DOMESTIC HOMICIDE REVIEW – PENINA ROBINSON

EXECUTIVE SUMMARY

Contents

REPORT INTO THE DEATH OF PENINA ROBINSON[1]

Name	Age at the point of the murder	Relationship
Penina Robinson	64	Victim
Rizwan Ahad Ibrahim[2]	31	Son in law / Perpetrator
Elizabeth[3]	28	Wife of perpetrator and daughter of victim
Child 1[4]		Child of Elizabeth and Rizwan
Child 2[5]		Child of Elizabeth and Rizwan

The family had a number of addresses in Brent including Address 1, which was searched by Hertfordshire Police in May 2013 in relation to allegations that Rizwan had sexually assaulted two former hospital patients. Address 2 is the home in Brent where Penina lived with her daughter and son-in-law and their twin children from June 2013 until her death.

SUMMARY OF THE CASE

Penina was a native of Fiji and lived there for most of her life. She was described by her daughter as a humble, caring and generous woman who was loved by everyone who met her.

In 2009, when she was in her early sixties, Penina and her husband moved to Britain where two of their three daughters lived. En route she experienced a stroke that left her with a degree of impairment, including the loss of speech in English.

On discharge from hospital, Penina and her husband went to live with their daughter, son-in-law and twin grandchildren in Brent. Penina remained largely independent, caring for her husband until his death in March 2012. However, in April 2013 she was admitted to hospital following a fall. Her health deteriorated over the next six months up until her death.

Penina's son-in-law Rizwan Ibrahim had come to the attention of both the Metropolitan Police and Hertfordshire Police prior to Penina's death. In 2001 he was accused of the kidnap and false imprisonment of a 15-year-old girl. The Metropolitan Police believed the allegation was malicious. The Metropolitan Police attended two domestic violence incidents, one in 2006, the other in 2008. The latter was sparked by an argument over Rizwan Ibrahim viewing pornography sites on the family computer. No further action was taken in either case.

[1] Not her real name
[2] Not his real name
[3] Not her real name
[4] Child 1
[5] Child 2

At the beginning of 2010, Rizwan Ibrahim applied to the University of West London to train as a nurse. He disclosed two cautions, one for cannabis possession and one for possession of a knife. His case was referred for an enhanced Criminal Records Bureau[6] (CRB) check and he was admitted when the information from the CRB check matched that supplied by him. He began training with the University of West London in September 2010.

On 30 April 2013, two female former patients of Northwick Park Hospital reported to Hertfordshire Police that Rizwan Ibrahim had sexually assaulted them at their homes. He was arrested on 2 May 2013 but denied the offences and was released later that day on conditional bail pending the completion of the police investigation. On 9 October 2013, police reinterviewed Rizwan Ibrahim. He maintained his innocence and was released on bail pending a CPS charging decision.

On 18 October 2013, the Metropolitan Police were called to Penina's home (Address 2) by one of her carers, a member of staff at Priory Nursing Agency & Homecare. The carer had found Penina bleeding and in pain. There was a large amount of blood on the floor. Penina was taken by the London Ambulance Service to St. Mary's hospital where she later died of her injuries, which had been inflicted during a violent sexual assault.

Rizwan Ibrahim was arrested on suspicion of murder.

THE REVIEW PROCESS

The Brent Domestic Homicide Review Panel was initially convened on 4 December 2013 with the following agencies that potentially had contact with Penina and Rizwan prior to the murder: Brent Council (Adult Social Services, Children's Social Care, Community Safety), Hertfordshire Police, Metropolitan Police, London Probation Trust, Brent Clinical Commissioning Group (CCG) and North West London Hospitals Trust. In addition, ADVANCE, a local voluntary sector agency working on violence against women and girls, was invited to join as a Panel member.

Additional agencies were invited to become involved in the Panel following discussion at the first meeting: University of West London, Women and Girls Network, Age UK (Brent), Nursing and Midwifery Council, Ealing Hospital NHS Trust and NHS England (London).

Nine meetings of the review panel were held, with the final one on 26 September 2014. The DHR took place in parallel with the criminal trial process, with agreement from the Senior Investigating Officer from the Metropolitan Police.

Agencies that had contact with the victim, perpetrator or the perpetrator's two children prior to the murder were asked to give chronological accounts and to complete an Individual Management Review (IMR) in line with the format set out in the statutory guidance. The full terms of reference that guided IMR authors can be found in the main report (Appendix 1). The schools that the children attended were asked to produce chronologies.

[6] The Criminal Records Bureau (CRB) merged with the Independent Safeguarding Authority (ISA) in 2012 to form the Disclosure and Barring Service (DBS)

All agencies requested to complete an IMR did so, other than London Probation who had not had any contact with either Penina or Rizwan so an IMR was not required and Priory Nursing Agency & Homecare who were interviewed by the Chair instead[7].

Following receipt of the IMRs, it emerged that Children's Social Care were aware of allegations that Rizwan had been 'peeping' at staff in the toilets and 'masturbating' at Willow Children's Centre where he was temporarily employed. As a result, an additional IMR was requested from Willow Children's Centre.

It also emerged from the University of West London that decision making in relation to Rizwan's admission to a degree in nursing was an important aspect of the review. To help understand both what happened and what, if anything, should change, information was sought from the Disclosure and Barring Service[8] (DBS). The DBS declined to provide the requested information until the intervention of the Home Secretary.

A total of thirteen IMRs and two additional chronologies were received from the following agencies:

- Metropolitan Police
- Hertfordshire Police
- London Borough of Brent – Adult Social Services, Children's Safeguarding, School Admissions, Special Educational Needs Assessment Service, Willow Children's Centre
- North West London Hospitals Trust
- University of West London
- Brent Clinical Commissioning Group (CCG) - General Medical Services
- Ealing Hospital NHS Trust - Adult community health, Children's community health
- Lyon Park School
- Manor School (chronology only)
- Gladstone Park School (chronology only)

Each IMR covered the following:

- A chronology of interaction with the victim, perpetrator and/or the children;
- What was done or agreed
- Whether internal procedures and policies were followed
- Whether staff have received sufficient training to enact their roles
- Analysis of the above using the terms of reference

[7] Following discussion with Priory Nursing Agency & Homecare, the Chair agreed to conduct an interview with the two workers who had been Penina's main agency carers and with their manager rather than having the agency complete an IMR

[8] The admissions process was in 2010 and the checks were made with the Criminal Records Bureau. The Criminal Records Bureau (CRB) has since merged with the Independent Safeguarding Authority (ISA) to form the Disclosure and Barring Service

- Lessons learned
- Recommendations

Each IMR and chronology was scrutinised at a panel meeting and, in some instances, additional recommendations were made which have been included in the action plan at Appendix 3 of the main report.

In addition to the IMRs/chronologies, the DBS provided a statement of the principles used in making enhanced DBS disclosures and information about disclosures relating to Rizwan Ibrahim. Interviews were undertaken with the manager and two carers from Priory Nursing Agency & Homecare and Elizabeth (daughter of the victim and wife of the perpetrator). The Chair wrote to Rizwan Ibrahim requesting his involvement in the review but did not receive a response.

The findings of this review are confidential and all parties have been anonymised.

PARALLEL INVESTIGATIONS

Other than the criminal case against Rizwan and the inquest, there were no other parallel investigations.

Issues relating to the children were fully considered throughout the DHR process and the Local Safeguarding Children Board has agreed to consider the report and its recommendations when it can be disseminated. The Local Safeguarding Adults Board has also agreed to consider the report and its recommendations when it can be disseminated.

CONTRIBUTORS TO THE REVIEW

Regular attenders at the DHR panel were as follows:

Davina James-Hanman, Independent Chair (Director AVA)
Hilary McCollum, Report writer
Chief Executive Officer, ADVANCE
Community Services Director, Ealing Hospital NHS Trust
Safeguarding Adults Designated Nurse, Brent CCG
Safeguarding Children Designated Nurse, Brent CCG
Head of Children's Safeguarding, Brent Council
Head of Reablement and Safeguarding, Adult Social Services, Brent Council
Head of Community Safety, Brent Council
Community Safety Officer, Brent Council
Detective Chief Inspector, Hertfordshire Police
Detective Sergeant, Metropolitan Police, (Specialist Crime and Operations)
Deputy Director of Nursing, North West London Hospitals Trust
Standards Development Officer, Nursing and Midwifery Council
Senior Probation Officer, Probation Service
Clinical Manager, Women and Girls Network
Patient Safety Lead for Mental Health, NHS England

The following agencies attended one meeting – Metropolitan Police in Brent, Age UK (Brent), University of West London.

All of the agencies were represented by senior staff who were independent of the case. IMR authors attended those Panel meetings where their IMR was discussed.

SUMMARY OF AGENCY CONTACTS

Edited highlights of the most significant events in terms of agency involvement with Penina, Rizwan and the twins are set out below. More detail is contained in the main report, along with a complete chronology of relevant agency involvement (Appendix 2 of the main report).

February 2001, Rizwan alleged to have kidnapped schoolgirl – Metropolitan Police

Rizwan first came to the attention of the Metropolitan Police in February 2001 when he was 18 years old. He was alleged to have kidnapped and falsely imprisoned a 15-year-old girl. The girl reported that she'd been approached by an unknown male who asked if she wanted to go home with him; she refused. He came to her school a few days later, grabbed her by the coat and told her to come with him. He warned her not to scream or he would kill her with a knife that he then produced. He took her to various locations by bus and then to an address where he took a photograph of her. On walking back to the bus stop, the suspect was approached by the victim's mother and ran off.

The girl was accompanied to the police station by her uncle who said the suspect was Rizwan Ibrahim (recorded at the time as Rizwam Ibrahim). The family wanted him to be warned.

Police enquires with the school and bus company found no evidence to corroborate the girl's report and revealed some inconsistencies. The police visited Rizwan's home address. He was not there but his mother explained that the girl's uncle had stolen items from her son. The police did not interview him. The police went back to the victim and challenged her about her account. She confirmed that she did not wish for the matter to be further investigated.

The Metropolitan Police believed that the allegation was malicious and no further action was taken. No other agencies were aware of this allegation until after Penina's murder.

April 2002 and November 2004, Rizwan cautioned – Metropolitan Police

On 26 April 2002 Rizwan Ahad Ibrahim was cautioned for cannabis possession. On 29 November 2004 he was cautioned for possession of a knife and given a fixed term notice for using threatening, abusive or insulting words or behaviour.

July 2005, Birth of twins – North West London Hospitals Trust

In July 2005, Elizabeth gave birth to the couple's first children, twins Child 1 and Child 2. The twins were born extremely prematurely and had multiple complex needs and ongoing health issues, resulting in frequent admissions to hospital and ongoing contact with various community health services.

July 2006 and March 2008, Domestic incidents – Metropolitan Police

On 24 July 2006, the police were called by neighbours to an argument between Rizwan and his wife. The police advised both parties about their future behavior but took no further action as there had been no physical violence.

The police attended a further domestic incident on 23 March 2008, which was sparked by an argument over Rizwan viewing pornography sites on the family

computer. The police arrested Rizwan for common assault as there was evidence of injury to Elizabeth. He made a counter allegation that she had assaulted him and police noticed scratches on him. Police decided no further action was warranted.

November 2008, Rizwan accused of 'peeping' and 'masturbating' at nursery – Willow Children's Centre and Brent Children's Safeguarding

In autumn 2008, Rizwan began temporary employment at Willow Nursery. In November 2008, female staff at the nursery complained that Rizwan was behaving inappropriately towards them. The nursery has not retained details of the allegations or any investigation but LB Brent Children's Social Care recorded that he was 'peeping' and 'masturbating' and 'flirting' with female staff in the toilets at the nursery. No other agencies were made aware of this alleged behaviour until after Penina's murder.

On 5 November 2008, Elizabeth was seen to hit Rizwan at Willow Nursery during an argument about him having an affair with a 16-year-old girl. His temporary employment contract was terminated as a result.

April 2009, Elizabeth and Rizwan report physical aggression to GP – Brent CCG

On 17 April 2009, Elizabeth and Rizwan attended the GP together saying they were having trouble controlling their anger, which was resulting in physical aggression. The GP referred them to the Brief Psychological and Counselling Service for anger management. The referral was not accepted by the Brief Psychological and Counselling Service and the GP wrote to Rizwan suggesting that the couple should try Relate.

August 2009, Arrival of Penina and John and Penina's stroke – Central Middlesex Hospital

On 22 August 2009, Elizabeth's parents came from their native Fiji to live in Britain. Penina suffered a Cerebral Vascular Accident (stroke) during the journey and was admitted to Central Middlesex Hospital. She was discharged from hospital on 11 September 2009 and she and her husband, John, went to live with Elizabeth, Rizwan and their twin children. The stroke left Penina with a degree of impairment, including the loss of speech in English (she had previously spoken both Rotuman and English), expressive dysphasia and right sided weakness but she remained largely independent, acting as the primary carer for her husband.

January – December 2010, Rizwan applies and is admitted to train as a nurse – University of West London, Criminal Records Bureau, Metropolitan Police

In January 2010, Rizwan applied to the University of West London to study Adult Nursing. His UCAS application did not state that he had any criminal convictions, however, at the University's Selection Day on 5 March 2010 he brought copies of his CRB disclosures[9] from 2008. Both disclosures provided details of two prior police cautions, the first for 'possession of a controlled substance, Class B, Cannabis' in 2002 and the second for 'having article with a blade or which was sharply pointed in

[9] The disclosures relate to employment as a minicab driver by the Public Carriage Office on 27 March 2008 and as an administrator by NHS Professionals on 19 November 2008

public place' in 2004. On disclosure of his cautions, he was referred to the University's Criminal Records Bureau (CRB) screening panel.

On 11 March 2010, the Chair of the CRB Screening Panel sent Rizwan a letter requesting further details of the listed cautions and advising him that the conditional offer to study was dependent on CRB information. On 22 March 2010, Rizwan sent a personal statement to the CRB chair, giving his account of the circumstances that led to the cautions. He also referred to his employment history, including his temporary employment as an administrator at Willow Children's Centre, which he said lasted twelve months. He did not mention the allegations against him by other staff at the Willow Children's Centre nor the circumstances surrounding the termination of his employment. The University accepted the statement at face value without conducting any checks with Willow Children's Centre.

The CRB Screening Panel met on 12 April 2010 and decided to defer Rizwan's application pending further investigation. On 16 April 2010, the CRB Screening Panel agreed to review Rizwan's file in response to his claim that his cautions were under review by the Independent Commissioner's Office.

On 11 May 2010, a letter was sent to Rizwan from the CRB Screening Panel notifying him that his application had been allowed to progress subject to the completion of a new CRB check. This was based on the offence being more than six years earlier and it having been disclosed by Rizwan.

On 5 July 2010, a University Administrator completed a new enhanced CRB check application form for Rizwan. The Criminal Records Bureau dealt with the cautions and convictions part of the enhanced disclosure and passed the request for other information to be disclosed on to the Metropolitan Police Service.

Although the CRB process was not yet complete, Rizwan was allowed to start his nursing training in September 2010 (students are permitted to begin their studies before the checks are complete but are not allowed to go into practice and have patient contact).

In November 2010, the CRB sent the completed enhanced disclosure to the University of West London. The cautions in relation to the cannabis possession and possession of a blade were included in the disclosure but the Metropolitan Police did not identify any other concerns in the non-conviction section of the CRB disclosure (i.e. the alleged kidnapping and false imprisonment and the domestic violence incidents were not disclosed).

On 10 December 2010, the University decided to offer Rizwan a place on the Advanced Diploma of Higher Education in Adult Nursing. His enhanced CRB disclosure matched his declared cautions, revealed no other convictions and no other concerns. The passage of time since the last caution and the absence of any indication of a tendency to re-offend also influenced the University's admissions decision.

May 2010 and May 2011, Rizwan reported to have hit each of the twins – Lyon Park School, Manor School, Brent Children's Social Care

In May 2010, Child 2 disclosed at school that Rizwan had raised his hand. According to the school, the designated teacher contacted LB Brent Children's Social Care and was advised that if Rizwan showed remorse when questioned about the incident, it would not need to go any further. LB Brent Children's Social Care

have no record of this conversation and dispute that this advice would have been given. The teacher met with Rizwan who showed remorse and no further action was taken.

In May 2011, Child 1 told the school that when used English at home to say 'pardon' Rizwan had 'smacked' the child. When Manor school called Rizwan, he confirmed that he had smacked Child 1 on the bottom because he wanted Child 1 to use Arabic at home. This incident was not communicated to Children's Social Care.

In the Chair's interview with Elizabeth, she said that she was not aware that either of the children had told school that Rizwan had hit them. She also said that the children were generally not required to speak Arabic at home and that she herself did not speak Arabic.

February 2011, Penina experiences ongoing pain – Brent CCG

In February 2011, Penina was prescribed Tramadol by her GP to relieve pain in her lower legs and feet. Further prescriptions for Tramadol were issued over the next two years until they were stopped in June 2013.

March 2012, John's death – Brent CCG

On 18 March 2012, Penina's husband, John, died.

June 2012, Penina's first fall – Brent CCG

On 13 June 2012, Penina was seen by her GP with Rizwan following her first recorded fall. There was no evidence of major injury. The GP made a referral for Penina to be seen by both Occupational Therapy and Physiotherapy for rehabilitation.

11 July 2012, Occupational Therapy visit Penina – Ealing Hospital NHS Trust

Penina was seen by occupational therapy on 11 July 2012. Rizwan assisted with interpreting Penina's views during the assessment, although he speaks little Rotuman.

5 April 2013 Penina falls - North West London Hospitals Trust

Penina had remained largely independent since her stroke in August 2009. However on 5 April 2013 she fell at home. She presented to the emergency department at Northwick Park Hospital and was assessed and discharged the same day. Her health deteriorated over the next six months up until her death.

12 April 2013 and 23 April 2013, Penina admitted to hospital – North West London Hospitals Trust

On 12 April 2013, Penina was admitted to hospital following another fall. She was discharged on 22 April 2013 but readmitted the following day. She was aggressive to hospital staff and behaved in a sexualised manner, both of which were out-of-character. Medical staff considered the changes to be linked to a series of mini-strokes and the effects of a urinary tract infection.

Staff struggled to cope with Penina's aggression and insisted a security guard was present at all times. The panel considered this to be a deprivation of liberty. Whilst the deprivation of liberty may have been appropriate in the circumstances, it does

not appear that due process was followed. There is no evidence that the necessary mental capacity checks were conducted or that a representative was appointed to make decisions on Penina's behalf until she had capacity. As such, the DOL was unlawful.

During this admission doctors conducted a lumbar puncture on Penina under general anaesthetic. Again, due process was not followed and the panel considered this procedure was unlawful.

30 April 2013, Rizwan alleged to have sexual assaulted two former patients – Hertfordshire Police

On 30 April 2013, a woman called Ruth told Hertfordshire Police that Rizwan had sexually assaulted her. Two weeks earlier, Ruth had been admitted as a patient to the hospital ward where Rizwan was a student. She was treated for chronic illness. During the course of her admission, Rizwan assisted her when she had a medical incident in the hospital toilets.

She alleged that Rizwan had visited her on 24 April 2013 at her home. He was wearing his nursing uniform and had a copy of her discharge papers (she had been discharged the previous day and it appears that he took the opportunity to obtain these when a ward computer was left unattended). Ruth alleged that he behaved in an over familiar manner. He returned that evening and got her phone number, calling and sending frequent texts over the next few days. Ruth told police that Rizwan visited her again on 26 April 2013 and kissed her against her will. She told her mother about the alleged assault on 27 April and reported it to the police on 30 April 2013.

On the same day (30 April) Ruth told her friend, Karen, about the alleged assault. Karen had also been a patient on the hospital ward where Rizwan was a student. Later that day, Karen reported to Hertfordshire Police that Rizwan had orally raped her. Rizwan had allegedly taken her to his brother's house and given her alcohol, which made her drowsy because of her medication. Allegedly he orally raped her that evening and the following morning. Rizwan allegedly visited her home address again and administered her morphine. Karen became drowsy and he allegedly orally raped her again. Karen stated this happened on 24 or 25 April 2013.

Karen made a written statement to Hertfordshire Police on 1 May 2013. She was back in hospital where she was recovering from an operation and due to her condition could only sign a brief account of her evidence. Karen raised concerns regarding her ill health and whether she would be well enough or have the strength to go through with the investigation.

2 May 2013, Rizwan arrested and suspended from University, safeguarding referrals re allegations – Hertfordshire Police, North West London Hospitals Trust, University of West London, Brent Adult Social Care

On 1 May 2013, Hertfordshire Police contacted North West London Hospitals Trust, who are responsible for the hospital where Rizwan met the former patients that he allegedly sexually assaulted. Later that day, North West London Hospitals Trust informed the investigation team of details of a possible suspect identified as Rizwan Ahad Ibrahim.

Rizwan was arrested at Northwick Park Hospital on the morning of 2 May 2013 and taken to Watford police station for questioning. He denied the offences. His car and home address (Address 1) were also searched and Elizabeth gave police items of clothing that they requested. The police did not tell her what he was accused of. He was released later that day on conditional bail until 27 June 2013 pending the completion of the police investigation. Rizwan's bail hearing was subsequently rescheduled twice pending forensic and telephone evidence and he was not reinterviewed until 9 October 2013.

On the same day as Rizwan's arrest (2 May 13), the University of West London suspended him; Hertfordshire Police made a referral to the Notifiable Occupation Scheme; and North West London Hospitals Trust made a safeguarding alert to Adult Safeguarding at London Borough of Brent (LB Brent). The alert should have been made to Hertfordshire Council as the offences were alleged to have been committed in Hertfordshire. There is a dispute between North West London Hospitals Trust and Brent Adult Safeguarding about the notification. Adult Safeguarding claim that they requested additional information but that this was not forthcoming so no action was taken. North West London Hospitals Trust claim that sufficient detail was provided but Adult Safeguarding decided the case did not meet the threshold for action. What is clear is that the alert did not result in an assessment of the risk posed by Rizwan to the women or children in his family or the wider community. Professionals who came into contact with the family in the period between Rizwan's arrest for sexual assault and Penina's murder remained unaware of the allegations.

2 May 2013, Penina discharged from hospital

Penina was discharged from hospital on 2 May 2013. The discharge letter refers to out of character behaviour including frequent sexual comments.

14 May 2013, Brent follow up safeguarding alert – North West London Hospitals Trust, Brent Adult Social Care

On 14 May 2013, a Senior Practitioner from Brent's Adult Safeguarding team emailed the Deputy Director of Nursing at North West London Hospitals Trust requesting more details regarding the safeguarding alert. The following day, the Deputy Director responded by email confirming that she had asked a colleague from Northwick Park Hospital to forward a safeguarding referral

June 2013, Penina's deteriorating health, provision of social care support – North West London Hospitals Trust, Brent CCG, Brent Adult Social Care

After Penina's discharge, she was initially cared for by her family. On 2 June 2013, Penina fell at home. She was seen in A&E the following day. On 5 June 2013, Rizwan requested a home visit from the GP due to Penina's falls (four in three days). She was treated for a urinary infection and her Tramadol prescription was stopped. Rizwan told the doctor that the family was struggling to cope.

On 6 June 2013, Rizwan contacted Adult Social Care requesting support to care for Penina. On 7 June 2013, the Short Term Rehabilitation and Re-enablement Service (STARRS) also referred Penina to Adult Social Care for support. From 12 June 2013, Penina received a domiciliary care package from Adult Social Care, initially via Health Vision, then Gentle Care and finally Priory Nursing Agency & Homecare.

6 June 2013, Karen withdraws support for investigation due to ill health – Hertfordshire Police

On 6 June 2013, Karen withdrew her support for the police investigation into the alleged sexual assaults committed by Rizwan. She maintained that the allegations were true but a combination of her ongoing ill health and concern about the stress of the criminal justice process had led to her decision.

June and July 2013, Further deterioration in Penina's health – North West London Hospitals Trust, Brent Social Care, Priory

On 26 June 2013, Penina was seen with Elizabeth at the out of hours clinic and then A&E following further falls. The following day, a Joint Reablement Review was held at Penina's home address. It noted that Penina experienced confusion, right sided weakness, speech difficulties, expressive dysphasia and frequent falls. There was a query about whether she had dementia. From 30 June 2013, an enhanced reablement service was delivered to Penina by Gentle Care. A key safe was installed to facilitate the carers' access to the house.

On 1 July 2013, Penina was seen in the neurology clinic with Elizabeth. It was recorded that she tended to be confused on waking and was excessively frightened if woken suddenly. The doctor thought Penina was likely to be developing significant subcortical cognitive impairment.

During July, the family had frequent contact with a range of professionals in relation to Penina's health and social care needs. On 8 July 2013, at a review of care meeting, it emerged that Rizwan was assisting with Penina's bathing. Penina's wishes about this arrangement had not been ascertained.

On a number of occasions, professionals observed sores on or around Penina's bottom. These included: a sore on Penina's bottom on 17 July 2013; a superficial skin laceration on upper left bottom on 29 July 2013; a skin infection on right thigh on 14 October 2013.

On 19 July 2013, Penina became unwell during a review of the use of bathing equipment. An ambulance was called and she was taken to hospital, suffering from a urinary tract infection. She was discharged on 21 July 2013.

An Enhanced Reablement review for Penina on 26 July 2013 discussed the risk of Penina falling on waking, her behaviour issues and her agitation towards enablers and family. The meeting decided that the package of support should be increased to three visits by one carer per day. This was implemented from 5 August 2013, with a change of provider from Gentle Care to Priory Nursing Agency & Homecare.

25 July 2013, LADO referral, no action – North West London Hospitals Trust, Brent Children's Social Care

On 25 July 2013, North West London Hospitals Trust sent a LADO Form to LB Brent Children's Social Care informing them of the allegations against Rizwan. This referral was made at the request of the Trust's Director of Governance. However, no action was taken by Children's Social Care as the allegations related to adult women and not to children. On 28 July 2013, North West London Hospitals Trust made an entry on the Datix software, which records patient safety concerns.

12 August 2013, Penina referred to GP for latent syphilis – Brent CCG

On 12 August 2013 Penina's GP received a letter from the genitourinary medicine clinic regarding Penina's latent syphilis, which she had contracted before coming to Britain. The clinic advised the GP to prescribe an antibiotic and that there was no need for further follow up.

September 2013, Penina continues to fall – Brent Adult Social Care, Brent CCG

On 2 September 2013, Rizwan requested a further review as Penina was still falling frequently. A review took place on 5 September 2013 but on 6 September 2013, Penina fell again. During September a number of reviews took place in relation to Penina's health and social care needs including assessments of the use of hoist equipment.

On 9 September 2013, the GP discussed concerns about Penina's falls with Rizwan. In a follow up call with the GP the next day, Rizwan queried the antibiotic that Penina was taking. The GP told him that it was for syphilis. This was a breach of Penina's confidentiality.

On 25 September 2013, Penina's care package was increased to two carers.

9 October 2013, Rizwan reinterviewed re sexual assault allegations – Hertfordshire Police

On 9 October 2013, Hertfordshire Police reinterviewed Rizwan regarding the sexual assault allegations. They had received the results of forensic and telephone evidence in September, which showed that he had lied to the police about his contact with the victims when he was interviewed in May 2013. He denied any wrongdoing stating he was in a sexual relationship with Karen and any sex since they met in March 2013 was consensual. He denied any sexual assault against Ruth, although admitted he tried to kiss her. He was released on bail pending a CPS charging decision.

Morning of 18 October 2013, Senior Occupational Therapist notes that Penina is different when Rizwan present – Brent Adult Social Care

On the morning of 18 October 2013, at a meeting to review Penina's care needs, the Senior Occupational Therapist remarked that Penina's behaviour appeared different when Rizwan was present. The carer responded that Penina 'is uncomfortable with personal care when Mr Ibrahim is around.'

Evening of 18 October 2013, Carers find Penina bleeding, Police and Ambulance called – Priory Care, Metropolitan Police

At around 8pm on 18 October 2013, one of Penina's carers arrived at the family home to provide care to her. On entering Penina's room, the carer found a large amount of blood on the floor and could hear Penina moaning. The carer asked Rizwan what was going on. She noticed blood on his top, which he said was a curry stain.

The carer then went outside and called the police and the ambulance service. She was joined by the second carer. They both went back into Penina's room and noticed that most of the blood on the floor had been cleaned.

On arrival the London Ambulance Service (LAS) went straight into Penina's room and began their treatment of her. She became unresponsive and was taken by

ambulance to St Mary's Hospital. Despite three rounds of CPR, the medical team were unable to stabilise her. Penina's life was pronounced extinct at 2240hrs.

Police went into the kitchen and noted Rizwan had blood on his clothes. They found blood stained rags in the laundry basket. Another laundry basket containing blood stained towels was recovered from the garden. Officers found the twin boys sitting in the living room. One of the boys told police they had heard shouting and screaming coming from their grandmother's room.

Rizwan was arrested, initially on suspicion of GBH and then on suspicion of Penina's murder. The following day he was charged with her murder. He was found guilty in June 2014 and sentenced a month later to a minimum of 25 years.

Following Penina's murder, six female members of Elizabeth's family came forward to say that he had sexually abused them.

The sexual assault file in relation to Ruth was initially put on hold following Rizwan's arrest for murder but on 13 November 2013 it was submitted to the CPS. On 10 December 2013, the CPS advised that Rizwan should be charged with sexual assault against Ruth. He was due to be tried in August 2014 but the trial was adjourned due to Ruth's ill health. She later stated that she did not wish to proceed with the court case and the case was withdrawn by CPS as not in the public interest to continue.

SUMMARY OF FINDINGS

It should be noted when reading the findings below that they relate to circumstances in place at the time of the murder. A number of changes have already been implemented to address these issues with further actions planned.

Communication and information sharing between services

There was good communication and information sharing between services on a number of occasions. For example, between health services particularly at points of admission and discharge for the twins and for Penina; and between Hertfordshire Police and North West London Hospitals Trust regarding the allegations of sexual assault against Rizwan. However there were also significant gaps:

- neither Willow Children's Centre nor Brent Children's Social Care alerted the police to allegations against Rizwan of sexually inappropriate behaviour;
- North West London Hospitals NHS Trust did not provide sufficient detail in the safeguarding alerts to agencies in Brent following the sexual assault allegations against Rizwan and this was not followed up robustly;
- there was a lack of communication between Brent Adult Social Care and Brent Children's Social Care regarding responding to the sexual assault allegations against Rizwan;
- Hertfordshire Police did not inform the Metropolitan Police that they were investigating an alleged sexual offender resident in the Metropolitan Police area despite searching premises in Brent;
- Metropolitan Police Service did not disclose an alleged kidnapping and false imprisonment and two domestic violence incidents involving Rizwan in an enhanced CRB disclosure requested by the University of West London.

Prior to Penina's murder, agencies were aware of the following allegations against Rizwan:

- alleged kidnapping and false imprisonment of a fifteen-year-old girl in 2001 in which was alleged to have used a blade to threaten her (Metropolitan Police Service);
- domestic violence incidents in 2006 and 2008 (Metropolitan Police Service, Brent Children's Social Care);
- pornography use in 2008 (the nature of the pornography that Rizwan was viewing that sparked the domestic violence incident in 2008 is not known) (Metropolitan Police Service);
- an alleged affair with a 16-year-old girl in 2008 (Willow Nursery, Brent Children's Social Care);
- sexually inappropriate behaviour at the nursery in 2008 (Willow Nursery, Brent Children's Social Care);
- alleged sexual assaults against two former patients, both of whom were still in ill-health at the time of the alleged assaults in 2013 (Hertfordshire Police, Brent Children's Social Care (limited information), Brent Adult Social Care (limited information), University of West London, North West London Hospitals Trust, possibly the Disclosure and Barring Service after Hertfordshire Police made a referral to the Notifiable Occupation Scheme).

The panel acknowledges that it is much easier to operate with the benefit of hindsight. Nevertheless, a different approach to communication and information sharing between services and to risk assessment (see below) might have revealed this picture of Rizwan's potentially escalating behaviour prior to Penina's murder.

Delivery of services (including professional standards; domestic violence policy, procedures and protocols; safeguarding adults policy, procedures and protocols)

There are examples of both high quality service delivery and of occasions where professional standards were not met and policies and procedures were not followed. For example:

- despite language barriers, the carers from Priory Care appear to have developed a good relationship with Penina and attempted to maintain her independence as far as possible;
- the immediate presenting health issues of the twins and Penina were largely treated effectively by health professionals;
- Hertfordshire Police made attempts to identify other potential victims from hospital settings where Rizwan worked and financial checks were undertaken to ensure that he was not working through an agency in another health setting.

There were also a number of occasions where processes and policies were not followed by agencies including:

- the administration of a lumbar puncture to Penina by North West London Hospitals Trust without either obtaining consent or following the mental capacity procedures;

- deprivation of Penina's liberty by North West London Hospitals Trust without following due process;
- breach of confidentiality by Penina's GP regarding her treatment for syphilis.

Response to referrals (including assessment, decision-making and effective intervention; actions taken; appropriateness of services and/or enquiries made; quality of risk assessments)

As in some other areas of the analysis, there is a mixed picture in relation to agencies responding to referrals. Whilst there are occasions when referrals were dealt with quickly and effectively resulting in good quality service delivery, there are also a number of failings:

- inadequate Metropolitan Police investigation of alleged kidnapping and false imprisonment;
- lack of action by Brent Children's Social Care and Willow Children's Centre in response to concerns about Rizwan's sexually inappropriate behaviour at Willow Nursery;
- University of West London's reliance on a personal statement by Rizwan that had not been validated;
- poor record keeping by University of West London and Willow Children's Centre;
- failure to properly assess Penina's needs by health and social care agencies (professional interpreters were never used to communicate with her and she was rarely seen alone);
- lack of required detail in initial alert made by North West London Hospitals Trust to Brent Adult Social Care and inadequate follow up of safeguarding alert by Brent Adult Social Care and Brent Children's Social Care;
- failure by health and social care agencies to assess the potential risks posed to Penina as a 'vulnerable person' within the terms of the 'No Secrets' guidance;
- failure to undertake routine risk assessments in the vast majority of North West London Hospital Trust's contacts with Penina and the twins;
- lack of consideration of Rizwan's potential risk to the people he lived with by Hertfordshire Police.

Respective awareness training of adult-focused and child-focused services

Agencies identified a range of relevant training available to professionals. Staff working at the Brent GP practice had not all received training on safeguarding adults, the Mental Capacity Act and Deprivation of Liberty. The lead GP indicated at interview that she felt training specifically around the application of the confidentiality guidance in circumstances where family members are the voice for their patients, would be welcomed.

Thresholds for intervention

A number of aspects of practice prompted concerns about thresholds for intervention in this case including:

- approach to risk assessment by Hertfordshire police, with a lack of join up regarding offending across forms of violence against women and girls/age groups/relationships;
- thresholds for disclosure of 'other information' in enhanced CRB disclosures;
- Brent Children's Social Care viewing sexual assaults against adults as not relevant to safety of children;
- Brent Children's Social Care not referring alert regarding alleged sexual assaults against adults to Adult Social Care;
- lack of consideration of potential victims who are not identified as 'vulnerable'.

Identity and diversity issues

All nine protected characteristics in the 2010 Equality Act were considered by both IMR authors and the DHR Panel and several were found to have potential relevance to this DHR.

Penina was a relatively recent immigrant to Britain. She had a number of impairments following a stroke, including losing her capacity to communicate in English. Her level of impairment increased markedly from April 2013 reducing her mobility and independence.

Penina was always seen in the company of either her daughter or Rizwan and independent interpreters were never used by any service. This meant that her wishes and feelings were never directly obtained or recorded and Penina was not afforded the opportunity to disclose any abuse that she may have been experiencing to someone outside the family.

Both health and social care staff have a responsibility to ensure that patients/clients have understood and, where needed, consented to treatment. When someone's capacity is reduced either temporarily or permanently this should lead to a full capacity assessment in line with the Mental Capacity Act. There was no evidence that health or social care staff completed mental capacity assessments over decisions about her health treatment or care package even when she clearly had significant difficulties with her mental capacity.

There is little evidence that agencies recognised the impact on the family of caring for both older adults and twins with complex health needs.

Escalation to senior management or other organisations/professionals

The decision by the Child Protection Education Worker not to act on the information relating to Rizwan's alleged sexually inappropriate behaviour, domestic violence incident and relationship with a sixteen-year-old girl was not escalated to senior management. Similarly, senior managers in Brent Adult Social Care were not alerted to the incomplete referral from North West London Hospitals Trust and the subsequent lack of follow up by the social care worker.

Impact of organisational change

There was a review of the Adult Safeguarding Team in 2012 and implementation of a new structure to the team in July 2013. At the time of the safeguarding referral the team was about to start a period of transition and there was a lack of administrative staff within that team. The team has now being restructured to provide for additional administrative support.

Learning in relation to the children

Both children had multiple hospital admissions and presentations. It appears that at the time covered by this review the emergency department did not have regular safety net meetings in place. Frequent presentations should trigger a review. Had this process been in place during the times the twins presented to the emergency department, this may have triggered a safeguarding discussion.

After Rizwan was arrested for alleged sexual offences at the beginning of May 2013, a number of agencies were aware that he had children that he lived with and had unsupervised access to. However, a safeguarding alert was not made to Brent Children's Social Care until late July 2013 and was not acted on. The panel considered that if an adult is accused of sexual offences, whether against adults or children, then Children's Social Care should be informed and should conduct a safeguarding assessment.

Additional lessons learned

It was a time-consuming and lengthy process to get the DBS to co-operate with the review and it was only after the Home Secretary's intervention that they agreed to release the information that the Panel required. This raises questions about the operation of Domestic Homicide Reviews.

DHRs were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13 April 2011. Section 9, subsection 4 identifies a number of organisations with a statutory responsibility to participate in a review, including police, local authorities, probation and health services.

The DBS is one of a number of services not specifically mentioned who held information of relevance to this review. Others included the University of West London; three schools attended by Child 1 and Child 2; and a voluntary organisation that provided home care services to the victim. The DBS was the only organisation that declined to co-operate with the review arguing that the provision of information for the purposes of a domestic homicide review is not provided for in statute and is not therefore considered to fall within the DBS 13 April 2011. However, as the DBS acknowledges on its website, its role is to help "employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children." Given this role, the circumstances of this homicide and the allegations of sexual assault against former patients by this perpetrator, the panel believes that the DBS could and should have co-operated with the review from the outset.

Under Section 9 of the Domestic Violence, Crime and Victims Act (2004), subsection 6, the Home Secretary has the power to amend subsection (4) of the Domestic Violence, Crime and Victims Act (2004) by order and could name the Disclosure and

Barring Service and all other organisations in receipt of public funding as bodies with a statutory responsibility to participate in domestic homicide reviews. This would ensure that the DBS and other publicly funded bodies would have to co-operate in any future review in which they held information of relevance to establishing whether there were opportunities to prevent homicide. The same requirement should apply to other statutory requirements to review.[10]

As set out previously in the section on Communication and Information Sharing, in the period before Penina's murder, agencies knew about a number of allegations against Rizwan of violence against women and girls and sexually inappropriate behaviour. Information about allegations against Rizwan and his potential for committing violence were not explored and brought together. It appears that agencies continue to respond to violence against women and girls as isolated incidents rather than potentially as patterns of behaviour. The failure to share information meant that each agency only had a very partial picture of Rizwan's behaviour and his potential risk to others. The review reinforced the need for agencies to act on the recommendations of the Bichard review.

The approach of agencies to safeguarding seems to focus more on finding potential victims to protect rather than on monitoring the behaviour of potential perpetrators and identifying effective interventions to prevent their behaviour escalating. This is reflected, for example, in the fact that Adult Social Care's IT system had the capacity to track vulnerable victims but no capacity to track and cross reference potential perpetrators of harm. The ability to record the alleged perpetrator on Adult Social Care records could improve the prevention of abuse.

A further problem with an approach that focuses on vulnerable victims rather than potential perpetrators is that it fails to protect people who are not considered 'vulnerable'. Although Penina was vulnerable, she was not recognised as being at risk and was therefore not protected from Rizwan. Elizabeth would not have been considered vulnerable. She was not warned that he was being investigated for rape and to consider her own risk and that of her mother and children. The panel recognised the need for better risk assessments of alleged perpetrators of violence against women and girls, including helping women not identified as vulnerable to assess their own risk. It recognised that this may require both policy and legislative change.

Contributory Factors and Root Causes

The following contributory factors and root causes were identified:

- information was not effectively shared between agencies which undermined safeguarding and risk assessment;
- Rizwan's behaviour was not recognised as a potential pattern but instead dealt with as individual incidents;
- there was a lack of focus on managing Rizwan as a potential perpetrator;
- Penina was not identified as an adult at risk and Rizwan's potential risk to her was never considered;

[10] This would include: serious case reviews, mental health reviews and serious incident reviews

- there was poor communication and follow up between agencies regarding the safeguarding alert made in May 2013;
- staff across health and social care episodes relied upon the family to interpret and provide information on Penina's behalf. Penina's voice was not heard.

These issues have been considered above and are addressed within the recommendations and action plan set out in the main report.

WAS THIS HOMICIDE PREVENTABLE?

In considering the question of whether this homicide could have been prevented, it is important to make a clear distinction between whether a homicide was 'predictable' and whether it was 'preventable'. As set out previously, parts of the picture were available to different agencies but there were failures to share information. There was a lack of proper risk assessment with regard to Rizwan's risk to family members.

A different approach to disclosure from the Metropolitan Police might have prevented the alleged sexual assaults against former patients and may have had an impact on his assessed risk against Penina as his status as a student nurse was recognised as influencing agency perceptions.

Even if all these areas had been improved, it might not have been possible to predict that Rizwan would murder Penina. However, Rizwan's patterns of behaviour amounted to a picture of ongoing and potentially escalating violence against women and girls and it should have been possible to predict that without intervention, he was likely to continue to offend against women and girls.

That, in turn, raises the question of who he was a risk to. In the months before her death, Penina was housebound, unable to communicate in English, rarely seen on her own, never offered interpreters, isolated, facing significant health issues and with a potentially declining mental capacity. She was a 'vulnerable adult' and as such should have been considered to be at risk. Had Penina's risk from Rizwan and his risk of offending within his family been considered differently, this homicide might have been prevented.

The Panel wishes to express its condolences to the children, family members and friends of Penina. May she rest in peace.

RECOMMENDATIONS

Recommendation	Lead Agency	Scope of recommendation i.e. local or regional	Action	Key milestones/ outcome achieved in enacting recommendation	Target and completion date
Query from the Home Office: 'The Nursing and Midwifery Council (who were represented on the panel) will be using the findings from this review to consider the future of the perpetrator as a nurse given that the Council do not appear to be conducting their own investigation'	The Nursing and Midwifery Council	Local	Letter from NMC has been attached as appendix 5	•	
1. When a child and family assessment is being conducted, it should include all household/family members	Brent Children's Social Care	Local	1. To be reinforced for staff in assessment training and related guidance 2. Guidance to be cascaded to all teams. 3. Management oversight on individual cases 4. Regular Audit of cases throughout the year	• Guidance to be issued to staff • Guidance and advice to be addressed in team meetings • Procedures in place and audits check on compliance • Audits Assessments show full compliance with requirements	November 14 December 14 Feb 14 Monthly
2. Each new allocated case worker must read back files	Brent Children's Social Care	Local	1. Management instruction for newly allocated	• All Team Meetings and forum discuss	By December 2014

			workers 2. Induction reminds social workers of key activity.	new action • Include guidance in new procedures	By December 14
3. Where sexually inappropriate behaviour is suspected by a person working or volunteering with children this must be discussed with the LADO who will in turn discuss this with the police. If such a situation arises and the person is an employee of Brent we will invoke the disciplinary procedures. If the person works for another agency we will recommend the employer invokes their own disciplinary procedures	Brent Children's Social Care	Local	1. Training of MASH workers to re direct LADO referrals 2. Evaluation of the MASH to ensure the process actively picks up all cases that should be referred on.	• MASH workers are trained through induction. • Audits and evaluation of the MASH show it risk assess all cases where sexual offences have been committed by an adult who is also a parent to ensure children are safeguarded	Completed Completed by Dec 16
4. Greater coordination and liaison is required between the CSC LADO and the Adult Safeguarding Manager on cases involving adults who may pose a risk to any vulnerable person..	Brent Children's Social Care	Local	1. Joint protocol and procedures updated to reflect new arrangements.	• Agreed protocol and procedures of cases of shared interest and concern now in place regular meetings to share information take place.	Completed

5. Accurate written records must be kept of all referrals into and out of CSC and the subsequent actions agreed from the referral clearly recorded.	Brent Children's Social Care	Local	1. The introduction of the MASH to effectively manage the referral system 2. LADO arrangements address HR issues when staff behave in an unsatisfactory manner to in ensure robust response and recording of allegations	• The LADO referrals are reported on a quarterly basis and highlight areas where referrals are low. • LSCB offer training on the LADO referral process and the need for professionals to be aware of how to refer, attendance is reported on the appropriate sub group	Completed
6. Children with special needs should have their progress notes/records transferred to school health following a: a. Verbal communication with lead health professional b. Written summary of history and current health needs c. Any outstanding interventions required	Ealing Hospital NHS Trust	Local	1. To incorporate within new Community Safeguarding Procedures 2. To audit a sample of Care Plans for CIN/CPP for 4 -5 year olds	• Procedures to be launched in Brent October 2014	30-11-14 31-12-14
7. To review the border arrangements between Brent/Harrow to ensure children and young people are followed up by the Named HV or School Nurse.	Ealing Hospital NHS Trust	Local	1. For discussion at Trust safeguarding children Group	• Robust follow-up of children	31-12-14

8. Key Principles of Child Protection Supervision to be addressed at all safeguarding training for all clinical staff that have contact with or work directly with children.	Ealing Hospital NHS Trust	Local	1. Safeguarding Children's Training for clinicians to include principles of CP supervision	Clinical staff aware of importance of child protection supervision in clinical practice	31-10-14
9. To remind all District Nurses to follow-up no-access visits as outlined in the Trust No Access Policy.	Ealing Hospital NHS Trust	Local	1. Meeting with Heads of Service across Trust 2. Memo to all District Nurses 3. No access policy to be re-circulated to District Nurses	District Nurses aware of importance of following-up all no-access visits	30-11-14
10. All patients who are dependent on others for their assisted daily living should be seen as 'adults at risk' and be given an opportunity to be seen on their own, at least in part, without any family member/carer present during the initial assessment.	Ealing Hospital NHS Trust	Local	1. Meeting with Heads of Service 2. Memo to all community nursing staff and therapists 3. Safeguarding adult training to include the lessons learnt from this case	• This will enable the voice of the patient to be heard and provides the patient with an opportunity to express any concerns/issues they may have which they do not wish to share with family or carers.	30-11-14
11. Where a number of professionals and agencies are involved, a multi-disciplinary team (MDT) meeting should take place to establish a joint	Ealing Hospital NHS Trust	Local	Where a clinician has a concern about a patient and is aware of other services/agencies	Appropriate sharing of information and co-ordinated	31-3-15

care plan and discuss any concerns.			being involved, they should consider requesting a multi-disciplinary meeting to discuss these concerns and develop a joint care plan	care	
12. All referral forms to be reviewed and ensure that they include information to establish the patient's mental capacity and if the patient is housebound or not.	Ealing Hospital NHS Trust	Local	1. Service managers to review their service's referral form to include mental capacity and if patient is housebound or not	• This information will help in the process of triage, offering the right type of appointment and avoid delays.	31-12-14
13. All healthcare professionals to be reminded that during an assessment they need to identify and document: • the patient's preferred language and communication abilities • whether the patient has mental capacity or not • whether the patient is able to express views, concerns or anxieties • the name and relationship of people who may answer the telephone or door at home visits and provide information about a patient This will be incorporated into annual record keeping audits to ensure improved documentation.	Ealing Hospital NHS Trust	Local	1. Learning to be shared in writing with staff		13-12-14
14. Safeguarding adult training to incorporate lessons learnt from this case	Ealing Hospital NHS Trust	Local	1. Share report with Safeguarding Lead Practitioner and incorporate into	• Incorporated the learning into the training	30-11-14

			training material	material	
15. To remind all staff that trained interpreters (telephone or face to face) should be used where the service user does not speak English as a first language in line with Trust policy, particularly for initial assessments	Ealing Hospital NHS Trust	Local	1. Memo to staff 2. Discuss at service manager meetings	• Regular use of interpreters for all initial health assessments	30-11-14
16. Trust to review its guidance to clinical staff regarding mental capacity assessments	Ealing Hospital NHS Trust	Local	1. To review the guidance and amend if appropriate in the light of learning from this report	• Amend guidance and re-launch	30-12-14
17. All GP's in Brent to be offered refresher training in adult safeguarding including recognising vulnerable adults	NHS Brent CCG (Clinical Commissioning Group)	Local	1. Training sessions	• Training sessions planned – Completed • Training commence- November 2014 • Training complete	Sept 2014 November 2014 March 2015
18. All GPs in Brent to be offered refresher training in the MCA.	NHS Brent CCG	Local	1. Training sessions	• Training sessions planned – Completed • Training commence- November 2014 • Training complete	Sept 2014 November 2014 March 2015
19. All GP's in Brent to be offered refresher training in confidentiality	NHS Brent CCG	Local	1. Training sessions	• Training sessions planned Sept 2014 • Training commenc	Sept 2014 Novemb

				e-November 2014 • Training complete	er 2014 March 2015
20. All health professionals should recognise twin pregnancies as vulnerable and offer enhanced services following the birth	NHS Brent CCG	Local	1. To write to providers asking them to disseminate the message to ensure risk factors for twins are better understood and identified 2. Request providers audit a set of records to evidence	• Letter • Message delivered to all health staff by providers • Provider audits completed	October 2014 Decemb er 2014 March 2015
21. Domestic abuse should be considered in the family context or household including the impact on children	NHS Brent CCG	Local	1. To write to providers asking them to cascaded the message 'think adult, think parent/carer' and the impact on children	• Letter sent to all providers • Message delivered to all health staff by health providers	October 2014 Decemb er 2014
22. The learning from this Domestic Homicide Review to be shared with all GPs in Brent and with those GPs interviewed as part of this process.	NHS Brent CCG	Local	1. DHR Workshop to be organised – Brent CCG Children's and Adult's Safeguarding Leads 2. Further discussion in place regarding developing a domestic abuse training programme for GPs which could be taken to the RCGP for		June/Jul y 2015

			accreditation.		
23. The GP surgeries involved in this case to review their policies and procedures for identifying and responding to domestic abuse and ensure all staff receive appropriate training to support contemporary practice for healthcare practitioners.	NHS Brent CCG	Local	1. Level 2 MCA and Adult Safeguarding Training has been provided Jan –Mar 2015 to GPs and healthcare practitioners. 2. There was Level 1 Safeguarding on 13th March for non-clinical staff	• Training provided by BHH Safeguarding Lead	Completed by end of Mar 2015.
24. All GP practices to develop and make use of a system that records what information their patients who are being cared for want sharing, who with, and in what circumstances.	NHS Brent CCG	Local	1. Brent CCG working with NHSE 2. NHSE to work with GPs on developing the Case Management Register	• Consideration will be given to addressing carer's needs more specifically within the GP contract. In addition, GPs to be required to use a risk stratification tool	01/04/15 and ongoing
25. GP practices should maintain a record code for self-reported domestic violence issues in the same way they would code a domestic violence notification. This would allow for all relevant incidents to be recognised when a review of notes is undertaken.	NHS Brent CCG	Local	1. Brent CCG working with NHSE 2. NHSE to work with GPs on developing the Case Management Register		01/04/15 and ongoing

26. All GP practices to be encouraged to develop a flagging system to identify vulnerable adults.			1. Brent CCG working with NHSE 2. NHSE to work with GPs on developing the Case Management Register		All the Brent DHR cases were registered with GPs and issues regarding recording and flagging of domestic abuse were raised for General Practice.
27. During their next appraisal, GP performers involved will be required to reflect upon their responses to Domestic Homicide. This may include making changes to their clinical practice as a result of this DHR.	NHS England, London, Medical Directorate, Practitioner Performance Team	Regional and local	1. NHS England, London will ensure the performer's annual appraisal includes reflection on their responses to Domestic Homicide.	• Process for checking the appraisal content regarding DH reflection to be defined and implemented.	At next appraisal.
28. NHS England, London will circulate advice to GPs and practice staff on the use of interpreters who act in a professional capacity to ensure staff meet a professional standard with the intention to lessen risks associated with using relatives or friends as interpreters.	NHS England, London, Medical Directorate	Regional and local	1. NHS England, London will develop and collate a summary of guidance and advice for GPs and Practice Managers on good practice in	• NHS England, London CCG Assurance leads will be informed they have the	By July 2015

			recognition and response to domestic violence and abuse.	option to include evidence of commissioning of interpreter services, in their CCG Assurance meetings.	
29. NHS England, London will forward the Royal College of General Practitioners' (RCGP) 'Responding to Domestic Abuse: guidance for general practices (2012) to all GPs and Practice Managers commissioned by NHS England, London.	NHS England, London, Medical Directorate	Regional and local	1. NHS England, London will develop and collate a summary of advice and guidance for GPs and Practice Managers. It will incorporate the Royal College of General Practitioners' (RCGP) 'Responding to Domestic Abuse : guidance for general practices'[11] (2012). The summary of advice and guidance will also include information on NHS England's Responsibilities	• This will be circulated to all London based GP Practices and Practice Managers, commissioned by NHS England, London and will also be shared with the London wide LMC for information.	By July 2015

[11] http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/Clinical%20Priorities/Domestic%20Violence/RCGP-Responding%20to%20abuse%20in%20domestic%20violence-January-2013.ashx

			to Carers highlighted in May 2014 'Commitment to Carers' publication[12]		
30. Recommend a 'major alert' note on the front page of electronic notes (which should be closed down before the patient enters the room) which will indicate those at risk of domestic violence, or perpetrators of domestic violence.	NHS England, London, Medical Directorate	Regional and local	1. NHS England, London will develop and provide a summary of guidance and advice for GPs and Practice Managers on good practice in recognition and response to domestic violence and abuse.	• This will be circulated to all London based GP Practices and Practice Managers, commissioned by NHS England, London and will also be shared with the Londonwide LMC for information.	By July 2015
31. Highlight best practice for patient notes to feature the correct EMIS codes which will indicate domestic violence and abuse. Where such notes are archived, to ensure that coded notifications are transferred along with the notes.	NHS England, London, Medical Directorate	Regional and local	1. NHS England, London will develop and provide a summary of guidance and advice for GPs and Practice Managers on	• This will be circulated to all London based GP Practices and	

[12] http://www.england.nhs.uk/wp-content/uploads/2014/05/commitment-to-carers-may14.pdf

			good practice in recognition and response to domestic violence and abuse.	Practice Managers, commissioned by NHS England, London and will also be shared with the Londonwide LMC for information.	
32. All Staff to be offered refresher training in adult safeguarding including recognising vulnerable adults with an emphasis on domestic homicide and domestic violence.	North West London Hospitals Trust	Local	1. Training sessions	• Training sessions planned • Training commenced • Training complete	Sept 2014 November 2014 March 2015
33. All Trust staff to be offered refresher training in the MCA.	North West London Hospitals Trust	Local	1. Training sessions	• Training sessions planned – Ongoing • Training commence- November 2014 • Training complete	Sept 2014 November 2014 March 2015
34. All staff to understand DOLs process and MCA.	North West London Hospitals Trust	Local	1. Training sessions	• Training sessions planned Sept 2014 • Training commenced	Sept 2014 Novemb

				November 2014	er 2014
35. Best Interest Assessors to be named	North West London Hospitals Trust	Local	1. Training sessions	• IMCA assessors to be named and training completed by March 2015	March 2015
36. Domestic abuse should be considered in the context of the family or household, especially the impact on children	North West London Hospitals Trust	Local	1. To write to providers asking them to cascade the message 'think adult, think parent/carer' and the impact on children	• Letter sent to all providers • Message delivered to all health staff by health providers	October 2014 Decemb er 2014
37. To establish and fund a Safeguarding Team	North West London Hospitals Trust	Local	1. Post advertised and substantive teams in place	• In post and substantiv e	Complet ed by October 2014.
38. To provide supervision and development of the Adults & Children's Safeguarding teams	North West London Hospitals Trust, Clinical psychologis t	Local	1. Adults safeguarding supervision for staff on a regular basis, (using this case study to form a basis).	• To provide monthly supervisio n ad hoc.	January 2015.
39. The development of a risk assessment tool to assist staff in identifying adults at risk, especially where the adult does not speak English should be considered. This risk assessment tool should be a generic tool for all adults who present to the emergency department. This tool should be	North West London Hospitals Trust, Safeguardin g Team	Local	1. Design, embed into training and allow a period of time for the assessment tool to be evaluated and audited	• Adult Safeguard ing Lead and ICO Safeguard ing Lead	March 2015

incorporated in the North West London Hospital's NHS Trust Safeguarding Adults at Risk Policy (2013) and form part of the level 3 safeguarding adult training.					
40. To review screening tool for Adult Safeguarding to ensure Pan London and Brent's procedures are followed, checks on the system are completed and the records are updated appropriately.	Brent Adult Social Care	Local	Adult Safeguarding screening tool to be reviewed and updated	• Complete	Completed November 2014
41. To review the current recording policy to evaluate what can be recorded on an alleged perpetrators file	Brent Adult Social Care	Local	The case recording policy is to be reviewed in conjunction with Brent Legal Services and Information Technology department to establish what can be recorded on the alleged perpetrator's file. This is then to be built into the Safeguarding Adults Team process.	• Partially complete	December 2014
42. To incorporate a mini risk assessment for all safeguarding alerts (including allegations screened out of the process) to enable the professionals to identify any other potential vulnerable adults or children at risk.	Brent Adult Social Care	Local	Adult Safeguarding screening tool to be updated to include consideration of any children or other adults who may be at risk with details of action to take if people are identified. The Safeguarding Adults' computer system to be updated to confirm/confirm if there are other adults or children at risk.	• Complete • Complete	Completed August 2014 Completed April 2014
43. To create a Lado process for Adult Social Care Safeguarding	Brent Adult	Local	A referral process to be developed	• Complete	Complet

team to ensure any safeguarding concerns raised regarding professionals working with vulnerable adults is investigated and followed up in accordance with Adult Safeguarding procedures.	Social Care Brent Children's Social Care		between the Children's LADO service and the Safeguarding Adults Team.		ed February 2014
44. To develop a local Adult Lado protocol in Brent to further safeguard vulnerable adults	Brent Adult Social Care	Local	The Adult LADO process is to be developed in Brent. To attain sign up to Adult LADO process from all key partners / commissioners via Safeguarding Adults Board To publicise and provide expectations of process and referrals to providers of commissioned services by key commissioners in the borough Commissioners to monitor compliance via contract meetings with commissioned providers	• Ongoing	February 2015
45. To improve operational links with Children's services and Adult Safeguarding to encourage joint understanding and identification of potential children at risk and to develop understanding of Children's services of potential adults at risk. To complete awareness raising across departments.	Brent Adult Social Care	Local	A staff member from the Safeguarding Adults Team to attend MASH Team meetings and Children's Services Team meetings to raise awareness of potential adults at risk and the process thereafter. Staff roles and responsibilities toolkit relating to Safeguarding Adults to be shared with Children's Services staff.	• Ongoing • Ongoing • Complete	Decemb er 2014 Decemb er 2014 Septemb

			The Safeguarding Adults Duty Team to sit next to the MASH team to enhance joint working. To incorporate awareness of children's need with ASC staff in Team Mangers meeting and team meetings To monitor referrals between departments to measure improved joint working	• Complete • Ongoing	er 2014 September 2014 Feb 2015
46. To review Brent Adult Social Care's expectation on language interpreters and ensure this is cascaded to all Adult Social Care staff and adhered to.	Brent Adult Social Care	Local	To attain agreement from DMT regarding the use of interpreters To role out expectation to ASC staff team	• ongoing	December 2014
47. To ensure that the Reablement Team are aware of the importance of engagement with the customer to ascertain their view in relation to how their personal care is met and to ensure staff know where to refer for further support if they need assistance to communicate with adults with communication needs and cognitive disabilities	Brent Adult Social Care	Local	Include the topic in a team meeting with discussion forums. Facilitate discussion / practice forums regarding the topic	• completed	September 2014
48. To embed Mental Capacity Assessments and Risk Assessment tools into the case recording systems and develop good practice guidelines regarding Mental Capacity and Risk assessments and reviews and implement this across Adult Social Care.	Brent Adult Social Care	Local	All Adult Social Care Staff to participate in core skills training where Mental Capacity Act Assessments and Risk Assessments are included. Review and implement a new structure for training on mental capacity assessments To embed the assessments on the	• Completed • Review completed • Ongoing	December 2014

			FWi system		
49. To improve awareness of signs of abuse and adults and children safeguarding across Adult Social Care with the aim to increase proactive identification of safeguarding concerns.	Brent Adult Social Care	Local	A risk triggers tool to be developed to promote professional curiosity and assist staff in the identification of potential/actual harm relating to adults. Risk trigger to be rolled out at staff quarterly and then within practice forums with all ASC staff	• completed • planning stage	February 2015
50. SOIT Officers to submit intelligence at an earlier stage of the investigation rather than the conclusion.	Herts Constabulary	Local	1. All SOIT staff to be given additional training	• This has already taken place. Intelligence is now submitted early on in the investigation. However all the information regarding the arrest will now be on PND for all Forces to view whether he is charged or not.	Complete
51. To review the policy regarding data protection surrounding suspects arrested for sexual offences where vulnerable persons are at risk.	Herts Constabulary	Local	1. Liaison with Constabulary legal department regarding drawing up a policy		01/02/15

			surrounding possible justified breaches of data protection.		
52. Brent BOCU should remind officers of the importance of generating MERLIN records for children of persons coming to notice of police whether present or not at the incident (domestic violence/abuse).[13]	Met Police (MPS)	Local	1. Training sessions	• Training sessions on-going • Continuous training for front line responders and secondary investigators by way of General Investigation Professional Development Days being rolled out across the MPS.	On-going
53. The team manager should ensure that all team members are aware of the Brent Safeguarding procedures.	Brent School Admissions	Local	Team members access LSCB and Brent Council safeguarding procedures on line	• All staff report accessing protocols	November 14
54. Team members should access the level 1 and level 2 multiagency safeguarding training provided by the Local Safeguarding Children Board.	Brent School Admissions	Local	All team member book and complete the level 1 and level 2 multiagency safeguarding training provided by	• All staff trained	March 2015

[13] Since 2002 the MPS have made significant improvements in the way it responds to domestic abuse (DA). Regular reviews are made of the DA policy, processes and procedures to ensure they are appropriate and robust to support the identification and positive investigation of any domestic related incident. This includes:

- ensuring mandatory elements of the MPS Police and checklists are adhered to.
- That the protection and safeguarding of vulnerable adults and children are assessed in line with the Vulnerable Assessment Framework (VAF), and relevant Adult Coming to Notice (ACN) or Pre Assessment check (PAC for Children) records made on the MERLIN system.

			the LSCB		
55. Responsibilities for safeguarding should be included in all job descriptions.	Brent School Admissions	Local	Managers to include safeguarding responsibilities in all new job descriptions	• All new job descriptions contain safeguarding responsibilities	September 2015
56. The team manager should ensure that all team members are aware of the Brent Safeguarding procedures.	Brent Special Educational Needs Service	Local	Team members access LSCB and Brent Council safeguarding procedures on line	• All staff report accessing protocols	November 14
57. Managers should monitor whether team members have accessed the level 1 and level 2 multiagency safeguarding training provided by the Local Safeguarding Children Board. Retraining should be requested every 3 years.	Brent Special Educational Needs Service	Local	All team member book and complete the level 1 and level 2 multiagency safeguarding training provided by the LSCB. Training is monitored by management	• All staff trained • And retrained in 3 years	On going
58. Managers should check that the responsibilities for safeguarding are included in all job descriptions and induction programs.	Brent Special Educational Needs Service	Local	Managers to include safeguarding responsibilities in all new job descriptions and induction programmes	• All new job descriptions contain safeguarding responsibilities. • All induction programmes include safeguarding.	September 2015
59. During the statementing process, all notes and assessments from Educational Psychologists should be stored on the SENAS Tribal database.	Brent Special Educational Needs Service	Local	Managers to instruct team members to store all notes and assessments on the Tribal System	• All notes and assessments are stored on the system	October 2014
60. As part of the statementing process, SENAS should check social care involvement through	Brent Special Educational	Local	All staff are trained to use the	• All SENAS staff check all cases	January 2015

accessing the Framework I database.	Needs Service		Framework I system	referred on framework I for social care involvement and contact as necessary	
61-66. The Chair of Brent Community Safety Plan should write to ACPO, Home Secretary, National College of Policing, Secretary of State for Education, Secretary of State for Justice, University of West London and Nursing and Midwifery Council regarding issues raised in this review	Brent Community Safety	Local	To write letters regarding issues raised in this review	All letters to be written by June 2015	June 2015