BRENT COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the death of Elena

June 2018

Independent Chair and Author of Report: James Rowlands

Associate Standing Together Against Domestic Violence

Date completed: July 2019

1. Executive Summary

1.1 The Review Process

1.1.1 This summary outlines the process undertaken by the Safer Brent Partnership (Domestic Homicide Review (DHR) Panel in reviewing the homicide of Elena[1], a resident of the London Borough of Brent.

1.1.1 Elena was murdered by her partner Razvan[2] at their home. Early one morning at the start of June 2018, Razvan called the London Ambulance Service (LAS) and told them he had killed someone. Both the Metropolitan Police Service (MPS) and the LAS attended the property. Tragically, Elena was pronounced dead at the scene. Razvan was arrested and charged with murder. At the time of her death, Elena was approximately six months pregnant. Sadly, her unborn child also died. Razvan was later charged with an additional offence of child destruction[3].

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

1.1.3 To protect the identity of the victim and the perpetrator, the following pseudonyms have been used:

The Principle People Referred to in this report						
Referred to in report as	**Relationship to V**	**Age at time of V death**	**Ethnic Origin**	**Faith**	**Immigration Status**	**Disability Y/N**
Elena	Victim	28	Romanian	Unknown	EEA[4] National	Unknown
Razvan	Partner	43	Romanian	Unknown	EEA National	Unknown

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

1.1.5 The DHR process began after a referral by the Metropolitan Police Service (MPS). Subsequently, the Safer Brent Partnership (the local Community Safety Partnership), in accordance with the December 2016 '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* (hereafter 'the statutory guidance'), commissioned this DHR. The Home Office was notified in June 2018.

1.1.6 Standing Together Against Domestic Violence (STADV) was commissioned to provide an independent chair (hereafter 'the chair') for this DHR in mid-June 2018. The completed report was

[1] Not her real name.

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

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

[4] European Economic Area.

handed to the Safer Brent Partnership in July 2019. In August 2019 it was signed off by the Chair of the Safer Brent Partnership, before being submitted to the Home Office Quality Assurance Panel in August 2019. In February 2020, the completed report was considered by the Home Office Quality Assurance Panel. In May 2020, the Safer Brent Partnership received a letter from Home Office Quality Assurance Panel [re: DHR into the death of Elena] the report for publication. The letter will be published alongside the completed report.

1.1.7 Given the circumstances of the case, the chair and the Review Panel have recommended that only the Executive Report is published.

1.2 Contributors to the Review

1.2.1 This review has followed the statutory guidance. On notification of the homicide, agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) from those agencies that had been in contact. A total of 15 agencies were contacted. 12 agencies returned a nil-contact, three agencies submitted IMRs and chronologies, and one agency provided a Summary Report due to the brevity of their involvement. The chronologies were combined, and a narrative chronology produced.

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

- Advance[5];
- Brent Clinical Commissioning Group (CCG) (this means that no General Practitioner (GP) was identified for either Elena or Razvan);
- Brent Council – Adult Social Care;
- Brent Council – Community Safety (including the Multi-Agency Risk Assessment Conference);
- Brent Council – Housing;
- Central and North West London NHS Foundation Trust (CNWLT) (Mental Health service);
- LAS (bar attendance at the home of Elena and Razvan at the start of June 2018, after Razvan called LAS and told them he had killed someone)[6];
- Maternity Services in the London Region[7];
- National Probation Service (NPS);

[5] Advance is a regional specialist domestic abuse service which works across a number of boroughs in London. They offer support to women, men and young people assessed as being at medium and high risk of domestic abuse and living in Brent. For more information, go to: Advance website.

[6] During the course of the review, additional contacts by the LAS were identified. These are detailed in the Overview Report's chronology and analysis.

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

- Refuge[8]; and
- Victim Support.

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

- Brent Council Children and Young People (CYP) including the Brent Family Front Door contributed IMR and Chronology[9]
- London North West Healthcare University NHS Trust (LNWHT) in relation to Emergency Department at Northwick Park Hospital contributed to the IMR and Chronology[10]
- MPS contributed to the Summary Report
- Westminster Drugs Project (WDP) contributed to the IMR and Chronology[11]

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

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

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

1.2.6 Finally, during the course of the review, additional agencies were approached for information, including:

- Two Romanian community organisations in Brent;

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[8] Refuge is national provider of specialist services for victims of gender-based violence, including domestic abuse. It offers a range of services, including a specialist advocacy service, staffed by multi lingual expert practitioners, for Eastern European women and children. For more information, go to: Webpage for Refuge's culturallly specific services.

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

[10] LNWHT is an Acute Healthcare Trust providing Emergency care at its Emergency Departments at the Northwick Park and Ealing Hospital sites. Additionally, LNWHT has maternity services on three sites: Central Middlesex Hospital and Ealing Hospital have Antenatal clinic services and Northwick Park Hospital has antenatal postnatal, community and delivery services. For more information, go to: London North West Hospital Trust's website.

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

- The Luton Community Safety Partnership and a Romanian community organisation in Luton;
- A sex work project in Brent; and
- The UK Visas & Immigration (UKVI), part of the Home Office.

1.2.7 These agencies all provided a nil-return, with the exception of the UKVI which provided information on the data of Elena and Razvan's date(s) of entry into the UK.

1.2.8 *Independence and quality of IMRs*: Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case. The IMRs were written by authors independent of case management or delivery of the service concerned. Some IMRs were not submitted within the requested timescales and this led to the IMR meeting being re-scheduled. However, all the IMRs received were comprehensive and enabled the panel to analyse the contact with Elena and/or Razvan and to produce the learning for this DHR. Where necessary further questions were sent to agencies and responses were received.

1.3 The Review Panel Members

1.3.1 The Review Panel members were:

- Beata Felinczak, Senior Service Delivery Manager, Victim Support
- Cathy Hickey, Violence and Vulnerability Support Officer, Brent Council Community Safety Team
- Clare Capito, Deputy Regional Maternity Lead for London, NHS England
- Colin Wilderspin, Community Safety Manager, Brent Council Community Safety Team
- Detective Sergeant Helen Rendell, Specialist Crime Review Group (SCRG), MPS
- Dionne Phillips, Criminal Justice Team Manager, WDP
- Francisca Chifambaon, Safeguarding Adults Manager, Brent Council Adult Social Care
- Grace Nartey, Named Midwife Safeguarding, LNWHT
- Janice Altenor, Interim Head of Safeguarding and Quality Assurance, Brent Council CYP
- Joy Maguire, Designated Nurse for Safeguarding Children, Brent CCG
- Lesley Tilson, Designated Nurse for Safeguarding Children, Brent CCG
- Julia Dwyer, Senior Operations Manager, Refuge
- Martina Palmer, Senior Operations Manager, Refuge
- Ioana Harris, Eastern European Independent Gender Violence Advocacy Service, Refuge[12]

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

- Melissa Altman, Director of Domestic Violence and Abuse Services, Advance
- Sharon Loving-Charles, Team Leader Homelessness Prevention and Relief, Brent Council Housing Needs Service

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

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

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

1.4 Chair of the DHR and Author

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

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

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

1.4.4 *Independence:* James Rowlands has no current connection with the local area or any of the agencies involved. James has had some contact with Brent prior to 2013 in a former role, when he was a Multi-Agency Risk Assessment Conference (MARAC) Development Officer with SafeLives (then CAADA)[13]. This contact was in relation to the development of the local MARAC as part of the national MARAC Development Programme and is not relevant to this case.

1.5 Terms of Reference for the Review

[13] For more information, go to: Safe Lives website.

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

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

1.5.3 As information was provided during the review, it was established that Elena and Razvan may have had contact with agencies in other parts of the country, specifically Luton. Agencies were contacted for information and this is discussed in 1.2.6 above.

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

- The communication, procedures and discussions, which took place within and between agencies;
- The co-operation between different agencies involved with Elena / Razvan [and wider family];
- The opportunity for agencies to identify and assess domestic abuse risk;
- Agency responses to any identification of domestic abuse issues;
- Organisations' access to specialist domestic abuse agencies;
- The policies, procedures and training available to the agencies involved on domestic abuse issues;
- Specific consideration to the following issues;
    - Immigration status
    - Language
    - Substance misuse
    - Criminality; and
- Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support. Summary of Chronology

Elena

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

1.5.6 In relation to the MPS, while Elena came to attention for a number of potential offences, her substantive contact was after an arrest for fraud in April 2018. Although no further action was taken, during this contact it was identified that Elena was pregnant, a crack cocaine user and

potentially homeless (or at least, her address was undermined). As a result, the MPS made a referral to the local drug project (WDP) for a compulsory Criminal Justice Initial Assessment. The MPS also made a referral to the BFDD, given concerns about Elena's unborn child.

1.5.7 The WDP had contact with Elena in relation to her drug use in May 2018. This contact was limited, and an initial assessment was begun but not completed. In this contact, there were examples of good practice (for example, Elena was allocated to a female member of staff. Staff also identified potential concerns regarding children[14] and pregnancy and made a referral to the BFFD). However, it is unclear why WDP did not take any further action after Elena failed to complete her initial assessment. This could have triggered a further appointment or a notification to the MPS that she was in breach of a compulsory Criminal Justice Initial Assessment.

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

1.5.9 Brent Council – CYP (via the BFDD) received referrals for Elena and Razvan on two occasions. The first of these followed the arrest of Elena and Razvan on the 29th April 2018. While the BFDD made extensive attempts to locate Elena's address (based on the information she and Razvan had given to the MPS), they subsequently closed the case. This was despite the potential concerns regarding her vulnerability, having children and being pregnant. After Elena and Razvan attended the Emergency Department at the Northwick Park Hospital on the 29th May 2018, referrals were made by the hospital and LAS. This triggered a prompt decision to conduct a Child and Family Assessment and Elena and Razvan were visited at home a day before the homicide. This was good practice, as was the use of an interpreter. However, Elena and Razvan were seen together and there was no consideration of the risk of domestic violence and abuse.

Razvan

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

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

[14] Elena told a number of agencies that she had two children. These children were from a previous relationship. The information available to the Review Panel suggests that Elena's children had lived in another European country with their father since 2016. However, it is important to note that agencies were not aware of this at the time.

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

1.6 Analysis

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

1.6.2 The violence and abuse experienced by Elena included physical and emotional abuse, as well as coercion, threats and intimidation.

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

1.6.4 An additional issue is economic abuse. In this case, there are indicators of economic abuse:

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

1.6.5 It also appears that Elena was being sexually exploited by Razvan, which this being linked to the (potentially forced) supply of drugs.

1.6.6 The Review Panel considered Elena's status as an EEA national. It is not possible to know if Elena was aware of the potential limits to her entitlements, because to exercise her treaty rights she would need to have been a 'qualified person' (for example, being a: Jobseeker; Worker; Self-employed; Self-sufficient person; or a Student). If someone is not a qualified person, they are likely to have limited entitlement to benefits or housing assistance i.e. they would have No Recourse to Public Funds (NRPF).

1.6.7 Sadly, the information available to the Review Panel suggests that if Elena had sought help, she may have been assessed as having No Resource to Public Funds (NRPF). This is significant because Elena had considered leaving Razvan. For a victim of domestic abuse, this can present significant barriers in accessing help and support, including for example refuge accommodation.

1.6.8 As an EEA national, Elena would have been eligible to apply to the EU Settled Status Scheme[15]. Members of the Review Panel expressed a concern that vulnerable, controlled and isolated victims may find it difficult to apply for this scheme, particularly if they are unable to provide proof of their status or have limited access to the technology and / or ability to speak English.

1.7 Conclusions and Key issues arising from the Review

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

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

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

1.8 Lessons to be learned

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

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

1.8.3 Further learning relates to multi-agency working and case closure. The Review panel identified examples where agencies did not communicate clearly or did not keep adequate records. Most significantly, it is not acceptable that a vulnerable victim's contact with statutory services can simply end when there has been no consideration to possible safety netting. Recommendations have been made to address this locally and also escalate this matter for consideration at a national level.

[15] This scheme is for citizens from the EU, an EEA country or Switzerland. It allows an individual (or their family) to apply to continue living in the UK after the 30th June 2021. For more information, go to: UK government website for EU Settled Status scheme.

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

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

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

1.8.7 Following the conclusion of a DHR, there is an opportunity for agencies to consider the local response to domestic violence and abuse in light of the learning and recommendations. Frustratingly, the Review Panel has identified that while a DHR relating to another Eastern European women was completed locally[16], a recommendation in relation to community awareness only led to a small number of actions being undertaken and these have not been sustained. This is disappointing. Learning from DHRs is relevant to agencies both individually and collectively, but the ambition of DHRs – to reduce the likelihood of future homicides – can only be achieved if there is a shared commitment to change (including implementing recommendations and delivering improved responses). The Review Panel hopes that the response to this DHR will be underpinned by a recognition that the response to domestic violence is a shared responsibility, that requires sustained action, as it really is everybody's business to make the future safer for others.

1.9 Recommendations from the review

IMR recommendations (Single Agency)

1.9.1 The following single agency recommendations were made by the agencies in their IMRs:

Brent CYP

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

LNWHT

1.9.3 Establish a standardised screening tool for use by Emergency Department clinicians in patients presenting to the Emergency Department routine enquiry will identify those experiencing domestic

[16] The case of Anna. For more information, go to: Webpage for Brent Council Domestic Abuse and Violence Against Women and Girls services.

violence, with a particular focus on those that have not presented as a result of suspicious injuries or after a disclosure of domestic violence.

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

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

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

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

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

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

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

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

WDP

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

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

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

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

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

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

DHR recommendations

1.9.18 The Review Panel has made the following recommendations:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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