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**TOWER HAMLETS COMMUNITY SAFETY PARTNERSHIP**

**DOMESTIC HOMICIDE REVIEW**

**EXECUTIVE SUMMARY**

**Report into the death of Salma**

**January 2019**

**Independent Chair and Author of Report: James Rowlands**

**Associate Standing Together Against Domestic Abuse**

**Date: September 2020**

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1. Executive Summary
	1. The Review Process
		1. This summary outlines the process undertaken by the Tower Hamlets Community Safety Partnership Domestic Homicide Review (DHR) Panel in reviewing the homicide of Salma[[1]](#footnote-1), a resident of the London Borough of Tower Hamlets (hereafter ‘Tower Hamlets’).
		2. Salma was killed by her husband Omar.[[2]](#footnote-2) She was found dead at home on a day in early January 2019, with fatal head and neck injuries. The London Ambulance Service (LAS) attended, as did police officers from the Metropolitan Police Service (MPS), but tragically Salma was pronounced dead at the scene.
		3. Omar had left before the MPS arrived, but he presented himself to a South London Police Station the following morning. He was subsequently arrested and charged with murder. In July 2019 Omar was found guilty of murder and sentenced to life imprisonment with a minimum term of 19 years.
		4. This DHR will consider agencies contact/involvement with Salma and/or Omar and their children from the beginning of 2008 to the date of the homicide.
		5. This DHR has been anonymised in accordance with the statutory guidance. The specific date of the homicide and the sex of any children have been removed (with anonymity further enhanced by the children being referred to as Child A, B and C and identifying information about their primary schools being removed). Only the chair and Review Panel members are named.
		6. The following pseudonyms have been used in this review to protect the identities of the victim, other parties, those of their family members and the perpetrator:

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

* + 1. In accordance with the December 2016 ‘*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews’* (hereafter ‘the statutory guidance’), the local Community Safety Partnership (CSP) – the Tower Hamlets CSP – commissioned this DHR. Having received notification from the MPS in early January 2019, a decision was made to conduct a DHR in consultation with CSP partners in February 2019 and confirmed in March 2019. Subsequently, the Home Office was notified of the decision in writing at the start of April 2019.
		2. Standing Together Against Domestic Abuse (Standing Together) was commissioned to provide an Independent Chair (hereafter ‘the chair’) for this DHR in February 2019, with this beginning in April 2019 once the decision to conduct the DHR had been made. The completed report was handed to the Tower Hamlets CSP in September 2020. On 24th November 2020, it was tabled at a meeting of the Tower Hamlets Community Safety Partnership and signed off, before being submitted to the Home Office Quality Assurance Panel on the 26th November 2020. In April 2021, the completed report was considered by the Home Office Quality Assurance Panel. In June 2021, the Tower Hamlets CSP received a letter from the Home Office Quality Assurance Panel approving the report for publication. The letter will be published alongside the completed report.
	1. Contributors to the Review
		1. This DHR has followed the statutory guidance issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004.
		2. On notification of the homicide, agencies were asked to check for their involvement with any of the parties concerned and secure their records. As there was involvement with both Tower Hamlets, and the neighbouring London Borough of Newham, scoping was completed in both areas. A total of 33 agencies were contacted to check for involvement with the parties concerned with this DHR. Of these, three had only limited contact and submitted a Summary of Engagement only. However, 10 had more extensive contact and were asked to submit Individual Management Reviews (IMRs). A narrative chronology was also prepared. The following agencies made contributions to this DHR:

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| **Agency** | **Contribution** |
| Aanchal[[3]](#footnote-3) | Summary of Engagement |
| Clarion Housing[[4]](#footnote-4) | IMR and Chronology |
| Primary School for Child B and C | Summary of Engagement |
| East London NHS Foundation Trust[[5]](#footnote-5) (ELFT) | IMR and Chronology |
| General Practice (GP) | IMR and Chronology |
| London Borough of Newham –Children’s Social Care and Early Help Service | IMR and Chronology |
| London Borough of Tower Hamlets – Children’s Social Care and Early Help Service | IMR and Chronology |
| Child A’s Primary School  | IMR and Chronology |
| London Borough of Tower Hamlets – Housing Options | IMR and Chronology |
| MPS | IMR and Chronology |
| The Royal London Hospital, part of Barts Health NHS Trust[[6]](#footnote-6) | IMR and Chronology |
| Tower Hamlets GP Care Group[[7]](#footnote-7) (THGPCG) | IMR and Chronology |
| Whittington Hospital, part of the Whittington Health NHS Trust[[8]](#footnote-8) | Summary of Engagement |

* + 1. Additionally, information was also provided by:
* A high street bookmaker (relating to Omar’s gambling); and
* The Home Office (information concerning immigration and citizenship).
	+ 1. *Independence and Quality of IMRs*: The IMRs were written by authors independent of case management or delivery of the service concerned. The IMRs received were for the most part comprehensive and enabled the Review Panel to analyse the contact with Salma, Omar, and their children, and to produce the learning for this DHR. In some IMRs, a lack of detail meant that further questions had to be sent to agencies. The Overview Report also summarises some additional considerations, including the involvement of the Primary School for Child B and C, the IMR and chronology provided by the GP, as well as the role of the Named GP for Adult Safeguarding, covering the Clinical Commissioning Groups (CCGs) in Waltham Forest, Newham, Tower Hamlets.
	1. The Review Panel Members
		1. The Review Panel members were:

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| **Name** | **Job Title** | **Agency** |
| Andrew Nowakowski | Tenancy Specialist Manager | Clarion Housing Group |
| Anna Davies | Named Midwife for Safeguarding Children & Gateway Team Manager | Barts Health NHS Trust |
| Beverley Williams | Specialist Crime Review Group (SCRG) | MPS |
| Caroline Fallan | Housing Management and Procurement Manager | Tower Hamlets Housing Options Service |
| Dinh Padicala | Associate Director for Adult safeguarding and Domestic Abuse | ELFT |
| Geraldine O'Donnell | Interim Service Manager, Safeguarding and Quality Assurance Service | Tower Hamlets Children’s Social Care and Early Help Service |
| Gurinder Lall | Named Professional for Safeguarding Children | ELFT |
| Helen Garratt | Director of Clinical Services | GamCare[[9]](#footnote-9) |
| Josephine Feeney | Operations Manager | Victim Support |
| Menara Ahmed | Senior Violence against Women and Girls (VAWG) and Hate Crime Manager | Tower Hamlets VAWG and Hate Crime Team |
| XXX XXX | Deputy Head Teacher/ Designated Safeguarding Lead | Child A’s Primary School |
| Mags Groves | Senior Operational Lead-Community Mental Health Teams, Perinatal Service | ELFT |
| Dawn Henry | Early Help Partnership Coordinator | Newham Children’s Social Care and Early Help Service |
| Richard Simmonds | Psychological Therapies Lead Tower Hamlets | Child and Adolescent Mental Health Services (CAMHS), ELFT |
| Robi Bibi | Senior Support Worker | Hestia - Domestic Abuse Service (Refuge) |
| Roisin Gavin | Safeguarding Coordinator | Barts Health NHS Trust |
| Ruth Walters | Director of Quality Assurance | THGPCG |
| Sarah Murphy | Joint Senior Strategic Safeguarding Adults Lead in Tower Hamlets | Tower Hamlets Adult Social Care / Tower Hamlets CCG |
| Sharifa Chowdhury | Education Safeguarding Manager | Tower Hamlets Education Safeguarding Service |
| Sufia Alam | Maryam Centre Manager | London Muslim Centre[[10]](#footnote-10) |

* + 1. The Review Panel is grateful for the participation of the following agencies, who did not have any contact but provided their expertise:
* The London Muslim Centre acted as a critical friend and provided comment and feedback on the report during drafting. The chair and Review Panel are grateful for their time and input. Their contribution is a reminder of the importance of being able to access local community expertise and knowledge in the course of a DHR;
* GamCare provided expertise concerning problem gambling. During the DHR, GamCare shared that in their experience, they are rarely approached to contribute to DHRs, which seems indicative of the general lack of awareness of gambling-related harms and domestic violence and abuse. The Review Panel agreed to note Gamcare’s involvement in order to encourage other DHRs to consider seeking support with these matters.
	+ 1. Additionally, Aanchal was invited to feedback on the report about their historical contact in this case.
		2. The chair wishes to thank everyone who contributed their time, patience and cooperation.
	1. Chair of the DHR and Author of the Overview Report
		1. The chair and author of the review is James Rowlands, an Associate DHR Chair with Standing Together. James has received DHR Chair’s training from Standing Together. He has chaired and authored ten previous DHRs and has previously led reviews on behalf of two Local Authority areas in the South East of England. He has extensive experience in the domestic violence sector, having worked in both statutory and voluntary and community sector organisations.
		2. Standing Together is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors’ safety, hold perpetrators to account and ultimately prevent domestic homicides. Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 80 reviews.
		3. *Independence:* James has no connection with the local area or any of the agencies involved, although he is concurrently chairing another DHR in the borough.
	2. Terms of Reference for the Review
		1. At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from the beginning of 2008 to the date of the homicide. This date was chosen because Salma’s first contact with agencies was in 2008, shortly after she arrived in the UK.
		2. *Key Lines of Inquiry:* The Review Panel considered the statutory guidance and identified the following case specific issues:
* The communication, procedures and discussions, which took place within and between agencies;
* The co-operation between different agencies involved with Salma and/or Omar [and wider family];
* The opportunity for agencies to identify and assess domestic abuse risk;
* Agency responses to any identification of domestic abuse issues;
* Organisations’ access to specialist domestic abuse agencies;
* The policies, procedures and training available to the agencies involved in domestic abuse issues;
* Specific consideration to the following issues: English as a second language, the use of translators and Immigration; and
* Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.
	1. Summary of Chronology

*Salma*

* + 1. Salma had contact with a range of different professionals. Within this contact, while the issues varied, a reoccurring feature was the extent to which professionals considered and responded to Salma’s limited English. This often meant that family members were (inappropriately) used as interpreters.
		2. In relation to health providers, Salma accessed both maternity and health visiting services until 2016. In these contacts, health professionals had no concerns about her parenting. Broadly speaking, there were opportunities to ask about domestic abuse which were not taken because a third party was present, largely because health professionals often used family members as interpreters. However, in some contacts interpreters were used e.g. by Barts Health NHS Trust.
		3. Throughout the timeframe covered by the DHR, Salma also had contact with her GP, albeit this was limited and related to specific health issues. This contact also related to health care for children A, B and C. Although family members were initially used as interpreters, after 2013 this was not required as Salma could speak directly with her GP.
		4. In these contacts with health providers there were no concerns around domestic abuse identified, nor were any disclosures made. It is of particular note that the GP was unaware of latter disclosures around domestic violence and abuse or other issues. Broadly put, it appears that other agencies – mostly significantly Newham and later Tower Hamlets Multi Agency Safeguarding Hub (MASH) – had not contacted or notified them of concerns. Given the GP had only limited contact with Salma, with no indicators of domestic violence and abuse, being made aware of these concerns would have been essential to trigger a targeted enquiry.
		5. In relation to housing providers, Salma had contact with Tower Hamlets Housing Options, principally in 2014 (when she was seeking accommodation) and in 2016 (in relation to her accommodation needs). In 2013, Salma first disclosed concerns about Omar’s gambling and her concerns about any tenancy. In relation to the former, this was not responded to with any consistency by Tower Hamlets Housing Options, which focused on Salma and Omar’s responsibility for rent payments, rather than exploring what help and support might be suitable. However, it is commendable that on one occasion a Housing Officer did speak to Salma alone about these issues, although they were not followed up again. In 2016, in relation to Salma’s disclosure of domestic violence and abuse, while this triggered referrals by the Housing Officer, including to the Newham MASH, these were not followed up. Additionally, when Tower Hamlets later became aware that Omar had moved back in with Salma, they did not take steps to notify any other agencies.
		6. Tower Hamlets Housing Options discharged their duty to Salma and Omar, by initially housing them in temporary accommodation from 2014 and then nominating them to permanent accommodation provided by Clarion Housing in 2017. However, they did not share information about Salma’s disclosure – both of gambling concerns and domestic violence and abuse – when they made the nomination to Clarion Housing. This has led to the identification of a lack of guidance as to what information can be shared when nominations are made to a housing provider. Finally, like other services, Housing Options primarily relied on family interpreters.
		7. Clarion Housing became landlords for Salma and Omar from 2017. It is commendable that, as part of the process for viewing properties, Clarion Housing took steps to ensure that staff on site could meet Salma and Omar’s language requirements. During their subsequent interactions with Clarion Housing, most of the staff that Salma and Omar interacted with could also speak with them directly. However, there is still learning from Clarion Housing in relation to this issue. For example, Tenancy Sign-Up documents are in English.
		8. More generally in relation to domestic violence and abuse, no disclosures were made to Clarion Housing by either Salma or Omar. Moreover, as noted above, Tower Hamlets Housing Options had not notified Clarion Housing of previous concerns. As a result, Clarion Housing would have been dependent on staff either identifying a concern or a disclosure by Salma. This has led to the identification of an absence of information in tenancy starter parks about domestic violence and abuse.
		9. The MPS received three reports concerning Salma. In the first two incidents, in June and September 2016, Salma made significant disclosures about Omar’s abusive behaviour. In October 2016, Salma made further disclosures, including an allegation of a sexual offence. In responding to the first two disclosures, there has been learning about how police officers risk assess, not least because in the June 2016 incident an assessment of ‘Medium’ risk was downgraded. This was because Salma said she was going to stay with a family member, but this was not revised when she returned home. In these contacts, police officers frequently used family as interpreters. This was most significant in October 2016, when this meant that family were interpreting when Salma disclosed a sexual offence. In particular, this led to confusion about when this offence occurred which meant that an opportunity to refer Salma to The Haven was not initially considered. The October 2016 contact has also revealed issues with both record keeping, how domestic and sexual offence allegations are managed in parallel, as well as highlighting issues such as officer welfare.
		10. Newham MASH received six referrals during the time the family resided in the borough. In assessing two referrals from the MPS in 2016, there was an over-reliance on police actions as determining the MASH’s assessment. In essence, because the MPS had taken no further action, nor did the MASH. A third referral from the MPS in 2016 led to a referral to Early Help. Other referrals, from Tower Hamlet’s Housing Options in 2016 and then from Beckton Primary School in 2017, led to the same result. When Beckton Primary School made a final referral towards the end of 2018, they were advised to contact the Tower Hamlets MASH.
		11. For both the MPS and Newham MASH, their contacts with Salma in 2016 could have been referred to Multi Agency Risk Assessment Conference (MARAC). Arguably, the MPS should have made a referral based on ‘professional judgement’. Additionally, the MPS and Newham MASH could have considered a referral to the local MARAC on the basis of ‘potential escalation’. However, in this case, the local threshold would not have been met. This has highlighted issues with thresholds of the MARACs in both Newham and Tower Hamlets, which vary by both frequency and type of incident, and which are higher than the national guidance.
		12. The various referrals to the MASH that led to Early Help referrals triggered a range of actions, including meetings with the family as well as consideration of referrals relating to domestic abuse and other measures around security in the home. However, partnership arrangements at the time do not appear to have been particularly robust, meaning many of the actions that were agreed do not seem to have been completed and/or there is a lack of clarity about outcomes.
		13. Child A’s Primary School also had contact in this case, relating to Child A. While the school provided support to Child A, including ultimately making a referral to CAMHS, as well as safeguarding referral(s), the focus was largely on their behaviour. As a result, concerns about domestic violence and abuse were not considered, in particular in the referral to CAMHS. This would have been an opportunity to alert another service that was going to work closely with the family about the history of domestic violence and abuse and so potentially inform their interventions.
		14. CAMHS received a referral for Child A in late 2018. This triggered an assessment and intervention, although this was delivered via Salma and Omar as Child A did not want to attend. While initial contact attempts included provision for interpretation, this was not consistently done in subsequent interactions, both in direct contact but also in writing. More generally, CAMHS did not consider domestic violence and abuse. This is perhaps understandable, given this was not highlighted in the referral from Child A’s Primary School (or subsequent contact with the MASH in first Newham and then Tower Hamlets). However, there was one reference to domestic violence and abuse in the record, while the concerns about possible behaviour from Child A to Salma, as well as other issues (like reports of Omar’s stricter parenting), could have triggered consideration. Moreover, the case handling in terms of supervision or case management appears limited; again, support from other colleagues may have drawn attention to the possibility of domestic violence and abuse.
		15. Tower Hamlets Children’s Social Care and Early Help Service had limited contact in this case, with some information in July 2017 (that did not trigger any further action), and a referral in December 2018. This was appropriately assessed, but reflecting the issues noted above, the focus of information shared by Child A’s Primary School and CAMHS was Child A’s behaviour and there was no information shared around domestic violence and abuse. If Tower Hamlets MASH had sought information from Newham, given it was aware that the children were attending school there, this would have provided an additional avenue through which this information could have been identified. Ultimately, the MASH signposted to Early Help although this had not progressed very far by the time of Selma’s death.

*Omar*

* + 1. Although Omar was in contact with some agencies, for example, Tower Hamlets Housing Options and Child A’s Primary School, in some senses he is relatively absent. In part, this is because Omar did not participate in this DHR, which has limited the amount of information available about him and his experiences. However, it also reflects how the focus tended to be on either Salma and Omar jointly (e.g. as tenants when in contact with Tower Hamlets Housing Options or Clarion Housing) or on Child A (e.g. in relation to contact with Child A’s Primary School or CAMHS).
		2. The only agency that specifically had contact with Omar in relation to domestic violence and abuse was the MPS, in response to reports relating to his behaviour. The MPS appear to have responded appropriately to Omar, including for example using bail conditions to remove him from the family home after the October 2016 sexual assault allegations. However, continuing the theme of Omar’s relative absence, it is of note that the MPS focused its risk assessment on Salma’s actions rather than his.
		3. A final issue for Omar was his gambling. Relatively little information is known about this, but it is clear that Omar was regularly gambling, and this was a concern to Salma and her wider family.

*Analysis*

* + 1. Taking into account the government definition above, information gathered by the MPS as part of the murder investigation, as well as provided by agencies and family, it is clear that Salma was the victim of domestic abuse by Omar, in addition to being killed at his hands.
		2. Tragically, it will never be possible to know the full extent of Salma’s experiences. However, as a minimum it appears Salma experienced the following:
* *Physical abuse*: Assaults by Omar, including strangulation and possibly the use of weapons. Child A also described an incident when Omar hit their mother;
* *Coercion, threats and intimidation*: The Review Panel does not have a full picture of Omar’s behaviour in this context, although there are reports (including by Salma to police officers) that he had made threats to kill. Whatever means he used to coerce, threaten and intimate, these were clearly effective: it has been reported that Salma was isolated, in part because Omar did not want her to go out. During a period when Salma had moved out of the family home, she was fearful of living there because she was worried that Omar would try and break in;
	+ - * *Emotional abuse and isolation*: The Review Panel does not have a full picture of Omar’s behaviour in this context, although as regular arguments were reported to the police and noted by family, this is likely to have been a significant feature of the relationship. Salma herself told police officers in June 2016 that Omar did not like her talking to other people;
			* *Sexual abuse*: In her contact with the MPS in September 2016, Salma disclosed that Omar forced her to have sex with him and that that had been happening for the past two years. While it is unclear what Salma would have called this, and charges against Omar were ultimately dropped, it is important to note that as a minimum this would constitute sexual assault, if not rape;
			* *Children and pregnancy*:It is unclear if or how the children were used by Omar to abuse Salma. However, it is of note that Salma’s niece (Samiha) said that Salma was fearful that contact with services could lead to the loss of her children. Samiha thought Salma believed this based on what Omar had told her. Child A said they had been hit by Omar and also tried to protect Child B and C. It also seems that Omar’s economic abuse was linked to the children, on at least one occasion he is reported to have asked for the child benefit; and
			* *Economic abuse*: Omar is reported to have either taken or demanded money, both to pay for his gambling and possibly also to send money to his family in Bangladesh. Based on the call outs to the MPS, and the account of family, Omar would respond to being challenged about finances with violence and abuse.There was also a broader impact on the family’s finances, with this being an ongoing concern.
		1. Additionally, Omar was known to gamble. While it is not possible to determine the extent of Omar’s gambling, this was clearly of concern to Salma, who reported that Omar had taken money for this purpose and was worried about the impact on the family’s finances (and tenancy). Salma’s family also described arguments as a result of gambling.
		2. Moreover, while the Review Panel cannot be sure what precipitated the murder of Salma, it noted that in addition to these factors:
			- There was an ongoing conflict over finances, precipitated by Omar’s behaviour; and
			- The Review Panel has not had any information to suggest that immediately before the homicide Salma intended to leave Omar, but it is relevant to note that at various points in the past Salma had left the family home or was reported as wanting to end the relationship or said this herself.
		3. Clearly, the picture of domestic abuse presented here was not known to all agencies, nor known in full. However, different agencies knew about domestic abuse during their contact with Salma and Omar, as well as the children.
		4. It appears that Salma told different people different things at different times. This is evident in her disclosures to family members, and it is also apparent in her contact with professionals. For example, while Salma did at times talk about her concerns about Omar, including making disclosures of domestic violence and abuse, at other times she said and behaved as if everything was fine. The Review Panel noted this as an example of the challenges that victims of domestic violence and abuse can face in talking about their experiences, particularly when also trying to manage their safety. However, it is important to note that Salma did find ways to talk about what was happening to her. It is difficult to know what may have helped or hindered Salma in this regard, with issues including fear of Omar, or indeed services, as well as the challenge of the language barrier.
		5. Relevant to all these issues is how Salma’s experiences of abuse, but also accesses to help and support from her family and friends, as well as agencies, was affected by her specific circumstances. She was originally from Bangladesh, although she had been naturalised as a British Citizen. She had limited English and was relatively isolated, bar support from her family. There is clear evidence that women from minoritized communities can face a range of barriers, including vulnerabilities to forms of abuse, as well as compounding affects like feelings of shame, language barriers and the impact of different cultural norms and expectations. The Review Panel has considered the impact of cultural attitudes and / or stereotypes, as well as agency responses, in particular how some agencies inappropriately used family members to provide translation. In Salma’s case, while her family appear to have been supportive, accompanying her to appointments and encouraging her to seek help, it was nonetheless inappropriate to use family in this way.
	1. Conclusions and key issues arising from this DHR
		1. Salma was a much-loved sister and aunt. She was also the mother of three children, who now face growing up without their mother as a result of Omar’s actions. The Review Panel extends its sympathy to the family and friends of Salma.
		2. The Review Panel has sought to try and understand Salma’s lived experiences and consider the issues she faced in order to try and understand the circumstances of the homicide and identify relevant learning. In this endeavour, the Review Panel has been aided to a great extent by help from family members and extends its thanks to all those who have participated in this DHR.
		3. Omar is solely responsible for Salma’s murder. Nonetheless, there has been significant learning identified during this DHR, which the Review Panel hopes will prompt individual agencies, as well as the appropriate partnerships, to further develop their response to domestic violence and abuse. This learning is summarised below.
	2. Lessons to be learnt
		1. The learning in this DHR relates to several key areas. First, *interpretation and translation*: While agencies did make some efforts to provide interpretation and translation this was inconsistent. Instead, agencies often relied on family members. This is not appropriate. Additionally, this DHR has highlighted that simply collapsing Sylheti into Bengali is unhelpful, given there are distinct differences which may present barriers to communication, yet many agencies and professionals do not appear to be aware of these differences. Recommendations have been made to address these issues.
		2. Second, *interagency communication*: There were examples of good interagency working, including an awareness of the importance of sharing information or making referrals where necessary. However, all too often communication took the form of ‘fire and forget’, with agencies failing to follow up correspondence, or enquire about outcomes, or respond promptly. There was also a reliance on indirect communication (particularly email) rather than speaking directly to another professional, which may have more readily resolved the issues causing confusion or concern.
		3. Third, *cross border working*: During the timeframe covered by this DHR, Salma, Omar and their family had been resident in both Tower Hamlets and Newham. It is important to note one fact: this was not their choice. They had come to live in Newham as a result of being placed in temporary accommodation there by Tower Hamlets Housing Options. Even before returning to Tower Hamlets, the children continued to access schools in Tower Hamlets and other services there also worked with the family. This caused considerable confusion, affecting decisions both on what service were offered but also meaning agencies did not always have a complete picture of the family’s risks and needs. This was exacerbated by the issues with interagency communication as summarised above, but also on occasion the failure of agencies to undertake enquiries with their counterparts in neighbouring boroughs (this is most pertinent to Tower Hamlets MASH). Additionally, this meant there were occasions when concerns either went unresolved (e.g. when Salma raised the security of the property in 2016), or the outcome of referrals were unclear (e.g. to the local specialist domestic abuse services, at that time provided by Aanchal).
		4. Individual agencies have made recommendations in relation to both interagency communication and cross border working. While it is impossible to say what the effect of resolving these issues may have been, the importance of prompt and clear communication, as well as the speedy resolution of areas of confusion, is important learning from this DHR.
		5. Fourth, *responses to domestic violence and abuse*: despite Salma’s fears for her children, as well as isolation and challenges given her limited English and potentially the impact of cultural norms and expectations, she did disclose her experiences of domestic violence and abuse, usually with the support of her family. The responses to these disclosures were mixed, with examples of risk being downgraded or not recognised. Critically, the issues identified around interagency communication above meant there were multiple attempts to refer Salma to Aanchal without success. While Salma would have needed to take up any offer, it clearly did not help that these attempts were disjointed and that agencies were often unaware that referrals had not been successful so could not consider what if anything else they could do to support Salma. Other areas of learning include issues around risk identification and assessment, not least referral to the MARAC; as well as the response to other issues in this context like gambling; and policy and practice that would encourage agencies to raise awareness of and identify domestic violence and abuse. Individual agencies have made recommendations in response to these issues, while multi agency recommendations have also been made.
		6. Finally, when Early Help, and later CAMHS, worked with the family, domestic violence and abuse was either not consistently responded to or was not the focus of intervention. Instead, concern about Child A’s behaviour took centre stage. While this is understandable in so far as this was the presenting issue for many agencies, there could and should have been a consideration as to the context (and possible cause) of Child A’s behaviour. This would have enabled agencies to consider how to either support Salma or begin to address Omar’s behaviour. Sadly, this did not happen. Individual agency recommendations have been made in response to this learning, but this is important learning that should remind all agencies of the importance of professional curiosity and a wide-angled lens to assessment.
		7. Following the conclusion of a DHR, there is an opportunity for agencies to consider the local response to domestic violence and abuse in light of the learning and recommendations. This is relevant to agencies both individually and collectively. Tower Hamlets was able to share information on its strategy and action plan, which will provide a basis on which to feed in learning from this DHR and to continue to develop local processes, systems and partnership working. The Review Panel hopes that this work will be underpinned by a recognition that the response to domestic violence is a shared responsibility as it really is everybody’s business to make the future safer for others.
	3. Single Agency Recommendations:

*Barts Health*

* + 1. “Health Advocates should be used for all pregnancy appointments, particularly the booking appointment”.

*CAMHS (provided by ELFT)*

* + 1. “MDT discussions are recorded routinely in clinical records. TH CAMHS clinical team leads to review systems to ensure that the outcome of MDT discussions in cases where the parents are reporting that their child is refusing to attend and has never been seen, are included in and inform the action plan”.
		2. “Tower Hamlets CAMHS leadership team to remind staff of their duties of documenting clinical supervision case discussions on to RIO”.
		3. “Tower Hamlets CAMHS to continue to communicate care plans verbally and by letter copied to GP directly following families attendance at assessment clinics”
		4. “Tower Hamlets CAMHS leadership team to ensure that ELFT Guidelines from risk of violence assessment are circulated and then made readily available to staff via the intranet”.
		5. “Tower Hamlets CAMHS clinical leadership to ensure that all staff are aware that in all new assessments, there is a record that past RIO records have been reviewed and relevant action plans taken into account, based on the review of notes”.
		6. “Tower Hamlets CAMHS to consider routinely checking for past or current involvement with social services at point of referral”.
		7. “If there is a past history of Social services involvement, for clinical team lead to remind staff on obtaining consent from parents to obtain information relating to Social Services involvement”.
		8. “Tower Hamlets CAMHS staff to be refreshed on and recirculate NICE guidelines on Conduct Disorders and to consider providing assessment guidance to clinicians for children and adolescents presenting with violence or aggression”.
		9. “Tower Hamlets CAMHS to consider implementing a pathway for young people presenting with violence or aggression and/or those that are hard to engage, as illustrated by the City and Hackney Conduct and Outreach pathway”.
		10. “Tower Hamlets CAMHS to review systems to ensure that MDT meetings and clinical supervision discussions are clearly recorded in the clinical records”.
		11. “Tower Hamlets CAMHS to review systems to ensure that interpreting services are booked routinely for initial assessment if referral states that the clients cannot speak English. Giving the patient the option to refuse if not needed”.
		12. “Tower Hamlets CAMHS to ensure clinicians are aware of the systems for accessing telephone interpreting services if face to face interpreter is not possible”.
		13. “There are clear supervision structures for Tower Hamlets CAMHS clinicians involved in the assessment, management and safeguarding of young people presenting with violence and aggression. Clinical team leads to ensure that clinical discussions in supervision are clearly documented”.
		14. “Tower Hamlets CAMHS clinicians are able to access safeguarding and clinical training relating to domestic abuse from a variety of sources. Clinical supervisors to ensure that CAMHS staff are aware of the range of training available”.

*Clarion Housing*

* + 1. “The sharing of recent and wider safeguarding concerns with registered providers of social housing at the tenancy nomination stage would be relevant to its housing management function”.

*Newham Children’s Social Care and Early Help*

* + 1. SafeLives Risk Assessment should be completed routinely in domestic violence cases and consideration taken of types of abuse outlined in the Power and Control Wheel”.
		2. “Training in these tools, general training in Domestic Abuse and MARAC refresher training should be provided for Practitioners”.
		3. “Risk assessments should clearly identify triggers which would indicate a change in the level of risk and the assessment should be reviewed at these points. Evidence clearly indicates relationship breakdown, reconciliation, pregnancy and major life events such as bereavements as trigger points, but assessments should be individual to each case”.
		4. “Practitioners working with families where domestic abuse is a factor should ensure they take into consideration any support that could be offered to the perpetrator to address contributing factors such as substance misuse, worklessness and gambling however it should be taken into account that perpetrator work in relation to violence itself is specialist and may require referral to a specialist agency”.
		5. “Interpreters/Translators should complete domestic abuse awareness training”.
		6. “Referrals should be made to Domestic Violence Support Services at the point of contact with the local authority or other agencies (already in place)”.
		7. “System Connectivity should be explored and there should be more information sharing between Local Authorities and Commissioned Providers (i.e. Hestia) so that we know if DV services are actively working with a family”.
		8. “Consideration should be given to reviewing Information Sharing Protocols in the light of this IMR”.
		9. “Protocols for information sharing when families relocate out of borough should be reviewed and / or developed”.

*MPS*

* + 1. “It is recommended that North East BCU SLT remind all front-line officers and Safeguarding investigators of the importance of Language Line / Interpreting services when reporting and investigating allegations of domestic abuse”.
		2. “It is recommended that North East BCU SLT remind all Safeguarding Officers of the MARAC referral pathway, when this should be considered and how to document the decision process and rationale”.
		3. “It is recommended that North East BCU SLT monitor and supervise Domestic Abuse closing reports to ensure there is an understanding and compliance with MPS and Local Authority Guidelines for MARAC referral”.
		4. “It is recommended that North East BCU SLT remind all staff of the requirements of the National Crime Reporting Standards, with regards to prompt reporting of the allegations of crime”.
		5. “It is recommended that North East BCU SLT ensure that all supervisors of rape and penetrative sexual offences are aware of and give due consideration to obtaining EIA from CPS RASSO and that this is documented as part of the investigation strategy”.

*Child A’s Primary School*

* + 1. “Children to understand what a positive relationship looks like through P4C/PHSCE and Bounce back days or Headstart Champions sessions”.
		2. “Safeguarding team to attend training on Domestic Violence”.
		3. “Safeguarding team to provide training for the all staff members in relations to Domestic Violence”.

*THGPCG*

* + 1. “To ensure that the current development of the organisational domestic abuse policy and on-going training additionally includes:
* The need to ask about Domestic Abuse at the initial contact with the Health Visiting Service (antenatal contact, new birth or movement in visit) and providing information about local domestic abuse services irrespective of the response.
* The need to ask to see woman alone should partners/ family members/ friends be present at the initial visit.
* The need to record on EMIS a plan should the above not be possible of how and when it can be asked at a future contact.
* The need to look for opportunities to ask about Domestic Abuse at all contacts (especially at key developmental reviews).
* Where potential predisposing factors to domestic abuse are identified there is an increased requirement to ask at every contact.
* The need to establish, prior to visits, whether an interpreter is required and if so ensure that one is booked and the inappropriateness of using a family member to interpret”.
	+ 1. “To ensure that the family health needs assessment includes, but is not limited to:
			- Establishing immigration status
			- Recording both parents’ religion
			- Household finances
			- Housing status
			- Bonding / attachment and barriers to this.
			- Knowledge of local specialist services as well as the local offer information.
			- Assessment of the impact of the above on parental relationships and parenting”.
		2. “To ensure that that it is clearly stated in policy or standard operating procedure (SOP) and staff to be reminded of:
			- The need to verify address and contact details at every time the family are seen and EMIS record updated accordingly.
			- The need to establish at initial contact whether an interpreter is required and to ensure that only organisationally approved, interpreters are used at planned contacts.
			- The need to initially offer a universal plus Health Visiting service following premature delivery and consideration of support via the MECSH programme.
			- The expected response to a potential non accidental injury, even if there are no obvious visible injuries”.

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

* + 1. “For consideration to be given to how consent is gained from families, when a referral is being made (to whatever service) for a broad range of services, including CSC, to be offered to them”.
		2. *Tower Hamlets – Housing Options*
		3. “Clients that disclose any difficulties within a family setting or with partners are interviewed further in an appropriate way to ascertain if there is a need for sign posting and/or referrals for assistance.”
		4. “Referrals made to other professionals in the context of domestic violence and/or safeguarding are followed up to establish what, if any, further action is required from the referring agency.”
	1. Multi Agency Recommendations:
		1. **Recommendation 1:** The Tower Hamlets CSP to satisfy itself that Child A, B and C (as well as their kinship carers) are offered support in relation to the publication of the DHR.
		2. **Recommendation 2:** After publication of this DHR, the Tower Hamlets CSP to ensure that this report is attached to Child A, B and C’s social care records. This is so that, if they wish to read the DHR when they are older, it will be available to them.
		3. **Recommendation 3:** The Ministry of Housing, Communities and Local Government (MHCLG) to review the learning from this case and issue appropriate guidance nationally to ensure housing providers can be informed of safeguarding concerns at the tenancy nomination stage.
		4. **Recommendation 4:** Clarion Housing to review its new tenancy starter information to include information on domestic violence and abuse.
		5. **Recommendation 5:** Clarion Housing to review it internal checklist for compliance against the Pre-Action protocol to explicitly address domestic violence and abuse.
		6. **Recommendation 6**: The Ministry of Justice to consider the learning from this case and review and / or issue appropriate guidance nationally to ensure consideration of domestic violence and abuse in the Pre-Action Protocol.
		7. **Recommendation 7:** Clarion Housing to work with Domestic Abuse Housing Alliance (DAHA)[[11]](#footnote-11) to address its concerns around the current accreditation framework in order to assist its decision in relation to accreditation at the conclusion of its restructure during 2020/21.
		8. **Recommendation 8:** The MPS to remind police officers of the importance of reviewing the risk of domestic abuse cases when changes to circumstances occur to order to identify, as illustrated in this case, the possibility of increased risk.
		9. **Recommendation 9:** Newham CSP to review its local MARAC threshold against the national guidance.
		10. **Recommendation 10:** Tower Hamlets CSP to review its local MARAC threshold against the national guidance.
		11. **Recommendation 11:** MOPAC to work with boroughs to conduct a review of MARAC thresholds in London.
		12. **Recommendation 12:** Tower Hamlets to run a learning event with local agencies around the use of translation and take action to assure itself that:
			+ All agencies have robust policies and procedures in place
			+ That family members are not used as translators
			+ There is easy access to appropriately trained professional translation, including provision for Sylheti were required.
		13. **Recommendation 13:** Tower Hamlets CSP to ensure that gambling is addressed in its economic abuse work programme.
1. Not her real name. [↑](#footnote-ref-1)
2. Not his real name. [↑](#footnote-ref-2)
3. Aanchal operate in Redbridge and Newham and provide support and services to help women in the rescue, rehabilitation and rebuilding of their lives after the trauma of abuse. For more information, go to: <https://aanchal.org.uk>. Aanchal led the ‘One Stop Shop’, working with three other services commissioned by Newham until May 2019. Since June 2019, a single service has been commissioned from the Hestia Domestic Abuse Service. [↑](#footnote-ref-3)
4. Clarion Housing is a housing association, managing 125,000 homes across 170 local authorities. For more information, go to: <https://www.myclarionhousing.com>. [↑](#footnote-ref-4)
5. Provides mental health services in the City of London, Hackney, Newham and Tower Hamlets and, Bedfordshire and Luton. For more information, go to: <https://www.elft.nhs.uk/About-Us>. [↑](#footnote-ref-5)
6. Provides a range of range of clinical services to people in east London and beyond. For more information, go to: <https://www.bartshealth.nhs.uk>. [↑](#footnote-ref-6)
7. The GP Care Group is a federation, a system that allows a group of general practices to come together as an organisation to share responsibility for delivering quality services to its local population. For more information, go to: <https://www.gpcaregroup.org/>. [↑](#footnote-ref-7)
8. Provides hospital and community care services to 500,000 people living in Islington and Haringey as well as other London boroughs including Barnet, Enfield, Camden and Hackney [↑](#footnote-ref-8)
9. Provides information, advise and support for anyone affected by problem gambling. For more information, go to: <https://www.gamcare.org.uk>. [↑](#footnote-ref-9)
10. The East London Mosque, which incorporates the London Muslim Centre and the Maryam Centre, offers a wide range of services including advice and counselling. For more information, go to: <https://www.eastlondonmosque.org.uk>. [↑](#footnote-ref-10)
11. DAHA partnership between three agencies: housing associations Peabody (London) and Gentoo (Sunderland), and London-based charity Standing Together Against Domestic Abuse. DAHA have established an accreditation standard to provide a UK benchmark for how housing providers should respond to domestic abuse in the UK. For more information, go to: <https://www.dahalliance.org.uk>. [↑](#footnote-ref-11)