EALING COMMUNITY SAFETY PARTNERSHIP
DOMESTIC HOMICIDE REVIEW

Executive Summary for the case of Rukhsana 2014

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Final Version: February 2017

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Executive Summary

1.1 The Review

1.1.1 The incident

(a) On Tuesday, 27 May 2014, at 20:59 the police were called to an address in Ealing. A neighbour reported hearing an argument that had escalated to shouting, screaming and the sound of something being hit.

(b) When the police arrived at the scene, Nasir ran from the garden of the house. The police pursued him and he was apprehended and detained. On entry to the house, the police found the body of Rukhsana. She had been beaten to death.

(c) Nasir was arrested and charged with murder.

(d) The Panel would like to express its sympathy to the family of Rukhsana for their loss and to thank them for their contributions and support for this process.

1.1.2 The criminal trial

(a) Nasir pleaded guilty to murder on 18 January 2015 and was sentenced to life in prison with a minimum tariff of 22 years on 28 January 2015.

1.2 Domestic Homicide Reviews

1.2.1 The purpose of the review is to:

(a) 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.

(b) 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.

(c) Apply those lessons to service responses including changes to policies and procedures as appropriate.

(d) Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.2.2 The process began with an initial meeting on 24 July 2014 of all agencies that potentially had contact with Rukhsana and Nasir prior to Rukhsana's death.

1.2.3 Pseudonyms and anonymising: The family of Rukhsana asked that the Chair provide pseudonyms for this report. The Chair asked Southall Black Sisters to do this and they did. The family were invited to approve the names but they did not respond.

1.3 Terms of Reference

1.3.1 The full terms of reference are included in Appendix 1.

1.3.2 The review looked at the involvement of statutory and voluntary agencies with Rukhsana, Nasir and their two children Samir and Naseem, during the period of 20 May 2011 to 27 May 2014. This time frame was agreed to be appropriate as Rukhsana's sister alleged that Nasir had indecently assaulted her in May 2011.

1.3.3 Agencies were asked to summarise their involvement before 20 May 2011 and provide chronological accounts and analysis of their contact with the members of this family from 20 May 2011 to Rukhsana's death on 27 May 2014. The chronologies are combined and in a separate document.

1.3.4 Where there was no involvement or insignificant involvement, agencies advised accordingly.

1.3.5 Each agency's report covered:

(a) A chronology of interaction with the victim and/or their family

(b) What was done or agreed

(c) Whether internal procedures were followed and

(d) Conclusions and recommendations from the agency's point of view

1.4 Independence

1.4.1 Safer Ealing Partnership appointed Laura Croom, an Associate of Standing Together Against Domestic Violence, to chair the review. Standing Together

is an organisation dedicated to developing and delivering a coordinated response to domestic abuse through multi-agency partnerships. The Associate has no connection with Ealing Council or any of the agencies involved in this case.

1.5 Parallel Reviews

1.5.1 Post mortem**.** On 29 May 2014, a Special Post Mortem was conducted. The cause of death was found to be head and neck injuries. Several other injuries were noted and it was and recorded that Rukhsana was initially hit with the table leg found at the scene.

1.5.2 Inquest. An inquest into Rukhsana's death was opened by the coroner on 18 June 2014 and adjourned, pending the outcome of the criminal proceedings. Criminal proceedings were instituted on a charge of murder and the defendant was sent to prison. There was no inquest held[1].

1.5.3 There were no other parallel processes undertaken in relation to this review.

1.6 Methodology

1.6.1 There were 16 organisations and agencies involved in the review and on the Panel. Five agencies responded as having had no contact with either the victim or the suspect.

1.6.2 The Panel was composed of senior managers from the following agencies.

(a) Metropolitan Police Service, Critical Incident Team, Pam Chisholm

(b) Ealing Police, Janet Jones and then Alex Bingley

(c) Ealing Safer Communities, Joyce Parker

(d) The CWHHE CCG Collaborative, a working partnership between these Central London, West London, Hammersmith and Fulham, Hounslow and Ealing CCGs, Richard Christou

(e) NHS England, Edward Ward

(f) Victim Support, Liz Gaffney, then Aiman Elal, then Caroline Birkett

(g) Southall Black Sisters, Pragna Patel

(h) Hestia, Lyndsey Dearlove

[1] Information updated from the London Borough of Hammersmith and Fulham's coroner's office on 12 July 2016.

(i) National Probation Service – were not involved and so were allowed to keep a watching brief

(j) Ealing Council's Children's Social Care, Ruth Lacey, then Farahdiba Rahman, then Sariah Eagle

(k) Ealing Safeguarding Adults – the question of Rukhsana's vulnerability kept arising, so Ealing Safeguarding Adults were asked to join the Panel. Sophia Shah joined us.

(l) Moorfields Eye Hospital NHS Trust, Edwina Curtis, then Julia Hall, then Sarah Phillip

(m) Royal National Orthopaedic Hospital NHS Trust, Julia Hall, then Laura Woodward

(n) London North West Healthcare NHS Trust, Lesley Tilson

(o) London North West Healthcare NHS Trust, Ealing Community Services, Andrea Edwards

(p) University College of London Hospitals NHS Foundation Trust, Betsey Lau-Robinson

1.6.3 The agencies that provided IMRs and chronologies were:

(a) Metropolitan Police Service

(b) Victim Support Service

(c) Ealing Children's Social Care

(d) Southall Black Sisters

(e) The family's GP surgery

(f) London North West Healthcare NHS Trust, Ealing Community Services

(g) London North West Healthcare NHS Trust

(h) University College of London Hospitals NHS Foundation Trust

(i) Royal National Orthopaedic Hospital NHS Trust

(j) Moorfields Eye Hospital NHS Foundation Trust

(k) London Borough of Ealing Education

1.6.4 The agencies that had no contact or no information to add were: Barts Health NHS Trust, Ealing Adult Social Care, Hestia, Hillingdon Schools (no records from this time period), National Probation Service (no contact and therefore kept a watching brief).

1.6.5 Additional information sought and reviewed by the Panel included:

(a) 'Guide to Understanding Mucopolysaccharidosis IVA and IVB' by the MPS Society2.

(b) The risk assessments completed by the police for Nasir on 6 and 7 January 2012, for Rukhsana on 7 January 2012 and 19 June 2012 and for Rukhsana's sister, Rehana , on 16 March 2012

(c) The draft divorce petition emailed by Rukhsana to her sister, Rehana on 16 January 2012.

1.6.6 There were several delays to this process: the family did not want to be interviewed until after the trial and sentencing of Nasir in January 2015. The more significant delay was the result of arising from changes in personnel in Ealing Children's Social Care's (ECSC) that led to the need for a revised IMR. In response to this delay and to concerns from Panel members, in January 2016 the Chair invited the Panel to provide updates on their practices and responses to domestic abuse so that this report could reflect current practice and the responsiveness of agencies to the concerns raised in the course of this review.

1.7 Contact with Rukhsana's family

1.7.1 The Chair and the Panel member from Ealing Safeguarding Adults visited the family at their home and spoke to Rukhsana's father, her two sisters and a brother in March 2015.

1.7.2 The family also gave permission for the Chair to read their witness statements and this informed the interview with the family and this review.

1.7.3 Rukhsana's family were sent the final report for their comments. At the time of this report being submitted, the family have not responded to attempts to gain their feedback. The Chair sent a letter explaining the next steps, providing a named person and details for someone in Ealing Council to

[2] http://www.mpssociety.org.uk/conditions/mps-diseases/mps-iva/

contact should they wish to feed back in the future, and letting them know that they would be notified before the report was published.

1.8 Contact with the perpetrator and others

1.8.1 The Chair contacted Nasir's probation officer in prison in March 2015 to enquire whether he wanted to contribute to this process. In July 2015, NA's probation officer reported that he had spoken to Nasir and Nasir did not wish to participate in this review.

1.8.2 The Chair and the Panel member from Southall Black Sisters met representatives of the mosque in October 2015.

1.8.3 Contact was sought with Nasir's family through the FLO who had had some contact with them and had informed them about the DHR process, but they did not respond to his overture.

2.1 Summary of the case

2.1.1 **Rukhsana and Nasir**

(a) Rukhsana was born and raised in the UK and had a university degree. Nasir was born in Pakistan and came to the UK following his engagement to Rukhsana. He'd had to work from a young age and therefore had little formal schooling. Rukhsana's family say that he spoke no English when he arrived.

(b) Rukhsana and Nasir were married for 16 years. Theirs was an arranged marriage and Nasir's mother and Rukhsana's mother were cousins.

(c) The couple had two children, Naseem and Samir, who were still young at the time of Rukhsana's death.

(d) Rukhsana had a deteriorating physical condition, the full extent of which was not known at the time of her marriage to Nasir, though Rukhsana's family report that they talked to Nasir's family about her difficulties. In her case, the disease led to problems with her sight, hearing, headaches, bone development, stability of her spine and hips, and her breathing. There is no specific treatment for the disease and symptoms were dealt with as they arose.

(e) In 2000 Rukhsana had emergency surgery to stabilise her spine. It seems that the likely extent of Rukhsana's disability became apparent

to Nasir at the time. He confronted Rukhsana's mother saying that he felt he had been lied to about his wife's physical problems.

(f) They had a child in 2002 and a second child in 2008. Rukhsana chose not to return to work after the birth of their first child. Nasir was doing well – running a store – and Rukhsana felt she'd be able to return to work later. With financial help from Rukhsana's family, the family moved to a larger house and started to renovate it.

(g) After the second child was born, Nasir complained that Rukhsana spent too much time with the new baby and was neglecting him. He also insisted that Rukhsana visit his family with him. When she refused, they argued.

(h) Nasir had responsibilities for his family of origin and, though his sister and mother came to live with them for awhile, Rukhsana did not support all his decisions regarding his own family and this also caused arguments.

(i) One evening, after the families had dinner together, Nasir assaulted Rukhsana and then went to get her mother to talk to her. Her mother encouraged her to help Nasir with his problems and not to call the police. She also advised Nasir to stop arguing with Rukhsana.

(j) Rukhsana told her sister, Rehana, that Nasir had tried to strangle her and had bitten her during one of their arguments.

(k) Rukhsana's family understand that Nasir had a relationship with another woman at this time. Rukhsana confronted him and told him that he should divorce her first so that she could marry again. This appears to have fuelled suspicions that Rukhsana was involved with another man and Nasir began to monitor her movements.

(l) Over the next few years, Rukhsana had two hip replacements. Though she was on crutches for months after these operations, her mobility was greatly improved.

2.1.2 The renovations on the house created financial strains. Nasir started to have problems at work too.

(a) In May 2011, Nasir faced a employment tribunal hearing. Rukhsana's sister, Rehana, had specialist legal knowledge and therefore offered to

help Nasir with his disciplinary proceedings. She accompanied him to the hearing to provide support and advice on the day. Rehana alleges that on the way home, Nasir made unwanted sexual advances towards her during which he touched her. She stopped him and was very upset by this experience.

(b) That night Rukhsana and Nasir took their children to Rukhsana's parents' house for supper and Nasir swore at their son and was rough with him. Rukhsana's parents were shocked and told Rukhsana that he would not be welcome at their house if he behaved this way. He reacted badly when Rukhsana told him this and said he would do as he liked with his son and no one had a right to say anything.

(c) The relationship between Nasir and Rukhsana's family deteriorated after this. When confronted by Rukhsana about the incident with Rehana, Rukhsana said he denied it, became agitated and then assaulted her. After this, Rukhsana told her family more about what was happening at home: about Nasir's behaviour towards her and his assaults. However, she said she would not talk to the police about this because Nasir would lose his job. For a period she stopped cooking for Nasir as she felt he had been mean and thankless for the help her family had provided.

(d) Nasir became more jealous and controlling and told Rukhsana that she should break with her family and do as he told her. He would get angry and smash things, sometimes into his own head and sometimes into walls. Rukhsana said that he tried to strangle her again.

(e) The advice that Rukhsana got from her family was mixed. Her sister encouraged her to report the assaults to the police while her mother told her that she needed to be patient and try to explain things differently so that Nasir understood. Rukhsana followed her mother's advice.

(f) Nasir enlisted Rukhsana's mother on several occasions, asking her to intervene to get Rukhsana to do as he asked.

(g) After this, the children told Rehana that Nasir would shout at them and was angry on occasion.

(h) On one occasion, Rukhsana's father noticed bruising to her face and commented on it. In response to her minimising excuse, he told her his suspicion that she was being beaten by her husband, that she did not need to live like that, and that he did not think it would get better. Rukhsana told him that she was prepared to make sacrifices to make her marriage work as she did not want her children to come from a broken home.

(i) Other family members noticed that Nasir was rough with Rukhsana.

2.1.3 **Involvement of agencies**

(a) The family came to the notice of Ealing services over a period of about 6 months in 2012. On 6 January 2012 Nasir reported to the police, to Ealing Customer Services and to one of the children's schools that Rukhsana had hit him and the children. Nasir also alleged that Rukhsana had threatened that her father would kill him if her family lost respect for him. He rang the police 4 further times that night to make allegations about threats posed to him by his in-laws.

(b) Ealing Customer Services passed the information they had received to Greenford Referral and Assessment Team where a decision was made to undertake an Initial Assessment – a process to establish whether a particular child is in need or whether there is reasonable cause to suspect that the child is suffering, or is likely to suffer significant harm.

(c) This first contact with agencies, where Rukhsana was identified as the perpetrator against Nasir and the children, appears to have informed the way agencies responded thereafter.

(d) The police were called to Rukhsana's and Nasir's house that night as Nasir had returned home without the children, having taken them to his sister's house. As a result of the earlier allegations, Rukhsana was arrested that night and bailed to return to the police station later that week to be questioned.

(e) Nasir and Rukhsana were interviewed by the police separately regarding the allegations. The police interviewed Rukhsana as a perpetrator, as required by the Police and Criminal Evidence Act 1984.

(f) During these interviews, a number of domestic abuse risk factors were identified and recorded, including a 'red flag' indicator of 'honour'-based

violence. There was enough information to support a higher assessment of risk and a more detailed secondary risk assessment. However, the case was not flagged as one of domestic abuse, there was no further police investigation of the risk factors identified, no referral to MARAC, and no emergency planning took place.

(g) The police found insufficient evidence and the case was dropped.

(h) As Nasir alleged that Rukhsana had hit the children, the police and Ealing Children's Social Care (ECSC)| agreed that ECSC would undertake a single agency Section 473 investigation which would involve a core assessment, an in-depth multi-agency assessment that gathers information to understand the child's circumstances and needs. The police closed the case, noting who was undertaking the Section 47 review, but did not update it later with the result of that review.

(i) ECSC interviewed each of the family members swiftly and at length for their core assessment. A great deal of information was gained from the family.

(j) The children reported incidents of physical chastisement from their mother and that their mother hit their father. They reported nothing about their father's behaviour and both appeared to feel safe with their father.

(k) In the course of this assessment, Rukhsana described to the social workers and staff at Samir's school the abuse she'd suffered from Nasir.

(l) Some of the allegations were verifiable – such as Rukhsana locking the children in their rooms yet Rukhsana said the rooms had no locks – but neither the police nor social services sought to verify the facts. Information that constituted risk factors were not identified by the social workers. ECSC undertook no risk assessment or safety planning with Rukhsana.

[3] A S47 child protection enquiry is required where the local authority is informed of a reasonable cause to believe that a child who lives within their area is suffering, or is likely to suffer, significant harm (Children Act 1989, S. 47).

(m) ECSC met with both parents later that same week to discuss their safety concerns for the children. They met with the parents separately and then together. The parents were told that the children could return home as the risk did not reach a threshold that would have precluded them returning to their mother. Rukhsana agreed to sign a written agreement to support the children, but Nasir refused to sign and repeated his allegations. Rukhsana and Nasir were advised that they needed to make decisions about where the children lived themselves.

(n) There was little involvement from the HV, school nurse or GP in the course of the core assessment. The schools were involved and expressed no concerns about either child. The children were interviewed at their schools later that January and, having returned home, they reported that things were better at home and they were happier.

(o) On 25 January, ECSC undertook a home visit. Rukhsana told the social worker (SW) more about her situation, about the differences in her and Nasir's background and language, about their difficulties over the last few years, about Rehana's allegation of Nasir's indecent assault, and about her own health problems. Rukhsana thought that Nasir was trying to turn the children against her.

(p) On 27 January, the schools and SWs attended a professionals meeting. The HV and school nurse did not attend. The outcomes of this meeting were for the assessment to continue to address any on-going concern about the children's emotional wellbeing and that the parents be advised to get counselling for their relationship, e.g. through Asian Family Counselling or the mosque. Verification of some of the allegations were to be sought. But the case would not go to a case conference. The meeting did not address the need for independent specialist domestic abuse services for either parent, nor did it address the additional vulnerability that Rukhsana's disability presented.

(q) In February, the children were again interviewed at school and reported improvements in their family situation, that their mother was making more of an effort at home. The schools and the children reported no more causes for concern.

(r) A further conversation was had with the parents where Rukhsana reported that they had been trying to spend more time together as a family. The SW noted that Nasir appeared uncomfortable when she discussed the assessment and their concerns about the parents' relationship and its impact on the children. She said there were still concerns because of the children's disclosures and Rukhsana's continuing denials. She recommended personal and/or relationship counselling.

(s) The core assessment concluded on 1 March 2012 with the SW unable to establish the truth of the conflicting allegations. She noted the unresolved relationship issues and that the SW had been unable to substantiate the allegations of physical chastisement of the children. The SW recommended that the parents seek counselling – both Rukhsana and Nasir said they wanted this support – and were signposted to Relate, Asian Family Counselling and SAFE4 0 -12 before the case was closed.

(t) Nasir contacted the SW several more times. He rang to say his wife had lied during the previous visit, that she'd forced his signature on a credit card application and was financially controlling him.

(u) On 5 March, the police received credible intelligence that Nasir was at serious risk of harm. The intelligence suggested that the threat was linked to HBV.

(v) MPS's policy for threats to life requires specific steps to be taken, including that the risk is assessed and graded and a strategy implemented to minimise the risk, including a referral to MARAC in such circumstances, and a new crime report to be made. The referral to MARAC did not take place and a new crime report was not made, instead the information was added to the previous report.

(w) When the police informed Rukhsana and Nasir about the threat, they asked them to think about what it might relate to. Rukhsana referred to their marital difficulties. Rukhsana and Nasir decided to stay at home rather than go to friends or family in light of the threat. The police installed a panic alarm at the house. There were no records made of

[4] Supportive Action for Families in Ealing.

considerations around the safety of the children and no MERLIN (child protection) report was completed.

(x) Nasir rang the SW at this time to ask for the Asian Counselling Service number and to tell the SW that the panic alarm had been installed at the instigation of the police as a result of threats to kill Nasir that they had received.

(y) The Detective Sergeant (DS) reviewing the case that night saw the action plan and the progress against it and determined that the risk had been reduced to an acceptable level. The next day, the MPS received notification that the threat no longer existed.

(z) Nasir then attended the police station and repeated his allegations that Rukhsana's family were intent on harming him or pushing him to suicide. The police noted that Nasir was unsure of himself and reluctant to take any action that would jeopardise his relationship to the children. No risk assessment was undertaken with Nasir or Rukhsana at this time.

(aa) When the SW sought information from police on the threats to kill, she was unable to get any clear information about the threat posed to the children. The police said they could not disclose the content of the information or its source and that Intelligence was dealing with it. The SW's enquiry ended there.

(bb) On 16 March 2012, Rehana went to the police station and told them about the alleged assault Nasir had made on her the previous May. She also described his behaviour as 'jealous' and told of the constant calls and texts from him in the month leading up to the alleged assault. She said that Nasir was spreading rumours that she had instigated the incident and she spoke of the problems between Rukhsana and Nasir. She wanted the police to know of Nasir's bad behaviour.

(cc) A risk assessment was completed that rated Rehana as at 'standard' risk, but the research informing the assessment did not reveal Rukhsana's allegations of assault by Nasir or a criminal intelligence record.

(dd) Nasir was invited to the police station and was interviewed under caution. He said that Rehana loved him but had ended their relationship and would not meet him to talk after the incident.

(ee) A DS reviewed the case and agreed to close it noting that it was one person's word against another and there was a lack of evidence, though no attempts were made to gather any evidence.

(ff) At the same time, Rukhsana self-referred to SAFE as a victim of domestic abuse. In response, SAFE's domestic violence worker (DVW) visited her at home. Rukhsana talked about her health and mobility problems, her asthma, the previous allegations and their impossibility (e.g. no locks on the children's doors). She said Nasir had changed dramatically since her pregnancies, that he took the car and left her stranded, that the children were frightened of Nasir, that he was taking her disability allowance. The DVW noted that Rukhsana was annoyed, angry and distressed rather than scared. The DVW gained a good deal of information from Rukhsana and concluded that Nasir was exercising power and control over her.

(gg) When the DVW spoke to the first SW about the case, they differed in their views about how much control Nasir exercised. The DVW noted that Nasir's pattern of behaviour fit that of many perpetrators of domestic abuse and noted that Rukhsana was not capable of some of the abuse alleged (e.g. kicking Nasir as she could not stand on one leg). She noted that children will often side with the perpetrator for self-preservation.

(hh) The DVW visited Rukhsana again and offered support. Rukhsana said that she wanted to remain in the marriage. The worker offered safety planning and advice about legal protection, but Rukhsana declined both.

(ii) The DVW contacted Rukhsana two more times – in April and in June – for updates on their situation. Rukhsana reported that the situation had improved and declined further visits. The DVW did not complete a risk assessment or refer Rukhsana to an independent specialist DV worker.

(jj) On 19 June, Rehana rang the police on Rukhsana's behalf saying that Rukhsana had suffered domestic abuse and it was escalating. The

operator spoke to Rukhsana who confirmed what Rehana had said and that Nasir hit her and had threatened to destroy her parents and brother. She said she'd reported this previously to ECSC and SAFE, but neither had done anything.

(kk) Rukhsana gave the operator a good deal of information that was not recorded by the operation. It was, however, available on a recording of the conversation that the MPS IMR writer accessed. It revealed a number of risks to Rukhsana – threats to kill, Nasir's 'paranoia', that she felt she didn't have a choice – and that she had managed to record an incident on an audio device.

(ll) The police attended Rukhsana the next day and she told them she was experiencing marital problems. They did not have access to the information that Rukhsana gave to the operator and she did not repeat all of it, though she explained that she had sought mediation and counselling but Nasir had refused to participate and that she and Nasir were related through her mother. She spoke of the threats to kill. She said they were a traditional Muslim family.

(mm) Rukhsana did talk about a specific incident when Nasir had hit her. She had no injuries from this and declined to make a statement or comment upon Nasir's intention. Though she gave sufficient detail for the police to investigate this assault, the crime report was recorded as a Specified Investigation. The risk assessment was 'standard'. The officer concluded that there may be cultural issues affecting her decision and that any further breakdown could lead to escalation.

(nn) A secondary investigation was undertaken on 21 June when a Community Safety Unit DS allocated the case. The police left a message for Nasir, the alleged perpetrator at this point, to make contact if he wanted to discuss the case further. Referrals for both Rukhsana and Nasir were made to Victim Support. This was followed with a phone call to Nasir on 26 June by a CSU DS when it was recorded that he did not want to add anything. The DS recommended that Nasir not attend Rukhsana's address. (We have no other evidence that Nasir was not living at home at this time – it is unclear if they were separated at this time.)

(oo) The police had informed Nasir, the perpetrator, of Rukhsana's attempts to get help – this would have increased her risk significantly. The research did not reveal the threats to kill nor pick up the missed referral to MARAC. No investigative strategy or review of the DASH risk assessment was recorded. An inspector should have been involved as there were threats to kill – this would have ensured a further risk assessment. This did not happen.

(pp) Nasir rang Ealing Children's Integrated Response Service (ECIRS) for advice several times and was sign posted to a solicitor.

(qq) Rukhsana was not contacted again regarding this by the police – they did not talk to her after talking to Nasir, offer further assistance, or refer her to an independent specialist DV organisation to which she had consented. Though the risk assessment noted a number of risk factors, the investigating officer noted that the situation had occurred a few days before and had calmed, showing a poor understanding of the risk assessment and the dynamics of domestic abuse.

(rr) In March 2012, Rukhsana contacted Southall Black Sisters through their email contact facility. She wrote about her situation in the email, but the record of the follow-up call has been lost. This is very unfortunate in that the Panel were unable to review the response she received from this organisation that was in a unique position to help Rukhsana.

(ss) In early February 2013, Nasir lost his job and received some compensation.

(tt) In November of 2013, Samir self-referred to A Place2Be at his school and said that his father gets angry and bashes his head against the wall. The school spoke to Nasir who appeared very stressed and repeated his allegations that Rukhsana's family were trying to kill him and that he was her sole carer. The school referred the case to ECSC.

(uu) A SW from the ECIRS team attended the family home to discover if Samir was witnessing arguments or domestic abuse. She interviewed the family members separately and then together. They all said that the situation was better though the parents still argued and there was continued tension between their extended families.

Rukhsana spoke of their financial pressures, that Nasir had lost his job and that she was unable to work. They declined support.

(vv) The SW determined that Samir had been talking about historic events and the case was closed in January 2014 with the agreement of the school and Place2Be that they would continue to monitor Samir's behaviour.

(ww) The school and Place2Be referred Samir to a therapy group within A Place2Be to help him for 6 sessions that ran from January 2014 to March 2014 which Samir attended. He did not disclose any incidents during these sessions.

(xx) Representatives of the family's mosque spoke to the Chair and a Panel member. Though the difficulties between Rukhsana and Nasir were known to members of the congregation, the mosque said that it had not been formally consulted about the relationship. They said that the teachings of the Centre are clear that abusing one's spouse is wrong and unequivocally prohibited in Islam and so they thought that people would not want to expose themselves by revealing their abusive situation. They also said that marital advice from the mosque recommends reconciliation, then arbitration and then family intervention.

(yy) Throughout this time and up to her death, Rukhsana attended her GP and a number of hospitals as a result of her health problems and the complications of her disease. In the time period of this review, IMRs noted over 200 medical appointments for the family, most for Rukhsana. Some were routine appointments and others were in response to specific concerns, including reduced vision and hearing and breathing difficulties. Several medical practitioners noted her independence and that she was self-caring. Several also recorded that she felt stressed and that her breathing problems were exacerbated by stress.

(zz) During these medical appointments and procedures, Rukhsana did not disclose domestic abuse and there was nothing in her notes that suggested to medical staff that she was suffering abuse.

(aaa) In the time period under review, Nasir attended the GP surgery 15 times, most often for stress in the time period leading up to and following his dismissal from work. He reported that he was feeling low and was not coping with life well. He declined non-therapeutic treatment, counselling and anti-depressants. He told the GP that he'd had several counselling sessions at the mosque but it was not helping much.

3.1 Issues Raised by the Review

3.1.1 **Equality**. Rukhsana was a university-educated Muslim woman of Pakistani background with a disability. Rukhsana's cultural understanding, race, disability and gender created obstacles for Rukhsana in asking for help and feeling able to leave Nasir. Living in the narrow band where these identities overlap, Rukhsana is likely to have felt that the obstacles she faced were almost insurmountable and likely to have made it particularly difficult for her to engage with agencies. Those agencies did not ask about or address the impact her cultural understanding had on her situation and decision-making, nor did they ask her about her disability and its effect on her daily life. They did not bring a gendered understanding to their engagement with her. So though Rukhsana spoke to agencies several times, she did not engage in plans to change her situation.

3.1.2 **What needs to change?**

(a) **Need to develop professionals' understanding of domestic violence.** This includes the gendered nature, the dynamics and cross-allegations, and barriers to disclosure and engagement with support.

(b) **Improve standard of response to reports of domestic abuse so that facts are checked, risks identified**, MARAC referrals made, multi-agency discussions undertaken. The role of independent specialist domestic abuse agencies needs to be better understood and utilised.

(c) **Improve accountability for adherence to agencies domestic abuse protocols and policies through training and supervision.** On several occasions, Rukhsana told professionals what was happening to her and they listened, but then did not follow through with a plan, pick up on the risks, or analyse the situation further. These lapses in

standard procedures were then missed in supervision. The complexity of this case commends it for training.

(d) Agencies need to understand the link between domestic abuse and child abuse and provide a robust response that recognises the link. The risks to the children were overlooked on a number of occasions here.

(e) **Agencies need to ensure that domestic abuse is a priority for their staff.** The lapses in this case suggest that the disclosures were not taken sufficiently seriously.

(f) **Increase understanding of each agencies' role in Ealing's coordinated community response to domestic abuse.** The agencies here were largely working in isolation. The cross-fertilisation of expertise and information in this case would have assisted them in their own assessments as well as delivering a more holistic and better response. It would have helped them explain other services to Rukhsana which may have helped her engage with further support.

(g) Rukhsana was regularly in contact with health services due to her condition but she did not disclose to them. As health services can provide a confidential and non-judgemental setting for victims and perpetrators to disclose abuse, the health services needed to review their provision against the NICE Guidance.

4.1 Conclusions and Recommendations from the Review

4.1.1 Rukhsana was an educated and articulate BME disabled woman. She was close to her family and cared about keeping together the family she had created with Nasir and the two children. Between January 2012 and December 2013, Rukhsana had contacts with the police, ECSC, Southall Black Sisters, and Victim Support and the children's schools. There are around 200 medical entries in the chronology noting meetings or alerting other medical services to medical interventions with Rukhsana and her family – none of the health agencies knew anything of the alleged abuse.

4.1.2 Her contacts with agencies about the abuse were incident-focussed and did not pay sufficient attention to the barriers she faced. Agencies did not address these in an effort to help her see and plan a way out of her

situation. Several agencies lost sight of the needs of the children, however Place2Be is to be commended for its approach.

4.1.3 This review found that the agencies that interviewed Rukhsana and her family about what was going on at home needed to develop their training on domestic abuse to reinforce an understanding of the dynamics of domestic abuse and their agency's expected response to disclosures. They also needed to take steps to ensure that the expected frontline response was reinforced by trained supervisors and the organisational ethos. The compounding danger of being marginalised and isolated because of race, ethnicity, religion or disability must be included in this training with practical guidance on how to reach across those barriers to help victims and their families.

4.1.4 The health agencies that have been involved were quick to identify where there were opportunities for disclosure in their interactions with patients. They saw that they needed to review their approach to their patients and consider the NICE guidance on domestic abuse regarding routine enquiry for their vulnerable patients, especially those made vulnerable by chronic conditions, disabilities and/or a reliance on carers. All of these may add to their dependence on others, increase the likelihood of abusive relationships and reduce the likelihood of their disclosing any abuse.

4.1.5 The coordinated community response to domestic abuse requires agencies to understand their role and how they can work together to protect victims of domestic abuse. Ealing Council is now taking steps to develop its CCR and this will need to continue to ensure that all partners play their part and the CCR becomes embedded in practice.

4.1.6 There are a large number of recommendations in this report and the Chair notes that the majority of the single agency actions were offered by the agencies involved in this review. This is strong evidence of their engagement with this process and their keenness to see changes made to their own agency's response to victims of domestic violence. Many of the agencies quickly began to implement plans to address the weaknesses they found. The delays in this DHR mean that some of the recommendations have already been addressed and are included here for completeness. The Action Plans reflect this.

4.1.7 **Metropolitan Police Service**

4.1.8 **Recommendation 1 (Ealing BOCU) –** Ealing Senior Leadership Team (SLT) develop and deliver a training package for primary and secondary frontline investigators and supervisors to ensure understanding and compliance with Domestic Abuse policies and procedures. This training should include:

(a) Dynamics of domestic abuse, its gendered nature, and approaches to cross allegations

(b) Domestic Abuse Policies and Toolkits

(c) DASH Risk Assessments – ACPO guidance for First Responders, ACPO Assessment Checklist for Specialist Police Staff and Part 2 Risk Assessments.

(d) Honour Based Violence investigative strategies and 'red flag' indicators.

(e) Multi Agency Risk Assessment Conferencing (MARAC) and the role of partner agencies in the local coordinated community response – the purpose of and process for referrals.

(f) Threats to Kill – investigative strategies and managing/assessing the risk.

(g) Safeguarding Children and when to complete the MERLIN entry,

(h) National Crime Recording Standards linked to allegations of Child Abuse and Specified Investigations

(i) The use of this case in training to address the additional barriers Rukhsana faced and improve police response particularly to BME, Muslim and disabled victims

4.1.9 **Recommendation 2 (Service Level) –** MPS make it mandatory to review the DASH Risk Assessment/Risk Management Plan as part of the Pre Release Risk Assessment in cases of Domestic Abuse.

4.1.10 **Recommendation 3 (Service Level) –** MPS review the provision of Specialist Domestic Abuse Training for officers newly appointed to Community Safety Units. This should include the creation of an information

package with a mandatory requirement for completion prior to posting, to ensure awareness/**understanding** of policies and processes.

4.1.11 **Recommendation 4 (Ealing BOCU):**

(a) Ensure that all Inspectors, Sergeants, and Constables employed as investigators within Community Safety Units (CSU) have received Specialist Domestic Abuse training and are put forward, at the earliest opportunity, for the CSU 1 week course (CS156) running at Peel Centre.

(b) Implement a system that regularly checks compliance with Domestic Abuse policies and Toolkits.

4.1.12 **Recommendation 5 (Service Level) –** MPS toolkits to include guidance to officers in responding and investigating allegations of Threats to Kill. (Previously recommended in Operation Kabala, dated 10/10/2014)

4.1.13 **Recommendation 6 (Service Level) –** MPS review NSPIC police in relation to the 'DV' on custody records to ensure that the feature is utilised and compliance measured. This will ensure that any statistics drawn accurately reflect the amount of arrests for Domestic Abuse.

4.1.14 **Ealing Children's Social Care**

4.1.15 **Recommendation 7 –** Domestic violence training should be reviewed to ensure that it includes all the latest information from research and the use of all relevant diagnostic tools, and a full understanding of the referral routes to independent domestic abuse workers. Training should include:

(a) Cross-allegations – the Respect Toolkit, the dynamic and impact of cross-allegations on the response of services

(b) Identification of risk factors/ SafeLives DASH risk assessment

(c) Engaging victims of domestic abuse

(d) Barriers to disclosure and how to help victims overcome them

(e) Helping victims to access other services

4.1.16 **Recommendation 8 –** When referrals are received where domestic violence is known or suspected to be a factor, consideration should be given to the need for specialist DV input or joint allocation with a domestic

violence worker from within ECSC and/or referral to an independent specialist domestic abuse service. This should be recorded in the file.

4.1.17 **Recommendation 9 –** Referrals of families where a parent or child has a disability should, in all cases, include full information about the disability and an assessment of how it affects the daily life of both that person and the family as a whole.

4.1.18 **Recommendation 10 –** That this case be used in training because of its complexity to

(a) Reinforce Recommendation 7 above.

(b) Improve SWs gather and analysis of information obtained when conducting an assessment and

(c) Reinforce the use of reflective practice and supervision to assist in the development of the analysis

(d) Highlight the value of the CCR when working with victims of domestic abuse

4.1.19 **Recommendation 11 –** Use of written agreements with families where there are allegations of domestic abuse to be reviewed in light of the additional risks posed and the absence of a link to improved safety outcomes with their use. Safety planning to be undertaken where written agreements are used.

4.1.20 **London North West Healthcare NHS Trust – Community Services**

4.1.21 **Recommendation 12 –** All Community Services staff that work with children and their families and all managers of those working with children and families have training on domestic abuse that includes:

(a) The impact of domestic abuse on children's health

(b) Clear undertanding of the role of health visitors and school nurses in S47 assessments and other child protection processes

(c) Clear processes to follow when alerted to a S47 assessment

(d) Dynamics of domestic abuse and assessing cross-allegations of domestic abuse

(e) The necessity of multi-agency engagement when working with families where there are allegations of domestic abuse and how to engage other services.

4.1.22 **Recommendation 13 –** Community Services to develop and train staff on clear processes for the following:

(a) Referrals from MASH

(b) Receipt of police notifications

(c) Recording information on RIO, with special attention given to

(i) Recording information related to protected characteristics and other factors that need to be taken into account to help families and individuals engaged with assessments and services

(ii) Recording communications with other agencies

(iii) Adding alerts to RIO

(iv) These should then be audited to confirm improvement.

4.1.23 **Southall Black Sisters**

4.1.24 **Recommendation 14 –** Southall Black Sisters to:

(a) Monitor the new processes to confirm improvements in the recording and retrieval of information on computerised and hard copy case management filing systems, including those for helpline enquiries;

(b) Monitor robust supervision measures for advice and case file management systems;

(c) Ensure that all staff are made aware of the lessons to be learnt from this review and to incorporate the lessons in all staff training and induction programmes;

(d) Continue to raise funds to improve the capacity of the helpline and advocacy services in order to continue to make improvements to the response time to enquiries and to the recording, monitoring and supervision of the helpline and advocacy services;

(e) Continue to improve the accessibility of advice and helpline services, especially for disabled BME women and those with special needs.

4.1.25 **London North West Healthcare NHS Trust**

4.1.26 **Recommendation 15 –** LNWH to document in case notes when in-patients have visitors or that they have not had visitors to assist in understanding the social history and context of patients. When staff note conflict involving patients on hospital premises, to alert the health professionals involved with that patient to enquire about their safety and abuse.

4.1.27 **Recommendation 16 –** LNWH to include questions about domestic abuse as part of social history taking with patients.

4.1.28 **Recommendation 17 –** LNWH to provide information on domestic abuse to patients and their families through posters and leaflets signposting them to services.

4.1.29 **Recommendation 18 –** LNWH to update domestic violence policy to reflect these changes.

4.1.30 **Royal National Orthopaedic Hospital NHS Trust**

4.1.31 **Recommendation 19 –** RNOH to have an identified member of staff to review patients with long term conditions to identify and address vulnerabilities, particularly asking about domestic abuse and relationship with any carer.

4.1.32 **Recommendation 20 –** RNOH to complete and implement new Domestic Violence Policy.

4.1.33 **Recommendation 21 –** RNOH to review and update the Adult Safeguarding Policy in light of new Domestic Violence Policy.

4.1.34 **Recommendation 22 –** RNOH to include sexual activity/function discussion to be part of the routine assessment of a patient.

4.1.35 **Recommendation 23 –** RNOH to document in case notes when in-patients have visitors or that they have not had visitors to assist in understanding the social history and context of patients. When staff note conflict involving patients on hospital premises, to alert the health professionals involved with that patient to enquire about their safety and abuse.

4.1.36 **Recommendation 24 –** RNOH to document why patients cancel an appointment to assist in understanding the social history and context of patients.

4.1.37 **Recommendation 25 –** RNOH to update Safeguarding Adult training to emphasise indicators of domestic abuse, noting 'stress', and provide practical guidance around asking patients about it.

4.1.38 **Recommendation 26 –** RNOH to ensure that clinical staff are countersigning student nurse entries in the case notes.

4.1.39 **Recommendation 27 –** RNOH to include questions about domestic abuse as part of social history taking with patients.

4.1.40 **Recommendation 28 –** RNOH to provide information on domestic abuse to patients and their families through posters and leaflets signposting them to services.

4.1.41 **Moorfields Eye Hospital Foundation Trust**

4.1.42 **Recommendation 29 –** Moorfields use this case as a case study in domestic violence/abuse training for staff, focussing on stress being a potential indicator of abuse.

4.1.43 **Recommendation 30 –** Moorfields Adult Safeguarding Lead and Named Nurse for Child Protection to review the Trust's domestic abuse policy and update it in light of this DHR and the learning from this review.

4.1.44 **Recommendation 31 –** Moorfields to review existing domestic violence/abuse pathways in light of the learning from the DHR. This includes developing joint working partnerships with specialist domestic violence/abuse agencies and considering whether routine screening within Accident & Emergency and Urgent Care can be implemented.

4.1.45 **Recommendation 32 –** Moorfields to review patients who frequently attend Accident and Emergency to identify and address any vulnerabilities and signpost or refer as appropriate.

4.1.46 **Recommendation 33 –** Moorfields to ensure information is available on domestic violence/abuse to patients and their families within the Trust through the use of domestic abuse posters and leaflets.

4.1.47 **Recommendation 34 –** Moorfields to share learning from the DHR with the Islington Safeguarding Adults and Children's Board.

4.1.48 **University College of London Hospital**

4.1.49 **Recommendation 35 –** UCL to ensure victims are identified early and safety planning for them is provided by:

4.1.50 Embedding staff awareness through training especially at emergency, maternity, child and OPD settings, noting indicators of domestic abuse including 'stress'.

(a) Training to highlight vulnerabilities and barriers to clients disclosing and provide staff with skills to reach across those barriers

(b) Providing screening tools for early/identification

(c) Increasing presence of IDVSA in high risk areas

(d) Provide a safe place for victims following disclosure

4.1.51 **Recommendation 36** – UCL to improve patient outcomes & safety risk assessments through referrals to MARAC & appropriate agencies.

4.1.52 **Recommendation 37 –** UCL to strengthen multi agency working with partners (Police, Social services, CCG's, providers services, volunteer services, Fire, London Ambulance, GP's, District Nurses) through the IRIS project, HAVEN, Sapphire and the Community Safety Units and Victim Support groups.

4.1.53 **Recommendation 38 –** UCL to assist with the criminal justice system by ensuring careful recording & documentation of allegations and harm caused to be used as evidence.

4.1.54 **Recommendation 39 –** UCL to include questions about domestic abuse as part of social history taking with patients. When staff note conflict involving patients on hospital premises, to alert the health professionals involved with that patient to enquire about their safety and abuse.

4.1.55 **Recommendation 40 –** UCL to review patients with long term conditions to identify and address vulnerabilities, particularly asking about domestic abuse and the relationship with any carer.

4.1.56 **Recommendation 41 –** UCL to provide information on domestic abuse to patients and their families through posters and leaflets signposting them to services.

4.1.57 **Dormer Wells Medical Centre**

4.1.58 **Recommendation 42 –** GP practice to review policy and procedures for identifying and responding to DV and ensure all staff are trained, especially on indicators of domestic abuse, including 'stress'.

4.1.59 **Recommendation 43 –** Practice to display information on domestic abuse and the support available in all new patient registration packs; in practice information leaflets provided to patients and on the website.

4.1.60 **Recommendation 44 –** Practice to consider the implementation of the IRIS programme for identifying and responding to domestic abuse in their practice.

4.1.61 **NHS England**

4.1.62 **Recommendation 45 –** Review the use and effectiveness of the IRIS Project across London GP practices to consider potential for wider commissioning of the project.

4.1.63 **Recommendations at a national level for schools**

4.1.64 **Recommendation 46 –** National recommendation: that DFE amend their guidance on the issue of records transfer and ask schools to keep a copy of records after a child has left the school. Such guidance could also advise on the length of time such files should be kept and the need for secure storage, including electronic storage.

4.1.65 **Ealing Council and the Ealing VAWG Strategic Group**

4.1.66 **Recommendation 47 –** Ealing VAWG Strategic Group to incorporate findings from this report in its plans for delivering the Ealing VAWG strategy, in particular:

(a) To ensure that the VAWG prevention priority includes raising awareness of domestic abuse, changing attitudes that tolerate abuse within communities and developing referral pathways to specialist support within local BME communities

(b) To engage the faith-based communities in this agenda, for instance, through the use of third party reporting mechanisms, to support the reporting of domestic abuse where parties do not want to go directly to the police, or a faith-based domestic abuse conference to improve the response of faith-based organisations to domestic abuse within their congregations

(c) That the VAWG training of staff includes information about the barriers victims face in reporting their abuse and how to help victims overcome these

(d) That the improved coordination of specialist VAWG services in Ealing recognises the variety of barriers that women face and ensures that vulnerable groups are catered for

(e) That the awareness-raising work and education in schools, with school staff and governors and with local communities address attitudes that encourage reconciliation and family stability at the expense of the safety of women and girls

(f) That the strategic group monitor and support the engagement of services in future domestic homicide review processes

(g) That the strategic group oversee the development of monitoring data to use to ensure that all partner agencies are engaged in Ealing's efforts to end violence against women and girls.

4.1.67 **Victim Support Service**

4.1.68 **Recommendation 48**: VS to revise its policies and practice to ensure that options for victims of historic abuse are explored and they are signposted or referred to specialist sexual violence services**.**

4.1.69 **Recommendation 49:** VS to use this DHR in training to develop a pro-active response to disclosures of concerns about children.

Appendix: Domestic Homicide Review Terms of Reference for Rukhsana

This Domestic Homicide Review is being completed to consider agency involvement with Rukhsana and her husband Nasir, and their children, Samir and Naseem following her death on the **27th of May 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 (DHRs) 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 **Rukhsana, Nasir, Samir and Naseem** during the relevant period of time: **20 May 2011 to 21:45 on 27 May 2014.**

3. To summarise agency involvement prior to **20 May 2011**.

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 or 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, panel deadlines and timely responses to queries.
9. On completion present the full report to the Ealing Safer Partnership.

Membership

1. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Your agency representative must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge.

2. The following agencies are to be involved:
   (e) CWHHE Clinical Commissioning Group Collaborative
   (f) General Practitioner for the victim and alleged perpetrator
   (g) London Borough of Ealing Education
   (h) London Borough of Hillingdon School and Education Welfare
   (i) Ealing Council's Children's Social Care
   (j) Ealing Council's Adult services
   (k) Ealing Community Services – London North West NHS Trust
   (l) NHS England
   (m) Safer Ealing Partnership
   (n) Metropolitan Police Service
   (o) Victim Support
   (p) Southall Black Sisters

(q) Hestia

(r) Moorfields Eye Hospital NHS Foundation Trust

(s) London North West Healthcare NHS Trust

(t) Royal National Orthopaedic Hospital NHS Trust

(u) University College of London Hospitals NHS Foundation Trust

(v) National Probation Service

3. 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.
4. If there are other investigations or inquests into the death, the panel will agree to either:
   (w) run the review in parallel to the other investigations, or
   (x) conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.

Collating evidence

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

2. Each agency must provide a chronology of their involvement with the Rukhsana, Nasir, Naseem and Samir during the relevant time period.

3. Each agency is to prepare an Individual Management Review (IMR), which:
   (y) sets out the facts of their involvement with Rukhsana, Nasir, Samir, and Naseem;
   (z) critically analyses the service they provided in line with the specific terms of reference;
   (aa) identifies any recommendations for practice or policy in relation to their agency, and
   (bb) considers issues of agency activity in other boroughs and reviews the impact in this specific case.

4. 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 Rukhsana, Nasir, Samir, and Naseem in contact with their agency.

Analysis of findings

1. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following six points:
    (cc) Analyse the communication, procedures and discussions, which took place between agencies.

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

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

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

    (gg) Analyse organisations access to specialist domestic abuse agencies.

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

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

1. Sensitively involve the family of Rukhsana 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.

2. Co-ordinate family liaison to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

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

Development of an action plan

1. London Borough of Ealing's Safer Ealing Partnership to establish a clear action plan for individual agency implementation as a consequence of any recommendations.

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

Media handling

1. Any enquiries from the media and family should be forwarded to the chair who will liaise with the Ealing Safer Partnership. 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.

2. The Ealing Safer Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

1. 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.

2. 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.

3. 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 be sent through secure email or be password-protected.

Disclosure

1. Disclosure of facts or sensitive information may be a concern for some agencies. We manage the review safely and appropriately so that problems do not arise and by not delaying the review process we achieve outcomes in a timely fashion, which can help to safeguard others.