Hamlets FIP.

2.11.5 **25th January 2012:** A meeting was set for HB to meet with the social worker and his tutor at the PRU. HB failed to attend. It was established that Integrated Pathways and Support Team (IPST) were carrying out an assessment on the whole family. There were concerns on HB's school attendance, he had also been excluded for using violence. It was also noted that he was sharing a bed with his brother GN. The NSPCC made several attempts to contact HB without success.

2.11.6 MK continued to have sessions with the NSPCC. She had eight sessions between January and May 2012. MK talked of HB slapping her and being controlling of her, threatening to lock her in her room.

2.11.7 **6th January 2012:** During a session, MK disclosed to the NSPCC that there had been an incident of domestic violence over Christmas. CJ had objected to HB's eighteen-year-old girlfriend staying over. HB had physically assaulted his mother and GN. CJ had called the police and as a result HB was no longer staying at home. This had also caused friction with MK's elder sister who was at the house with her husband. MK was afraid of her brother and her mother could not control his behaviour. The NSPCC contacted the Integrated Pathways team at Social Services and informed them of the disclosure. There was a concern expressed by the social services that there was little that could be done as MK was likely to withdraw her allegations. There were concerns that MK would withdraw from services. NSPCC and CSC agreed that no action would be taken unless MK made further repots.

2.11.8 There is no evidence of any NSPCC management corroboration of this course of action. NSPCC practice is that any safeguarding concerns must be discussed by the practitioner and their manager by the end of that working day.

2.11.9 In January 2012 the NSPCC worker continued to work with the family.

2.11.10 **9th January 2012:** NSPCC had a discussion with the outreach worker working with GN concerning school attendance. They were informed that HB had been arrested as a result of his violence, but CJ and MK had declined to press charges. On 12 January 2012 NSPCC spoke with the family support worker who described the family as 'high risk'. They believed that CJ withheld information, did not act on advice and may be depressed. GN had called the police twice in two weeks saying that he did not want to remain living at home. He had also gone missing on two occasions, once from New Year's Eve for five days and he was not formally reported missing. CJ was due to be attending a parenting class and the NSPCC practitioner requested the input of a Bengali speaking female worker to support CJ. It was felt that her language was a barrier to her engagement. It was also felt by the NSPCC practitioner that a professionals meeting to coordinate concerns on the family should be held with Tower Hamlets. This does not appear to have been taken further.

2.11.11 During February 2012 MK continued to tell the NSPCC about domestic abuse at home.

2.11.12 **3rd February 2012:** MK told her NSPCC practitioner that HB had threatened to hit his mother after his trousers had been ruined in the wash. There had been shouting and GN stood between his mother and HB. CJ had threatened to call the police. MK also suspected that her elder sister had been slapped by HB. MK said that GN had also forced open a locked draw and taken his mother's money. MK was also concerned that her sister was due to be married in March 2012. She shared a bed with her sister and was concerned that if her sister left home, that her mother would share the bed with MK allowing HB to move his girlfriend into their mother's bed to be with him. MK said that a man from Social Services has spoken to them all individually, but she did not know why. On 8th February 2012 the concerns were shared with a Tower Hamlets Social Work Student who was assessing the family. MK was told of the disclosure being made to CSC and was concerned that she would be blamed.

2.11.13 **17th February 2012:** The practitioner made an unannounced visit and found HB at home. He discussed his relationship with an older woman. She came and stayed with him every two weeks. HB felt that his girlfriend was better support for him than his family. He said that he would be taking responsibility for his family after his sister married in March 2012. HB understood this to mean that he would have to shout at his siblings on some occasions and be kind on others. The NSPCC practitioner planned to work with HB on relationships, choices and power in relationships.

2.11.14 **9th March 2012:** The NSPCC Manager made the decision that MK should be referred to a more appropriate service. Her situation was now known to be more complex and included concerns about social isolation and inappropriate levels of power being exerted by her brother HB. The NSPCC practitioner was tasked to find out the outcome of the Tower Hamlets local authority assessment and seek help in finding a new service for MK. Tower Hamlets CSC were emailed.

2.11.15 **13th March 2012:** During an individual session, MK informed the practitioner that her sister got married the day before. On 29th March 2012 MK stated that her sister was on honeymoon. She discussed her fears on forced marriage.

2.11.16 **4th April 2012:** The NSPCC practitioner, who dealt with HB, contacted CSC duty officer to find out the outcome of the Tower Hamlets assessment. They were told

that there were no concerns on the children's' development. There would be ongoing involvement of attendance, welfare and also outreach work. There would also be a referral to a parenting course for CJ. It was not clear that the NSPCC practitioner discussed this with their manager as there were still concerns about MK.

2.11.17 **13th April 2012:** A NSPCC case file was opened on GN, as he had been reported as missing from home since 11th April 2012 and it was not known if his mother had reported him missing to the police. A referral was then made to the police.

2.11.18 **3rd May 2012:** The case file on GN was later closed. The NSPCC did not work directly with GN. He had been seen on some home visits by NSPCC practitioners. He was described as seeming like a moody teenager but nothing out of the ordinary was noted.

2.11.19 **16th April 2012:** The NSPCC confirmed that Tower Hamlets had closed the case as there were no immediate concerns on the family. There were recommendations that CJ complete a parenting programme to manage her children and set appropriate boundaries, CJ to work with FIP and Outreach to determine a better outcome for her childrens' well-being, CJ to contact police if she was concerned for her or her childrens' safety, and case to be monitored by Team Around the Child to ensure the work is coordinated.

2.11.20 **18th April 2012:** The NSPCC practitioner saw HB at home. HB was still seeing his girlfriend and GN was in prison for robbery. HB was told that the NSPCC service was changing and he needed to refer himself to a new service "Protect and Respect" if he wanted support. HB continued to meet with the NSPCC and made some disclosures. He had threatened someone with a pool cue at his education establishment and his brother was 'loving it' in prison. He said that GN wanted to go and live with his uncle in Birmingham. In late May 2012 HB was concerned that his mum wanted him out of the house. He also mentioned that GN had got into trouble because he had been locked out of his house without a key and had been unable to get in for his curfew.

2.11.21 **3rd May 2012:** A referral was made by NSPCC to Tower Hamlets CSC Integrated Pathways and Support Team expressing concerns of neglect of MK. The referral included concerns on social isolation, dependency of mother on MK, HB taking parent role, domestic violence incident on 3rd February 2012 – involving theft,

domestic incident on 11th December 2011 – over HB's girlfriend, both brothers not in education, GN's arrest and being missing from home.

2.11.22 **9th May 2012:** The NSPCC had a hand over meeting with MK at school. MK disclosed domestic violence incident on 7th May 2012. It was reported that HB had hit his brother with a belt and then GN hit HB with a lamp. MK was present during the incident, she was frightened and her mother was powerless to do anything. MK was now sharing a bed with her brother GN. HB is planning a trip to Bangladesh. MK was scared of the matter being reported to Tower Hamlets as her brothers have hit her in the past. This information was passed to CSC and the concerns of the 3rd May 2012 referral were confirmed again with the CSC duty officer.

2.11.23 **1st June 2012:** Another referral was made, to CSC, of the domestic violence disclosure made by MK, and reiterating the information in the previous referral.

2.11.24 **14th June 2012:** There was an NSPCC management decision to close the case as there were services in place due to the referral. On 18th June 2012 the NSPCC practitioner sought feedback from CSC. NSPCC was informed that HB was planning to take a trip to Bangladesh in the summer. The social worker seemed to be uncertain on how to deal with forced marriage. The CSC assessment was that MK did not meet the threshold of 'Child in Need'.

2.11.25 Then NSPCC decided to keep the case open due to concerns on forced marriage. There was also consideration of escalation procedures due to concerns on the response from CSC (IPST).

2.11.26 **11th June 2012**: The NSPCC team manager emailed Tower Hamlets CSC IPST manager, informing them that HB was coercing MK into wearing a scarf and refusal would result in her hair being cut off. HB was reported to have been violent and emotionally abusive to his mother and sister. The manager felt it was no longer appropriate to have the case open, due to GN's aggression towards NSPCC on home visit. It should be noted that there are no details of this visit on NSPCC files.

2.11.27 **16th July 2012**: In the NSPCC final session with HB, he stated that there had been an incident with GN. GN was smoking in the house with a friend. HB slapped them both causing GN to have a nose bleed.

2.11.28 **18th July 2012:** An ICPC was held. This was attended by an NSPCC practitioner. MK and GN were made subject of a child protection plan with the categories of at risk of physical and emotional abuse.

2.11.29 **20th July 2012:** MK's NSPCC case was closed.

2.12 Lifeline – Tower Hamlet's Young Person Drug and Alcohol Service

2.12.1 Lifeline is a national charity that supports individuals, families and communities affected by drug and alcohol use. Lifeline are commissioned to provide substance misuse services for young people up to the age of 19 years in the London Borough of Tower Hamlets.

2.12.2 **21st June 2013:** Lifeline received a telephone referral from GN's social worker. The referral was taken and actioned for a practitioner to see GN at City Gateway School, and then report back to the social worker. The referral stated that GN was on bail conditions not to come into the borough of Tower Hamlets. The practitioner attempted to contact the referring social worker and found that they were on leave. On 8th July 2013 the referral details were added to the Lifeline case management system.

2.12.3 **15th July 2013:** A decision was made to close the referral because GN was living out of the borough. A case closure form was completed and the social worker was informed of the decision.

2.12.4 There was discussion between Lifeline and the CSC and it was not clear from the Lifeline records whether the social worker was responsible for GN's care or if it was a general referral. At the time the decision to see clients living outside the borough was taken on a case by case basis. The general policy was that if a young person was in the care of Tower Hamlets and placed outside the borough, Lifeline would deal with the case. If they were not under care, lived outside the borough and attended school inside the borough, the process would be to try and refer to a service where they were residing. It is not known if Lifeline tried to refer GN to a service in another borough in this case. There was no direct engagement between GN and Lifeline.

2.13 Integrated Youth and Community Services

2.13.1 The aim of the Targeted Youth Support Team (TYS) is to support young people and work with other agencies to provide a multi-disciplinary intervention to keep them engaged in education and employment or training.

2.13.2 **5th August 2013:** GN was referred to the TYS by a Social Worker from the Family Support and Protection team in CSC. This was due to his offending behaviour. GN was allocated to a case worker.

2.13.3 **27th September 2013:** GN attended the initial appointment with the case worker at TYS alone for a one to one meeting. GN said that he was confused with the number of appointments he was required to keep. His case worker told GN that he would be supported in maintaining the appointments. GN was in a hurry to leave the meeting and did not want to stay long. GN was advised that he would be supported with his literacy work. He was told that they would be discussing personal things over the following weeks at TYS appointments. GN was asked about his criminal convictions. He did not want to discuss in depth.

2.13.4 After this initial assessment the TYS case worker tried to engage with GN for a period of two to three weeks. GN failed to take up the offer of one to one meetings and working on a development plan. He failed to attend agreed appointments and did not respond to phone calls. GN stated that he was getting support from other agencies. The TYS worker was unable to devise a support plan due to GN's lack of engagement. It is not clear from the IMR how and when the case was formally closed by TYS.

2.14 Community Safety Enforcement

2.14.1 The Council's Anti-Social Behaviour (ASB) team investigate complaints from residents concerning nuisance and anti-social behaviour across the London Borough of Tower Hamlets.

2.14.2 **12th January 2012**: An ASB file was opened due to nuisance, damage, graffiti and smoking in the communal areas in CJ's block. On 2nd February 2012 GN was identified by police as being a possible perpetrator of ASB. On 27th February 2012 an ASB warning letter was delivered to GN at home. The next day the ASB team were notified by the YOT team that GN was known to them and had been given a police reprimand.

2.14.3 **20th March 2012**: A second ASB letter was sent to GN's parent asking them to attend a joint RFC contract meeting. On 26th March 2012 CJ and GN attended a meeting at Bow Police Station and signed an RFC. The case was closed by the ASB team on 26th March 2012.

2.15 Housing – Circle Housing Old Ford (CHOF)

2.15.1 CHOF is a housing association. They provide general needs and supported housing. CHOF housing management includes the management of anti-social behaviour where a resident's behaviour has an impact within the locality of their home. Any tenant would be contractually liable for the behaviour of visitors and household members.

2.15.2 **21st September 2009:** CJ's tenancy with CHOF commenced. Translation services are offered to all tenants. CHOF was aware that CJ's main language was Bengali. When CJ completed her Equality and Diversity Form for tenants she indicated her preference for communication by written letter and/or direct spoken translation.

2.15.3 During 2011 there were contacts between CJ and CHOF. The concern came from her sons' anti-social behaviour and congregating in communal areas of the housing block. Both HB and GN were invited to sign RFC's. GN failed to attend his appointment to sign. CJ was sent a warning letter concerning further complaints about GN and informed her that a Notice Seeking Possession Order would be served on 1st November 2011. No further action is recorded concerning this order. There were discussions between CHOF and YOTs team on the duplication of efforts in both teams applying for RFCs.

2.15.4 There is no recorded contact or concerns for 2012. In March 2012 GN signed an RFC. The housing file shows that GN was given an ASBO at Thames Magistrates Court.

2.15.5 **24th July 2012**: GN was seen fighting with a gang by a CHOF contractor. GN then threatened the contractor with a knife. The contractor was advised to report to police. On the following day a CHOF employee saw GN fighting with other youths near his home. GN was verbally abusive to the employee. The matter was reported to the police.

2.15.6 **10th September 2012**: GN was verbally abusive towards a CHOF security guard near his home. The following day a warning letter was sent to CJ concerning her son's behaviour. On 19th September 2013 GN was reported to be keeping a dog.

2.15.7 **27th January 2013**: A CHOF employee reported GN damaging a letter box of a flat, with another youth. A warning letter was sent. On 29th January 2013 CHOF served a notice on CJ seeking possession of her flat.

2.15.8 **7th February 2013**: CHOF wrote to CJ informing her that they were proceeding with court action concerning GN's behaviour. Three days later GN was witnessed breaking a window at another block. On 27th February 2013 CHOF wrote to CJ with an appointment for GN to sign onto an RFC.

2.15.9 During March 2013 CHOF prepared an application for an injunction against CJ as she was contractually responsible for her son. This was considered as a final legal step before submitting a Claim for Possession. This coincided with GN being taken into foster care. This resulted in a significant reduction in anti-social behaviour incidents linked to CJ's home. It was therefore considered a disproportionate action to proceed against CJ.

2.15.10 **23rd October 2013:** CHOF served a Notice Seeking Possession on CJ as a result of rent arrears.

2.15.11 **29th January 2014:** The CHOF were informed by police Safer Neighbourhood Team that GN had been arrested. Police informed them that they believed that GN was a ring leader of a group of Asian youths. Police advised CHOF to consider an Anti-Social Behaviour Injunction (ASBI) to prevent him associating with groups of more than two persons. Due to GN being under the age of eighteen, an injunction was not an available option. CHOF took action to improve the lighting and environment where the youths were said to be congregating.

2.15.12 **February 2014:** The CHOF Housing Officer for CJ's block of flats went to meet her. Also present was an interpreter and a social worker. The purpose of the meeting was to discuss CJ's tenancy being at risk. The interpreter went to CJ's flat, the housing manager and social worker remained on the ground floor. This was at the same time that GN had attacked his mother outside. The translator took a photograph of the scene on her phone and went back to inform the housing officer and social worker. Access to counselling was offered to the staff involved.

2.16 Domestic Violence and Hate Crime Team

2.16.1 The London Borough of Tower Hamlets Domestic Violence and Hate Crime Team are responsible for the running of Multi Agency Risk Assessment Conferences (MARAC) for the borough. They have oversight of DV1 forms which are completed and referred to the team. They also monitor cases listed at the Specialist Domestic Violence Court.

2.16.2 **9th April 2013**: A social worker sent a DASH risk assessment to the MARAC coordinator. The referral named GN as the victim of domestic abuse and his older brother HB as the perpetrator. At the time GN was fourteen years old and HB was sixteen years old. Contained in the referral was information that GN stated that his brother had previously hurt his mother and younger sister, MK. The MARAC coordinator advised the social worker of the need to complete a MARAC referral and consent form.

2.16.3 **11th April 2013:** The MARAC referral forms for GN were completed. The MARAC form recorded GN as living in a temporary address in Lewisham. The MARAC coordinator informed the social worker that they should send the referral form to Lewisham. It was noted that should the victim move back to Tower Hamlets, then a referral could be made to the local MARAC.

2.16.4 **15th April 2013:** The social worker indicated in an email to the MARAC coordinator that MK has also been a victim of domestic violence and control by HB. The MARAC coordinator then re-sent the MARAC referral forms for the social worker to complete. No referral on MK was received. There were no other referrals in relation to GN or CJ and the family were never discussed at the Tower Hamlets MARAC.

3. Analysis

3.1 Key Issues

3.1.1 This review has established that a large number of external agencies and departments within the London Borough of Tower Hamlets had contact with CJ's family during the review period. All of the agencies have completed IMRs and where appropriate they have made internal recommendations. This section of the report will focus on those agencies key to the issues of prediction of violence and preventability of CJ's death. Reference will be made to other agencies referred to earlier in the report where there are interactions that would come under the areas of mental health, CSC, YOS and police. This section will focus on analysis of interaction of the family, protocols, communication and inter-agency working.

3.2 East London Foundation Trust (ELFT) - mental health

3.2.1 CJ's three youngest children were all referred to Tower Hamlets CAMHS during the review period for this DHR. Whilst the examination of the provision of mental health care to siblings is important in understanding the CAMHS relationship with the family, the key area for analysis is the treatment of GN, predictability of harm and risk assessment.

3.2.2 HB was referred in April 2013 due to concerns that he perpetrated domestic violence towards his mother and younger siblings. He was offered a mixture of individual and family services. His case was closed in February 2014 due to his lack of engagement. The ELFT IMR identified some concerns on the risk assessment and care planning for HB. In considering the risk factors for HB, referred as a perpetrator of domestic abuse, his factors for violence were not highlighted by the care co-ordinator. There were also concerns on liaison between ELFT and CSC in relation to parenting assessments. This matter falls outside the scope of this review.

3.2.3 MK was referred to Tower Hamlets CAMHS in April 2013. The referral followed concerns that she was experiencing physical and emotional abuse from her older brother. There were concerns about the lack of protection and support from her mother. It may be considered that the lack of support was evident when MK's mother failed to bring her to appointments. The CAMHS service demonstrated commitment to engage with MK, through arranging appointments at MK's school.

There were no concerns in relation to the level of adherence to protocols, communication with other agencies or level of care of MK identified by this review.

3.2.4 GN was originally referred to CAMHS in 2010, he did not attend his appointment. GN was referred again in 2013 when he was subject to a CP plan. He was referred again in January 2014 when a family friend was concerned about GN hearing voices. In considering ELFT's dealings with GN, it was assessed that none of the professionals involved had a comprehensive understanding of his offending history. There was an awareness that GN was involved with the YOS but the extent of his criminal behaviour was not appreciated. Without this knowledge ELFT staff were not in a position to produce an adequate risk assessment. GN was not given a diagnosis of conduct disorder. This was a clinical finding from the examination of GN following his arrest for his mother's murder.

3.2.5 When GN was referred to ELFT on 4th April 2013 there was clear information provided that GN had an offending history that included stabbing, alcohol misuse and attempted robbery. GN had one appointment with a child psychotherapist in May 2013 and then failed to attend follow up appointments. GN was eventually seen again on 13th September 2013 by a psychotherapist and family therapist at home. During this visit GN declined to access CAMHS services. GN's case was closed to CAMHS on 9th November 2013. On referral to CAMHS the referral form indicated conduct problems and when discharged GN's closure form had been changed to 'emotional problems'. This is concerning as CP minutes held by CAMHS refer to GN becoming 'unmanageable' in the community. It was not apparent that CP minutes had been considered in assessing the risk presented by GN. This shows a failure to consider multi-agency information when managing patients.

3.2.6 On 9th January 2014 GN was seen by Tower Hamlets CAMHS as an emergency referral. On this occasion he presented with a three-year history of hearing voices and noises inside his head. The violent incident with the vacuum cleaner before New Year was also referred to and his cannabis use. GN was seen by a trainee psychiatrist. There was no reference to GN's offending history in considering the risk he presented. At this point GN was known to have perpetrated a number of violent crimes and he was due to appear in court later

that month for an offence of robbery. The CAMHS risk assessment determined GN to be low risk to himself and others.

3.2.7 There was a second opportunity for CAMHS to assess the risks presented by GN on 17th January 2014. During this appointment GN gave an excuse that he could only stay at the appointment for ten minutes. He was again assessed as being low risk with 'no suicidal ideation or thoughts to harm others'. There was no reference to GN's offending behaviour. It is difficult to see how a medical examination and assessment of risks could be completed in ten minutes. If GN found it difficult to stay for the appointment, then immediate steps should have been taken to continue the assessment as soon as practicable. In this case there was no further appointment and the family therapist planned to review GN in three weeks. This review would have been due in the week before CJ's death. The ELFT reviewers were told that the family therapist had been in telephone contact with the social worker to arrange a new appointment with GN, however some of the telephone calls were not noted in the case notes.

3.2.8 There was a poor level of communication with other disciplines from CAMHS. Following the emergency assessment in January 2014 there was no letter written to the referrer or GP. The trainee psychiatrist drafted letters to the Consultant Neurologist and the GP, however these were never forwarded. It was also found that this was due to problems with staff understanding of opening emergency referrals on the electronic patient record system (RiO).

3.2.9 On 24th January 2014 CAMHS were represented at the CP conference by the care co-ordinator for MK. The family therapist who dealt with GN at CAMHS was on leave at the time of the meeting and the psychiatrist was not available. As there was no GP referral letter for GN and the emergency referral was not recorded on RiO, the person representing CAMHS had no clinical information on GN to pass to the conference. The meeting raised concerns on GN's offending behaviour and level of risk. It is not apparent that any of this information was acted upon by ELFT to update GN's risk assessment or inform his clinical diagnosis. There was no further review conducted by the family therapist before CJ's death.

3.2.10 The ELFT IMR found that the trainee psychiatrist's assessment of GN's mental state was thorough although his conclusion did not fully reflect his findings. The assessment did not fully take account of GN's lengthy offending history, drug use and historical risk factors. There was no attempt made to obtain collateral history

about GN's functioning and his denial of assaulting his mother was accepted at face value. The fact that GN had smoked a considerable amount of cannabis before his first assessment did not exclude the possibility of an emerging psychotic illness.

3.2.11 There was consideration given to the role of a trainee psychiatrist in conducting the examination of an adolescent. The doctor was an experienced trainee in dealing with adults but had more limited exposure to emerging psychosis in adolescents. The NICE Guidelines on Psychosis and Schizophrenia in Children and Young People state that assessment of the young person with possible psychosis should include a consultant psychiatrist and the use of multi-disciplinary services. Where there is uncertainty about the diagnosis the consultant psychiatrist should be trained in child and adolescent mental health. GN was never seen by a consultant before his mother's death. It is noteworthy that after his arrest for murder GN's mental state continued to be hard to assess. There were differing opinions between several experienced psychiatrists as to whether GN was showing evidence of a psychotic state.

3.2.12 When focusing on the information that was available to Tower Hamlets CAMHS it could be seen that it was predictable that GN would assault his mother again. The ELFT IMR author states that 'the severity of the assault which led to his mother's death was qualitatively different and could not have been predicted'. Given the fluctuations in GN's mental state since the event there was no guarantee that psychosis would have been identified and treatment agreed and commenced in such a way as to prevent the homicide. It should be noted that the IMR was completed before GN was considered to be in a stable state for interview. When the DHR chair visited GN in hospital medical opinion on predictability had not changed. It was not considered predictable that GN could have committed an assault of the severity that resulted in his mother's death.

3.3 Children's Social Care (CSC)

3.3.1 In consideration of the role of CSC it is important to appreciate that this agency had the majority of the contact with CJ's family. CSC services will be focused on the safety and welfare of children and young people. There also needs to be consideration that child safety will include ensuring that a parent or carer is safe too. The assessment framework for child protection considers three domains, parenting capacity, environmental factors and a child's developmental needs. It should be considered that the capacity for parenting is impaired if the parent is

not safe. The CSC IMR identifies that the London Child Protection Procedures focus on protecting children from domestic violence and abuse as opposed to protecting parents from violence from their children. The guidance suggests that a Child Protection Referral is the appropriate way to respond to children who harm. Whilst this approach is understandable it is important to ensure that authorities have working procedures and protocols that consider the safety of all persons at risk of or experiencing domestic abuse.

3.3.2 The review of CSC relationships with the family show a high level of support for the children and a great deal of time spent supporting a family that were considered 'troubled'.

3.3.3 The issue of the risks posed to CJ by her sons was recognised in Child Protection Processes. CP conferences note that CJ should call the police if she became fearful of harm in the home. The IMR author states 'as far as I can ascertain no other measures were explicitly taken by any staff to protect CJ'. It was considered proportionate by CSC to rely on CJ calling the police as a low level of physical harm had previously occurred.

3.3.4 Examination of CSC records show that the consideration of risks of domestic violence and the understanding of services available to CJ come from the Family Intervention Project (FIP). The prompt for a referral to MARAC came from the FIP. On 13th March 2013 the Service Manager from Family Interventions emailed YOS and the CSC social worker requesting that DASH risk assessment be completed to consider the risk issues. They were also requested to raise the family for consideration at the MARAC. This instruction showed a good awareness of the availability of MARAC. It should be noted that the social worker requested guidance on the DASH process and requested that someone else should complete the risk assessment as they were due to go on leave. The risk assessment was not competed until 9th April 2013.

3.3.5 Whilst the cross government guidance on domestic violence and abuse omits cases where the perpetrator is under the age of sixteen, the MARAC process does not. A MARAC referral in March 2013 was entirely appropriate.

3.3.6 At the time of the referral GN, a named subject of the abuse, was temporarily placed out of borough. The MARAC referral to Tower Hamlets was met with a response from the Domestic Violence and Hate Crime team that as GN, the victim, was residing in another borough the referral should be made there. It was

considered that as there was no risk to GN when out of the borough the MARAC referral should be made again when he returned to Tower Hamlets. This decision was based on the Safe Lives Guidance that the MARAC should be held where the victim resides, whether permanent or otherwise.

3.3.7 At this point there was still the issue of MK experiencing control and excessive discipline from a sibling. It would have been appropriate to continue with a MARAC referral in Tower Hamlets at this time. The referral forms were sent to the social worker by the MARAC co-ordinator. No referral was made. A MARAC referral at this point would have provided a crucial opportunity for the family to access a wider range of services that focus on the needs of victims of domestic abuse. It would have resulted in engagement with a level of expertise on domestic abuse that was not available from the family social worker.

3.3.8 The consideration of a MARAC referral was suggested to CSC again by the Troubled Families team on 29th August 2013. CSC did not make the MARAC referral despite prompting from Troubled Families. It must be considered that at this point there had been a recent CSC strategy meeting on 15th August 2013 where GN's propensity for violence against women had been discussed, as there were concerns on him harassing his girlfriend. The meeting concluded that there were no concerns on his attitudes towards women in general. It is not apparent that this meeting considered GN's aggressive and sexually abusive behaviour towards female staff at college, use of threats and obscene language towards a female social worker or his targeting of lone females to rob when reaching this decision. The failure to refer to MARAC at this point must be considered as a missed opportunity.

3.3.9 The lack of knowledge on DASH risk assessments in CSC may have been a contributing factor in the failure to record risk assessments considering the position of CJ. On 26th September 2012 there was acknowledgement at a CP conference that there was a potential for violence at CJ's home. It was decided that she should call police if HB or GN became aggressive or violent. There was no requirement for a risk assessment to be completed.

3.3.10 On 18th October 2012 during a CP visit the social worker spoke with GN. GN expressed his positive views of his older sister and that he would never hurt her. GN stated 'he would hurt his mother because he does not care for her'. This statement by GN does not appear to have triggered a risk assessment.

3.3.11 On 5th March 2013 GN disclosed to school and social worker that he had been involved in a violent incident with his brother at home. During a fight GN was in fear that his brother would use a knife from the kitchen. A referral was made to the police but there was no record of a risk assessment being undertaken by CSC. This incident took place eight days before CSC and YOS were directed to complete a DASH risk assessment.

3.3.12 On 7th January 2014 CJ informed GN's social worker that GN had assaulted her. GN had described how he became intimidating to his mother. He was quoted to have said 'He could have murdered her'. Given the previous advice on undertaking a DASH risk assessment and making a referral to MARAC, it is not known why the social worker did not make the referral after this event. This was not addressed in the CSC IMR. Within two days of this disclosure GN was taken to CAMHS as an emergency referral. This was a missed opportunity to consider the potential risks to CJ.

3.3.13 It appears that the response to manage the risks of violence within the family was often considered through CP procedures. In January 2014 CSC did hold a professionals meeting to discuss the situation within the family. There did not appear to be sufficient consideration of potential risks to CJ. It would have been helpful to involve the Domestic Violence and Hate Crime Team at this time. The failure to consider a DASH risk assessment was another missed opportunity.

3.3.14 On 22nd January 2014 the CSC Understanding Families Review considered statements from GN that would indicate a potential for harm to his mother. It was considered that GN's emotional and mental health were key at that point and it was recommended that he was made subject to a CP plan. There does not appear to be an acknowledgement of the needs of CJ as the potential victim of domestic abuse. The CP conference two days later did not consider a DASH risk assessment and MARAC referral as an option. It should be noted that this meeting involved a multi-agency panel and parties outside CSC did not propose the options either.

3.3.15 There were missed opportunities by CSC to make referrals to Lifeline substance misuse services. On 12th July 2012 GN had contact with his social worker. GN's behaviour led the social worker to suspect that GN had been smoking 'weed'. There was no suggestion of a substance misuse referral.

3.3.16 On 30th May 2013 a Local Authority Care Review Meeting actioned the CSC social worker to refer GN to Lifeline. The referral was made three weeks later on 21st June 2013. GN did not use the service because he was living out of the borough at that time, however he was still suspected to have been using drugs. On 11th July 2013 CSC noted concerns on substance misuse and the use of 'legal highs'. The case was closed by Lifeline on 15th July 2013 and CSC were informed. On 29th July 2013 GN was noted as being at home in Tower Hamlets borough and CAMHS noted that the CSC were to refer GN to a substance misuse worker. There is no evidence of any further referral to Lifeline by CSC. Given that GN was living back in the borough there is no apparent reason why GN was not referred back to Lifeline.

3.3.17 The work of the FIP is worthy of note. This department took a number of steps to support CJ. The initial proposal for the statutory workers to complete a DASH risk assessment came from FIP. The FIP worker made practical efforts to support CJ in dealing with her housing issues. It should also be acknowledged the CSC had made a number of efforts to engage with CJ to address her lack of parenting skills.

3.4 Youth Offending Service (YOS)

3.4.1 The Tower Hamlets YOS had a great deal of contact with GN. Whilst the work of YOS was considered together with CSC under one IMR reviewer, this report will analyse the work of YOS separately. YOS demonstrated some use of risk assessments but there were missed opportunities to fully assess the risk GN presented at home. The IMR author stated that the quality of risk assessments 'was not to a high standard'. The service did spend time with GN considering his attitudes towards offending and managing his behaviour and this should be considered as good practice.

3.4.2 Tower Hamlets use the Asset system. This system does focus on the risk of serious harm; however, this does not effectively focus on the risks GN posed to his family. The Asset system considers domestic violence and abuse but the process focuses on the young offender as the victim or witness. The Asset system does not fully consider a young person as a potential perpetrator of domestic violence.

3.4.3 There have been no concerns identified in the management and monitoring of GN as an offender within the criminal justice system. This analysis will focus on

the management of risk within the domestic environment and working with other agencies.

3.4.4 From his first referral to YOS on 8th March 2012 GN described how he could get angry very quickly and that he would fight with his mother and smash things at home. The plan for GN included a referral to CAMHS, it did not include an assessment of the risks to CJ.

3.4.5 Throughout GN's dealings with YOS he would often state how he had no support from his mother. This was seen as a being linked to his continued associations with groups of youths outside the home. GN was seen as gaining a level of support and esteem from his network of friends that was not forthcoming at home. When YOS challenged CJ on her parenting abilities she became verbally aggressive and GN cited his mother's lack of knowledge of his place of education as proof of her lack of care.

3.4.6 When the FIP Service Manager emailed YOS and CSC on 14th March 2013 requesting that one of the teams completed a DASH risk assessment there was no apparent response from YOS. The CSC social worker indicated that they were about to go on leave it is not apparent why the YOS could not have taken the lead on this occasion.

3.4.7 The first acknowledgement of the risks presented by GN in a domestic setting came on 14th May 2013. YOS completed a risk assessment plan and it was noted that GN sees violence as way of dealing with conflict in the community or domestic partnership. At this stage GN was in a foster placement. It is not apparent that consideration was given to the potential for harm to foster carers or CJ if GN were to return home. No further steps were taken to assess the risk when GN was reported to have returned home on 25th July 2013.

3.4.8 There was a further opportunity to assess risks presented by GN on 17th October 2013. GN told his YOS worker that he had been thrown out of City Gateway for using a weapon against a teacher. Although GN said things were fine at home this incident involved the use or threat of a weapon against an authority figure. Given GN's propensity to deal with conflict by using violence this was a missed opportunity to conduct a risk assessment.

3.4.9 There was YOS work with GN that considered his behaviour in a domestic setting. On 9th December 2013 part of a YOS session was aimed at minimising conflict at home. GN discussed strategies on how he could deal with arguments.

This was seen as a positive session with GN and should be considered good practice. However, there was still another violent incident that month.

3.4.10 On 7th January 2014 there was reflection on the incident with the vacuum cleaner at the end of December 2013. There is no mention of a risk assessment being undertaken at this point. YOS did make a referral to CAMHS in relation to GN. This shows appropriate use of mental health services.

3.4.11 There was a further session with GN to consider conflict with others on 24th January 2014. The session gave particular focus to the potential conflict between GN and his mother. GN was asked to consider how other people would feel and what strategies could be used to reduce conflict. This meeting shows an appreciation of risks towards CJ and should be considered good practice. There does not appear to be a formal risk assessment and consideration of MARAC. It should be noted that this meeting followed a CP conference where others did not consider the option of a MARAC referral.

3.4.12 In considering the use of a multi-disciplinary response to GN there does not appear to be an appropriate use of commissioned substance misuse services. When GN was seen by a YOS worker on 4th February 2014 it was considered that he may have been under the influence of drugs and 'stoned'. There does not appear to be consideration of referral to Lifeline. At this stage GN had already been seen by CAMHS as an emergency referral and had been formally referred to CAMHS by YOS. The involvement of an agency specialising in substance misuse would have brought an additional level of support to manage GN's offending behaviour.

3.4.13 It should be noted that YOS demonstrated support to GN in his CAMHS appointments. There was regular liaison and it was suggested that future CAMHS appointments could be held with YOS if GN failed to attend his appointments. This shows flexibility and a commitment to the two agencies working together.

3.5 Police

3.5.1 A key area for the police was the failure to consider the abuse of CJ by her sons as domestic violence and abuse. The cross government definition of domestic violence and abuse, of March 2013, was designed to ensure that there is a common approach to domestic violence and abuse by different agencies. The definition defines domestic violence and abuse as: '…violence or abuse between those aged 16 or over who are or have been intimate partners or family members…'. This definition is at odds with the guidance for DHRs where a DHR is required in circumstances where a death of person aged 16 or over results from violence and abuse from an intimate partner or family member. This DHR definition applies regardless of the perpetrators age. The processes for the management of domestic violence within the MPS are set to adhere to the March 2013 guidance. The processes will directly affect the policies and procedures that are applied to reports of abuse and violence when they are in a domestic context. A domestic case where both parties are sixteen years of age, or older, should result in a level of risk assessment and supervision that is not routinely applied to other types of abuse. The classification of an incident as domestic violence or abuse, by the police, would also allow police refer to Independent Domestic Violence Advisors (IDVA) and MARAC procedures.

3.5.2 In the first incident reported to police in December 2011 when HB assaulted his mother. The police dealt effectively with HB in arresting him for a breach of the peace, in the absence of his mother supporting a prosecution. The officers completed MERLIN reports, notifying appropriate agencies of children coming to notice of the police. As HB was under the age of sixteen at the time, the incident was not identified as domestic abuse. As a result, there was no subsequent risk assessment and referral to a specialist domestic violence team CSU. Given the admission made by HB to assaulting his mother, the treatment of the incident as domestic abuse may have resulted in a positive arrest for assault and not simply a breach of the peace.

3.5.3 The subsequent incidents involving GN as the perpetrator towards his mother were not recorded as domestic abuse.

3.5.4 In dealing with the December 2011 assault the police did not record the allegation made by CJ on the CRIS (Crime Recording) system. This is a breach of Home Office policy on reporting crime. Whilst a CRIS report would not have been passed to the CSU, a report of assault would have been notified to Victim

Support. This would have provided an opportunity for CJ to access services focussed on her needs and vulnerability.

3.5.5 The report of this incident in 2011 also shows CJ's apparent disinterest in her son GN. Police were present at 1:30am when GN returned home and CJ 'was not bothered' about his lateness.

3.5.6 In further contact with the family HB often took the leading role. This may have been due to CJ's language difficulties or HB taking the lead in household matters. In dealings with the family police did rely on family members to interpret. This practice is against MPS policy. It has been a requirement to use 'Language Line' since July 2013.

3.5.7 There was a further failure by the MPS to record a crime reported by CJ. In the incident of 9th March 2012 CJ called police because GN had been 'hitting and hurting'. The officers attending did make appropriate referrals to CSC in relation to GN coming to notice of the police. The police did not record CJ's call to the police as an allegation of crime. CJ did not wish to assist the police, but if a CRIS report had been completed then Victim Support may have been notified.

3.5.8 The final incident reported to police before the homicide was another allegation of assault. On 29th December 2013 MK spoke to the police operator and clearly stated that her mother had been hit with a hoover. Although the officers attending decided that matter did not amount to a crime, a formal report should have been recorded. This was another incident that was not recorded as an allegation of crime on the CRIS system. The failure to complete a CRIS was a final missed opportunity to provide Victim Support services to CJ. The officers did complete a MERLIN report, but this was not forwarded to CSC. This demonstrates a failing in the systems of the police Public Protection Desk at Tower Hamlets. The matter has been addressed by an internal recommendation. The failure to communicate the incident to CSC was not critical as CSC were fully aware of the situation.

3.5.9 The work of the MPS CAIT team generally reflects the child protection concerns recorded at Tower Hamlets CSC. It demonstrates appropriate levels of communication throughout the involvement of police in CP procedures.

3.5.10 GN came to the attention of the police on a number of occasions as a result of anti-social and criminal behaviour. The response from the MPS is considered entirely appropriate. There were regular notifications to CSC using the MERLIN system. The MPS also paid regular attention to monitoring GN's conditions of

bail and curfew orders. There were issues concerning the accuracy and timeliness of information from the Electronic Monitoring Service (EMS). The MPS IMR authors have made internal recommendations to deal with the matter through MPS criminal justice liaison officers.

3.5.11 The MPS have reviewed all custody records dealing with the detention of GN. No concerns on mental health issues were specifically raised by GN or the custody team. There was one incident that gives cause for concern. After his arrest on 27th January 2014 GN did request to see the Custody Nurse Practitioner (CNP) concerning his recovery from taking cannabis. He then later became aggressive whilst being detained, this behaviour was out of character when considered against previous periods of detention. It does not appear that any information on GN's behaviour was passed to other agencies. At this time GN was subject to a referral to CAMHS. Notification by MERLIN to CSC would have provided additional information on GN's condition that may have helped mental health professionals dealing with him. This case presents an ideal opportunity to make a further referral to substance misuse agencies, Lifeline, commissioned in Tower Hamlets. It appears that this was not considered.

3.6 What Might Have Helped?

3.6.1 It is clear that there was a great deal of input and support for CJ's family from a number of agencies. That work was generally focused on the children living at home. There was a lack of focus on the needs of CJ as a parent. There was no formal assessment to consider CJ as a potential victim of domestic abuse.

3.6.2 The CSC IMR identified that CJ had been on a number of parenting programmes. It also identified that there was not any assessment specifically considering CJ's needs and whether she was competent as a parent. It appears that CJ was reluctant to engage with support programmes to help her parenting abilities. It may have been useful to direct support for CJ to consider her esteem and value in the community and not to be seen as the mother of children experiencing problems. It could also be considered that CJ's eldest son adopted the role of head of the house on the death of his father. This was a role that he was not equipped to deal with.

3.6.3 It is thought that more timely referrals to support agencies may have helped. The initial direction to CSC or YOTS to complete a DASH risk assessment took several weeks to be completed. The Care Review direction to the social worker

to refer GN to Lifeline took three weeks for a referral to be made. It is felt that a greater level of intrusive supervision and support for the social worker may have helped progress these referrals in a timely manner. An appropriate level of supervision would have also ensured that the need for these external referrals was considered when there was a change in GN's home circumstances. It was clearly stated by the Troubled Families team to 'use more agencies to get better outcomes'.

3.6.4 In considering the response of all parties it would have helped if there was a national definition of domestic violence and abuse that reflected the cross government definition to the MARAC and that set out in the DHR guidance. This may have resulted in further opportunities for DASH assessments by police and another pathway to MARAC and IDVA services.

3.6.5 There was an apparent lack of knowledge across agencies on the commissioned substance misuse services. Referrals by healthcare, social care and criminal justice agencies for GN may have provided him with a further level of support.

3.7 Good practice

3.7.1 CHOF have a Diversity Statement for all new tenants where they can record their language and their preferred form of communication. This process makes it clear to all members of staff how best to communicate with clients. This should be considered as good practice. It should be noted that CHOF staff were accompanied by an interpreter when they visited on the day that CJ died.

3.7.2 The Data Manager at Troubled Families takes a proactive interest in identifying cases for MARAC. This shows a good level of knowledge of domestic violence and abuse and appropriate intrusive supervision. This good practice should be considered by the CSC and YOS teams.

3.7.3 Within the YOS there was an acknowledgement of GN's potential to offend at home when they met with him. Meetings in December show work with GN to internalise strategies to avoid and minimise conflict with others at home and within the community.

4. Conclusions and Recommendations

4.1 Preventability

4.1.1 This case has allowed examination of current statutory systems and processes in relation to risk assessment, management and domestic violence. In working with the family there was a clear focus on the children living at home with CJ. The systems for managing the family were child centred. This view applied to both social and criminal justice agencies. Although agencies have generally followed policies in relation to their internal working relationships, there was limited focus on the potential for domestic violence and abuse towards CJ.

4.1.2 This was an extremely tragic event resulting from a young man experiencing an extreme psychotic episode. His psychotic condition was not diagnosed at the time. It took a team of medical experts several months to diagnose the nature of the illness and a considerable period of time to stabilise his condition. The panel did not believe that the extremity of the attack by GN on his mother could have been predicted. The fact that GN was likely to assault his mother should have been predicted.

4.1.3 The propensity for GN to display violence towards women was clear. He had: demonstrated threatening and abusive behaviour towards his girlfriend; robbed and kicked a lone woman; shouted at, threatened and used obscene language to his social worker; and threatened female workers at school. When speaking to statutory workers GN had expressed his hatred of his mother saying how he could hurt her. The report of domestic abuse at the end of December 2013 and the consistent expression of anger by GN towards his mother made the likelihood of continued violence towards her predictable.

4.2 Policies and Processes

4.2.1 There was an initial opportunity for CSC and YOS to refer this case to MARAC. This would have allowed an experienced panel to consider the overall levels of concern for this family, offer appropriate support and risk management. That opportunity was missed. A further direction to CSC workers to refer the case to MARAC also appears to have been overlooked.

4.2.2 The option of a making a MARAC referral should be considered at child protection meetings. It appears that the first option for dealing with the risk to CJ was covered by an action that she should contact the police if her sons became

violent. There was no consideration of a multi-disciplinary response to CJ's vulnerability as a victim of domestic abuse from her sons.

4.2.3 The conflict of government policies has also resulted in criminal justice agencies' failure to consider the incidents in CJ's home as domestic abuse. The Domestic Violence, Crime and Victim's Act 2004 set the statutory definition for the circumstances requiring a DHR. DHR reviews are required where the victim is aged sixteen or over and is killed by a person of any age, being in personal relationship. In March 2013 the cross government definition of domestic abuse stated that both victim and perpetrator of abuse had to be aged sixteen years or older. Whilst the 2004 act clearly identifies the need for policies to protect people from domestic abuse by perpetrators of any age, the cross government definition excludes persons under sixteen from other systems that would identify risk. It has to be questioned that cross government guidance suggests a lower level of scrutiny and guidance than the law provides.

4.2.4 In this case the fact that the abusive sons within the family were under the age of sixteen did not affect CSC's ability to identify a potential MARAC case. This definition did hinder police processes.

4.2.5 When considering police procedures, the cross government definition of domestic violence had a marked effect on the identification of risk. If police were required to treat the reports of violence towards CJ as domestic violence or abuse, then a different level of support could have been provided. A DASH risk assessment would have been required, a report would have gone to the CSU for specialist investigation, and the services of IDVAs and MARAC would be available.

4.2.6 The Asset system structured assessment tool used by YOS in England does not effectively work as a tool to manage adolescent violence in the home.

4.2.7 There were good levels of communication between agencies. In particular, there was regular communication between City Gateway College, CSC and YOS. It was noted the NSPCC provided updates to statutory services and provided an additional level of support in the early stages of the review period. There was also flexibility shown in working practices. It was noted that both GN and his mother missed some key appointments with agencies. Agencies worked hard to support attendance. They offered joint agency appointments and gave regular prompts and reminders to both parties.

4.2.8 It should be noted that a new Anti-Social Behaviour Partnership Action Group (ASBPAG) was established in Tower Hamlets in February 2015. This is chaired by the Police (Chief Inspector) and is attended by Registered Providers of social housing, victim support, FIP and CMHT. This provides agencies with the opportunity to refer and case-manage vulnerable victims of anti-social behaviour as well as prolific perpetrators of ASB.

4.2.9 It is not known to what extent GN's substance misuse contributed to his psychosis. It is apparent that despite knowledge of GN's substance misuse problems he was only referred to local services on one occasion. This case was not followed up because GN was temporarily living out of Tower Hamlets Borough at the time. There were missed opportunities for CAMHS, CSC and YOS to refer GN to Lifeline substance misuse services.

4.2.10 The failure of CAMHS to send staff, with sufficient knowledge of GN's mental health assessments to the Child Protection conference shortly before the death of CJ was critical to his care. At that point CSC had assessed that CAMHS support was a priority for GN. It is not apparent that any further steps were taken to prioritise GN's assessments at CAMHS following the CP conference.

4.2.11 There can be improvements made in national policies, local policies and working practices that could help bring future cases to a more positive conclusion. Recommendations are made to promote changes in those areas.

4.3 Recommendations

4.3.1 The recommendations below are, in the main, for the partnership as a whole but many organisations have internal recommendations. It is suggested that the single agency action plans should be subject of review via the action plan hence the first recommendation.

4.3.2 Recommendation 1: That all agencies report progress on their internal action plan to the relevant task and finish group of London Borough of Tower Hamlets CSP.

4.3.3 Recommendation 2: That the Home Office amend their definition of 'Domestic Abuse' to incorporate incidents involving perpetrators of domestic abuse under the age of sixteen years.

4.3.4 Recommendation 3: The Home Office and Ministry of Justice review the Asset Plus structured assessment tool used by YOS in England to ensure that the

system considers children and young people as perpetrators of domestic abuse and has clear pathways to DASH risk assessment and MARAC.

4.3.5 Recommendation 4: That ELFT, London Borough of Tower Hamlets, Lifeline and MPS – Tower Hamlets Borough review processes and referral pathways to substance misuse services. This should be followed up with an awareness training programme for all staff. Training should include understanding a young person presentation with substance misuse problems and how to refer to support services.

4.3.6 Recommendation 5: That London Borough of Tower Hamlets CSC and YOS conduct a review of training on domestic violence procedures and processes, including DASH risk assessment and MARAC.

4.3.7 Recommendation 6: The London Borough of Tower Hamlets, ELFT, Tower Hamlets CCG, MPS and Non-Government Organisations involved in this DHR process scope, develop and deliver training on cultural sensitivities in the borough.

4.3.8 Recommendation 7: London Borough of Tower Hamlets CSP review the work of the new High Risk Management Panel and promote any good practice identified to the Home Office and London Safeguarding Board.

Appendix 1: Domestic Homicide Review Terms of Reference for CJ

This Domestic Homicide Review is being completed to consider agency involvement with ***CJ***, and **her son**, ***GN and any other known children of CJ*** following **her** death ***in February 2014.*** The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

1. Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.

2. To review the involvement of each individual agency, statutory and non-statutory, with ***CJ*** and ***GN*** during the relevant period of time: **01/01/2012 – date of the homicide.**

3. To summarise agency involvement prior to **01/01/2012.**

4. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.

5. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.

6. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.

7. To commission a suitably experienced and independent person to:

    a) Chair the Domestic Homicide Review Panel;

    b) Co-ordinate the review process;

    c) Quality assure the approach and challenge agencies where necessary; and

d) Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

8. To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the ***Tower Hamlets Community Safety Partnership.***

Membership

9. The following agencies are to be involved:

a) Clinical Commissioning Groups (formerly known as Primary Care Trusts)

b) General Practitioner for the victim and alleged perpetrator

c) Local domestic violence specialist service provider e.g. IDVA and Victim Support

d) Education services

e) Children's services

f) Adult services

g) Health Authorities

h) Substance Misuse Services

i) Housing services

j) Local Authority

k) Local Mental Health Trust

l) Police (Borough Commander for Tower Hamlets and the Critical Incident Advisory Team/SCRG)

m) National Probation Service

n) Tower Hamlets Youth Services

10. Where the need for an independent expert arises, for example, a representative from a specialist BME women's organisation, the chair will liaise with and if appropriate ask the organisation to join the panel.

11. If there are other investigations or inquests into the death, the panel will agree to either:

    a) Run the review in parallel to the other investigations, or

    b) Conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.

Collating evidence

12. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

13. Each agency must provide a chronology of their involvement with the ***CJ*** and ***GN*** during the relevant time period.

14. Each agency is to prepare an Individual Management Review (IMR), which:

    a) Sets out the facts of their involvement with CJ and/or GN

    b) Critically analyses the service they provided in line with the specific terms of reference;

    c) Identifies any recommendations for practice or policy in relation to their agency, and

    d) Considers issues of agency activity in other boroughs and reviews the impact in this specific case.

15. 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 ***CJ*** or ***GN*** in contact with their agency.

Analysis of findings

16. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following six points:

    a) Analyse the communication, procedures and discussions, which took place between agencies.

    b) Analyse the co-operation between different agencies involved with the victim, alleged perpetrator, and wider family.

    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.

    d) Analyse agency responses to any identification of domestic abuse issues.

    e) Analyse organisations access to specialist domestic abuse agencies.

    f) Analyse the training available to the agencies involved on domestic abuse issues.

Liaison with the victim's and alleged perpetrator's family

17. Sensitively involve the family of ***CJ*** in the review, if it is appropriate to do so in the context of on-going criminal proceedings. Also to explore the possibility of contact with any of the alleged perpetrator's family who may be able to add value to this process. The chair will lead on family engagement with the support of the senior investigating officer and the family liaison officer.

18. Coordinate with any other review process concerned with the child/Ren of the victim and/or alleged perpetrator.

Development of an action plan

19. Establish a clear action plan for individual agency implementation as a consequence of any recommendations.

20. Establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.

Media handling

21. Any enquiries from the media and family should be forwarded to the chair who will liaise with the CSP. Panel members are asked not to comment if requested. The chair will make no comment apart from stating that a review is underway and will report in due course.

22. The CSP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

23. 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.

24. 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.

25. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents can be password protected.

Appendix 2: Members of the Panel

Agency represented	**Panel members**
Barts Health NHS Trust	Jane Callaghan
Circle Housing Old Ford	Barbara Lord Andrew Nowakowski Jonathan Vincent Laura Smith
City Gateway School	John Barker
East London Foundation Trust (ELFT) – Mental Health Services	Cathie O'Driscoll Gurinder Lall Janet Boorman Bill Williams
Lifeline	Charlotte Talbott Lisa O'Shea Sarah Fox
London Borough of Tower Hamlets and Children's Social Care	Moksuda Uddin Nikki Bradley Paul McGee Steve Liddicott
London Borough of Tower Hamlets Head of Community Safety	Emily Fieran-Reed
London Borough of Tower Hamlets Domestic Violence and Hate Crime	Sharmeen Narayan Menara Ahmed
London Borough of Tower Hamlets – Youth and Community Services	Dinar Hossain Claire Belyard
London Borough of Tower Hamlets - Safeguarding Adults	Joy Calladine Melba Gomes
London Borough of Tower Hamlets – Youth Offending Services	Stuart Johnson

London Borough of Tower Hamlets – Housing Options	Janet Slater
London Borough of Tower Hamlets – Public Health	Chris Lovitt
Metropolitan Police Service (MPS)	Mike Nicholls Jack Spratt Jonathan Burks Tony Gowen Stephen Underwood
Metropolitan Police Service (MPS) – Specialist Crime Review Group	Phil Fitzgerald Tracey Hunt Paul Warnett
National Probation Service	Yannik Mackenzie Ann Bartrum Linda Neimantas
National Society for the Prevention of Cruelty to Children (NSPCC)	Elizabeth Morris Marian Moore
NHS England	Nicola Clark
Standing Together Against Domestic Violence	Mark Yexley Mark Pigeon
Tower Hamlets Clinical Commissioning Group (CCG)	Richard Fradgley
Victim Support	Maddi Joshi

Appendix 3: Action Plan

	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	What is the over-arching recommendation?	*Should this recommendation be enacted at a local or regional level (N.B national learning will be identified by the Home Office Quality Assurance Group, however the review panel can suggest recommendations for the national level)*	*How exactly is the relevant agency going to make this recommendation happen?* *What actions need to occur?*	*Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation ?*	*Have there been key steps that have allowed the recommendation to be enacted?*	*When should this recommendation be completed by?*	*When is the recommendation and actually completed?* *What does the outcome look like?*
1	That all agencies report progress on their internal action plan to the						

	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	relevant task and finish group of London Borough of Tower Hamlets Community Safety Partnership						
2	That the Home Office amend their definition of 'Domestic Abuse' to incorporate incidents involving perpetrators of Domestic Abuse under the age of sixteen years						
3	The Home Office review the Asset structured assessment tool used by Youth Offending Services in England to ensure that the system considers children and young people as perpetrators of domestic abuse and has clear pathways to DASH risk assessment and MARAC		The Ministry of Justice through the Youth Justice Board have developed a new assessment tool for Youth Offending Services called Asset Plus. This				

	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
			is being rolled out across the country and LBTH YOS are due to be trained in the tool in June 2015. Asset Plus is a much more holistic assessment tool than the current YOS assessment and has in its favour an ongoing review process that mitigates a) against the loss of history and b) the opportunity				

	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
			to capture a wider range of risk factors with a greater emphasis on the family and wider environmental factors.				
4	That East London Foundation Trust, London Borough of Tower Hamlets, Lifeline and Metropolitan Police Service – Tower Hamlets Borough review processes and referral pathways to substance misuse services. This should be followed up with an awareness training programme for all staff. Training should include						

	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	understanding a young person presentation with substance misuse problems and how to refer to support services						
5	That London Borough of Tower Hamlets Children's Social Care and Youth Offending Service conduct a review of training on domestic violence procedures and processes, including DASH risk assessment and MARAC						
6	The London Borough of Tower Hamlets, East London Foundation Trust, Tower Hamlets CCG, Metropolitan Police Service and Non-Government Organisations involved in this DHR process.						

	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	Scope, develop and deliver training on cultural sensitivities in the Borough						
7	NB to provide Standing Together with a paragraph explaining how the Child Protection assessment can be adapted to assess wider risks in the community						