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Chris Williams
Head of Community Safety and Public Protection
Community Services
London Borough of Brent

26 October 2015

Dear Mr Williams,

Thank you for submitting the Domestic Homicide Review report for Brent to the Home Office Quality Assurance (QA) Panel. The report was considered at the Quality Assurance Panel meeting on 23 September 2015.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel found this to be a thorough and robust report with a high level of analysis and which demonstrated sound knowledge of domestic abuse and sexual violence. The Panel particularly commended the chair and author for their resolve in obtaining information from an agency that initially declined, and which ultimately led to new lines of enquiry.

There were some aspects of the report which the Panel felt may benefit from further consideration, or be revised, which you may wish to consider before you publish the final report:

- The Panel suggested the gender and ages of the children should be removed to further increase anonymity;

- The Panel queried whether 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 action plan requires additional information. For example, there is no date of completion and outcome column. There are no actions in the plan for recommendation 11.

- The Panel queried whether the lack of robust action in following up the reporting of the perpetrator's inappropriate sexual behaviour at the Children's Centre in 2008 requires recommendation 3, for Children's Services, to be framed in such a way to

demonstrate that failure to deal with such incidents in future may result in disciplinary action being taken;

- The Panel noted the use of family members as interpreters and felt a recommendation around the possible risks associated with this may be useful;

- Please ensure the recommendations feature in the executive summary to allow it to be read in isolation;

- The Panel noted that a common feature with DHR reports from Brent is that they lack a front title page. The Panel asked if this could be addressed in this and future reports.

There were also a number of typing or other errors which you may wish to correct:

- Please proof read as the reports have formatting issues. For example, paragraphs 364, 370 and 382 have different line spacing compared to other spacing. The text size changes at the bottom of page 16, recommendation 3 section 7 and recommendations 28 to 31. Paragraph 3 (page 3) in the executive summary also has small text in one sentence.
- Paragraph 297 (page 57) line 3 – "be" should be "he".
- Paragraph 299 (page 57) – should be *Nursing* and Midwifery Council and not *Nurses* and Midwifery Council.
- Paragraph 143 (page 28) and paragraph 349 (page 66) – should "Islamia school" be "Islamic school"?
- Paragraph 469 (page 87) line 4 – "Had she have been recognised" – "have" not needed.

The Panel does not need to see another version of the report, but I would be grateful if you could include our letter as an appendix to the report when it is published.

I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR QA Panel

DOMESTIC HOMICIDE REVIEW

London Borough of Brent

Case of Penina Robinson

DOMESTIC HOMICIDE OVERVIEW REPORT – PENINA ROBINSON

CONTENTS

[1] Special Educational Needs Assessment Service

REPORT INTO THE DEATH OF PENINA ROBINSON[2]

Name	Age at the point of the murder	Relationship
Penina Robinson	64	Victim
Rizwan Ahad Ibrahim[3]	31	Son in law / Perpetrator
Elizabeth[4]	28	Wife of perpetrator and daughter of victim
Child 1[5]		First child of of Elizabeth and Rizwan
Child 2[6]		Second 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.

[2] Not her real name
[3] Not his real name
[4] Not her real name
[5] First child
[6] Second child

SECTION 1 - INTRODUCTION

1. This Domestic Homicide Review (DHR) report examines agency responses to Penina Robinson, a resident of London Borough of Brent, her son-in-law, Rizwan Ahad Ibrahim, and Rizwan Ahad Ibrahim's children up to the point of Penina's murder in October 2013.
2. The key purposes for undertaking DHRs are to:
    - Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
    - Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
    - Apply these lessons to service responses including changes to policies and procedures as appropriate; and
    - Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.[7]

About Brent

3. Brent is an outer London borough in north-west London with a population of approximately 312,000. It includes the areas of Kilburn, Wembley, Willesden and Harlesden. It is composed of industrial, commercial and residential land and includes Wembley Stadium within its boundaries. More than half of Brent's residents are from black and minority ethnic communities and it is recognised as one of the most ethnically diverse local authorities in the country[8]. It has relatively high levels of child poverty. Brent includes three parliamentary constituencies - Brent North, Brent Central, and Hampstead and Kilburn, which also includes part of the London Borough of Camden.
4. The crime rate in Brent is considered by the Metropolitan Police to be average for London. It has one of the highest crime detection rates in London[9]. In 2013, when Penina was murdered, there were a total of 6524 domestic violence reports made to the Metropolitan Police in Brent. Of these, 1984 were recorded as crimes with the remaining 4540 logged as non-crime domestic incidents. This was 14% above the London average (based on the total number of domestic incidents and offences recorded by the Metropolitan Police divided by 32 (boroughs covered)). In common with many local areas, Brent has a MARAC and an IDVA service.

Summary of the Case

[7] Home Office, 2011, Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, p6, https://www.gov.uk/government/publications/statutory-guidance-for-the-conduct-of-domestic-homicide-reviews
[8] http://www.londoncouncils.gov.uk/services/lept/boroughmap/brent/
[9] http://www.londoncouncils.gov.uk/services/lept/boroughmap/brent/

5. 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.

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

7. 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.

8. 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.

9. 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[10] (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.

10. 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.

11. 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.

12. Rizwan Ibrahim was arrested on suspicion of murder.

Post Mortem

13. On Saturday 19 October 2013, a Special Post Mortem was conducted on Penina at Northwick Park Hospital by Home Office Pathologist Dr Jerreat. The cause of

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

death was given as haemorrhage caused by blunt trauma to her lower body (anus and vagina).

Inquest

14. The inquest was opened and adjourned by Dr Walker on 31/10/2013 at North London Coroners Court pending police inquiries. As a result of Rizwan's conviction at the criminal trial, it was not resumed.

Court Dates

15. Rizwan Ibrahim went on trial in May 2014 with the jury finding him guilty of murder. He was sentenced to a minimum of 25 years.
16. He was also charged with sexual assault in relation to one of the patients at Northwick Park Hospital. The trial was scheduled to take place in August 2014. It was initially adjourned due to the ill-health of the victim. She later stated that she did not wish to proceed with the court case and the Crown Prosecution Service decided it was no longer in the public interest to pursue the case.

SECTION 2 - THE REVIEW

Decision to Hold a Review

17. When Brent Community Safety Partnership was notified of the murder, records were immediately secured and, in consultation with partners, a decision was made to instigate a DHR. The Home Office was duly notified on 14 November 2013.
18. Brent Local Safeguarding Adults Board did consider a separate Serious Case Review but agreed that the DHR was the most appropriate structure. The Board agreed to consider the report and its recommendations when it can be disseminated.
19. Children's issues were 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.
20. Davina James-Hanman was appointed as Independent Chair of the Review, with Hilary McCollum as report writer.

Convening the Panel

21. 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)
    - North West London Hospitals Trust
22. In addition, ADVANCE, a local voluntary sector agency working on violence against women and girls, was invited to join as a Panel member.
23. 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
    - NHS England (London)

Scope of the Review

24. Penina moved to LB Brent in 2009 from Fiji. This seemed an appropriate point at which to set the start of the scope for participating agencies in relation to Penina and her grandchildren. It should be noted that information gathered from interviews and several IMRs also covered earlier years.

25. At the time of the murder, Rizwan was on police bail regarding two allegations of sexual assault against two former patients, Ruth and Karen. There was a CRIS (Crime Reporting Information System) report regarding an alleged kidnap of a young girl in 2001 by Rizwan. At the time, police believed it was a malicious allegation, but given this history of alleged sexual offending, and the sexual nature of the assault which led to Penina's death, the Panel decided that the beginning of 2000 was an appropriate point at which to set the start of the scope for participating agencies in relation to Rizwan.

26. The panel decided to include the perpetrator's children's within the review to ensure that any learning relating to safeguarding children could be captured.

27. The Review considered agencies' contact/involvement with Penina and her grandchildren from 1 January 2009 and with Rizwan from 1 January 2000.

28. The panel received some information relating to the children that referred to the period prior to 2009. This is included in the report, where relevant.

Terms of Reference

29. The Review's terms of reference were agreed at the first meeting of the Review Panel on 4 December 2013 and are attached as Appendix 1. The areas for the review to consider were:

    <u>Specific Areas of Inquiry</u>

    Each agency's involvement with the following family members between 1 January 2009, or in the case of Rizwan Ahad Ibrahim 1 January 2000, and the murder of Penina Robinson on 18 October 2013 (all resident at Address 2):

    (a) Penina Robinson

    (b) Rizwan Ahad Ibrahim

    (c) Child 2

    (d) Child 1

    Whether, in relation to the family members, an improvement in any of the following might have led to a different outcome for Penina Robinson:

    (a) Communication between services

    (b) Information sharing between services with regard to the safeguarding of adults and children

    Whether the work undertaken by services in this case was consistent with each organisation's:

    (a) Professional standards

    (b) Domestic violence policy, procedures and protocols

    (c) Safeguarding adults policy, procedures and protocols

The response of the relevant agencies to any referrals relating to Penina Robinson, Child 1 and Child 2, concerning domestic violence or other significant harm from 01/01/09 and any referrals relating to Rizwan Ahad Ibrahim concerning domestic violence or other significant harm from 01/01/00. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

(d) The quality of the risk assessments undertaken by each agency in respect of Penina Robinson and Rizwan Ahad Ibrahim.

The training provided to adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done so as to safeguard and promote the welfare of children or vice-versa.

Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.

Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any special needs on the part of either of the parents or the child were explored, shared appropriately and recorded.

Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

Terms of Reference for the Child's Element of the Domestic Homicide Review

In relation to this Review the children are not identified as victims as specified in paragraph 3.3, 3.4 and 3.6 of the DHR Guidance. The primary role of this element of the Review in relation to the children affected is to highlight any learning from this case which would improve safeguarding practice in relation to domestic violence and its impact on children.

In particular the Review should identify whether there is any learning in relation to effective communication, information sharing and risk assessment for all those children's services involved in Brent Council and also any other agencies and local authorities. It should also highlight any good practice that can be built on.

Family involvement and Confidentiality

The review will seek to involve the family of both the victim and the perpetrator in the review process, taking account of who the family wish to have involved as

lead members and to identify other people they think relevant to the review process.

We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

We will identify the timescale and process and ensure that the family are able to respond to this review endeavouring to avoid duplication of effort and without undue pressure.

IMRs and Chronologies

30. Agencies were asked to give chronological accounts of their contact with the victim and perpetrator prior to the murder (see Appendix 2 for detailed chronology) and to complete an Individual Management Review (IMR) in line with the format set out in the statutory guidance.

31. The following agencies were asked to complete an IMR:

- Metropolitan Police
- Hertfordshire Police
- London Borough of Brent – Adult Social Services, Children's Safeguarding, School Admissions, Special Educational Needs Assessment Service
- North West London Hospitals Trust
- University of West London
- NHS Brent Clinical Commissioning Group (CCG) - General Medical Services
- Ealing Hospital NHS Trust - Adult community health, Children's community health
- Priory Nursing Agency & Homecare
- London Probation

32. The following schools that the children attended were asked to produce chronologies:

- Lyon Park School (produced IMR and chronology)
- Manor School
- Gladstone Park School

33. 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[11]. The three schools produced a chronology and additionally Lyon Park School produced an IMR**.**

[11] 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

34. 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.

35. 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[12] (DBS). The DBS initially refused to provide information to the Review Panel about the requested enhanced check, stating that, "we do not believe there is any specific legal provision to rely upon in order for DBS to provide the information requested." The DBS did provide information about the principles that it applies when making disclosures and, following the intervention of the Home Secretary, eventually provided information about the checks that had been carried out on Rizwan Ibrahim.

36. A total of thirteen IMRs, two additional chronologies and an agency interview (with Priory Nursing Agency and Homecare) were completed. 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
- Lessons learned
- Recommendations

37. 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.

Timescales

38. This review began on 4 December 2013 and was concluded on 26 September 2014. Nine meetings of the DHR Panel took place.

39. The review began within seven weeks of Penina's death and continued in parallel with the criminal investigation. The decision not to suspend the review process pending the criminal trial was made by the Chair in conjunction with the Senior Investigating Officer as it did not appear from the initial meeting and first draft chronologies/IMRs that the continuation of the review would prejudice the trial.

Parallel Investigations

[12] 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

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

41. 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

42. Regular attenders at the DHR panel were as follows:

Name/Job title	**Role/Agency**
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

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

44. All of the agencies were represented by senior staff who were independent of the case. The Panel contained a mixture of those who were IMR authors and those who were not. IMR authors attended those Panel meetings where their IMR was discussed.

45. In addition, to the IMRs/chronologies, interviews were undertaken with the following:

- Two carers from Priory Nursing Agency & Homecare who had been providing care services to Penina and who found her fatally injured on 18 October 2013;

- The manager of the two carers from Priory Nursing Agency & Homecare;
- Elizabeth (daughter of the victim and wife of the perpetrator).

46. The Chair wrote to Rizwan Ibrahim requesting his involvement in the review but did not receive a response.

Dissemination

47. DHR Panel members, Elizabeth, her sister, Lynn, and Fiona Ledden from LB Brent Legal Department have all received a copy of this report.

Confidentiality

48. The findings of this review are confidential and all parties have been anonymised. For ease of reading, the victim, perpetrator, the victim's daughter and her children, have been allocated alternative names.
49. Information has only been made available as described above. The report will not be published until permission has been given by the Home Office to do so.

Independence

50. This report was written on behalf of the DHR panel by the Independent Chair of the Review, Davina James-Hanman, and the Report Writer, Hilary McCollum.
51. Davina James-Hanman is the Director of AVA (Against Violence & Abuse), which she took up following five years at L.B. Islington as the first local authority Domestic Violence Co-ordinator in the UK. From 2000-08, she had responsibility for developing and implementing the London Domestic Violence Strategy for the Mayor of London.
52. She has worked in the field of violence against women for almost 30 years in a variety of capacities including advocate, campaigner, conference organiser, crisis counsellor, policy officer, project manager, refuge worker, researcher, trainer and writer. She has published innumerable articles and two book chapters and formerly acted as the Dept. of Health policy lead on domestic violence as well as being an Associate Tutor at the national police college. Davina has also authored a wide variety of resources for survivors.
53. She was also formerly a Lay Inspector for HMCPSI, acted as the Specialist Adviser to the Home Affairs Select Committee Inquiry into domestic violence (2007/08) and Chairs the Accreditation Panel for Respect. From 2008-09 she was seconded to the Home Office to assist with the development of the first national Violence Against Women and Girls Strategy. In recent months, her focus has been on improving commissioning and increasing survivor involvement in service design and development. Davina is also a Trustee of Women in Prison.
54. Hilary McCollum has worked for more than twenty-five years within the public and voluntary sectors on issues related to violence against women and girls. She has been a specialist adviser to the Cabinet Office and developed the draft London Violence against Women Strategy, *The Way Forward*, for the London Mayor. She was a member of the Metropolitan Police Force's Domestic Homicide

Review Group, the London Domestic Violence Steering Group and the London Safeguarding Children Board. Hilary has also worked on hate crime and led the formal inquiry into disability harassment for the Equality and Human Rights Commission, including preparing the final report, *Hidden in Plain Sight*.

55. Neither the Chair nor the report writer had any connection with the attending agencies.

56. This report was written in April-October 2014. It is based on:

- the Individual Management Reviews undertaken by:
  - Metropolitan Police
  - Hertfordshire Police
  - London Borough of Brent – Adult Social Services, Children's Safeguarding, School Admissions, Special Educational Needs Assessment Service
  - North West London Hospitals Trust
  - University of West London
  - NHS Brent Clinical Commissioning Group (CCG) - General Medical Services
  - Ealing Hospital NHS Trust - Adult community health, Children's community health
  - Lyon Park School
  - Willow Children's Centre
- chronologies provided by:
  - Manor School
  - Gladstone Park School
- information provided by:
  - the daughter of Penina Robinson
  - Priory Nursing Agency & Homecare

57. It also includes information provided by the DBS and comments on the DBS's reasons for declining to co-operate with the review until directed to do so by the Home Secretary.

58. None of the IMR report writers had contact with the victim or perpetrator or line managed anyone who did. Each IMR was signed off by a senior manager within the organisation. DHR Panel members were similarly independent.

Equality and Diversity Issues

59. 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. These were:

Age: Penina was 64 years old at the time of her murder. Rizwan was 31 years old. Over the course of the DHR, allegations emerged that Rizwan had sexually assaulted or behaved in an inappropriate sexual manner to women of a variety of ages.

Disability: Penina had a number of impairments following a stroke in 2009, including loss of speech in English (she had previously been bilingual in Rotuman and English), expressive dysphasia[13] and right sided weakness. Her level of impairment increased markedly from April 2013 reducing her mobility and independence. Carers visited daily from June 2013 until Penina's death in October 2013 to help with her care.

Both of Rizwan and Elizabeth's twin children have Attention Deficit Hyperactivity Disorder (ADHD). Child 1 also has autistic spectrum disorder and Child 2 has asthma.

Religion and belief: Rizwan was a Muslim, Penina was a Christian. Rizwan wanted his children to be educated at an Islamic school but his wife was opposed. At the time of Penina's death, LB Brent was making arrangements for the twins to attend an Islamic school at Rizwan's request. His wife was unaware of this. Child 1 reported at school that Rizwan had smacked him for speaking English rather than Arabic at home. Rizwan confirmed this account.

Ethnicity: Penina was a Fijian woman who had been bilingual in Rotuman and English prior to her stroke in 2009. Services relied on Elizabeth and Rizwan to interpret for Penina. Although Elizabeth was fluent, Rizwan spoke little Rotuman. Penina was never seen without other family members present and her wishes in terms of her personal care were never directly sought.

Rizwan was born in Somalia.

Rizwan and Elizabeth's twin children are of dual heritage.

Sex: There is extensive research to suggest that females are at a greater risk of being sexually assaulted than males.[14] The majority of perpetrators are men known to the victim.[15]

Involvement of Family and Friends

60. An interview was conducted with Penina’s daughter, Elizabeth.

Pen Portraits of Family Members

[13] Expressive dysphasia is difficulty in putting words together to make meaning

[14] For example, the Crime Survey for England and Wales found that females are more than five times as likely as males to have been a victim of a serious sexual offence (including attempts) in the previous 12 months (An Overview of Sexual Offending in England and Wales**,** Ministry of Justice, Home Office & the Office for National Statistics, 2013, p6, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214970/sexual-offending-overview-jan-2013.pdf)

[15] ibid, p16

61. ***Penina Robinson*** - the murder victim, Penina Robinson, was a Fijian woman who was 64 years old at the time of her death. Her daughter described her as a humble, caring and generous woman who was loved by everyone who met her. She was a kind and sweet individual who was often smiling and slow to anger. She was a Christian who enjoyed reading her Bible and went to Bible studies each Friday. A carer who supported Penina during the final months of her life said she was 'so nice, like a bigger sister to me'. The carer also said that Penina was a woman who was surrounded by love in her life. A doctor who treated her described her as a 'delightful lady'.

    Two of Penina's three daughters lived in Britain and in August 2009 she moved with her husband from Fiji to London. During the journey to London, Penina had a stroke which left her with a number of impairments including loss of speech in English (she had previously been bilingual in Rotuman and English), expressive dysphasia and right sided weakness. Following the stroke, Penina and her husband went to live with their daughter, Elizabeth, son-in-law, Rizwan, and their grandchildren, Child 1 and 2.

    Penina remained largely independent following the stroke and was the primary carer for her husband, who had dementia, until his death in 2012. Penina's level of impairment increased markedly from April 2013 and from June 2013 she received daily social care support. In the final six months of her life she experienced a number of falls and had periods of confusion that were considered to be linked to a series of urinary tract infections. Her mobility was markedly reduced in this period and she was largely confined to the ground floor of the house she shared with her daughter's family, other than to attend occasional hospital appointments.

    She was anally and vaginally raped on 18 October 2013 and died as a result of haemorrhage caused by blunt trauma to her lower body.

62. ***Rizwan Ahad Ibrahim*** - Rizwan Ahad Ibrahim, the perpetrator, is Penina's son-in-law, having married her daughter, Elizabeth, in December 2004. He was charged with Penina's murder on 19 October 2013. He was 31 years old at the time.

    Rizwan was born in Somalia before coming to Britain with his birth family. He worked in a number of roles including as a minicab driver, a temporary receptionist in a nursery and an administrator in a fostering and adoption service before beginning training as a nurse in September 2010. He received positive reviews at the end of both his first year and second year of the training.

    His relationship with his mother-in-law was generally viewed positively by professionals, however in the days prior to her murder at least two people noticed that Penina appeared to be uncomfortable in his presence.

    Following Penina's death, enquiries conducted by the police and other agencies revealed a number of incidents relating to his sexual behaviour including:

    - an alleged kidnapping of a 15-year-old girl in 2001 which had been believed to be malicious by police;
    - viewing pornography on the family computer in 2008 which prompted an argument with his wife;

- allegations that he had been ‘peeping’ at female staff and ‘masturbating’ in the toilets at the nursery where he worked in 2008;
- allegations that he had been having an affair with a 16-year-old girl in 2008;
- viewing pornography showing violent rape, gang rape and incest on his mobile phone and computer in the months before the murder.

At the time of Penina’s murder, Rizwan was on police bail to Hertfordshire Police for allegations of serious sexual assault on two victims committed in April 2013. The two victims had previously been patients at Northwick Park Hospital where Rizwan was a Trainee Nurse.

Since Penina’s murder, six females from within Elizabeth’s family have told her they were the victims of sexual touching by Rizwan.

He bought expensive penis enlarging tablets and visited the GP on at least five occasions with concerns about his penis. Elizabeth described him as having ‘a high sex drive.’

63. ***Elizabeth Robinson*** – Elizabeth is Penina's daughter and Rizwan’s wife. She was born in Fiji before moving to London. She married Rizwan in December 2004 when she was 18 and he was 22. She gave birth to twins in July 2005. She began training as a nurse after her children started nursery.
64. ***Child 1 and 2*** – Child 1 and Child 2 are Rizwan and Elizabeth's twin children. They are of dual heritage and were born in London in 2005. Both children were born extremely prematurely at 28 weeks and had a number of health and development issues as a result. Child 1 has autistic spectrum disorder and Attention Deficit Hyperactivity Disorder (ADHD); Child 2 has ADHD and asthma. Both children were in the next room at the time of Penina’s murder and overheard the assault.

Acknowledgments

65. The Chair of the Review would like to thank all members of the Review Panel for the professional manner in which they conducted the Review. The Chair also extends her thanks to the Individual Management Review (IMR) authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies. The Chair would like to thank Penina’s daughter, Elizabeth, for her willingness to participate in this review.

Condolences

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

SECTION 3 - CHRONOLOGY

67. A complete chronology of relevant agency involvement is attached at Appendix 2. Below are edited highlights of the most significant events.

February 2001 – November 2004

Rizwan alleged to have kidnapped schoolgirl; cautioned for cannabis possession and for having a knife

68. 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.

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

70. 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.

71. 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.

72. 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. Both these matters were recorded on his Police National Computer (PNC) record.

December 2004 - July 2009
Birth of twins; domestic incidents; Rizwan accused of 'peeping' and 'masturbating' at nursery; Elizabeth and Rizwan attend GP because of physical aggression to each other

73. In December 2004, Rizwan and Elizabeth got married.

74. On 23 July 2005, Elizabeth gave birth to the couple's first children, twins –Child 1 and Child 2. The twins were born extremely prematurely at 28 weeks and remained in hospital for more than four months. Both twins had multiple complex needs and ongoing health issues due to their prematurity, resulting in frequent admissions to hospital. In the period to July 2009, Child 1 had 18 separate episodes of care and Child 2 had 26 separate episodes of care at Northwick Park Hospital. The level of hospital admissions reduced over time, indicating better management of their conditions. The family also had ongoing contact with various community health services.

75. On 24 July 2006, the police were called by neighbours to an argument between Rizwan and his wife about a birthday cake for the twins' 1st birthday. Elizabeth threw away Rizwan's penis enlarging pills. The police advised both parties about

their future behaviour but took no further action as there had been no physical violence.

76. 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.

77. In autumn 2008, Rizwan began temporary employment at Willow Nursery. There is no evidence that an enhanced disclosure was carried out for this employment but as he was employed via an agency rather than directly it has not been possible to establish this conclusively.

78. 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.

79. 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.

80. He is believed to have gone on to gain employment as a senior administrator in a local authority Adoption and Fostering Service.

81. In December 2008, Elizabeth told a social worker that her relationship with Rizwan was 'rocky' due to the demands of the twins' health needs. In March 2009, Rizwan told a consultant community paediatrician that the family could not cope with the twins' behaviour.

82. In April 2009, a Consultant Community Paediatrician told a social worker that the children were not disabled and suggested their behaviour was as a result of inconsistent parenting.

83. 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. In June 2009, the Brief Psychological and Counselling Service rejected the GP's anger management referral stating that the issue was one of communication style difference between the couple and advising that the couple should attend Relate. The GP wrote to Rizwan suggesting that the couple should try Relate.

August 2009 – December 2010
Arrival of Penina and John; Penina's stroke; Rizwan hits Child 2; Rizwan starts training as a nurse; Rizwan's erectile dysfunction concerns

84. On 22 August 2009, Elizabeth's parents came from their native Fiji to live in Britain, where two of their three daughters were already settled. On arrival at the airport, Elizabeth noticed that her mother, Penina, was unable to speak in English (Penina was previously bilingual in Rotuman and English), unable to

walk properly and that her speech was slurred. Penina was admitted to Central Middlesex Hospital where she was diagnosed as having suffered a Cerebral Vascular Accident (stroke).

85. Penina 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, expressive dysphasia and right sided weakness but she remained largely independent, acting as the primary carer for her husband, who had significant health issues.

86. In September 2009, the twins started at Lyon Park Infant School. In May 2010, Child 2 disclosed at school that Rizwan had hit them. 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.

87. A paediatric medical report in January 2010 reported that both parents were students in the NHS *(Author's note – at this time Rizwan had applied to train as a nurse but had not yet been accepted)*. The report concluded that they were both warm and loving parents who had bonded well with both children. They had enhanced their parenting skills by attending a Strengthening Families Strengthening Communities course.

88. 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[16] 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 public place' in 2004. On disclosure of his cautions, he was referred to the University's Criminal Records Bureau (CRB) screening panel.

89. 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 stated that he was continuing to work to build a good reputation and better future for himself, referring to marrying his long term girlfriend, the birth of the twins and 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.

90. The CRB Screening Panel met on 12 April 2010 and decided to defer Rizwan's application pending further investigation, including a request for further

[16] 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

information from Rizwan. The form recording the outcome of the panel's decision was incorrectly completed referring to only one offence with the wrong date recorded and a decision of 'not allowed to proceed' instead of 'deferred pending further investigation'. Despite these recording errors, the University did proceed with Rizwan's application as a deferred one needing investigation.

91. 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 *(Author's note: the University's risk assessment form recorded that Rizwan had disclosed the offences on his UCAS form but they were not actually disclosed until he completed the University's Declaration for Suitability form on 5 March 2010)*.

92. On 5 July 2010, a University Administrator completed a new enhanced CRB check application form for Rizwan. Rizwan was allowed to start his nursing training in September 2010 as student's are permitted to begin their studies before the checks are completed but are not allowed to go into practice and have patient contact. On 10 December 2010, the University decided to offer Rizwan a place on the Advanced Diploma of Higher Education in Adult Nursing. According to the University (and subsequently confirmed by the DBS), his most recent CRB disclosure matched his declared cautions and revealed no other convictions, nor did the police 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). The passage of time since the last caution and the absence of any indication of a tendency to re-offend also influenced the admissions decision.

93. Also during 2010, both children were issued with a statement of special educational need (May 2010). Child 1 had been diagnosed as on the autistic spectrum and Child 2 was diagnosed with ADHD. Child 1 now met the criteria for a child with disability service. Elizabeth requested support through the direct payments service with recruiting after-school childcare as both she and Rizwan were intending to return to college in September 2010. Child 1 started at Manor School, a special needs primary, in September 2010, with Child 2 continuing at Lyon Park school.

94. Rizwan spoke to his GP on a number of occasions about erectile dysfunction. He first raised concerns on 3 July 2010 and was prescribed a drug treatment. On 26 July 2010 Rizwan phoned the GP regarding his erectile dysfunction treatment and was given a different drug. On 2 August 2010, he phoned the GP again and was offered another drug and the option of a referral to the erectile dysfunction clinic. Rizwan decided to try the new drug treatment first. On 23 August 2010, Rizwan contacted the GP again regarding his erectile dysfunction. He was in the process of moving house and agreed to seek referral to the erectile dysfunction clinic from his new GP.

January 2011 - December 2012
Penina experiences ongoing pain; Rizwan hits Child 1; John's death; Penina's first fall

95. In February 2011, Penina was prescribed Tramadol by her GP to relieve pain in her lower legs and feet. The pain had been gradually getting worse over the previous 18 months and was worse when walking. In May 2011 she had an injection in her right knee to relieve pain. In November 2011, Penina was again prescribed Tramadol for pain in her joints and over the next six months either Rizwan or Elizabeth rang approximately monthly for repeat prescriptions.

96. On 10 March 2011, Rizwan reported difficulties with penile erection to his new GP. He said that he could only sustain an erection for 20 minutes compared to 1.5 hours previously and that this was causing problems with his wife so he was now avoiding sex *(Author's note: In her interview for this review, Elizabeth said that the duration of his erections was not an issue)*. The GP referred him to a psychosexual counsellor.

97. In May 2011, Child 1 told his school that when they used English at home to say 'pardon' Rizwan had 'smacked' them. When Manor school called Rizwan, he confirmed that he had smacked Child1 on the bottom because he wanted Child 1 to use Arabic at home. This incident was not communicated to Children's Social Care.

98. 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.

99. Rizwan received a positive review at the end of his first year student nursing placement in July 2011. He also received positive reviews for his second year placements in 2012.

100. On 1 November 2011, Rizwan asked his GP to write a mitigation letter to the University as he was struggling to sleep due to the care needs of the children. He was advised to put this in writing and the GP duly wrote a letter to the University on his behalf. He made the same request in February 2012 but the GP indicated that the previous letter was sufficient. However the GP advised Rizwan to seek therapy for his stress.

101. In January 2012, Gladstone Park school admitted Child 2 with funding for extra support.

102. On 3 January 2012 Rizwan attended the GP practice with flaky skin to his penis, which appeared after intercourse. He was worried regarding spots and indicated that he had had previous sexual partners but not for the last seven years while he has been married. He was given a prescription and advised to attend the genitourinary medicine (GUM) clinic if it did not resolve. In February 2012, he told the GP that the GUM found nothing abnormal.

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

104. In May 2012, Penina's dose of Tramadol was increased. A few weeks later Penina attended the GP and was prescribed amoxycillin (a type of penicillin) for a persistent cough even though her records stated that she was allergic to penicillin. Elizabeth noticed the error and a different antibiotic was prescribed.

105. 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.

106. The following month, Penina was seen by occupational therapy. Rizwan assisted with interpreting Penina's views during the assessment, although he speaks little Rotuman. He declined the occupational therapist's suggestion of a second handrail on the staircase as he said the family was due to move to Lincolnshire in September. Penina appeared to support this. The occupational therapist suggested a four-wheeled walker to assist Penina with outdoor mobility, which was agreed.

107. Further repeat prescriptions for Tramadol for Penina were issued in July and August 2012. On 12 October 2012 Rizwan requested Tramadol for himself for headaches, which was refused. On 16 October 2012, the GP's records indicate that Penina's husband rang on her behalf requesting more Tramadol. Penina's husband was already dead and it is now thought that this request was made by Rizwan. This raises questions about whether all of the Tramadol was used by Penina. Two further repeat prescriptions were requested in December 2012 and then none until June 2013 when they were stopped by the GP.

108. In September 2012, Rizwan transferred from the Advanced Diploma of Higher Education in Adult Nursing at University of West London to the B.Sc. (Hons) in Adult Nursing.

January 2013 – October 2013
Penina's hospital admissions; Rizwan's alleged sexual assault of two former patients; Rizwan's arrest and suspension from University; response of agencies to allegations; Penina's deteriorating health

109. In January 2013, Elizabeth told Children's Social Care that Rizwan wanted to remove Child 1 from Manor school and transfer them to an Islamic school. She did not agree to this.

110. On 19 March 2013, Child 2 was treated at hospital for acute exacerbation of asthma and was discharged on the same day.

111. In March 2013, a woman called Karen was admitted as a patient to the hospital ward where Rizwan was a student. She remained in hospital for approximately five weeks. Rizwan and Karen became friends and exchanged phone numbers and texts.

112. 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. A week later, 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. *(Author's note: the Senior Investigating Officer who led the murder inquiry believes that Rizwan may have started sexually abusing Penina around this time. Elizabeth also thinks, in retrospect, that this may have been the case.)* Medical staff considered the

changes to be linked to a series of mini-strokes and the effects of a urinary tract infection. Her health deteriorated over the next six months up until her death.

113. On 16 April 2013, a woman called Ruth was 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.

114. Both Karen and Ruth were discharged on 23 April 2013.

115. On 30 April 2013, Ruth told Hertfordshire Police that Rizwan had sexually assaulted her. 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 (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, stroking her hand and asking to rub cream into her feet. He returned that evening and got her phone number, calling and sending frequent texts over the next few days.

116. 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.

117. On the same day (30 April) Ruth told her friend, Karen, about the alleged assault. Karen said that she had also been targeted by Rizwan. Later that day, Karen reported to Hertfordshire Police that she had been sexually assaulted by Rizwan. Karen alleged that Rizwan had orally raped her. Rizwan had allegedly taken her to an address, which he told her was 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.

118. 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.

119. On the same day, 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, the Deputy Director of Nursing at North West London Hospitals Trust informed the investigation team of details of a possible suspect identified as Rizwan Ahad Ibrahim.

120. 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. Police considered that Rizwan did not meet the threshold to be remanded in custody and he was released later that day on conditional bail until 27 June 2013 pending the completion of the police investigation. Rizwan's bail was subsequently extended twice pending forensic and telephone evidence and he was not reinterviewed until 9 October 2013.

121. The University of West London has stated that Rizwan was suspended on the same day as his arrest (2 May 13).

122. On 2 May 2013, Hertfordshire Police made a referral to the Notifiable Occupation Scheme. North West London Hospitals Trust made a safeguarding alert to Adult Safeguarding at London Borough of Brent (LB Brent), as the hospital where Rizwan was on placement is in 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.

123. Penina was discharged from hospital on 2 May 2013, coincidentally the same day as Rizwan's arrest. The discharge letter refers to out of character behaviour including frequent sexual comments.

124. On 3 May 2013, Child 2 attended an Outpatients appointment at Northwick Park Hospital.

125. On 14 May 2013, a Senior Practitioner from Brent's Adult Safeguarding 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. She also said that the perpetrator was due to go to court on 27 May 2013 *(Author's Note: this was incorrect, it was a bail return date not a court appearance and was on 27 June not 27 May)* and that no crime reference number was available but that it would be forwarded when available.

126. After Penina's discharge, she was initially cared for by her family. On 31 May 2013 she was unable to get out of bed unaided. 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) and reduced mobility. She was treated for a urinary infection and her Tramadol prescription was stopped. Rizwan told the doctor that the family was struggling to cope.

127. 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. Hertfordshire Police proceeded with their investigation into the allegations made by Ruth.

128. Also 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), which provides rehabilitation services to

patients, 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.

129. On 10 June 2013, a district nurse visited Penina to take a sample for a blood test at the request of the GP. The nurse was informed that Penina was not at home as she had gone to a hospital appointment. Ealing Hospital (acute unit) records show that Penina was seen in the out-patient clinic that day.

130. On 19 June 2013, a strategy meeting was held regarding the sexual assault allegations against Rizwan. It involved Hertfordshire Police, University of West London and North West London Hospitals Trust. No agencies from Brent, where the alleged perpetrator was living, were involved.

131. 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 (which she shared with Elizabeth and Rizwan and their children). 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 as Elizabeth and Rizwan were returning to work.

132. 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.

133. The following day, 2 July 2013, Elizabeth saw Child 1's class teacher at Manor school. She said that the family had recently moved house and that Penina was living with them after falling ill. Penina's changing needs meant that Elizabeth was spending less time with the children and their routines had been affected. She also told the teacher that Rizwan had started smoking and she was worried that this may affect Child 1's asthma.

134. On 8 July 2013, Rizwan contacted Brent Social Care's Fostering Team to request that he be assessed as a foster carer for looked after children in Brent. He was interviewed by a member of the fostering team as part of an initial assessment and his application was rejected.

135. 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. The morning bathing call from Gentle Care was put on hold until new hoist equipment could be delivered.

136. 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.

137. 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.

138. 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.

139. 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.

140. 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. On the same day, Rizwan brought Child 1 to a specialist paediatric review.

141. During August 2013, Rizwan was seen in hospital uniform at an outpatient appointment for the twins. It is not clear why he was in uniform as he had been suspended from University, his family were aware of the suspension and his details had been provided to the Notifiable Occupations Scheme so he should not have been able to work in a nursing related role through an agency.

142. 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 an assessment of the use of the hoist equipment (9 September 2013), an equipment review (13 September 2013), a review of the use of the hoist (26 September 2013) and reviews of manual handling (20 and 30 September 2013).

143. On 3 September 2013, Rizwan contacted the Special Educational Needs Assessment Service (SENAS) to request that both twins be given places at Islamic school. Elizabeth was unaware of this request but had previously told Children's Social Care that she was opposed to the children going to an Islamic school.

144. On 9 September 2013, the GP discussed concerns about Penina's falls with Rizwan and separately with the STARRS service. 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.

145. On 25 September 2013, Penina's care package was increased to two carers to enable the hoist to be used safely. On 30 September 2013, following the review of manual handling, Adult Social Care decided to withdraw the other equipment. On 2 October 2013, Elizabeth requested that the equipment collection should be put on hold but this was denied due to safety issues. The

Senior Occupational Therapist and Occupational Therapist from Adult Social Care planned to visit alongside Priory Care on 18 October.

146. 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.

147. On 14 October 2013, Penina celebrated her 64th birthday.

148. 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.'

149. At around 8pm that evening (18 October 2013) one of Penina's carers arrived at the family home to provide care to her. She noticed that the twins were sitting in the living room and that someone had walked from Penina's room into the kitchen and shut the door behind them. On entering Penina's room, the carer found a large amount of blood on the floor and could hear Penina moaning. Penina's chair was in a reclined position. The carer asked Rizwan what was going on. She noticed blood on his top, which he said, was a curry stain.

150. 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 her chair was now in an upright position and that most of the blood on the floor had been cleaned.

151. Police officers and the London Ambulance Service (LAS) both arrived at the same time. The LAS went straight into Penina's room and began their treatment of her. Police went into the kitchen and noted Rizwan had blood on his clothes and was cleaning work surfaces. They found blood stained rags in the laundry basket. Another laundry basket was recovered from the garden containing blood stained towels within. Officers found the twins sitting in the living room. One of the child told police they had heard shouting and screaming and something like 'get off' coming from their grandmother's room.

152. Elizabeth then arrived at home early from work after being contacted by the carer. LAS continued to work on Penina who became unresponsive. She 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.

153. 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.

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

155. 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.

SECTION 4 - INDIVIDUAL AGENCY RESPONSES

156. A detailed chronology of agency contacts is provided at Appendix 2. In the accounts that follow, agency involvement has been summarised to focus on those contacts of most significance to the DHR.

NORTH WEST LONDON HOSPITALS' TRUST

Summary of involvement regarding Penina

157. Penina arrived in Britain from Fiji in August 2009 and was immediately admitted to Central Middlesex Hospital with a confirmed cerebrovascular accident (stroke) experienced en route. As a result of the stroke she lost her fluency in speaking English. Throughout her contact with hospital and other health services over the next four years, she was never seen alone and never communicated with in her own language through an independent interpreter. She became reliant on her daughter and son in law for access to health care and support with activities of daily living. Although the quality of treatment for presenting health issues was often good, underlying social and domestic issues were not explored and, at times, 'care' was intrusive including depriving her of her liberty and conducting a lumbar puncture without due process. She was not identified as an adult who was potentially at risk of harm from her son-in-law. She was socially isolated and essentially had an unheard voice in the UK healthcare system.

Key events regarding Penina

158. In August 2009, Penina was admitted to Central Middlesex Hospital with a confirmed cerebrovascular accident (stroke) experienced en route from Fiji to London. The CVA rendered her unable to speak English where she had previously been fluent. Penina was a native Fijian and remained able to communicate in Rotuman. Penina was admitted to hospital for a total of 20 days following her CVA. She was noted to have expressive dysphasia, (difficulty in communicating). The medical records made no reference to how this diagnosis was obtained. Documentation was clear that Penina's family, primarily her daughter Elizabeth, was used to translate and extrapolate information regarding her health and wellbeing.

159. Penina was noted to be the sole carer for her elderly husband, John, at the time of her arrival in the UK. There was no reference to Penina's ability to care for her husband, and limited documentation about Penina's ability to care for herself post CVA. Penina was reviewed at regular intervals following her discharge from hospital regarding her CVA and was noted to be making satisfactory progress. She was referred to the speech and language service for assessment and ongoing support.

160. Over the years 2009-13, Penina had multiple attendances at Northwick Park Hospital regarding speech and language service, neurology, orthopaedic services and the emergency department for recurrent falls and complex medical challenges. It was noted that Penina had communication difficulties, language barriers and expressive dysphasia. Health care staff used Penina's family to interpret or extrapolate information regarding her health and well-being and to plan care. There is no evidence that Penina was ever spoken to by any health professional independently of her family.

161. On 5 April 2013, Penina presented to the emergency department at Northwick Park Hospital having suffered a fall at home. There is no documentation as to who had accompanied Penina or how staff were able to understand or extrapolate the information they needed to make an assessment.

162. A week later, Penina presented again to the emergency department with acute shortness of breath, breathlessness on exertion and a recent fall. She was admitted to the Coronary Care Unit, her physical conditions were treated and controlled and her condition stabilised. On admission to the ward the Registered Nurse allocated to care for Penina did a full admission assessment, which included full skin integrity check. The nurse noticed an old bruise on Penina's right thigh and also a blister on her right hand. The nurse documented her finding, which is good practice. Penina was reviewed by the attending doctor who associated the bruising and blister with Penina's fall one week previously. The same doctor also noted that Elizabeth had administered morphine to Penina just prior to her admission. On review of the emergency admission record it was noted the GP had prescribed Penina morphine for pain management after a recent bout of falls.

163. On 13 April 2013, a student nurse documented that Elizabeth had told her that Penina struggled to get herself out of bed or to reposition herself once in bed. On discussion Elizabeth agreed to have some mobility aids. The student nurse asked Elizabeth if Penina would benefit from home care and documented Elizabeth as denying the need for it.

164. On 22 April 2013, Penina was discharged home to the care of Elizabeth at the family address, given as Address 2. *(Author's note: there were inconsistencies in agency records about where members of the family were living at various times. At this time, Elizabeth, Rizwan and their children were recorded as living at a different address nearby. By the end of June 2013, Penina, Elizabeth, Rizwan, Child 1 and Child 2 were all living at Address 2, which is where the murder took place).* The following day, Penina was taken to the family GP by Elizabeth who was concerned that Penina was confused and making inappropriate sexual comments, which was out of character for her. The GP referred Penina to the emergency department at Northwick Park Hospital. She was admitted for a total of seven days and eventually diagnosed with a urinary tract infection following an array of examinations including a lumbar puncture. The side effect of the infection caused confusion and aggression, which was noted as attempting to hit and bite staff. Penina was reported to have removed her cannula with her teeth; the staff struggled to cope with her aggression and insisted a security guard was present at all times. This practice is used as a last resort. As the infection cleared, the aggression diminished along with the confusion.

165. The question arose during this review whether placing a security guard outside Penina's bedroom door was in fact a deprivation of her liberty by inhibiting her freedom of movement. Deprivation of Liberty Safeguards (DOLS) are part of the Mental Capacity Act and aim to make sure that people are only deprived of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them. The hospital guidance on DOLs states that the care manager must consider the circumstance in which placing an application for a DOL is in the best

interest of the patient and a DOL should be avoided if there is a less restrictive option.

166. The placing of a security guard outside Penina's room was to safeguard staff from Penina's aggressive behaviour and to promote Penina to stay within the room to reduce the risk of infection to other patients. Penina was known to be infectious, the origin of which remained unknown at that time. 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.

167. On 24 April 2013, Penina was given a mini mental capacity test in which she scored 1/10. Any patient who has a mini mental capacity test and scores poorly should have the test repeated; a second poor score should have initiated a referral to the Psychiatric Liaison Team for follow up and referral. There is no evidence in the medical records that a subsequent test was performed or that any referral was made to have Penina assessed in more depth.

168. On 25 April 2013, Penina underwent a lumbar puncture, which is an invasive procedure that required her to have a general anaesthetic; the doctor performing this procedure used an Adult Consent Form 4, which essentially allows the doctor to act in the best interest of a patient who lacks capacity. There was a lack of documentation on the form, the only entry on the form was the doctor's signature, and it is unclear from the form itself if this was the consent form used to perform the lumbar puncture procedure. Entries made in the medical records by the anaesthetist questioned the issue of consent. In order for the patient to be identified as lacking capacity, a mental capacity test should have been undertaken and, where necessary, repeated. The appropriate process was not adhered to regarding referral to the Psychiatric Liaison Team. This would have been an opportunity for staff to identify what capacity and understanding Penina actually had, what she was capable of understanding and a window of opportunity to explore the sexualised comments she was reported to have made. Due process was not followed and the lumbar puncture procedure went ahead without regard to consent and a capacity to consent. As such, the conduct of the lumbar puncture was unlawful.

169. Penina was discharged on 2 May 2013. On 1 July 2013, she was seen at an outpatient appointment in the neurology clinic at Northwick Park Hospital. This appointment was a follow up for possible frontal lobe activity due to the change in Penina's behaviour, essentially aggression and confusion, during Penina's admission to Northwick Park Hospital (23 April – 2 May 2013). A recent Electroencephalography (EEG, which records electrical brain activity) demonstrated no epileptic activity, but Penina's Epilim medication, which controls epilepsy, was increased. Penina was kept on this higher dose of Epilim. She was also noted to have had recurrent falls and that her carers who attended her three times daily were struggling to cope with her increasing comprehension difficulties. Penina was reported to be excessively frightened on waking from sleep and being restless in her sleep. On assessment Penina struggled to follow basic commands, appeared disengaged and vague, her recent brain imaging demonstrated excessive white matter changes consistent with her

cerebrovascular risks. The neurology team had an impression of developing cognitive impairment. A suggestion was made for an urgent referral to the mental health memory clinic; in the meantime Clonazepam (sedative) was prescribed.

170. On 10 July 2013, the GP referred Penina to the falls clinic.

171. On 19 July 2013, Penina presented to the emergency department via London Ambulance. Her presenting problem was confusion and falls. She was accompanied by Elizabeth. Whilst in hospital the STARRS team was asked to review Penina and an assessment was undertaken. The STARRS nurse documented (incorrectly) that Penina lived in a house alone and noted the suggestion of a referral to the memory clinic. The STARRS nurse also documented that she communicated with Penina who responded well speaking a mixture of English and Rotuman and understood basic verbal instructions. Penina was reviewed by the doctor on duty who noted STARRS were unable to make an assessment at that time due to the language barrier and needed to wait until Penina's daughter was present to translate and assess if it was safe to discharge Penina home.

172. On 28 August 2013, Penina did not attend an appointment with the falls clinic. Penina's daughter had cancelled this appointment stating difficulty in transporting Penina to the clinic. Elizabeth requested a domiciliary visit.

173. The documentation by the falls clinic team is the last noted entry of Penina's contact with the health service at Northwick Park Hospital. As mentioned previously, there is no evidence that Penina was ever spoken to by any health professional independently of her family and no use of professional interpretation services to ascertain her needs and wishes despite documentation of her difficulties in communicating in English.

174. Penina had undergone invasive medical procedures such as a lumbar puncture without due process regarding consent and had failed a mini mental capacity test, which was not repeated. Care was not individualised or tailored around Penina's holistic needs. Rather it centred on her physical medical presentation.

175. Windows of opportunities to have explored social and domestic arrangements were missed. There were no discharge planning meetings, no evidence of communication between the acute or community services which triggered any concerns or points for further discussion with a multi-disciplinary team.

Summary of involvement regarding Rizwan

176. North West London Hospitals Trust provided placements for Rizwan during his nursing training with University of West London. After being alerted to allegations that he had sexually assaulted former patients, the Trust responded promptly in identifying the alleged perpetrator and assisting police in his arrest. However a safeguarding alert regarding Rizwan was made to Brent Adult Social Care when it should have been made to Hertfordshire Adult Social Care. It appears that the detail provided in the referral was inadequate although North West London Hospitals Trust dispute this, suggesting that the referral was properly completed but did not reach the safeguarding threshold. The risk that Rizwan posed beyond healthcare settings was not properly considered by agencies with a responsibility to safeguard adults at risk.

Key events regarding Rizwan

177. Rizwan applied to access Adult Nurse Training at University of West London in 2010 and was admitted to start training following an investigation regarding two cautions. Rizwan completed his 1st and 2nd year nurse training quite uneventfully, undertaking placements with North West London Hospitals Trust. He met expected learning and practice standards in his first two years and continued into his third and final year of study in September 2012.

178. On 1 May 2013, Hertfordshire Police contacted the Deputy Director of Nursing at North West London Hospitals Trust, regarding allegations that two former patients had been sexually assaulted. The Deputy Director of Nursing informed the investigation team of details of a possible suspect identified as Rizwan Ahad Ibrahim and he was arrested at Northwick Park Hospital the following morning with the co-operation of the hospital. Rizwan had met and cared for the victims whilst working as a student nurse. He was suspended from his training course by the Dean of the University. Due to the seriousness of the allegations, University of West London and North West London Hospitals Trust agreed to suspend Rizwan until the police investigation was complete.

179. On 2 May 2013, the Deputy Director of Nursing made a safeguarding alert to Brent Adult Safeguarding. Although the hospital where Rizwan was undertaking his placement, and where he met the patients, is in Brent, the alleged incidents were in Hertfordshire and the referral should have been made to Hertfordshire Adult Social Care. On 14/05/2013, Brent Adult Safeguarding requested further information by email. The Deputy Director responded the following day confirming that she had asked the Matron from Northwick Park Hospital to forward a safeguarding referral and informing Adult Safeguarding that the perpetrator was due to go to court on 27 May 2013. *(Author's note: this was incorrect and appears to have been confused with his police bail return date of 27 June 2013).*

180. 2 May 2013 was the last day Rizwan presented to Northwick Park Hospital in his student nurse capacity. No further interactions with Rizwan have been noted or recorded until the Deputy Director of Nursing at Northwick Park Hospital was notified by the police that Rizwan had been arrested for sexually assaulting and murdering Penina.

Summary of involvement regarding the twins

181. There was extensive hospital contact with both twins. They were born prematurely at the Whittington Hospital on 23/07/2005, hospitalised for a total 129 days and known to have complications of prematurity with respiratory distress syndrome of the new-born being a major complication. Numerous presentations were made to hospital and the focus was on dealing with the immediate presenting medical problem. Risk assessments should be conducted routinely on admission to emergency care but out of 48 emergency presentations, a risk assessment was conducted only once.

Key events regarding the twins

182. Between 2005 and 2009, Child 1 had a total of 19 separate episodes of care at Northwick Park Hospital due to his complex health needs as well as usual childhood aliments. From 2010-2013, Child 1 had eight episodes of care at Northwick Park Hospital. Six episodes were presentations with breathing

difficulties and exacerbation of asthma; he was seen, treated and discharged promptly from the emergency department. His last presentation to the emergency department at Northwick Park Hospital was on 1 June 2012. The remaining two episodes of care are reported as routine follow up appointments with a Consultant Paediatrician. All his admissions were directly related to his chronic respiratory problems or normal childhood aliments.

183. Child 2 had a total of 27 separate episodes of care at Northwick Park Hospital all due to the complex health needs and usual childhood aliments from 2005 until 2009. Between February 2009 and March 2013, Child 2 had 15 separate episodes of care at Northwick Park Hospital. In nine of the 15 episodes of care, Child 2 was presented with breathing difficulties and exacerbation of asthma. Child 2 was admitted to Northwick Park Hospital children's ward on two occasions during this time frame; on seven occasions Child 2 was seen, treated and discharged home the same day. The last presentation to the emergency department at Northwick Park Hospital was on 19 March 2013. The remaining six episodes of care were noted as routine follow up appointments with the Paediatric Consultant and physiotherapy team. All Child 2's admissions were directly related to the chronic respiratory problems or normal childhood aliments.

184. During these dates there were no triggers in the emergency department regarding safeguarding concerns for children who frequently attend for treatment. The family had a card, which enabled quick access to A&E as a result of the twins' ongoing health issues. The children were not perceived as children at risk and there was minimal and inadequate documentation regarding the risk assessment on presenting to the emergency department on each admission for both children. Admission documentation contains a risk box to prompt staff to ask or think about risk. Child 2 had a total of 27 emergency presentations and only one risk assessment was completed. Child 1 had a total of 21 emergency presentations and never had any risk assessments completed.

185. Information about these multiple attendances was not shared with the Children's Community Health Service.

ADULT COMMUNITY HEALTH SERVICES

Summary of involvement

186. Penina received services from the Short Term Assessment, Rehabilitation and Reablement Service (STARRS), District Nurses and Continence Nurse. As discussed in relation to North West London Hospitals Trust, much of the care was good but adult community health services failed to adequately address Penina's communication difficulties and relied on family members to interpret and provide information for her. She was discharged from adult community health services several times due to not responding to letters requesting contact despite known language and cognition issues. There were issues of co-ordination between hospital and community based health services with home appointments booked at times when Penina was due to be at hospital. On at least one occasion, however, it appears that community based services were told that Penina was at the hospital when there was no record of any appointment. Records are not always clear about who in the family professionals have been in contact with. There are references to superficial sores and skin tears on Penina's

bottom which were addressed as pressure sores or as resulting from a fall. A possible link to sexual assault was never considered. Adult Community Health Services were not aware of the sexual assault allegations against Rizwan and this may have influenced their perceptions.

Key events

187. On 16 May 2012 a letter was sent to Penina requesting that she contact the STARRS team and arrange an appointment. This followed a referral from her GP for an occupational therapy assessment. As no response was received by the STARRS team, Penina was discharged from the waiting list on the 8 June 2012. Although this process followed the guidelines that are in place in the STARRS service, no attempt was made to establish who her next of kin was and to contact them to secure an appointment. Penina had difficulties communicating, both verbally and in writing but the referral did not indicate this. The referral did not mention her mental capacity, hence it was not known at that time if she was able to communicate and agree to an appointment (although it would have been assumed that if she did not have capacity that this would have been detailed in the referral).

188. On 18 June 2012, a new referral was received by the STARRS team for physiotherapy assessment. The team telephoned the patient's home, which was answered by a man who confirmed that Penina was able to attend as an outpatient. An agreement was reached to contact Penina once an appointment was available. The name of the person who answered the telephone call was not recorded.

189. On 4 July 2012 Penina attended the Physiotherapy Out-Patient Clinic and was assessed by the physiotherapist. There is no record on either the referral form from the GP or on the assessment form to indicate that Penina did not speak/understand English and would have required an interpreter. Based on the assessment Penina was able to respond to basic commands that enabled an assessment of her mobility. The plan recorded in the notes included a follow-up session in two weeks' time and a referral to Speech and Language Therapy as Penina was found to have difficulty in communication. The assessment does not state if Penina had mental capacity or what her first language was.

190. On 11 July 2012 the Occupational Therapist (OT) visited Penina at home and completed an assessment. Rizwan was present and assisted with interpretation (he spoke little Rotuman but interpreted her gestures). The GP had not outlined Penina's communication issues on the referral form. Had this been done a visit with an interpreter could have been arranged. When the OT found that Penina had communication issues, a follow-up visit should have been arranged with an interpreter and with Elizabeth (as next of kin) to discuss the care plan and adaptation options. The OT, in interview for the review, stated that they believed Penina was able to understand the discussions and proposals. The OT offered a second rail on the staircase but Rizwan declined it, stating that the family was moving to a bungalow in Lincolnshire in September. The OT also suggested a four-wheeled walker to assist Penina with her outdoor mobility and this was accepted.

191. On 10 August 2012 Penina failed to attend an Out-Patient appointment for physiotherapy. Although the STARRS team were aware of Penina's communication difficulties, they relied on letters and telephone calls to contact

Penina. No attempt was made to contact Elizabeth. Penina was discharged from the service on 25 October 2012.

192. On 10 June 2013 the GP referred Penina to the District Nursing Service for a blood test. A registered nurse visited and was informed by the patient's son-in-law that Penina had gone to a hospital appointment. Ealing Hospital (acute unit) records show that Penina was seen in the out-patient clinic that day.

193. On 18 June 2013 a Continence Nurse visited Penina at home to carry out an incontinence assessment. The assessment was completed. Elizabeth was present and interpreted. This was a delayed visit as the referral from STARRS was received by the Continence Department in April 2013. An appointment had been offered for Penina to attend the Continence Clinic at Wembley Centre for Health and Care but Elizabeth phoned to request a home visit as Penina was now housebound.

194. On 18 July 2013 Penina was visited by a District Nurse who carried out a full assessment in the presence of Penina's daughter. A mental capacity assessment was not carried out. This is not routinely done by the District Nurses unless there is a safeguarding concern and/or a need identified to establish a patient's mental capacity. At this stage Penina was able to respond and act on basic requests to which she shook her head appropriately to say "yes" or "no". The nurse did not have any concerns regarding Penina's care.

195. On 29 July 2013 a registered nurse visited Penina. Her son-in-law was present and he stated that Penina had been found on the floor the previous morning. The son-in-law left the room. On examination, the nurse found a superficial skin laceration on Penina's bottom. She cleaned and dressed the wound. The nurse did not identify any concerns at the time of this visit.

196. On 5 August 2013 there was a planned visit by the district nursing service. The visiting nurse was informed that Penina was not at home as she was attending a hospital appointment. The nurse did not document who gave her the information but remembers that the son-in-law answered the door. As part of this IMR process it has been established that Penina did not have a hospital appointment on this day at either Ealing Hospital or North West London Hospitals Trust.

197. On 12 August 2013 Penina was visited by the district nursing service. Penina's wound on her bottom had healed and a week later Penina was discharged from district nursing care.

198. On 18 October 2013 Penina was visited by a registered nurse following a referral from the GP to the district nurse service. The nurse completed the assessment document in the presence of Penina's daughter and examined the wound on Penina's upper left thigh. The daughter stated that the wound may have developed due to friction. The nurse assessed and dressed the wound. Penina was found to be bedbound at this time which indicated deterioration in her condition from the previous visits. This was the last visit by the district nursing service.

199. No safeguarding concerns were identified by the STARRS, District Nursing or Continence Services.

GENERAL PRACTITIONERS

Summary of involvement

200. Two GP practices provided services to family members. The GPs were generally responsive and made any onward referrals promptly. However a presentation regarding conflict between the couple led to a referral for anger management, which is contra-indicated in situations of domestic violence. No referral was made to Children's Social Care. Other agencies failed to inform the GPs of key developments, including the two recorded domestic incidents and the allegations of sexual assault against Rizwan, leaving them to act in the dark. Penina's confidentiality was breached on at least one occasion, with information shared inappropriately with Rizwan. There are some examples of inadequate record keeping. As with other health providers, Penina was never seen on her own and independent interpreters were never used so her views and needs were never assessed directly.

Key events 2000 - 2005

201. In the five years prior to the birth of the twins, there is nothing of significance to this review to report in relation to Rizwan's contact with the GP practice.

July 2005 – August 2010

202. The twins were born at twenty-eight weeks gestation and had a variety of illnesses related to their prematurity. The twins' health needs were managed within secondary care leading to a situation where the majority of the care being delivered by the GPs was preventative in the form of childhood vaccinations and seasonal influenza vaccinations.

203. In April 2009, Rizwan and Elizabeth attended the GP. The couple indicated they were having trouble controlling their anger. The issues were said to be long standing but had recently turned to physical aggression. When the GP asked, the couple said this aggression was not directed to the children. They both described themselves as having short tempers since childhood and indicated they were now unable to control this. It was thought by the GP to be related to the stress of looking after twins with medical problems. The GP indicated that he would discuss this with the Health Visitor and refer the couple for anger management from the Brief Psychological and Counselling service. The Brief Psychological and Counselling service rejected the referral, saying that the issue was one of communication style difference between the couple and advised that the couple should attend Relate as the service did not offer relationship counselling,. The GP wrote to Rizwan indicating the decision and gave advice on the Relate service with contact details.

204. Anger management is contra-indicated for domestic violence. When interviewed as part of this review, the GP stated his view was that this was a couple coming for help in managing their anger. He stated that if there had been any serious injuries he would have documented these. He also stated that he had considered the children, hence his documentation that the couple's anger was not directed at the children. The GP was of the opinion that the couple were being very proactive in seeking help for this issue. He would not have coded this as an active problem within health records as he considered there was no definitive diagnosis. He felt the referral and flagging this up with the Health Visitor

was appropriate as there were no other concerns. He indicated he felt he had two options at that time, either to alert the health visitor or to speak to the Child Safeguarding Lead. In view of no previous concerns he opted to contact the Health Visitor who was GP attached and he knew well. The GP should also have alerted Children's Social Care. The GP contacted the Health Visitor but there was no communication between the Health Visitor and the GP regarding this issue in the following weeks. The overall GP response in this instance indicates a need for further GP guidance and training.

August 2009 – August 2010

205. Following Penina's Cerebral Vascular Accident (CVA/stroke), she was discharged from hospital with a care package that included speech and language therapy. She was cited as the carer for her 82 year old husband. In March 2010 a letter from Neurology outpatients indicated her speech and her right sided weakness had improved as a result of the care she had received and that neurologically she had made a good recovery. During this period Penina had a number of additional health needs which led to regular contact with secondary care services. The GP had little involvement other than to prescribe as directed.

206. In July 2010 Rizwan attended the GP with erectile dysfunction. The GP prescribed recognised treatments and recognised that there may be a need for secondary care. However due to the family moving house, and at Rizwan's request, a referral was not made for specialist input at this point. This lack of referral meant that the presenting problem was not coded on the GP system and was not addressed until Rizwan raised it with the new GP practice in March 2011.

August 2010 – October 2013

207. In February 2011, Penina attended the new GP practice with Elizabeth. This was her first appointment following registration six months earlier. She was reviewed with regards to her previous CVA and swelling in her left ankle. He prescribed Tramadol and paracetamol and arranged for Penina to be reviewed annually with regards to her CVA.

208. Penina was seen again three weeks later, accompanied by Elizabeth, with worsening pain in her lower legs and feet. The GP made an appropriate referral to a vascular surgeon. Over the following year Penina was seen approximately every three months with arthralgia of multiple joints and was appropriately referred to Orthopaedics. Rizwan or Elizabeth contacted the surgery on an approximately monthly basis for repeat prescriptions of Tramadol. Penina's medication was reviewed in May 2011 and again in November 2011 which was good practice.

209. On 23 May 2012, Penina was prescribed Amoxycillin for a cough. Her daughter contacted the GP the following day to inform them Penina was allergic to Penicillin. This had the potential to be extremely serious if Elizabeth had not recognised the error. The GP indicated this was not on the system and apologised, however there is an entry under 'active problem' on the previous GP's records dated 6 July 2010 stating adverse reaction to Penicillin. This information was transferred to the receiving GP's record so the GP should have been aware of it.

210. Penina's first reported fall was on 7 June 12 and the GP made prompt and appropriate referrals to Occupational Therapy and Physiotherapy for rehabilitation and to ensure safety mobilising. From 8 April 2013 until her death there were increasing numbers of falls and increasing amounts of confusion. During her hospital admission from 23 April 2013 to 2 May 2013, Penina was said to be acting out of character, was aggressive and was making inappropriate sexualised comments and exhibiting inappropriate sexualised behaviours. Penina had a urine infection at this point and confusion is a recognised symptom. Rizwan was arrested around this time following allegations of serious sexual offences. There is no correspondence within the records to indicate this was known to the GP and so they were not prompted to think anything other than that these behaviours were illness related.

211. Following these admissions, Penina had further falls and was seen in A&E as well as home visits being requested. In June 2013 Rizwan informed a locum GP that the family were unable to cope. The GP made appropriate referrals for carer support, and for an additional assessment from the occupational therapist and STARRS, however there was no assessment of Penina's mental capacity. Social care provided a care package, however Penina continued to have falls.

212. At an appointment with the neurologist on 1 July 2013, Penina was found to be vague and somewhat disengaged; she was found to have extensive white matter changes consistent with her known vascular risk and she was believed to be developing significant subcortical cognitive impairment. Her daughter was present and these changes were recognised as having an impact on both her and her carers' lives. An urgent referral to Mental Health Memory clinic was appropriately made and the review of medication at this point was also appropriate.

213. The GP had contact with Rizwan on 9 September 2013 regarding the number of falls Penina was having. Although GPs were responsive to Penina's increasing care needs, there is no record that a full assessment was conducted of the levels of stress created within the family home. The following day, the GP contacted Rizwan suggesting a visit from the community Occupational Therapist. During this discussion, Rizwan queried why Penina had been prescribed doxycycline and was informed it was her treatment for latent syphilis. In an interview for this review, the GP stated she was aware that Penina had been accompanied to her previous appointment and believed the family were aware of her diagnosis. Although Penina lived in the same house as Rizwan and he often accompanied her to medical appointments it was his wife, not Rizwan that was identified as Penina's next of kin within her records. Penina had not specifically authorised the GP to share information with Rizwan and she had not been assessed as lacking capacity at that time. The GP was of the opinion she was sharing information on a need to know basis in line with GMC guidance[17] but this view is open to challenge.

214. The GPs stated that at no time during their involvement with any of the subjects did they suspect there was any abuse. Latterly a locum was involved in Penina's care; in interview she stated she had received safeguarding children training including training on domestic violence and MARAC, she had however no specific training for safeguarding adults.

[17] General Medical Council. (2009) Confidentiality. London: General Medical Council

215. Penina was always seen in the company of either her daughter or Rizwan, she had dysphasia and struggled with her language skills having lost a good amount of her English when she suffered a CVA. These factors meant she was never seen by any member of GP staff on her own; there are no entries indicating the wishes and feelings of Penina.

216. Through interviews, the GPs indicated that Elizabeth came across as a very confident nurse. She was viewed as caring and was believed to be acting in her mother's best interests. She never approached the GP's indicating any difficulties in caring for her mother, except when adaptations were required on the property. The GPs stated they viewed Rizwan in the same vein although one GP described him as "a bit cocky".

217. The couple worked shifts and it was not unusual for either of them to attend with Penina. The GPs indicated they saw no change in demeanour of Penina dependent on who accompanied her. The GPs indicated they saw Rizwan as a concerned and caring son-in-law although the second GP stated she felt the couple over-played their status as nurses. Penina was never deemed to require an advocate. Although Elizabeth and Rizwan were acting as carers for Penina, this wasn't recorded in the practice's carer register or in Rizwan's records.

218. The chronology demonstrates evidence of good communication and information sharing between health services particularly at points of admission and discharge for the two children and for Penina. However, a lack of information sharing between external agencies and the GP practice meant the practice was unaware of police involvement in domestic violence incidents in 2006 and 2008, nor were they aware of the serious allegations of sexual assault made in April 2013. Although there is no specific protocol for GPs relating to the Brent MASH (Multi-Agency Safeguarding Hub), GPs follow the Working Together 2013 guidance[18] and share information with the MASH on a case by case basis.

219. The GPs indicated that if they had known of the serious sexual assault allegations in April 2013 they would have acted differently. The minimum that would have happened would have been a discussion at the weekly clinical meeting where safeguarding children, domestic violence and safeguarding adult cases are standing items on the agenda. Penina was never discussed at this weekly meeting until after her death as she was not recognised as a vulnerable adult at risk of harm. *No Secrets* (2000)[19] guidance places a responsibility on agencies and the professionals working for those agencies to safeguard adults who are deemed vulnerable, defined as someone:

"who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".

[18] HM Government (2013) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* http://www.workingtogetheronline.co.uk/documents/Working%20TogetherFINAL.pdf

[19] Department of Health (2000) *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* London, Department of Health

220. Although there is no record that her mental capacity was assessed in her GP records, she was known by the GP to have periods of confusion (in April and July 2013 during hospital admissions and on at least one clinic visit); to face communication barriers; to be housebound and in receipt of a care package. As such, she met the *No Secrets* definition of a vulnerable person but GPs did not treat her as such and, in common with other health and social care agencies, did not consider whether she was potentially at risk of harm and in need of safeguarding.

221. Nevertheless, the information known by the GP practice means there were no obvious points when they could have reasonably been expected to make a safeguarding adults referral.

CHILDREN'S COMMUNITY HEALTH SERVICES

Summary of involvement

222. Children's Community Health Services had extensive contact with the family, linked to the children's health needs following their premature birth. Families with twins meet the health visiting service criteria to receive an enhanced level of service regardless of whether the twins have complex health needs but there is no evidence that assessments considered this. Elizabeth and Rizwan faced some significant health and developmental challenges with their children and needed to manage appointments for asthma, autism spectrum disorder, attention deficit hyperactivity disorder, prematurity, speech/language delay and other related appointments. There were issues with the family not attending health appointments in 2008 and 2009.

223. Children not attending appointments is a theme within Serious Case Reviews and may be an indication of neglectful parenting. There are examples of good practice in clearly documenting where and when the family had failed to access appointments, whether the parents had acknowledged receipt of appointments and how these were communicated to the referring agencies. However, there is no evidence to suggest that the non-attendances were communicated to the health visiting or school nursing service. The case has highlighted the need for the health visitor, school nurse or GP to be informed even if they were not the referring professional.

224. There are some issues in relation to record keeping. The birth notification gave the mother's name as Elizabeth Robinson and showed details of her as a one-parent family, housewife, living at an address in the Edgware area. The notification had no information on the father.

225. Penina's name does not appear on any of the children's clinical records reviewed, suggesting that children's community health services were not aware that she lived at the same address. There is no evidence that services were aware that from August 2009, Rizwan and Elizabeth were also caring for Elizabeth's parents and the impact that this might have on the family. There was a lack of communication about the family with health visiting and school nurse services.

BRENT ADULT SOCIAL CARE

Summary of involvement

226. Penina was known to Adult Social Care from 2009, both in relation to her own social care needs and those of her husband, John. From June 2013, Adult Social Care provided support to Penina as a result of a number of falls and her deteriorating health. A number of assessments were carried out during this period but Penina was rarely seen alone and independent interpreters were never used to ascertain her needs and wishes. Nevertheless, the quality of the care that Penina received appears to have been good, her carers developed a rapport with her and the level and type of support was responsive to her changing needs.

227. Adult social care received a safeguarding alert from North West London Hospitals Trust in May 2014 regarding allegations of sexual assault against Rizwan. They failed to either redirect the referrer to make this alert to Hertfordshire Social Care, who should have led the safeguarding response as the alleged offences took place in Hertfordshire[20], or to secure sufficient details to follow the alert up themselves. As a result, Rizwan's risk to Penina was not assessed and professionals who came into contact with the family between the date of the notification (2 May 2013) and Penina's murder (18 October 2013) were not alert to potential signs of abuse. Despite meeting the *No Secrets* guidance definition of a 'vulnerable person', her risk of harm from others was not identified or considered in her care planning.

Key events

228. Adult Social Care assessed both Penina and her husband, John, in 2009 and provided basic bathing aids. In 2010, Adult Social Care were involved in registering John on the visual impairment register and in providing a care package to meet his social care needs. At that time, Penina and John were living with Rizwan and Elizabeth and their children at their previous address. Penina is recorded as the main informal carer for John up till his death in March 2012 and was offered a carers assessment in relation to this.

229. On 02/05/13, the Deputy Director of Nursing at North West London Hospitals Trust sent Brent Adult Safeguarding team an alert about Rizwan's alleged sexual assaults of hospital patients. It appears that the email did not contain the names or any other details of the victims. The alleged perpetrator was named in the email, however both the first name (Rizwam) and surname (Ibrahm) were spelt differently than in Adult Social Care records (Rizwan Ibrahim). Inconsistent spelling of names between agencies can cause difficulties in identifying the right individual and agencies should also provide date of birth and address where possible to allow triangulation.

230. The Pan London Safeguarding guidance indicates that safeguarding referrals should be screened within 48 hours but no response to the alert was made until 14 May 2013 when a Senior Practitioner within Brent's Adult Safeguarding Team emailed the Deputy Director of Nursing requesting further information. The Deputy Director of Nursing responded the same day confirming that she had asked the matron from Northwick Park Hospital to forward Brent a safeguarding

[20] Under the Pan London Safeguarding procedures, the responsibility to refer to the appropriate authority and agency lies with the referrer (in this case, North West London Hospitals Trust, who have signed up to Pan London procedures). However good practice would be for Brent Adult Social Care to redirect the referrer if referred inappropriately.

referral and that the perpetrator was due to go to court on 27 May 2013. *(Author's note: as mentioned previously, this information was incorrect.)* In a further email the following day, the Deputy Director of Nursing said that there was no crime reference number at present and this would be forwarded when it was known.

231. Although North West London Hospitals Trust maintain that the referral was sent, there is no evidence that it was received by Brent Adult Safeguarding team. When the referral was not received, Brent Adult Safeguarding should have followed it up. This did not happen.

232. The crime was known to have taken place in Hertfordshire. *No Secret's* guidance requires that the local authority where the alleged incident took place is responsible for taking the lead in the safeguarding investigation. The Senior Practitioner from Brent's Adult Safeguarding Team should have redirected this referral to Hertfordshire Social Services for screening, appropriate safeguarding procedures and to ensure that the Disclosure and Barring Service had been informed, as Rizwan was a student nurse. This did not happen.

233. Adult Social Care took no further action when the referral form was not received from Northwick Park Hospital. North West London Hospitals Trust maintain that phone calls took place and that Adult Social Care agreed that the referral did not meet threshold. The follow up to this alert was not robust and did not satisfy obligations as set out in the Pan London Safeguarding policy. The Pan London Safeguarding guidelines would expect that as part of the referral process the risk to the alleged victims was assessed in addition to a risk assessment of people the alleged perpetrator had access to and other possible victims. This would include other vulnerable adults and the risk to children the alleged perpetrator has contact with.

234. At this time, Penina was not known to Brent Adult Social Care as a vulnerable adult as she was not in receipt of a care package. However she probably would have met the definition of a vulnerable adult as someone "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation". Penina had recently been released (on 2 May 2013) from hospital following a fall. During her hospital stay, she had failed a mini mental capacity test, been subject to a deprivation of liberty and had a lumbar puncture performed in her own best interests without her consent. She continued to have expressive dysphasia and difficulties in communicating. During an earlier hospital stay, a student nurse had suggested that Penina might need home care services.

235. Brent Adult Social Care could not identify Rizwan on their system due to the difference in spelling between the alert and their records. Even if they had been able to identify him, their records at this time would not have indicated that Penina was vulnerable or that she was living at the same address as Rizwan. Their records for Penina related to the period when Penina's husband had been in receipt of services at a different address.

236. Within six weeks of the alert, Penina was in receipt of social care services and her correct address was registered on Brent Adult Social Care systems. However no information had been recorded on the adult social care IT system

(FWi) as a result of the alert which might have acted as a trigger for action once she was in receipt of care services. This was due, at least in part, to the fact that the FWi system is organised on the basis of potential victims and not potential perpetrators making it difficult for Adult Social Care to record and manage risk when there is not a named vulnerable person living within Brent but there is a named potential perpetrator living in the borough. As a consequence of this review the Adult Safeguarding team are working with their IT department to devise a means of flagging alleged perpetrators of abuse against vulnerable adults so that this information is more readily available in the future and decrease the dependency on information being made available by the police and Disclosure and Barring Service. The ability to record the alleged perpetrator on Adult Social Care records could improve the prevention of abuse.

237. On 6 June 2013 Rizwan referred Penina for an assessment from Adult Social Care services. A referral was also received from STARRS Rapid Response Team to the Reablement Team on 7 June 2013. Although these referrals both related to Penina it is notable that they gave different addresses for Penina's residence - STARRS provided the address where Penina had lived with her husband; Rizwan gave the current address. At the initial point of assessment it was determined that she was residing with her daughter, Elizabeth, and son in law, Rizwan at Address 2. Reablement service provision was provided on 10 June 2013 in line with procedure for STARRS Rapid Response directly referring to reablement services. A review of this service was made on 27 June 2013. No correlation to the previous allegations against Rizwan was made at this time as this had not been recorded on the client database FWi.

238. From 10 June 2013 Penina received a domiciliary care package from Social Care - initially reablement via Health Vision, then enhanced reablement provided by Gentle Care and then a care package provided by Priory Care. Penina was visited by the Occupational Therapist and Care Assessor several times during this period, and was observed transferring and managing her personal care to enable the Occupational Therapist to demonstrate equipment. During those visits Penina's family members were present, including Rizwan on several occasions. On one occasion he was the sole family member present. Throughout all the visits completed by professionals from Adult Social Care no signs of abuse were identified.

239. There were some incidents where concerns regarding Penina's care support were raised:

- On 4 July 2013, Elizabeth contacted Adult Social Care to complain about the enhanced reablement service provided to Penina. The service had been moved from a reablement service to the enhanced reablement service on 30 June 2013, which had involved a change of provider. A review took place on 8 July 2013 to explore Elizabeth's concerns and offer solutions. This resulted in the morning personal care support being put on hold for one week until bathing equipment was delivered. During the visit it was established that Penina's preference was to have a bath as opposed to a strip wash. The method that Elizabeth used to get Penina into the bath was not safe for the enablers or Elizabeth but did not pose any moving and handling risks to Penina. It was established that Rizwan was assisting Elizabeth with manoeuvring Penina into the bath and was present whilst Penina was bathing. Whilst it appears he was not involved in washing Penina,

there is no evidence that the workers explored with the family whether it was appropriate for Rizwan to be involved with the personal care. Independent interpreters were not used on this, or any other, occasion to ascertain Penina's wishes directly. The workers were not aware of any safeguarding risks in relation to Rizwan's involvement in Penina's personal care at the time and did not identify any indications or evidence to suggest that Penina was at risk or suffering abuse.

This is an area to be addressed with the reablement team, as it is good practice that the provision of personal care either by formal or informal carers is explored with the assessed person to ensure they are comfortable with the support. There should also be consideration to the person's capacity to make this decision and appropriate best interest decisions recorded if the person lacks capacity. There was no evidence of a mental capacity assessment completed throughout the reablement team's involvement.

During the IMR process, the Care Assessor from Brent Adult Social Care who was involved in the case indicated that Penina lacked capacity to make decisions regarding her care. The Care Assessor did not record this assessment or complete the necessary best interest decision-making process, which could have helped identify any safeguarding risks.

- On 23 July 2013, a joint visit with the enablers was abandoned after being unable to gain access. This was due to the key not being present in the key safe. It later transpired that the key had been taken out by Elizabeth, who explained to the Occupational Therapist that Penina had woken early and was badly soiled, therefore Elizabeth had bathed her and she had not wanted the enablers to go in and bathe her again. The enablers would gain access via a key safe, as usually there was no one else present in the property. Penina had expressive dysphasia and cognitive needs and would not have been able to communicate that she had had a bath to the enablers. The Occupational Therapist called Elizabeth in line with the Brent No Replies policy and informed her of the risks to Penina if the key is taken out of the key safe. There were no similar incidents following this. The enablers confirmed that the key had been returned to the key safe by the lunch call.

  The Occupational Therapist did not raise any further concerns at this time as the reasons Elizabeth had for withdrawing the key were adequately explained, although Elizabeth was advised that in future she should call to cancel appointments if required. As the visit was prevented by a family member and considering Penina's communication difficulties and cognitive needs a review of her wellbeing and risk assessment on the following visit would have been good practice to rule out the possibility that the family were attempting to hide abuse or injuries from external professionals.

- On 2 October 2013 Elizabeth was recorded to have refused collection of equipment. This appears to have been due to a preference for Penina to continue to use weight bearing transfer equipment when the Occupational Therapist had advised that this was currently unsafe following the manual handling assessment on 30 September. The Occupational Therapist reassessed this on 18 October 2013 and accepted that Elizabeth's refusal was to enable Penina to maintain less intrusive manual handling techniques for as long as possible. A plan for manual transfers was agreed with the Occupational Therapist, Care Agency and family

where either method of manual handling was available to Penina depending on her abilities on the day.

- On 18 October 2013 during a routine assessment regarding manual handling the Senior Occupational Therapist had remarked on the difference between this visit and the previous visit when Rizwan had been present. The Senior OT reported that the carer responded to this to say that 'Penina is uncomfortable with personal care when Mr Ibrahim is around'. At this time, the Senior OT was unaware of the outstanding allegation against Rizwan, had no information that he posed a risk nor that he had been involved in the personal care of Penina. The Senior OT did not attribute significant concern to this comment and did not make any further enquiries at the time. If they had known about the previous concerns, the Senior OT would have made further enquiries with the carers in regards to this comment to risk assess the situation in terms of potential safeguarding.

PRIORY NURSING AGENCY & HOMECARE

Summary of involvement

240. Priory Nursing Agency & Homecare Ltd is a privately owned independent care agency providing a range of care and support services. The agency provided daily care to Penina from 5 August 2013 up until her death. Initially one carer was allocated for 14 hours per week. This was increased in mid September to one carer for 19.25 hours per week and then to two carers from the last week of September onwards to enable the safe use of the hoist. The carers appear to have developed a good rapport with Penina.

241. Two of Penina's carers (carer 1 and carer 2) were interviewed as part of the review process.

242. Penina would joke and talk with her carers. The carers confirmed that there was a language issue. Penina could speak English but it was difficult when she got agitated and would speak in her own language. The carers tried to encourage her to get walking again and to promote her independence. Usually Penina was ready waiting for the carer. She would use the commode before going to bed. She would go to bed after lunch.

243. Rizwan would often give Penina food before the carers would come. He was always around during care visits and would brief the carer about what had happened each day.

244. Carer 1 had no suspicion of any ongoing issue and was shocked about what had happened. Carer 2's impressions of Rizwan were also good. He would go and get Penina medication if she was running out. It never crossed the carer's mind that he could do something like this.

245. Carer 1 described Penina as being surrounded by love. If Elizabeth was out, other family members would take turns in supporting Penina.

246. Penina was living downstairs in the period before her murder but it is unclear for how long this arrangement had been in place. Carer 2 felt that something might have been going on since Penina moved downstairs.

247. When they were washing Penina the carers noticed that she might ‘be dry or have a rash’ in her genital area. This was not identified as a possible indicator of sexual abuse and referred to safeguarding.

248. In the last few days before Penina’s death, she was saying she wanted to go home, back to Fiji. On the day of the murder, when the carer went in she was speaking in her own language. Carer 1 was part of a discussion that morning in which the senior occupational therapist said Penina seemed to be a bit nervous around the son-in-law. The carer recalled that Penina sort of had nervousness around him in the later days. This was not identified as a possible indicator of abuse and referred to safeguarding.

249. Neither carer witnessed any previous abuse against Penina.

METROPOLITAN POLICE

Summary of involvement

250. There were no identified police incidents involving Penina and Rizwan. However the police had contact with Rizwan in relation to allegations against him prior to his relationship with Elizabeth and were called to two domestic incidents involving Elizabeth and Rizwan. Without conducting a full investigation (Rizwan was not interviewed), the police believed that an allegation against Rizwan of kidnapping and false imprisonment of a 15-year-old girl in 2001 was a malicious allegation and took no further action. This had a knock on effect in terms of other agencies not considering Rizwan as a potential risk. Police investigations into two domestic incidents were proportionate but risk assessment forms and Merlin references were not always completed. Neither the alleged kidnapping and false imprisonment nor the domestic violence incidents were disclosed when an enhanced CRB disclosure was requested by the University of West London via the Criminal Records Bureau, resulting in Rizwan being admitted to train as a nurse. The Metropolitan Police were not alerted by Willow Children’s Centre or Brent Children’s Social Care about Rizwan’s alleged sexually inappropriate behaviour at Willow Nursery, nor were they alerted by Hertfordshire Police to the sexual assault allegations made against Rizwan even though he was resident in London and Hertfordshire Police made a search of his home address in Brent. This left the Metropolitan Police unsighted in relation to a potential sexual offender.

Key events

251. In February 2001, a 15-year-old female victim attended a local police station with her uncle where she alleged she’d been approached by an unknown male who asked if she wanted to go home with him. She had refused. The suspect then attended the victim’s school a few days later, grabbed her by her coat and told her to come with him. He told her not to scream but that if she did he would kill her with a knife that he then produced. He took her to various locations on the bus then to an address where he took a photograph of her. On walking to the bus stop the suspect was approached by the victim’s mother. He ran off.

252. The allegation was reported on the day after the alleged offence had taken place. A full description was taken from the female victim and her uncle provided

details of the suspect, later recorded as Rizwam Ibrahim,[21] who was 18 years old at the time. The family wanted him warned. CCTV enquires and further enquires with the school and bus company were undertaken but no evidence was found to corroborate the victim's account. There appeared to be inconsistencies in her story. The suspect's home address was visited. He was not there but his mother explained that the uncle had in fact stolen items from her son. The victim was further challenged about her account where she confirmed she did not wish for the matter to be further investigated. The allegation was then closed as it was believed by the police to be malicious. No further police action was taken.

253. *Author's note: Whilst efforts were made by the police to investigate this allegation, the suspect, Rizwan, was never interviewed. The investigation cannot, therefore, be considered as being full and complete. The police appear to have given undue weight to the assertion by Rizwan's mother that the girl's uncle had stolen items from her son. On receipt of this information 'the victim was <u>further challenged</u> about her account' (author's emphasis), and decided she did not wish for the matter to be pursued. No evidence is presented to support the belief that the allegation was malicious other than that the police could not find corroborating evidence. This is insufficient to establish that the allegation was, in fact, malicious. No further action was taken. The police believe a different approach would be taken now and that Rizwan would have been arrested and interviewed*.

254. Information about this allegation was not shared with any other agency until after Penina's murder. It was not disclosed by the police as part of an enhanced CRB check requested by the University of West London when Rizwan applied to train as a nurse (see below).

255. In July 2006, the police were called by neighbours who could hear Elizabeth and Rizwan arguing. This is the first occasion a domestic incident was recorded. On arrival Elizabeth was in the bath. Both were spoken to separately and denied any other incident had taken place. They had argued over a missing cake for a party held the previous day (the birth date of their twins). Elizabeth said the argument had 'got out of hand' and she had got so angry she had thrown away Rizwan's expensive 'penis enlarging' pills. This enraged him whereby he'd thrown a cup on the ground. Both confirmed neither had been violent towards the other and that it was a 'stupid argument'.

256. Both were advised about their future behaviour. It was suggested by police Rizwan should leave and stay the night at his mother's home to calm down. He agreed and police left after Rizwan had left the family home. The 124D risk assessment was recorded as having been completed. However there is no mention of the initial grade of risk assessment on the police crime reporting systems.

257. The investigation was allocated to specialist staff within the Community Safety Unit (CSU) at Kilburn Police Station. Following intelligence searches they noted no previous incidents had been recorded for the couple. A telephone message was left for them offering a point of contact with Borough Operational

[21] Rizwan Ibrahim's name was recorded on this occasion as 'Rizwam Ibrahm'

Command Unit (BOCU) CSU. A standard CSU letter was also sent. No further action was taken in relation to this matter and the incident was closed.

258. It is not clear why no primary or secondary risk assessment was completed and recorded within the CRIS report. A referral was not made to a specialist domestic violence service, as required by the protocol in place in Brent at the time. Further, there is no mention of the children, or a MERLIN reference recorded. Since the introduction of *Every Child Matters* in April 2008 it is mandatory for a MERLIN to be generated and sent for the attention of other statutory agencies.

259. In March 2008, the police were called by Rizwan to a second domestic incident. He had locked himself in the family bathroom, alleging Elizabeth had assaulted him. On arrival she explained that whilst using the family computer she had noticed the browser history indicated a number of pornographic web sites had been visited. She confronted Rizwan about this which resulted in them arguing. She alleged he then pushed her onto the bed and would not let her go. When she was eventually able to walk out of their room, she alleged he punched her right shoulder and continued to assault her, at one point striking her using a full length mirror.

260. Injuries were seen on Elizabeth and photographs taken. There were signs of a disturbance with a broken window noted in the bathroom. Rizwan alleged he had been assaulted by his wife. However he was arrested for Common Assault. It was recorded they had two young children. A MERLIN reference was generated for them and sent to Social Services two days later.

261. Rizwan was interviewed by specialist staff from the CSU at Kilburn Police Station. He admitted he'd looked at pornography sites on the family computer and had forgotten to delete the history. When this was found by his wife she had become very angry which had resulted in them arguing. He alleged she had assaulted him. He denied assaulting her in any way and was too embarrassed to make any allegation about her behaviour due to him visiting the pornography sites. He also stated she had anger management issues he was trying to get her to address via their GP. Rizwan was noted to have scratch marks and other injuries. Following consultation with a Detective Sergeant a decision was made to take no further action against Rizwan. The rationale was that he had called police, had injuries consistent with self defence, had given a full account, his wife was unwilling to assist with any prosecution, and there was insufficient evidence to pass the threshold for CPS advice. The allocated Investigating Officer conducted detailed intelligence enquires from 1998 to complete the secondary risk assessment, which they assessed as 'standard'. They identified the domestic incident of 2006. The investigation was conducted according to the procedures and processes in place at that time.

262. The University of West London requested an enhanced check from the Criminal Records Bureau in July 2010 in relation to Rizwan's application to train as a nurse. It took some time for the Panel to identify the Metropolitan Police's role in this process. An enhanced CRB disclosure (now an enhanced DBS disclosure) is made up of two parts:

i. Criminal records, centrally held on the Police National Computer (PNC) - managed by the CRB (now DBS)

ii. Other information held by police force(s).

263. The CRB would have dealt with part (i) itself and would have approached the Metropolitan Police (and potentially other forces) in relation to part (ii) to check whether any information was held locally which was relevant to the role and which ought to be included on the certificate. Under Section 113(B) of the Police Act 1997 the CRB would play no role in deciding whether any information held by the police was relevant to the application and ought to be disclosed (this is also the case for the DBS). That decision would be made by the police force, in this case the Metropolitan Police Service, taking into account guidance and case law. The CRB/DBS would then include the information disclosed by the chief officer in the certificate.

264. The CRB provided the University of West London with the enhanced CRB disclosure certificate relating to Rizwan in November 2010. It identified only the cautions in relation to cannabis possession and possession of a blade that the CRB would have been aware of from the PNC. No information was included in the police section of the disclosure about either the alleged kidnapping and false imprisonment or the domestic violence incidents.

265. The Metropolitan Police was asked to provide information about the vetting process in this case. The alleged kidnapping and false imprisonment was not found at the time of the disclosure as Rizwan Ibrahim's name had been incorrectly recorded (Rizwam Ibrahim), there was no exact date of birth and no address. Although the system does search for variations of names it would need a corresponding date of birth or address to find it. In addition, had Rizwan's address been recorded into the CRIS report it may have been found. If the PNC had shown a NFA or Not Guilty verdict this would have been noted and the report found.

266. However, the Disclosure team are of the view that even if the kidnapping allegation had been found, it would not have been suitable for disclosure as 'Other Relevant Information' as:

- the applicant was not arrested or questioned. Had he been questioned he may have been able to provide evidence to prove the allegation to be false or malicious;
- there were issues around the credibility of the complainant and the officer in the case is clearly unbelieving of her;
- the account from Rizwan's mother, which seems to be accepted by the Officer in Charge, undermines the account of the girl.
- the incident would have been 9 years old in 2010 and the only allegation of this nature.

267. It is unclear whether the 2006 domestic violence incident was identified by the Disclosure team but the 2008 domestic violence allegation was found by the Metropolitan Police's systems. It was considered by the Disclosure Team and deemed not to be suitable for disclosure as 'Other Relevant Information'. The notes used to dismiss the allegation as being suitable to disclose state:

"CRIS1906973/08 - domestic argument - victim stated she was hit with a large mirror on her legs - victim did not want to substantiate the allegation - incident

confined to relationship - between adults - no further incidents of the nature - no independent witnesses - n/r"

268. The issue of enhanced disclosures will be considered further in the Analysis section.

269. In December 2010, the police were called to a domestic disturbance at the family address. Elizabeth and her sister Lynn had argued over the level of care provided by Elizabeth to their parents. Lynn wanted her parents to come and live with her.

270. On police arrival Elizabeth explained she wanted her sister to be removed from her home. All parties were advised to speak to each other the following day after they had calmed down. No offences were alleged or identified. The initial investigating officer noted that John and Penina were safe and well. Form 124D was completed by the officer and the DASH Risk Assessment noted as 'standard'. The 'risk management' was recorded as being completed after Lynn left the family address.

271. The investigation was allocated to specialist staff within the CSU at Kilburn Police Station. They completed intelligence enquires on all listed parties and noted the two previous incidents for Elizabeth and Rizwan. The officer then called and spoke with Lynn. She wanted no further police action. She was given details of support agencies and told to call police for any further assistance which she confirmed she would do if she needed to. The officer received no reply from their attempt to call Elizabeth and Rizwan.

272. The incident was supervised by a DS from the CSU who confirmed the risk as being 'standard', with the investigation as complete. The matter was then closed. The investigation was conducted according to the procedures and processes in place at that time. However no MERLIN reference was recorded as having been generated for either Child 1 or Child 2. They were not mentioned in any way on this CRIS. The initial investigating officer had recorded against the question, *'MERLIN ref (For any child/ren of victim/susp at scene or not)?'* the response *'N/A'.* It is not known whether they were present or not at the time of the family argument or had been mentioned by the family to the officer. Since April 2008 it became mandatory under 'Every Child Matters' for a MERLIN to be completed for any child coming to notice, regardless of whether they were present at the incident or not. In that way, any emerging escalation of potential risk to the child/ren could be identified and appropriate action taken to safeguard their well being.

273. This was the last contact the Metropolitan Police had with the family until they were called to the murder scene.

274. Hertfordshire Police did not inform the Metropolitan Police about the allegations of sexual assault made against Rizwan in April 2013 even though his home and car in London were searched as part of the investigation. Under the Police and Criminal Evidence Act, Hertfordshire Police should have notified the local police station about the search.

HERTFORDSHIRE POLICE

Summary of involvement

275. At the time of Penina's murder, Rizwan was on conditional bail to Hertfordshire Police for offences of rape and sexual assault which were alleged to have occurred in April 2013. Officers showed persistence in carrying out the investigation, pursuing telephone and forensic evidence to support the case and attempting to identify other potential victims. Support to the victims appears to have been good. The police had safeguarding discussions with colleagues in North West London Hospitals Trust and University of West London but took a relatively narrow approach to assessing risk. As a result, concerns were not raised regarding Rizwan's children or immediate family members. There was no contact with the Metropolitan Police, despite conducting a house search in Brent and bailing a potential serial offender to a Brent address. Due to concerns about breaching the Data Protection Act, Hertfordshire Police did not inform Elizabeth that Rizwan was being investigated for sexual offences during the period that he was on police bail.

Key events

276. On Tuesday 30 April 2013, a woman called Ruth contacted Hertfordshire to report that she had been sexually assaulted. Between 16 and 23 April 2013, Ruth had been admitted to Barnet General Hospital and treated for chronic illnesses. She met the suspect, Rizwan, at the hospital when he had come to her assistance after she had suffered a medical incident in the toilets. On two occasions between 24 and 26 April 2013, Rizwan had attended her address, dressed in a nurse's uniform, identified himself as a nurse and showed her discharge papers from her previous visit to hospital.

277. On 24 April 2013, she had allowed him into her house believing him to have been there genuinely. Her mother and sister both left after his arrival. Ruth states Rizwan was over familiar, stroking her hand and asking to rub cream into her feet. Rizwan returned later that evening asking for Ruth's phone number which she gave him. Rizwan then called Ruth frequently from a withheld number.

278. On 26 April 2013, Rizwan again attended the address. He sat next to Ruth on the sofa and started kissing her neck. After being told to stop he berated Ruth calling her narrow minded and indicated an attraction for her. Rizwan then tried to kiss Ruth on the mouth, Ruth began crying and told Rizwan to leave. She showed him to the front door and again he tried to kiss her before leaving.

279. Ruth disclosed what had happened to her mother on 27 April 2013. On 30 April, she reported the matter to the police. After reporting to police, Ruth spoke to her friend, Karen, who disclosed that she believed she had been targeted by the same person.

280. Karen met Rizwan when she was admitted as a patient at St Mark's Hospital about five weeks earlier (late March). They became friends, exchanged phone numbers and started texting. She was discharged on 23 April 2013.

281. In the days after Karen's discharge, Rizwan met up with her and they went out together. Karen went with Rizwan to an address which he told her was his brother's house and after giving her alcohol and having taken medication she became drowsy and believes she passed out. Rizwan allegedly orally raped her that evening and the next morning. Karen told Rizwan not to do that again.

282. Rizwan allegedly orally raped her on another occasion after attending Karen's address. He administered her morphine making her drowsy. Karen stated this happened on 24 or 25 April and although Karen stated she had a relationship with Rizwan she did not consent to what happened and that due to her drowsiness she was vulnerable.

283. Karen reported to police on 30 April 2013 and made a statement on 1 May.

284. The allegations were initially dealt with locally then passed on to the Sexual Offences Investigation Team (SOIT). The police visited Karen in hospital where she was recovering from an operation. Due to her condition she could only sign a brief account of her evidence. She raised concerns regarding her ill health and whether she would be well enough or have the strength to go through with the investigation. She was assured all her views would be considered and she would not be forced into anything.

285. The police also contacted the Deputy Director of Nursing at North West London Hospitals Trust regarding disclosure of the two offences as part of safeguarding procedures who responded the same day (1 May 2013), providing details of a possible suspect identified as Rizwan Ahad Ibrahim.

286. On 2 May 2013 Rizwan was arrested at Northwick Park Hospital. He was conveyed to Watford police station, Hertfordshire where he was interviewed regarding the two offences. He denied the offences but agreed he had visited both victims at their home addresses, Karen as a friend who had asked him to visit, Ruth as she was feeling down. Rizwan agreed his behaviour could be classed as inappropriate but said he hadn't done anything else wrong. He denied having sexual contact with either woman.

287. On the same day, a S18.5 search (authority to search after arrest) was carried out on his car, which was believed to have been used by Rizwan to take Karen to his address. The car was registered to Penina, with insurance details in the names of Rizwan and Elizabeth. The police officers dealt with Elizabeth and Rizwan's sister in relation to the vehicle. In an interview on 9 May 2013, his sister confirmed that Penina had been in hospital at the time of the alleged offences and therefore had not used the vehicle.

288. A S18 search (authority from an inspector to search premises) was carried out at Rizwan's home address (Address 1) on 2 May 2013 in the presence of Elizabeth. A written statement was obtained from Elizabeth who stated she resided at the address with Rizwan, her mother, Penina, her two children and Rizwan's sister. She informed the police that she had been visiting her mother in hospital on the date of the alleged offence. She supplied officers with clothing identified by Karen as having been worn by Rizwan at the time of the alleged offence. Penina was not present at the address at this time as she was in hospital (she was discharged later that day (2 May 2013)).

289. Elizabeth was informed of Rizwan's arrest but was not told that he was accused of rape. This is in line with police practice aimed at complying with the requirements of the Data Protection Act and at protecting the confidentiality of suspects until they are charged with an offence. This issue is discussed further in the Analysis section.

290. Hertfordshire Police did not notify the Metropolitan Police about the investigation, despite the fact that Rizwan was living in London and the house

searched was a London address. Under PACE (Police and Criminal Evidence Act, 1984) a 'search register should be maintained at each sub-divisional or equivalent police station. All search records required under paragraph 8.1 shall be made, copied, or referred to in the register.' After Rizwan's address had been searched, the officers completing the search record were not aware a copy should be forwarded to the local substation or equivalent police station. There is no national policy in relation to notifying other forces when a suspect has been arrested for an offence. At the time of this investigation, Hertfordshire Police SOIT practice was to submit intelligence to another force at the conclusion of an investigation. Intelligence will now be submitted at an early stage of the investigation.

291. Rizwan was released from custody on conditional bail on 2 May 2013 as he did not meet the threshold for remanding him in custody. He was not considered to pose a risk at his bail address (address 1 where Rizwan lived with Elizabeth, their children, Rizwan's sister and Elizabeth's mother) and was bailed to return to the police station on 27/06/13 pending further enquiries. Subsequent bail dates were cancelled due to the time taken to gather forensic and telephone evidence in order to substantiate any possible charges. The bail conditions included:

- 'Not to enter Hertfordshire'
- 'Not to interfere with witnesses'

292. Karen had further surgery in May 2013 and withdrew her support for the investigation on 6 June 2013. She maintained that the allegations were true but she was very ill and concerned about extra stress which she feared would lead to a breakdown.

293. On 9 October 2013, Rizwan was interviewed again and denied any wrongdoing stating he was in a sexual relationship with Karen and any sex since they met in March 2013 was consensual. He stated that he had taken Karen to his home address and they had stayed the night where they had had consensual sexual intercourse. He also admitted attending her address where she had performed oral sex on him. He denied any sexual assault against Ruth, although he admitted he tried to kiss Ruth and his behaviour may have been inappropriate.

294. A file was prepared and was due to be sent to CPS for a charging decision when Rizwan was arrested for murder on 19 October 2013. It was put on hold and subsequently sent to CPS on 13 November 2013. CPS advised on 10 December 2013 to charge Rizwan with sexual assault against Ruth. The case was expected to come to trial in August 2014 but was adjourned due to the ill-health of the victim. Ruth later stated that she did not wish to proceed with the court case and the CPS decided it was no longer in the public interest to pursue the case.

295. The investigation was dealt with reasonably robustly from the start although the failure to contact the Metropolitan Police meant that investigating officers were unaware of information held on Metropolitan Police systems but not on the Police National Computer (PNC) or Police National Database (PND) including the alleged false imprisonment and kidnapping and the 2006 domestic violence incident. Although the aim of PND is to share information of this nature as well as on convictions and cautions, at the time of the investigation police forces were at

varying stages in populating the database. The Metropolitan Police Service's CRIS system was not on the PND during the investigation although this has since been rectified. If a search was to be conducted now it would reveal these incidents as long as officers searched on various permutations of his name - some records relate to Rizwam Ibrahim and others to Rizwan Ibrahim.

296. It was some months before a file was forwarded to CPS. This was as a result of delays in the investigation due to problems in unlocking Rizwan's phone in order to be able to access messages and photos that had been sent. Immediate care was given to the victims including welfare calls, checks, and SIG markers being placed on their addresses. Several enquiries were made to try and identify any additional victims.

297. There is evidence of partnership working regarding Rizwan's occupation as a nurse. Hertfordshire Police were concerned that Rizwan might have victimised other women that he could have met via his nursing placements. The police contacted the university and identified all placement locations that he had worked at. As a result of this, the police wrote to all the hospitals stating that they were carrying out investigations into serious sexual offences involving a placement nurse and vulnerable victims to try and identify any further victims. Only one response was received but it turned out to be a different suspect.

298. Hertfordshire Police also carried out financial checks on Rizwan to see if he was working for any nurse agencies. The recorded rationale states that this was "to establish if he is working for an agency and bank working at any hospital or establishment where he has care over vulnerable people."

299. Hertfordshire's disclosure unit of notifiable offences informed the Nursing and Midwifery Council. There was regular liaison with hospital and university staff regarding safeguarding issues. On 2 May 2013, following a meeting with officers, the University Head of Graduates informed officers that they had suspended Rizwan with immediate effect. A referral to the Notifiable Occupation Scheme was made on the same day. On 19 June 2013, a safeguarding meeting took place at Northwick Park Hospital with the Deputy Director of Nursing at North West London Hospitals Trust and the University Head of Graduates.

300. There is little evidence of consideration of Rizwan's potential risk to either women outside health settings that he might come into contact with, including family members, or to his children. Hertfordshire Police acknowledge that Brent Children's Social Care should have been informed when Rizwan was bailed to a Brent address where children were living. This did not happen until 25 July 2013 when North West London Hospitals Trust made a LADO alert.

301. Hertfordshire Police consider that there was not any information to suggest that Rizwan would continue committing similar offences or to identify any persons as being in danger from Rizwan. Although officers had no direct dealings with Penina (as she was in hospital at the time of the search) they were aware from Elizabeth's statement on 2 May 2013, that Penina lived at the same address as Rizwan and that she was (or had been) in hospital. It appears that Hertfordshire Police did not establish whether Penina might be in need of protection despite the fact that they were responding at the time to allegations that Rizwan had sexually assaulted two women with significant health issues who had just been discharged from hospital.

302. Hertfordshire Police have stated that “the tragic events in North London demonstrate a disproportionate degree of sexual violence on an elderly victim both known and related to the defendant. This does not correlate directly to the modus operandi and risk posed to the wider public and vulnerable females in the Hertfordshire offences. On that basis the now known level of risk posed by him could not have reasonably been foreseen.”

303. *Author’s Note: Many perpetrators of violence against women and girls offend in a variety of ways against a range of targets. The idea of a single ‘modus operandi’ is not supported by evidence. The issue of ‘modus operandi’ in sexual offences cases and assessment of risk is considered in the Analysis section below*.

BRENT CHILDREN’S SOCIAL CARE

Summary of involvement

304. Children’s Social Care had contact with the family in relation to concerns about domestic violence and child protection, nursery provision for the twins and the care needs of Child 1 after they were diagnosed as autistic. Children’s Social Care were made aware that Rizwan was reported to have been behaving in a sexually inappropriate manner at Willow Nursery when he worked there and that he was having a sexual relationship with a 16-year-old girl but this was not followed up and was not referred to the police. A LADO referral was made to Children’s Social Care in relation to the sexual assault allegations against Rizwan but did not prompt either a consideration of whether he was a risk to his own children or a referral to Adult Social Care. The children were visited at home by social workers but no record was made that Penina lived in the same household. The low-level support package for childminding was appropriate and well managed and enabled Elizabeth and Rizwan to engage in study.

Key events

305. In March 2008, Children’s Social Care were informed of a domestic incident between Elizabeth and Rizwan via a police form 78 notification. No detailed information about what took place is recorded on either the police 78 or the Integrated Children’s System (ICS) although Children’s Social Care recorded (wrongly) that no one was hurt or distressed at the time. Following this incident a referral for an assessment under the Common Assessment Framework (CAF) was initiated and a Health Visitor was tasked to complete this assessment. The use of a CAF maintained the case management at a lower level of intervention so that it did not ‘step up’ into a statutory child protection process. This decision appears in line with practice expectations at the time as it was the first incident that was notified and was not considered serious enough to warrant greater intervention. At the time, common practice for a low level first incident was to refer to Early Intervention Services for an assessment and write to parents offering support via a domestic violence voluntary sector agency. No evidence is available on the records to confirm if this offer was ever made. The assessment concluded that the children did have some health and emotional needs but not as a result of domestic violence.

306. Between March and September 2008 there were numerous calls from the parents to the department about the services they required for their children including a nursery placement for Child 2 and a specialist nursery placement for Child 1. The interaction between the department and the family was at times difficult. Rizwan was demanding, occasionally putting the phone down during calls but he was not reported as aggressive or threatening.

307. In a case recording of 5 November 2008 it was alleged by staff at Willow Nursery, a specialist disability nursery, that Rizwan had had a relationship with a 16-year-old girl. Rizwan would have been approximately 25 years old at the time this information came to light. A relationship with such a young girl, in addition to the domestic violence incident, should have raised professionals' curiosity as being a potentially inappropriate or exploitative relationship and the possibility of a referral to Children's Social Care for consideration of risk to the 16 year old.

308. Related to this, a domestic incident was witnessed by two Children and Families (CAF) workers between Rizwan and Elizabeth outside Willow Nursery where Rizwan worked as a receptionist. Elizabeth allegedly hit Rizwan. Records do not indicate that either parent was spoken to about this incident, whether the children were present or if any further action took place. Although noted on the records, no link was made between the previous reported domestic violence incident which may have resulted in further questions about the parental relationship and the subsequent impact on the children. There was no evidence on the records that the children were asked about incidents during the initial or subsequent assessment.

309. On the same record of 5 November 2008, the department was informed that it had been alleged that Rizwan had been acting in a sexually inappropriate manner at Willows Nursery where he worked, with what was described as 'peeping in the toilets', 'masturbating' and 'flirting excessively' with women employees whilst on nursery property. It was noted on the records that this was never substantiated but this comment is not attributed to anyone specifically. Some of this behaviour was reported by workers at the nursery. Rizwan's temporary contract was terminated although the termination appears to be related to the incident of domestic violence between himself and his wife outside the nursery.

310. A referral was made to the Child Protection Education Worker but no investigation appears to have been conducted under the local authority designated officer responsibilities (LADO). On questioning the Child Protection Education Worker she did not remember the specific incident but on reviewing the information stated that she would not have made a referral to the LADO as Rizwan's behaviour did not reach the thresholds for such a referral as it did not directly involve children.

311. Although not directly affecting a child, it would have been appropriate to take further action on this information as the reported behaviour took place within a nursery. All the information that arose around Rizwan's behaviour should have been considered so that a more holistic view could have been taken about who might be at risk and who else might need to know this information or act upon it. No consultation with more senior managers in the early years service or safeguarding is noted and there is no record of the matter having been referred to the police. There is no evidence that the incident caused safeguarding

concerns about Rizwan's own children but their welfare was not considered in relation to this incident.

312. *Author's note - the response to the concerns raised about Rizwan's behaviour at the nursery is considered further in the Analysis section*.

313. On 6 January 2009 Rizwan came into conflict with Brent Early Years Service when he wanted his children to attend Willow Nursery which was fully subscribed at the time. In one recording, Rizwan mentions that he feels a 'past incident' is stopping him from getting the places at Willow. There is no evidence that any further discussion took place about this.

314. The view from medical professionals at this time was that the children did not require specialist nursery. At a case consultation in April 2009, the Consultant Community Paediatrician told the social worker that the children did not have disabilities and their behaviour and lack of toilet training is as a result of poor boundary setting and inconsistent parenting. This was based on her assessments of the children and their parents during visits to her office. *(Author's note: when the children started school less than 5 months later, they were treated as having special needs; both received medical diagnoses of disability (Child 1 - ADHD and autism; Child 2 – ADHD) the following year).*

315. The children's case was closed by the Early Intervention Team in May 2009. At the time neither boy had diagnosed disabilities and therefore no service could be provided and there were no other recorded concerns of a child protection nature.

316. In April 2010, a new contact was recorded when Rizwan requested an assessment for direct payments as the family were not able to find suitable childcare after school. At the time the children were not eligible for support as they did not have a medical diagnosis of disability but the following month Child 1 was diagnosed as on the autistic spectrum and Child 2 was diagnosed with ADHD. Child 1 now met the criteria for a child with disability service and, following an assessment, the Brent resource panel agreed to support Direct Payments which could be used towards child care. No concerns about parenting were recorded.

317. At a home visit on 23 August 2010, the assessor noted that the children were reported to be close to their paternal grandmother although no mention was made of the maternal grandmother. Both parents were noted to be studying nursing at University. A report from Heath Development Progress Team to the allocated worker stated they were working with the children, the family were cooperating well and no concerns were noted.

318. In December 2012, the direct payments hours were increased to enable Child 1 to do activities in the community. The department's involvement at this time represented a typical low need care package which would only be reviewed annually.

319. On 8 July 2013, the Fostering Team received a request from Rizwan that he be assessed as a foster carer for looked after children in Brent. Rizwan was interviewed by a member of the fostering team as part of an initial assessment. This resulted in Rizwan being rejected from progressing any further as the assessor identified that one of Rizwan's children went to school alone in a taxi and his mother in law was living in the household but not offering any child care

support. Neither of these issues were felt to be commensurate with the fostering of vulnerable looked after children. The reason for this lack of support from his mother in law was not explored but this was not an in-depth investigation.

320. On 23 July 2013, the Deputy Director of Nursing at North West London Hospitals Trust made a telephone call to the Children's Social Care LADO to refer a matter relating to Rizwan and his arrest in Hertfordshire for sexual offences. This telephone call was followed by a referral form sent by email on the 25 July 2013 stating that the referral had also gone through the 'vulnerable adults at risk pathway'. There was no detailed information on the referral form. As this referral was not related to allegations involving children no further action was taken by the Children's Social Care LADO.

321. On interviewing the LADO, she recalls no further discussions took place about this until after Penina's murder. On review of these events a revision of the process has taken place and the Children's Social Care LADO will always now check the household members on the FWi system to be able to form a view about what other action might be necessary and maintain a written record of all referrals that are received and conversations with other professionals.

WILLOW CHILDREN'S CENTRE

Summary of involvement

322. Willow Children's Centre is a local authority nursery, which employed Rizwan as an agency worker during autumn 2008. There is no evidence that an enhanced CRB disclosure related to this employment was carried out. The only CRB requests relating to Rizwan in 2008 were a standard check in March 2008 for a role as a minicab driver and a standard check in November 2008 (after he had left Willow Nursery) from NHS Professionals regarding his employment as an administrator. The request would have been made by the agency that supplied Rizwan as an agency worker but Willow Nursery should have verified with the agency that the check had been completed.

323. In November 2008, Willow Children's Centre alerted Brent Children's Social Care to allegations that Rizwan had been "peeping" at female staff in the toilets and "masturbating" and that he was having a relationship with a 16-year-old girl. Willow Children's Centre also informed Children's Social Care that Rizwan's contract had been terminated following a domestic incident with Elizabeth outside the nursery.

324. Willow Children's Centre could provide no information about these allegations. No members of current staff had any recollection of any incidents relating to him. There were no records of any employment details, any supervisions, any allegations, any safeguarding issues or any domestic violence incidents. Information storage protocols do not seem to have been followed and there is no evidence to suggest that communication between agencies took place.

325. As a result, other agencies (except Children's Social Care) were unaware of these allegations. Had these incidents been reported to the police, the Metropolitan Police Service would have been able to consider disclosing them as part of the enhanced CRB check conducted at the request of the University of

West London in 2010 (see above under Metropolitan Police and below, University of West London). Awareness of these incidents might also have influenced the police's perceptions of the other information that they held on Rizwan which was not disclosed. This is considered further in the Analysis section below.

UNIVERSITY OF WEST LONDON

Summary of involvement

326. University of West London admitted Rizwan to train as a nurse in 2010. His application to study was referred to the University's Criminal Records Bureau Screening Panel after he declared two cautions relating to cannabis possession and possessing a blade. Rizwan's statement to the CRB screening panel was accepted at face value; as a result false claims within the statement were not uncovered. Record keeping at the panel meeting was poor and the wrong information was recorded against his name. Nevertheless, an enhanced CRB check was requested from the Criminal Records Bureau, which was the appropriate action. When the enhanced check confirmed the declared cautions but did not highlight any other cautions, convictions or concerns, he was formally admitted to study. During his third year he was alleged to have raped/sexually assaulted two former patients who he had met while on student placement. The University have stated that he was suspended promptly once they were notified of the allegations.

Key events

327. Rizwan applied to study at the University of West London on 16 January 2010. His UCAS application did not state that he had any criminal convictions; however at the University's Selection Day in March 2010, he provided details of two prior police cautions. The first caution was 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 public place'* in 2004.

328. On disclosure of his cautions, he was referred to the University's Criminal Records Bureau (CRB) screening panel. The CRB Screening Panel met in April 2010. The University's risk assessment form that was presented at the meeting recorded that Rizwan had disclosed the offences on his UCAS form but they were not actually disclosed until he completed the University's Declaration for Suitability form on 5 March 2010. The UCAS declaration was a factor considered to reduce his risk.

329. Rizwan sent a personal statement to the CRB chair, giving his account of the circumstances that led to the cautions. It referred to his temporary employment as an administrator at Willow Children's Centre, which he said lasted twelve months. The University accepted the statement at face value without conducting any checks with Willow Children's Centre. Had they done so, they would have discovered that his employment was terminated after only three months and may also have been made aware of allegations of sexually inappropriate behaviour against him and of a domestic incident at the nursery.

330. The panel decided to defer Rizwan's application pending further investigation. The form recording the outcome of the panel's decision was

incorrectly completed referring to only one offence with the wrong date recorded and a decision of 'not allowed to proceed' instead of 'deferred pending further investigation'. Despite these recording errors, the University did proceed with Rizwan's application as a deferred one needing investigation.

331. On 5 July 2010, a University Administrator completed a new enhanced CRB check application form for Rizwan. He was allowed to start his course in September 2010 but not to have contact with patients pending the outcome of the CRB Screening Panel process, in line with University policy. On 10 December 2010, the University decided to offer Rizwan a place on the Advanced Diploma of Higher Education in Adult Nursing. According to the University, his most recent CRB disclosure matched his declared cautions and revealed no other convictions, nor did the police identify any other concerns in the non-conviction section of the CRB disclosure. The passage of time since the last caution and the absence of any indication of a tendency to re-offend also influenced the admissions decision. *Author's note – some members of the Review Panel considered that this decision was incorrect and that possession of a blade was something that would have given them greater cause for concern. It is of note that the 15-year-old girl that alleged that he had kidnapped and falsely imprisoned her said that he had produced a blade to threaten her, although University of West London would not have been aware of this as the Metropolitan Police Service did not disclose it. The Nursing and Midwifery Council provided a statement about its role to the panel, which is attached as Appendix 4. It states that tighter checks for admission of nursing students came into place in September 2010. Rizwan had already been offered a provisional place to study before implementation of these tighter checks.*

332. Rizwan first studied on the Advanced Diploma of Higher Education in Adult Nursing before transferring to the BSc (Hons) in Adult Nursing in September 2012. Reports for Rizwan were consistently good and gave no reason to suggest any inappropriate behaviour or other causes for concern. As a student he performed well.

333. On 1 May 2013, the University was notified of allegations of sexual assault made against Rizwan. The allegations related to two female patients on the Haldane Ward at Northwick Park Hospital. Rizwan was on placement at Northwick Park Hospital at the time. The Dean of College took the decision to have Rizwan immediately removed from his placement and a suspension letter was sent on 2 May 2013. Suspension from the University of West London means that a student's swipe access card is deactivated, the student no longer has access to any University Campus or associated buildings, cannot attend their placement premises and cannot access their student email account. At the time of Rizwan's suspension a student would not have been required to return their uniform. The University has now amended the student handbook to request the return of any uniform should a student be suspended.

334. On 21 October 2013 the University received notification from the Deputy Director of Nursing at Northwick Park Hospital that Rizwan had been arrested for the murder of Penina. Rizwan was still on suspension from the University and his placement at that time.

335. Student suspensions are usually followed by a swift internal investigation and subsequent hearing at which the student is able to state their case. However with

instances of a sexual nature in which the police are involved, the University waits for an outcome from any police inquiry before launching its own, internal investigation. Due to the sensitive nature of Rizwan's alleged crimes at that time, the University took advice from an external law firm regarding Rizwan's suspension. The advice received confirmed that no action other than suspension should be taken until the police had finished their own investigations. Consequently, the University had no further direct contact with Rizwan.

336. As a student at the University of West London, Rizwan was bound by the Student Code of Conduct, which covers actions on and off campus. Acts of violence or threatening behaviour are covered under the Student Code of Conduct in the Student Handbook. Any student who breaches the relevant code of conduct is subject to disciplinary procedures, which, if sufficiently serious (as in the case of an allegation of sexual abuse), would culminate in exclusion from the University.

337. The University would in addition provide a report to the Disclosure and Barring Service on the circumstances of any such exclusion where the student in question is registered on a nursing programme. In the case of Rizwan, disciplinary proceedings would have ensued following completion of the police investigation even in the event of a decision by the police not to charge him with a criminal offence. The University's approach is to investigate all potential unprofessional conduct that gives cause for concern regarding a student's ability to practise as a nurse irrespective of a decision by the police not to pursue the matter further. Under normal circumstances, no steps would have been taken by the University regarding Rizwan until the criminal proceedings relating to the allegations had been exhausted. The Nursing School would then have completed a fitness to practice panel. However due to the nature of his conviction the University decided that the panel would go ahead as soon as possible.

DISCLOSURE AND BARRING SERVICE

Summary of involvement (note - this summary was provided by the author not DBS)

338. Between 2008 and 2009, Rizwan was employed in several roles which would have required a Criminal Records Bureau (CRB) check (the Criminal Records Bureau was the forerunner to the Disclosure and Barring Services).

339. In March 2008, the Public Carriage Office requested a standard disclosure from the CRB in relation to Rizwan's employment as a minicab driver. In November 2008, NHS Professionals made a similar request regarding his employment as an administrator. On both occasions two cautions were disclosed - one relating to possession of cannabis in 2002, the other for possession of a knife in 2004.

340. Rizwan was also employed via an agency in a local authority run nursery (Willow Nursery) in 2008. There is no record of a CRB check in relation to this role in 2008. According to his statement to the University's CRB screening panel, he went on to be employed in a local authority fostering and adoption service. There is no record of a CRB check in relation to this role.

341. In 2010, he applied to the University of West London to train as a nurse. The University requested an enhanced CRB disclosure in July 2010 as part of its consideration of Rizwan's application to train as a nurse following his disclosure of the two cautions mentioned above. The University has stated that it received the enhanced disclosure from CRB in November 2010, confirming the two cautions. No other concerns were mentioned in the non-conviction section of the CRB disclosure.

342. It took the DHR Panel a considerable amount of time to confirm what had been disclosed to the University in the enhanced CRB disclosure process and to establish why the alleged kidnapping and false imprisonment and domestic violence incidents were not included on the disclosure certificate.

343. The University did not retain the CRB disclosure in line with the DBS's code of practice which requires that the information revealed is considered only for the purpose for which it was obtained and should be destroyed after a suitable period has passed - usually not more than six months (the copies of his disclosures from other employers in 2008 which the University did supply to the panel had been retained in error). The DHR panel requested information from DBS in March 2014 to confirm what was disclosed to the University. For more than five months, the DBS refused to provide this information stating that it had no powers enabling it to co-operate with a Domestic Homicide Review (see email from DBS, Appendix 5). It was not until the Home Secretary intervened at the request of the Chair of the Panel that the DBS confirmed the University's account of that only the cautions for cannabis possession and possession of a blade were disclosed.

344. Prior to the Home Secretary's intervention, the Chair of the Panel had written again to the DBS in August 2014 requesting that they provide, at least, an account of their decision making process in relation to enhanced disclosures. This was supplied promptly and is attached as Appendix 6. Until receipt of this letter, the Panel believed that the CRB had made the decision not to disclose the information about the alleged kidnapping. However the DBS letter clarified that it was in fact for police forces to decide what other information to disclose in an enhanced disclosure and that the DBS plays no decision making role in relation to this. It was only at this point, that the Metropolitan Police was asked to provide information on their role in the enhanced disclosure process. The enhanced disclosure process is considered further in the Analysis section below. Issues regarding the challenges in gaining DBS co-operation with this review are also considered further in the Analysis section.

BRENT EDUCATION – SCHOOL ADMISSIONS AND SPECIAL EDUCATIONAL NEEDS ASSESSMENT SERVICE

Summary of involvement

345. Both the school admissions team and Special Educational Needs Assessment Service had contact with the family.

346. The school admissions process was simple and straightforward and resulted in both children starting at Lyon Park Infant School in September 2009 when they were four years old.

347. In November 2009 SENAS were contacted by Lyon Park Infant School requesting a statutory assessment of special needs for both Child 1 and Child 2. This resulted in Child 1 transferring to specialist provision at Manor School in 2010 and Child 2 remaining at mainstream with support. In June 2011 Rizwan requested that Child 1 move to attend Gladstone Park with Child 2 but withdrew this request in October 2011.

348. Following an annual review at Manor in March 2013 the documentation states that: “parents would like to move Child 1 to mainstream school where Child 2 attends (Gladstone Park).”

349. In September 2013 Rizwan requested that both children to be considered for Islamic Primary. This was being progressed without Elizabeth’s knowledge until Manor school contacted SENAS the week after Penina’s murder.

350. Most of the contact with the family and service was conducted through email and telephone conversations. At no stage did staff raise any concerns. No disclosures were made by either Child 1 or Child 2 during the statementing process and no concerns were expressed about their safety.

SCHOOLS – LYON PARK INFANTS, GLADSTONE PARK PRIMARY AND MANOR SPECIAL SCHOOL

Summary of involvement

351. Both twins started Lyon Park in September 2009. Child 1, who has more significant impairments, left in July 2010 to go to Manor School, Child 2 in January 2012 to go to Gladstone Park. Both children have special needs and the length of the school day was initially adjusted to help address this.

352. In May 2010, Child 2 disclosed at Lyon Park School that the dad had raised his hand. According to the school, the designated teacher took advice from social care who said that if Rizwan showed remorse it would not need to go further (*Author’s note: this is disputed by Brent Children’s Social Care who say they have no record of this contact and would not give this advice)*. No further action was taken as Rizwan showed remorse when the teacher saw him.

353. Child 1 started at Manor special needs school in September 2010 when five years old. In March 2011, Child 1 alleged that the father had kicked the leg. Rizwan said he had nudged Child 1 with his foot to hurry up. There was no mark or injury and an escort witnessed the event and confirmed that Rizwan did not kick the child.

354. In May 2011, Child 1 said that they used English at home to say “pardon” Rizwan had smacked the child. In a phone call, Rizwan confirmed this. He said it was because he wanted Child 1 to use Arabic at home. The school set up a meeting to discuss more helpful strategies for Child 1 to learn rules and expectations but it is not recorded what came out of it.

355. Child 2 started at Gladstone Park school in January 2012 with full time support from a Learning Support Assistant. Nothing of significance to this review was reported by the school.

SECTION 5 - ANALYSIS AND CONCLUSIONS

Each agency's involvement with Penina, Rizwan, Child 1 and Child 2

356. Each agency provided an individual chronology of relevant contacts with their agency and subsequent actions. These have been merged into a single chronology attached at Appendix 2.

Communication and information sharing between services

357. 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 two children and for Penina.

358. There were a number of recorded "did not attend" appointments for the children. These missed appointments were clearly communicated across therapy services and to community paediatricians. However, there is no evidence in the health visiting or school nursing records of being informed of the missed appointments.

359. Hertfordshire Police quickly contacted North West London Hospitals Trust after they became aware of the allegations of sexual assault against Rizwan. In turn, North West London Hospitals Trust responded speedily and facilitated Rizwan's arrest.

360. However there were also significant gaps in communication and information sharing:

- neither Willow Children's Centre nor Brent Children's Social Care alerted the police to allegations of sexually inappropriate behaviour against Rizwan while he was working at Willow Children' s Centre;
- 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.

361. Enhanced disclosures – As set out previously, it took five months for the Disclosure and Barring Service to confirm that only Rizwan's cautions for cannabis possession and for the possession of a blade had been revealed to the University of West London in the enhanced CRB disclosure. The Chair of the Panel exchanged correspondence with the DBS on a number of occasions between March and August 2014 in an attempt to secure information about what had been disclosed to the University of West London in the enhanced CRB

disclosure. The DBS maintained that it had no legal power to co-operate with the Domestic Homicide Review and refused to release the requested information.

362. During this time, the Panel mistakenly believed that it was the DBS (formerly the CRB) that decided what would be disclosed in an enhanced disclosure. However, in a letter of 29 August 2014 (see Appendix 6), the DBS clarified that its role was:

- to provide relevant information held on the Police National Computer relating to convictions and cautions (section 113A of the Police Act 1997)[22]
- to contact police forces to ask if they hold any information locally "which the chief officer reasonably believes is relevant to the role or workforce applied for and in their opinion ought to be included on the certificate." (section 113B of the Police Act 1997)

363. In other words, it is for the local police force, not the DBS, to decide whether any information it holds is relevant and ought to be disclosed. The DBS will then include the information disclosed by the chief officer in the certificate.

364. The purpose of enhanced disclosures is to enable organisations to identify candidates who may be unsuitable for work involving children or vulnerable adults. As with a standard disclosure, an enhanced disclosure includes checks by DBS for spent and unspent convictions, cautions, reprimands and final warnings. In addition, it includes "information held by local police that's reasonably considered relevant to the workforce being applied for (adult, child or 'other' workforce)."[23] This includes information that has not led to a criminal conviction but may indicate someone is a danger to vulnerable groups.

365. Following receipt of the DBS letter, the Metropolitan Police Service provided the Panel with information about the principles it uses in decision-making on enhanced disclosures. There is a large volume of both national guidance and case law, which guides the force decision maker towards disclosure/non-disclosure. Factors which influence decision-making include (but are not limited to) the relevance of the information to the position sought, the 'quality'/reliability of the information held, the age of the information, recidivist behaviour and human rights considerations.

366. As set out previously, the Metropolitan Police Service did not identify the alleged kidnapping and false imprisonment at the time that the enhanced CRB disclosure was requested but have stated that it would not have met the threshold for vetting disclosure due to the age of the incident and the inconsistencies in the allegation.

367. The Metropolitan Police's Disclosure Team have reviewed the CRIS report from the 2008 domestic violence incident which was identified and have

[22] At the time of the 2010 disclosure, if there was an admission (eg caution) or a finding of guilt (eg conviction) recorded on PNC, this information would have been automatically disclosed by the CRB on the certificate. This is because the law said at that time that all convictions/cautions are automatically disclosed. This has since changed and older/more minor PNC information is no longer automatically disclosed by the DBS but is treated in the same way as any other information.

[23] https://www.gov.uk/disclosure-barring-service-check/overview

confirmed that the allegation should not have been disclosed because it is inconclusive:

- Rizwan denied the allegation and claimed that he was acting in self-defense;
- Rizwan called the police, which may support the fact that he was the victim;
- Rizwan had more injuries than the female (Elizabeth). It is not clear from the report whether or not the injuries were thought to have been caused by the female being aggressive or if they were thought to have occurred from the female acting defensively;
- Rizwan's account is considered to be believable by police;
- there is no independent evidence or witnesses to show who was more likely to be telling the truth.

368. The Disclosure Team also stated that the "allegation is domestic and does not necessarily suggest a risk outside of this environment."

369. The Disclosure Team considered that even if both the kidnapping and domestic violence allegations had been considered together, they would not reached the threshold for disclosure.

"The allegations are individually weak. Having read both reports the impression I get is that in the 2008 allegation the applicant's account is thought to be true/likely to true and in the 2001 allegation the girl is believed to be lying or exaggerating. We are then left with two unreliable and inconclusive allegations. The allegations in no way support each other and don't show a course of conduct. Given these factors a proportionate and fair disclosure would not have been possible so no Other Relevant Information would be disclosed."

370. The Panel considered whether the decision not to disclose this information was of relevance to the subsequent murder of Penina. The University has stated that if it had been aware of the alleged kidnapping and domestic violence incidents Rizwan would not have been admitted to train as a nurse. The Metropolitan Police Service's decision not to disclose directly affected the University's decision to admit Rizwan to train as a nurse. Panel members were of the view that professionals were less suspicious of Rizwan because he was training as a nurse. (One of the GPs who was interviewed as part of the review said that Rizwan's nursing career impacted on the GP's view of him as coping with his role as a carer. Community health services also said that its staff may have been overly influenced by the nursing backgrounds of both Rizwan and Elizabeth in their assessments of the family.) At the least, Rizwan would not have had access to vulnerable patients who he was alleged to have sexually assaulted if he had not been admitted as a student nurse.

371. The Panel also asked the Metropolitan Police whether they would have disclosed the allegations of sexually inappropriate behaviour at the Willow Nursery if they had been aware of them. The Disclosure Team could not give a definitive answer as it would have depended on what was in the crime reports.

"For the allegation to be disclosed, the Chief Officer or his delegate would have had to have been happy that the information was, on the balance of probabilities, likely to be true. In addition, they would have had to conclude that the information was indicative of a risk to children or vulnerable adults in the role applied for, in

this case Nurse. The age of the material and whether or not there was a course of conduct would also need to be considered."

373. The Disclosure Team went on to state that:

"In terms of a course of conduct the alleged abduction in 2001 may have possibly supported the fact that he had a propensity towards 'concerning behaviour', but given that the allegation is weak it would not have added much weight."

374. The decision-making processes set out above raise questions about the thresholds for disclosing information relating to alleged sexual offences, kidnapping and domestic violence that has not resulted in conviction or caution, to a prospective employer or to an organisation providing training in professions which have contact with vulnerable people. The panel was concerned that there appeared to be little difference in practice between standard DBS checks and enhanced DBS checks as information that the panel considered relevant may not be disclosed in an enhanced check. Panel members expressed concerns that they would no longer be able to rely on the enhanced disclosure system in making recruitment decisions and that the system did not offer the expected protection to children and vulnerable adults.

375. There were also concerns about the consistency of enhanced disclosures with the possibility of different police forces making different disclosure decisions about similar types of information. Panel members wondered if greater consistency would be achieved if the police were required to share all the information that they hold about an individual with the DBS who would decide what should be disclosed. The Panel recognises that this would require a change in legislation.

376. The panel believe that the Home Secretary should order a review of the operation of the enhanced disclosure system to ensure that information is appropriately and consistently disclosed so that people at risk of committing harm are not given opportunities to work or train in professions which give them access to children and vulnerable people.

377. Operation of DHR's - 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:

- University of West London;
- three schools attended by Child 1 and Child 2; and
- a voluntary organisation which provided home care services to the victim.

378. The Disclosure and Barring Service is the only organisation that declined to co-operate with the review. The DBS has argued 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.

379. 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.[24]

380. Communication about sexually inappropriate behaviour, sexual and domestic violence - The Metropolitan Police Service's failure to disclose information regarding concerns about Rizwan was perhaps the most glaring but there were also failings by other agencies.

381. Willow Children's Centre could provide no information about what action it took in relation to allegations about sexually inappropriate behaviour by Rizwan when he was employed at the Centre in 2008 via an agency. It is not known whether Willow Children's Centre informed the agency that supplied Rizwan about the allegations that he had been excessively flirtatious and had peeped at female staff and masturbated in the toilets. According to Rizwan's statement to the University as part of the process of the CRB screening panel, he went on to take up employment in a local authority fostering and adoption service. He also supplied the University with a CRB disclosure from November 2008 relating to employment as an administrator by NHS Professionals, a recruitment agency created by the Department of Health to manage the supply of temporary staff to the NHS. This was also subsequent to his employment by Willow Children's Centre.

382. Willow Children's Centre informed Brent Children's Social Care about the sexually inappropriate behaviour and his alleged relationship with a sixteen-year-old girl. Brent Children's Social Care staff also witnessed a domestic incident outside the nursery when Elizabeth allegedly hit Rizwan because of his affair with the sixteen-year-old. There is no suggestion that either Willow Children's Centre or Brent Children's Social Care shared any of these issues with the police, despite an expectation that such concerns would be shared following the Bichard inquiry into the Soham murders[25]. Had these incidents been correctly reported and recorded, the Metropolitan Police would have been in a position not only to investigate them but to consider disclosing them in the enhanced CRB disclosure (although, as set out above, there is no guarantee that they would

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

[25] http://dera.ioe.ac.uk/6394/1/report.pdf

have been disclosed). This in turn might have prevented him being accepted to study as a nurse. The Local Safeguarding Children's Board should consider how to ensure that all those involved in children's safeguarding refer concerns to the Brent Children's Safeguarding team and the Metropolitan Police Service where appropriate.

383. After Rizwan was suspended in May 2013 following the alleged sexual assaults against patients, the initial referral by North West London Hospitals Trust to Brent Adult Social Care contained insufficient detail. The alleged perpetrator was named in the email, however the first name was spelt differently to the social care records. Running a search on using the first 3 initials of first name and surname on Social Care's FWi system generated 18 possible people with similar names and spellings. It would have been difficult to identify Rizwan on the database and therefore connect him to any other vulnerable adults or children.

384. The Safeguarding Adults Manager attempted to follow up the alert and there is some email correspondence with North West London Hospitals Trust. The content of the emails confirmed that the vulnerable adults in Hertfordshire were protected from further harm, the alleged perpetrator had been removed from his post at the hospital and the police were investigating.

385. In order to raise the adult safeguarding referral, the Safeguarding Adults Manager would have required the alleged victim's details, location of the abuse and alleged perpetrator. This would have been loaded up onto the electronic systems and screened for whether it meets the threshold for Adult Safeguarding.

386. North West Hospitals Trust subsequently sent a referral form but it appears that it did not reach Brent Adult Social Care. This was not followed up by Brent Adult Social Care. It appears that the lack of follow up resulted in part from the referral being made directly to a member of the safeguarding team rather than following the correct procedure of sending it via either Brent Customer Care or the Brent Safeguarding mailbox. There is no evidence that the Adult Safeguarding Team received the full referral form from Northwick Park Hospital. The allegations received in May 2013 had taken place in Hertfordshire and should have been referred directly to Hertfordshire local authority (and were so referred by Hertfordshire Police). As Brent was not the lead agency the expectation may have been that the safeguarding investigator within Hertfordshire Safeguarding team would have conducted any necessary checks. There is no evidence that Brent Adult Social Care were contacted by either Hertfordshire Police or Hertfordshire Social Services in regards to the investigation in May 2013. This would have generated checks on the electronic system and enabled Brent Social Care to complete a risk assessment.

387. There was no connection made by Brent Council between Rizwan and Penina as an Adult at Risk, as at the time of the alert Penina was known only as a carer of her husband (then deceased) and was not in receipt of a package of support to meet any Adult Social Care needs. In addition, at the time of the referral Penina was still recorded as living at the family's previous address. Therefore a search would not have shown that they were living at the same address in May 2013.

388. The Pan London Guidelines require that feedback is given to those who raise

an alert. There is no evidence that the Safeguarding Adults Manager advised North West London Hospitals Trust of the correct processes or the outcome of the alert. In addition, Pan London guidelines would expect that as part of the referral process the risk to the alleged victims are assessed in addition to a risk assessment of people the alleged perpetrator has access to and other possible victims. This would include other vulnerable adults and the risk to children the alleged perpetrator has contact with. This action was not carried out because of the lack of information available to the safeguarding team.

389. A further referral was made by North West London Hospitals Trust in July 2013 to Brent Children's Social Care LADO but no action was taken because the allegations related to adults not children. This second referral was not discussed with or passed on to Brent Adult Social Care.

390. Hertfordshire Police did not make the Metropolitan Police aware of their investigation into the sexual assault allegations or that a person accused of committing these offences resided within their area. Hertfordshire Police were not aware that Rizwan had been previously accused of kidnapping and falsely imprisoning a 15-year-old girl as this was not on his national police record. This information would now be available on the Police National Database but at that time the database was still in development and did not reflect the information held in the Metropolitan Police's CRIS system. Had Hertfordshire Police made contact with the Metropolitan Police and asked what they knew about Rizwan, they might have been alerted to this information and this might have influenced their assessment of his risk.

391. There is no national policy in relation to notifying other forces when a suspect has been arrested for an offence. What would be expected is intelligence would be submitted from the investigation team, which would be disseminated if thought appropriate to the interested force. This would be the responsibility of one of the officers from the investigation but may or may not be completed depending on an assessment of risk, harm and threat. The practice of Hertfordshire Police at the time was to submit intelligence at the conclusion of an investigation. As a result of this review, Hertfordshire Police have decided that intelligence will be submitted at an early stage of the investigation. This recommendation has already been put in place.

392. The review has also highlighted that searching of property and seizure from premises are regulated by Code of Practice B to the Police and Criminal Evidence Act 1984. This creates the requirement for a search register to be maintained at each sub-divisional or equivalent police station and that all search records should be made, copied, or referred to in the register.

393. The officers completing the search record after Rizwan's address had been searched were not aware that a copy should have been forwarded to the local substation or equivalent police station. The search record form has an area to be completed detailing times and dates the form was forwarded to the local intelligence officer at the substation or equivalent as well as a supervisor's signature. If this had been done the local police would at least have been aware of an address being searched within their area.

394. Penina is not recorded as living at the same address as the children in the children's social care records or any of their clinical records, nor as living at the

same address as Rizwan in any of Northwick Park Hospital's records. She was still being looked after in Northwick Park Hospital on 2 May 2013, when Rizwan was arrested at the hospital and suspended from his placement there for allegedly sexually assaulting the two former patients but no connection between Penina and Rizwan was documented in either her medical records or his student records so no safeguarding concern was identified. A better picture of the household, the stresses and protective factors would have been established if all members of the household had been linked at the time of assessments or referrals.

395. There was a lack of information sharing between external agencies and the GP practices. The GPs were unaware of police involvement in the domestic violence incidents, nor were they aware of the serious allegations of sexual assault made in April 2013. This meant they could not factor this information into their assessments. The recent development of the GP information sharing protocol has the potential to improve information sharing in the future.

396. One of the key findings of the Bichard Inquiry was “the inability of Humberside Police and Social Services to identify Huntley’s behaviour pattern remotely soon enough. That was because both viewed each case in isolation and because Social Services failed to share information effectively with the police.” A similar argument could be made across agencies in relation to Rizwan. Prior to Penina’s murder, agencies were aware of the following:

- alleged kidnapping and false imprisonment of a fifteen-year-old girl in 2001 in which he 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).

397. 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.

398. In July 2013 Brent children's social care established a multi agency safeguarding hub MASH. The MASH is the first point of entry for every contact made with the Children's Social Care department and coordinates a multi agency approach to collecting and analysing information about contacts before they become referrals. This coordinated approach allows for much greater confidence about the decision making of the levels of risk to children and how services should be provided with assistance and protection in the early stages. However there is a need for a standardised approach across London to GP sign up to MASH.

399. Within Adult Social Care there are also information sharing agreements when an adult at risk is identified as being a victim of alleged abuse. The subsequent investigations are multiagency with all key agencies within the police, health and social care signing up to Pan London adult safeguarding procedures. There may be some additional learning from the MASH model to promote a more preventative approach to safeguarding and adult protection, which would entail all agencies committing resources to an Adult MASH as they have done for the children's MASH.

400. The panel considered that that the Association of Chief Police Officers (ACPO) should review the approach to investigating sexual offences and consider recommending the following as routine practice:

- if the suspect is resident outside the police service area, investigating officers should contact the police service where he is resident to inform them of the allegations and establish whether there is any intelligence on the suspect that is not reflected on the Police National Database;
- investigate whether there is any history of domestic violence for all suspects of alleged sexual offences.

401. ACPO should also review the operation of the Police National Database to ensure that relevant historical information about suspects is available across police forces.

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

402. 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.

403. 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.

404. The investigation by Hertfordshire Police into the allegations of sexual assault and rape by two former patients was dealt with robustly. The victims were offered support and the alleged perpetrator was quickly identified and arrested. Attempts were made to identify any 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. The police continued to

investigate Karen's allegation of rape even after she withdrew her involvement due to her ongoing ill-health.

405. The investigation took some months, with Rizwan being bailed on a number of occasions. Lengthy investigations can put pressure on victims and contribute to the withdrawal of allegations. The delay was as a result of difficulties in unlocking Rizwan's phone to access saved text messages and photographs of relevance to the investigation. During this lengthy period. Rizwan had almost unfettered access to Penina. Shortly after the investigation concluded, Rizwan murdered her.

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

- the administration of a lumbar puncture to Penina without either obtaining consent or following the mental capacity procedures;
- deprivation of Penina's liberty in hospital without following due process;
- the breach of confidentiality by Penina's GP regarding her treatment for syphilis.

407. Lumbar puncture and deprivation of liberty - while in Northwick Park Hospital in April 2013, Penina was noted to be confused and aggressive. The doctor decided to carry out a lumbar puncture procedure for diagnostic purposes. The medical team felt that Penina lacked capacity, scoring 1 out of 10 in a mini mental capacity test. It is unclear what communication method staff used to ascertain that Penina lacked capacity but an independent interpreter was not used. As part of adult safeguarding policy any patient who scores poorly in a mini mental capacity test should have it repeated; a second poor score should have initiated a referral to the Psychiatric Liaison Team for follow up and referral. There is no evidence in the medical records that a subsequent test was performed.

408. The lumbar puncture went ahead the following day without adequate documentation in relation to either obtaining Penina's consent or following the required procedures if she lacked capacity. Although the anaesthetist questioned the issue of consent the procedure went ahead under anaesthetic analgesia. Whilst one may argue the procedure was undertaken in the best interest of Penina, the required process for doing so was not adhered to. This was unlawful.

409. Similarly, the required procedures were not followed when a security guard was placed outside Penina's bedroom door during the same hospital stay. This amounted to a deprivation of her liberty by inhibiting her freedom of movement. Whilst the deprivation of liberty may have been appropriate due to her aggressive behaviour and the risk of infection to other patients, 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 required under the Mental Capacity Act. This was unlawful.

410. Breach of confidentiality - When Rizwan asked why Penina had been prescribed doxycycline the GP informed him it was for treatment of latent syphilis. Rizwan often accompanied Penina to health but was not her next of kin. Penina had not specifically authorised the GP to share information with him and

she had not been assessed as lacking capacity at that time. The GMC guidance[26] states:

"You should establish with the patient what information they want you to share, who with, and in what circumstances. This will be particularly important if the patient has fluctuating or diminished capacity or is likely to lose capacity, even temporarily. Early discussions of this nature can help to avoid disclosures that patients would object to. They can also help to avoid misunderstandings with, or causing offence to, anyone the patient would want information to be shared with."

411. In Penina's case this was made more difficult as her language issues commenced prior to her registration with the practice. The practice never used an independent interpreter to communicate with Penina, nor did they ever conduct a mental capacity test.

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

412. As in 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 police investigation of alleged kidnapping and false imprisonment;
- Lack of action in response to concerns about sexually inappropriate behaviour and domestic violence at Willow Nursery;
- University reliance on a statement that had not been validated and poor record keeping;
- Failure to properly assess Penina's needs;
- Lack of required detail in initial alert made by North West London Hospitals Trust to Adult Social Care and inadequate follow up of safeguarding alert by Adult Social Care and Children's Social Care;
- Failure to recognise the risks posed to Penina as a 'vulnerable person' within the terms of the 'No Secrets' guidance.

413. Alleged kidnapping and false imprisonment - the first recorded incident of concern in relation to Rizwan was an accusation that he had kidnapped and falsely imprisoned a 15-year-old girl. The victim attended the police station with her uncle, who identified the suspect as Rizwan.

414. Whilst efforts were made by the Metropolitan Police to investigate this allegation, including undertaking CCTV inquiries, Rizwan was never interviewed. Instead, the police decided to re-interview the victim after Rizwan's mother said that the uncle had stolen items from her son. There were also apparent inconsistencies in the victim's account. The police appear to have given undue weight to the assertion by Rizwan's mother which does not seem to have been substantiated. On receipt of this information 'the victim was *further challenged*

[26] General Medical Council. (2009) Confidentiality. London: General Medical Council

about her account' (author's emphasis), and decided she did not wish for the matter to be pursued.

415. The allegation was then closed as it was believed by the police to be malicious. There was no evidence to support the belief that the allegation was malicious other than that the police could not find corroborating evidence. This is insufficient to establish that the allegation was, in fact, malicious. No further action was taken. Information about this allegation was not shared with any other agency until after Penina's murder and was not disclosed as part of an enhanced CRB disclosure.

416. Police should not consider an allegation to be malicious without positive evidence to support this belief. An absence of evidence to confirm an allegation should not be deemed sufficient to suggest it is malicious.

417. Concerns at Willow Nursery - Brent Children's Social Care were aware of allegations that Rizwan had had a relationship with a 16-year-old girl, had behaved in a sexually inappropriate way in Willow Nursery and was involved in a domestic violence incident outside the nursery. Rizwan would have been approximately 25 years old at the time this information came to light. A relationship with such a young girl, in addition to the domestic violence incident, should have raised professional curiosity as being a potentially inappropriate or exploitative relationship and the possibility of a referral for consideration of risk to the 16 year old.

418. There is no record that either Rizwan or Elizabeth were spoken to about the domestic violence incident, whether the children were present or if any further action took place. No link was made with the domestic violence incident in 2008 for which Rizwan was arrested.

419. A referral was made to the Child Protection Education Worker but no investigation appears to have been conducted under the local authority designated officer responsibilities (LADO). On questioning the staff member, she did not remember the specific incident but on reviewing the information stated that she would not have made a referral to the LADO as Rizwan's behaviour did not reach the thresholds for such a referral as it did not directly involve children.

420. 'Working together' Chapter 2, 2006 1st Edition describes the role of the LADO as to be alerted to all cases in which it is alleged that a person who works with children has:

- behaved in a way that has harmed, or may have harmed, a child
- possibly committed a criminal offence against children, or related to a child
- behaved towards a child or children in a way that indicates s/he is unsuitable to work with children

421. The LADO role applies to paid, unpaid, volunteer, casual, agency and self-employed workers. They capture concerns, allegations or offences.

422. Both the domestic violence incident and alleged sexually inappropriate behaviour took place in a venue for vulnerable children. In cases such as this discussion should take place with other professionals and managers about the right approach to managing this information and any actions necessary. The minimum expectation would be that a discussion with the police would have

taken place, even if it was concluded that no offence had been committed. In addition Rizwan's own children should have been considered in light of this information at any subsequent assessment to ensure that they were protected from his inappropriate behaviour.

423. No consultation with more senior managers in the early years service or safeguarding is noted neither is there a record of the matter having been referred to the Police. There is no evidence that the incident caused safeguarding concerns about Rizwan's own children but their welfare was not considered.

424. Rizwan's employer, an agency, should have been alerted to the fact that Rizwan may be unsuitable to work in such environments and safeguards should have been considered around his future employment via references and referrals to appropriate bodies including the CRB (now the DBS). It is not clear whether this was done, but according to his supporting statement to the University he went on to take up an administrative role for a local authority fostering and adoption service. A CRB check for NHS Professionals was carried out later in November with only the two cautions for cannabis possession and possession of a blade being disclosed.

425. University admission process - The University made a number of recording errors in the CRB screening panel process. The Risk Assessment was incorrectly completed, giving Rizwan credit for declaring his cautions on his UCAS application when he did not declare them until later in the admissions process. The form makes reference to incorrect conviction dates and outcomes as a result of an administrative error after the panel meeting. The supporting statement provided by Rizwan to the CRB screening panel was not checked and was accepted at face value. The document recording the panel decision was incorrectly marked as "not allowed to proceed" rather than the correct "deferred pending further investigation".

426. Despite this catalogue of errors, the University's admission decision was based on the information disclosed in relation to the correct convictions. As previously discussed, the additional information relating to the alleged kidnapping and domestic violence incidents was not made available to the panel in the enhanced CRB disclosure. In collating the information requested by the Review Panel, the University established that Rizwan's CRB forms had only been partly destroyed. The form relating to the University's own enhanced CRB check was destroyed, in keeping with DBS regulations, but the two CRB forms submitted by Rizwan following declaration of his convictions were still on file.

427. Needs assessment - during the entire period of her contact with health and social care services, Penina had expressive dysphasia and limited capacity to speak English. There are suggestions that at times she may also have struggled to understand English. Elizabeth and Rizwan were used to interpret even though Rizwan spoke little Rotuman so can only have interpreted Penina's gestures and expressions not her words and would not have been able to interpret the words of professionals to Penina. Independent interpreting services were never used. As a result of the decision to rely solely on family interpreters, Penina was almost never seen alone and her needs were never directly assessed.

428. Risk assessment - routine risk assessments were not undertaken in the vast majority of hospital contacts with Penina and the twins. Admission

documentation contains a risk box that should prompt staff to ask or think about risk including non-accidental injury and domestic violence. The twins had a total of 48 emergency presentations and only one risk assessment was completed. Of the one completed risk assessment, no concerns were identified. No risk assessment was completed on any of Penina's hospital or other health presentations.

429. Risk assessments and Merlin referrals were not always completed by the Metropolitan Police in relation to call outs to domestic incidents.

430. Hertfordshire Police gave consideration to the potential safety of the alleged sexual assault victims including carrying out welfare calls and checks and placing SIG markers on their addresses. They also considered the risk to future patients, ensuring that Rizwan was not able to work or study in health care during the investigation. However, there does not appear to have been the same consideration of Rizwan's potential risk to the women with whom he had the greatest contact, those he lived with. Penina and Elizabeth were not alerted by the police to assess their own risk from him. There is nothing to suggest that this approach was out of step with practice in police forces across the country.

431. Hertfordshire Police considered there was insufficient evidence to meet the threshold bail test (see Appendix 7, Full Code Test, paragraphs 5.1-5.13) and, as a result, Rizwan was bailed while they investigated the allegations rather than being charged and potentially remanded in custody. Whilst this decision complied with current standards and thresholds, it resulted in Rizwan being at home with considerable access to Penina during the day whilst Elizabeth was at work.

432. In her statement to the Metropolitan Police following her mother's murder, Elizabeth said that she was not aware her husband was on bail to Hertfordshire Police nor that the allegations against him included rape. In her interview with the Chair of the Panel, Elizabeth said that the fact that he was not remanded in custody led her to believe that the crimes he was accused of were of a relatively minor nature reassuring her in relation to her own, her children's and her mother's safety. Police generally keep the nature of the crimes that they are investigating confidential until a suspect is charged. However that can leave women who live with alleged sexual offenders at risk. Elizabeth has said that she would have taken steps to protect her mother had she been aware of the nature of the allegations against him. There is evidence that men who sexually offend outside the family often begin their abuse within the family and may continue to abuse within the family as well as outside it[27].

433. Rizwan was re-interviewed and released on bail on 9 October 2013 to await a charging decision from CPS. Again, this decision complied with current standards and thresholds as the charges were unlikely to lead to a custodial sentence of more than a year.

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[27] Stanko, E, (2004) *Reviewing the evidence of hate: Lessons from a project under the Home Office Crime Reduction Programme*: Sage
http://www.brown.uk.com/domesticviolence/stanko.pdf

434. The Panel recommended that the Chair of Brent Community Safety Partnership should write to the Association of Chief Police Officers requesting a national review of approaches to:

- investigating sexual offences including whether routine questioning of other family members should be introduced to assess whether they have also been victims;
- bail conditions in sexual offences cases including consideration of whether children and/or vulnerable adults live at the bail address;
- notifying other household members if an alleged sexual offender is bailed to their address including supporting household members to conduct their own risk assessments;
- notifying Children's and Adult Social Care if an alleged sexual offender is bailed to an address where a child or person at risk of experiencing harm is known to live.

435. The Panel also recommended that the Chair of Brent Community Safety Partnership should write to the Home Secretary requesting a review of approaches to bailing alleged sexual offenders prior to charging and to communicating the nature of their alleged offences to others living at the same address and to Children's and Adult Social Care if a child or person at risk of experiencing harm is known to live at the address.

436. Hertfordshire Police have said that there was not any information to suggest Rizwan would continue committing similar offences or to identify anyone as being in danger from him. Officers had no dealings with Penina as she was in hospital at the time of the initial investigation. Hertfordshire Police have said that they were unaware that Penina was vulnerable. However they were aware that she was in hospital and that he had met the two alleged victims in hospital. This suggests the need for further training and guidance for police officers on how to identify adults at risk of harm.

437. According to Hertfordshire Police, the degree of sexual violence used in the murder and the fact that Penina was both known and related to Rizwan does not correlate directly to the modus operandi and risk posed to the wider public and vulnerable females in the Hertfordshire offences. As set out previously, this suggests a relatively narrow approach to consideration of how sexual offenders operate and to risk assessment in relation to suspects accused of sexual offences.

438. Police should be aware that most perpetrators of sexual offences are not brought to justice due to both low reporting rates and high levels of attrition and that when dealing with alleged sexual offenders they may well only have a partial picture. The well-publicised cases of Worboys and Reid highlighted problems within the police investigative process, with failures in making connections between attacks. This resulted in both men offending repeatedly over a period of years and police failing to take action that would have brought them to justice at an earlier stage.

439. Many perpetrators of violence against women and girls offend in a variety of ways against a range of targets. The idea of a single 'modus operandi' is not supported by evidence. However, even within this narrow model, the Hertfordshire offences were against two vulnerable women dealing with

significant health issues who had recently been discharged from hospital. Penina also met this profile yet she was not seen as potentially at risk of harm from her son in law. Whilst it might not have been possible to predict that he would go on to murder her, it seems at least possible to predict that without serious intervention, he would pose a potential threat to her.

440. The Panel recommended that the Chair of Brent Community Safety Partnership should write to the Association of Chief Police Officers requesting a national review of guidance and training of police officers in understanding models of sexual offending. The Chair of Brent Community Safety Partnership should also write to the National College of Policing recommending a review of training on rape and sexual offences.

441. Safeguarding - No safeguarding concerns were identified by a range of agencies that had contact with Penina and she was not recognised as an adult who may be at risk of harm. The definition of a vulnerable adult is someone "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".

442. In the last six months of Penina's life, she experienced numerous falls, was admitted to hospital with signs of confusion and was also noted to be confused on a GP visit. During her hospital stay in April 2013, Penina failed a mini mental capacity test, was subject to a deprivation of liberty and had a lumbar puncture performed in her own best interests without her consent. She had expressive dysphasia and difficulties in communicating in English. From June 2013 she was in receipt of care services and as early as April 2013 a student nurse had suggested that they might be required. Yet she was never considered to be a vulnerable adult at risk of harm and was never discussed as part of a multi-disciplinary meeting or discharge planning meeting. The Panel has suggested that a checklist of risk triggers should be circulated to all staff involved in adult safeguarding, backed up by training as required. A draft checklist is attached as Appendix 8.

443. There is no evidence of communication between hospital and home services. There were opportunities for better liaison and for health professionals to have acted upon the information they documented in the medical records:

- 1 July 2013 Penina was seen by the neurology team as an outpatient. She was noted to be vague, disengaged, struggling to follow simple basic commands, noted to have a higher dose of Epilim despite not having epileptic activity, as confirmed by EEG. Penina was noted to have had frequent falls, and was diagnosed as having extensive white matter changes consistent with her cardiovascular risk, which essentially meant Penina was developing cognitive impairment, which would have a major impact on her life and that of her carers. There was a missed opportunity to explore with the family what other support there was for Penina.
- On 19 July 2013 Penina was assessed by the STARRS Rapid Response Team (provided by North West London Hospitals Trust) who documented that Penina lived alone. This was incorrect but it should have triggered awareness that Penina was a vulnerable adult. Elizabeth was in attendance at this point

and expressed her concerns about Penina's ability to cope. It was not evident from reading the medical records that these concerns were escalated or acted upon, by health staff. This was a missed opportunity to have a multi-professional meeting to discuss Penina's social and domestic living arrangements.

444. Staff documented conflicting information regarding Penina's living arrangements. This is concerning as Penina was discharged home unable to articulate herself in English and communicate the most basic information, presumed to be living alone with the support of two carers three times a day. One would question would this be considered a safe discharge from hospital and discharge planning appears inadequate.

445. No adult safeguarding issues were noted by staff throughout Penina's contact with health services. There were windows of opportunities to have held a discharge planning meeting and assess Penina's social and domestic arrangements, especially in light of the STARRS nurse documenting Penina lived alone and recording Penina's daughter stating her concerns about Penina's ability to cope at home.

446. The GP practice holds weekly clinical meetings which include discussion of any safeguarding children, domestic violence and safeguarding adult issues. Penina was known to be housebound, occasionally confused, in receipt of care services, unable to communicate in English and having expressive dysphasia. However she was not identified as at risk of harm and was therefore never discussed at a clinical meeting until after her death.

447. North West London Hospitals Trust made a safeguarding alert to Brent Adult Social Care in May 2013 following Rizwan's arrest for allegedly sexually assaulting two former patients. As set out previously, this referral should have been made to Hertfordshire Adult Social Care. A LADO referral form was completed although details of the alleged victims were not included. This was the wrong referral form although it displayed an intuitive insight about potential risk. North West London Hospitals Trust maintain that Brent Adult Social Care decided the referral did not meet the safeguarding threshold, whilst Brent Adult Social Care insist that they were unable to act because insufficient detail was provided.

448. Penina was still in Northwick Park Hospital at the time of Rizwan's arrest but she was not identified as potentially at risk. As mentioned above, Penina had recently failed a mini-mental capacity test which was not repeated, had been subject to a deprivation of liberty and had a lumbar puncture performed in her own best interests. Her hospital records contained no reference to her living at the same address as Rizwan and no connection was made between Rizwan and Penina by either the hospital or Brent Adult Social Care.

449. The North West London Hospital's NHS Trust Safeguarding Adults at Risk Policy (2013) was developed in accordance with the guidance from Protecting adults at risk: London Multi-agency policy and Procedures to Safeguard Adults from Abuse. Both documents appear to be centred on the actions to be taken after abuse or concerns has been raised or identified. Neither document focuses on how to identify an adult as risk. Staff are not directed on what questions to ask an adult or not to use the family as a means of communication or the necessity to

have an independent communication system. Independent interpreting may have allowed an adult like Penina the freedom to voice any concerns she may have had regarding her social and domestic circumstances.

450. Brent Adult Social Care received a safeguarding alert from North West London Hospitals Trust but it contained insufficient detail for them to be able to identify Rizwan. Even if they had, it is unlikely that they would have linked him to Penina as she was not registered at the same address and as far as Adult Social Care knew, was not a vulnerable adult at the time. If Adult Social Care had identified Penina, it is likely that she would have met the threshold to be assessed as vulnerable at the time. Within six weeks of the alert, Penina was in receipt of social care services and therefore undoubtedly met the definition of a vulnerable adult. However no information had been recorded on the adult social care IT system (FWi) as a result of the alert which might have acted as a trigger for action once she was in receipt of care services.

451. As set out in the section on individual agency responses, this was due at least in part to the fact that the FWi system is organised on the basis of potential victims and not potential perpetrators and Brent Adult Safeguarding team are already working to address this with their IT department.

452. A further opportunity for the connection between Penina and Rizwan to be made occurred in July 2013 when a LADO alert was made to Brent Children's Social Care. However as the allegations related to sexual offences against adult women, Brent Children's Social Care decided to take no action. As discussed previously in relation to the police, this suggests a relatively narrow understanding of sexual offending which fails to recognise that some sexual offenders abuse both adults and children. The alert was not referred on to Adult Social Care which might have triggered an appraisal of the risk Rizwan posed to Penina, who was by then in receipt of care services and would have met the definition of a vulnerable adult. Had Adult Social Care received this referral it is likely that further investigations would have occurred to ensure that Penina was closely monitored for signs of abuse and was not left in the sole care of Rizwan to minimise any risk of harm. Brent Adult and Children's Social Care have taken steps to ensure reciprocal referral processes and better communication when either or both of them receive a safeguarding alert.

453. The GP decided not to contact the Child Safeguarding Lead at the time that Elizabeth and Rizwan reported anger issues, including physical aggression, between them. The self-reporting of violence did not receive the same response from the GP that a domestic violence notification would have. The GP felt the couple were being proactive in seeking help to address their issues and said he did not want patients to feel they could not raise these issues. The GP was unaware that the police had been called to a previous domestic violence incident. He made an anger management referral, which is contra-indicated in situations of domestic violence.

454. The GPs indicated that when parents self-report violence, it is not treated with the same level of concern as would be afforded a notification of domestic violence from an external source. Self-reporting is not coded as an active problem whereas an external referral is.

455. The GP believes he now has a lower threshold for referral of child

safeguarding concerns in situations of potential domestic violence. The practice around this issue requires further exploration and GPs may need further guidance so the impact of reported violence on children is fully assessed.

456. Role of violent pornography - it was clear at his trial that Rizwan was a regular viewer of violent pornography and the prosecutor argued that Penina's murder was linked to this. There is only one reference to Rizwan's pornography use in agency contact prior to her death. The Metropolitan Police were called to a domestic violence incident in March 2008 which had been triggered when Elizabeth noticed the browser history on the family computer indicated a number of pornographic web sites had been visited. The nature of the pornography that Rizwan was viewing at that time is not known although in the period before the murder he was searching for videos of incest pornography and violent rape. The police have indicated there would have been little scope for them to seize the computer unless it was thought that he was viewing child pornography.

457. The Panel recommended that the Chair of Brent Community Safety Partnership should write to the Home Secretary, Secretary of State for Education and Secretary of State for Justice requesting a review of whether possession of violent pornography should be included in risk assessments for domestic violence, safeguarding adults and children, and sexual offences.

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

458. Agencies identified a range of relevant training available to professionals. For example, Ealing NHS Hospital Trust provides regular mandatory joint domestic violence training and professional updates across both adult and children's community services.

459. Staffs working at the Brent GP practice have received training at a level appropriate to their role for safeguarding children but not all staff have yet had training on safeguarding adults, the Mental Capacity Act and Deprivation of Liberties. 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

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

- Narrow approach to risk assessment with a lack of join up regarding offending across forms of violence against women and girls/age groups/relationships;
- Children’s Social Care viewing sexual assaults against adults as not relevant to safety of children;
- Children’s Social Care not referring alert re sexual assaults against adults to adult social care;
- Lack of consideration of potential victims who are not identified as ‘vulnerable’.

461. These issues have been explored above.

Identity and diversity issues

462. As set out previously, 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.

463. Penina was a relatively recent immigrant to Britain, arriving from her native Fiji in 2009. She had a number of impairments following a stroke suffered during the journey, including expressive dysphasia and right sided weakness. Prior to the stroke, Penina had been bilingual in Rotuman and English, but lost her capacity to communicate in English. At times, she appears to have struggled with her understanding of English. Her level of impairment increased markedly from April 2013 reducing her mobility and independence. Carers visited daily from June 2013 until Penina's death in October 2013.

464. As discussed previously, 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. Agencies have said that her expressive use of hand gestures indicated understanding of basic commands such as moving her arm, attempting to stand etc but relying on such basic communication did not afford Penina the opportunity to express her views nor to disclose any abuse that she may have been experiencing.

465. When a patient is unable to communicate in English, additional measures should be sought rather than routinely using the family to interpret. North West London Hospitals NHS Trust Language and Interpretation Service policy 2011 clearly states that any patient whose first language is not English has a right to an interpreter. The policy further states that it is a health professional's responsibility to ensure the patient understands what they are being told.

466. Throughout all care episodes there were windows of opportunity for staff to have spoken to Penina via an interpreter, in order to ascertain her level of capacity and to get her consent in relation to the care she received but these were never taken. Penina was a migrant with no experience of health care or health services in the UK and was reliant on her daughter and son-in-law to access care.

467. Penina was discharged from community health services on a number of occasions for not responding to or attending appointments but it does not appear that any account was taken of her communication and language barriers.

468. 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.

469. Penina was never deemed to require an advocate however, as research has shown, "An advocate will have an opportunity to see an older person's life as it

really is, rather than a sanitised version which may be 'offered' to someone from a statutory service such as a social worker or police officer".[28] Had she been recognised as a vulnerable adult who possibly lacked capacity she would have had access to an Independent Mental Capacity Advocate (IMCA).

470. Both Rizwan and Elizabeth were relatively young when the twins were born (22 and 19 respectively). The twins were born prematurely resulting in considerable health issues. From 2009, the couple also provided support to Elizabeth's parents after their arrival from Fiji. Penina suffered a stroke en route as set out above and her husband John required care related to dementia. It is well recognised that those caring for children with extensive medical needs or adults with extensive care needs or a combination of both need support. Carer organisations suggest that existing issues within relationships can increase when a caring role is taken on.

471. There is little evidence that agencies recognised the impact of these caring demands on the family. Although Elizabeth and Rizwan were acting as carers for Penina this was not recorded in the GP practice's carer register or in Rizwan's records. There were long periods of time between each occasion when Rizwan was displaying signs of not coping (such as sleeping difficulties) and his wife only indicated difficulty in coping once. Full use of carer registers, not only for those in care establishments but for relatives, will increase GPs awareness of those individuals who may have fluctuating support needs.

472. There are gaps identified in some areas of practice including information on the received GP referral information; how appointments are offered to patients who may be dependent on carers/family and similarly how patients are discharged from STARRS; routine use of interpreters and some record keeping issues. These are addressed in the recommendations to improve practice.

473. The panel recognised that Penina and Rizwan's sex could be relevant. As mentioned previously there is extensive research to suggest that females are at a greater risk of being sexually assaulted than males.[29] The majority of perpetrators are men known to the victim.[30] The pornography that Rizwan was accessing in the period prior to Penina's murder was about incest and violent rape and this was seen as directly relevant to the murder. The senior investigating officer in the case believed that the abuse may have been going on for some period. In the few days before her death, Penina told her carers that she wanted to return to Fiji. Whilst agencies had little awareness of Rizwan's pornography use, as set out previously different agencies did have parts of a picture of his potentially escalating offending behaviour but this was not brought together.

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[28] Action on Elder Abuse (AEA) (undated C2007) *Elder Abuse Advocacy Toolkit, funded by the Department of Health*, London: Action on Elder Abuse

[29] For example, the Crime Survey for England and Wales found that females are more than five times as likely as males to have been a victim of a serious sexual offence (including attempts) in the previous 12 months (An Overview of Sexual Offending in England and Wales**,** Ministry of Justice, Home Office & the Office for National Statistics, 2013, p6, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214970/sexual-offending-overview-jan-2013.pdf)

[30] ibid, p16

Escalation to senior management or other organisations/professionals

474. As set out previously, 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.

475. Similarly, senior managers in Brent Adult Social Care were not alerted to the incomplete referral from North West London Hospital Trust and the subsequent lack of follow up by the social care worker.

476. It is not recorded if the near miss when Penina was prescribed the wrong type of antibiotics was escalated to senior management. The error was averted by Penina's daughter Elizabeth, and, as no dose had been administered, no treatment was required.

Impact of organisational change

477. There was a review of Adult Safeguarding Team in 2012 and implementation of a new structure to the team in July 2013. This was to improve the skills and ability of the team to undertake safeguarding investigations. It is noted that at the time of the safeguarding referral the team was about to start a period of transition. The transition was shared with all partner agencies via the Safeguarding Adults Board and existing locum staff were used to provide consistency to the team during the transition. At the time of the alert on 2 May 2013 there was a lack of administrative staff within that team. The team has now being restructured to provide for additional administrative support. However the worker was aware of the requirement to record the information or escalate the matter to the duty inbox.

478. There is no evidence within the records that organisational change over the period covered by the review had impacted in any way on partnership agencies' ability to respond effectively.

Learning in relation to the children

479. Both children had multiple hospital admissions and presentations. Liaison between health and therapies worked well to promote optimal health to both children. It appears that at the time covered by this review the emergency department did not have regular safety net meetings in place. Safety net meetings should include the Paediatric Liaison Health Visitor, who is best placed to act as a conduit between acute and community health services. The presence of a Paediatric Liaison Health Visitor assists in identifying children who frequently attend the emergency department and ensures their information is uploaded on the RIO system, a community health database. 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.

480. 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

481. Information about allegations against Rizwan and his potential for committing violence were not explored and brought together. As set out previously in the section on Communication and Information Sharing, in the period before Penina's murder, agencies knew a number of things about Rizwan:

- alleged kidnapping and false imprisonment of a fifteen-year-old girl in 2001 in which he was alleged to have used a blade to threaten her (Metropolitan Police);
- domestic violence incidents in 2006 and 2008 (Metropolitan Police, 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);
- 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).

482. This suggests that agencies continue to respond to violence against women and girls as isolated incidents rather than potentially as patterns of behaviour. The approach 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.

483. 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. It is not known whether the two alleged sexual assault victims were formally identified as 'vulnerable' within the No Secrets definition. However it is certainly possible that an offender like Rizwan could have groomed adult women in hospital who would not have been formally considered as 'vulnerable' but who might have been at greater risk due

to their health needs and the relative position of power that Rizwan occupied. Elizabeth would not have been considered vulnerable but he was alleged to have physically assaulted her previously and she was not warned that he was being investigated for rape and to consider her own risk and that of her mother and children.

484. Agencies need to consider who the perpetrator will have contact with and what risk he may pose to them, regardless of whether they are formally an 'adult at risk'[31]. A greater focus on managing potential perpetrators would enhance safeguarding. 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.

485. 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 lack of any multi-agency sharing process for considering either Penina or Rizwan (beyond the relatively limited approach of Hertfordshire Police, University of West London and North West London Hospitals Trust) meant that the information that was known was never brought together. The development of the MASH process will help to fill this gap in relation to children. There is a need for an equivalent LADO process for vulnerable adults. Both the children's and adults' processes need to work together in recognition that perpetrators may offend against both adults and children.

486. The review also reinforced the need for agencies to act on the recommendations of the Bichard review. If Willow Children's Centre or Brent Children's Social Care had made a referral about Rizwan's sexually inappropriate behavior to the police, then that information might have been logged on the Police National Database and been available to Hertfordshire Police. This might have encouraged them to expand their investigation, including making contact with the Metropolitan Police. Had the Willow information been available to the Metropolitan Police Service, it might also have influenced their decision about what to disclose to the University of West London. Agencies should refer concerns about sexually inappropriate behaviour and sexual offending to the police in order that they can be investigated.

Contributory Factors and Root Causes

487. 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;

[31] The term 'vulnerable adult' is being replaced by 'adult at risk' but the changing wording does not alter the scope of who it applies to i.e. it would not widen agencies' considerations beyond people in receipt or in need of care services

- 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 as an individual.

488. These issues have been considered above and are addressed within the recommendations and action plan.

SECTION 6 - WAS THIS HOMICIDE PREVENTABLE?

489. All agencies that commented believed this homicide was not 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.

490. A different approach to disclosure from the Metropolitan Police might have prevented the alleged sexual assaults against former patients (though he may have come to attention for sexual offending in a different arena - see above re issue of escalating behaviour that requires intervention) 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.

491. Even if all these areas had been improved, it might not have been possible to predict that Rizwan would murder Penina. However, as set out previously, 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.

492. 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.

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

SECTION 7 - RECOMMENDATIONS

CHILDREN'S SOCIAL CARE (CSC)

1. When a child and family assessment is being conducted, it should include all members of the household.
2. Each new allocated case worker must read back files to ensure that they understand previous concerns and can act appropriately if new concerns emerge.
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.
4. Greater coordination and liaison is required between the Children's Social Care LADO and the Adult Safeguarding Manager on cases involving adults who may pose a risk to any vulnerable person.
5. Accurate written records must be kept of all referrals into and out of Children's Social Care and the subsequent actions agreed from the referral clearly recorded.

EALING NHS HOSPITAL TRUST

Children's Community Health Services

6. Children with special needs should have their records transferred to school health following a:
    a. verbal communication with lead health professional
    b. written summary of the history and current health needs
    c. any outstanding interventions required.
7. To review the border arrangements between Brent and Harrow to ensure that children and young people are followed up by Named Health Visitor/Named School Nurse.
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 in line with the Trust Child Protection Supervision Policy.

District Nursing Service

9. To remind all District Nurses to follow-up no-access visits as outlined in the Trust No Access Policy.
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.
11. Where a number of professionals and agencies are involved, a multi-disciplinary team (MDT) meeting should take place to establish a joint care plan and discuss any concerns.

All Adult Community Health Services

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. This information will help in the process of triage, offering the right type of appointment and avoid delays.
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.
14. Safeguarding training to incorporate lessons learnt from this case.
15. To reinforce best practice to all community staff regarding the use of interpreters, especially for initial assessments.
16. Trust to review its guidance to clinical staff regarding mental capacity assessments.

BRENT CCG - GPs

17. All GPs in Brent to be offered refresher training in adult safeguarding, including recognising vulnerable adults.
18. All GPs in Brent to be offered refresher training in the Mental Capacity Act. This training is to include referral procedures for adult safeguarding, domestic abuse (including the risks of anger management where there is a possibility of domestic violence), information sharing, undertaking Mental Capacity assessments and acting in a person's Best Interests.
19. All GPs in Brent to be offered refresher receive training in confidentiality.
20. All health professionals should recognise twin pregnancies as vulnerable and offered enhanced services following the birth.
21. Domestic abuse should be considered in the context of the family or household, including the impact on children.
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.
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.
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.

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.
26. All GP practices to be encouraged to develop a flagging system to identify vulnerable adults.

NHS ENGLAND

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.
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.
29. NHS England, London will forward the Royal College of General Practitioners' (RCGP) 'Responding to Domestic Abuse: guidance for general practices'[32] (2012) to all GPs and Practice Managers commissioned by NHS England, London.
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.
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.

NORTH WEST LONDON HOSPITALS TRUST

32. All staff to be offered refresher training in adult safeguarding including recognising vulnerable adults with an emphasis on domestic homicide and domestic violence
33. All Trust staff to be offered refresher training in the Mental Capacity Act (MCA).
34. All staff to understand Deprivation of Liberty process and MCA.
35. Best Interest Assessors to be named.
36. Domestic abuse should be considered in the context of the family or household, especially the impact on children.
37. To establish and fund a safeguarding team.
38. To provide supervision and development of the Adults & Children's Safeguarding Teams.

[32] 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

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 incorporated in the North West London Hospitals NHS Trust Safeguarding Adults at Risk Policy (2013) and form part of the level 3 safeguarding adult training.

BRENT ADULT SOCIAL CARE

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.
41. To review the current recording policy to evaluate what can be recorded on an alleged perpetrator's file.
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.
43. To create a LADO process for Adult Social Care Safeguarding team to ensure any safeguarding concerns raised regarding professionals working with vulnerable adults is investigated and followed up in accordance with Adult Safeguarding procedures.
44. To develop a local Adult Lado protocol in Brent to further safeguard vulnerable adults.
45. To improve operational links between 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.
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.
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.
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.
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.

HERTFORDSHIRE POLICE

50. SOIT officers to submit intelligence at an earlier stage of an investigation rather than the conclusion.

51. To review the policy regarding data protection surrounding suspects arrested for sexual offences where vulnerable persons are at risk.

METROPOLITAN POLICE SERVICE

52. Brent BOCU should remind Initial Investigating 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).

SCHOOL ADMISSIONS

53. The team manager should ensure that all team members are aware of the Brent Safeguarding procedures.

54. Team members should access the level 1 and level 2 multiagency safeguarding training provided by the Local Safeguarding Children Board.

55. Responsibilities for safeguarding should be included in all job descriptions.

SPECIAL EDUCATIONAL NEEDS ASSESSMENT SERVICE

56. The team manager should ensure that all team members are aware of the Brent Safeguarding procedures.

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.

58. Managers should check that the responsibilities for safeguarding are included in all job descriptions and induction programmes.

59. During the statementing process, all notes and assessments from Educational Psychologists should be stored on the SENAS Tribal data base.

60. As part of the statementing process, SENAS should check social care involvement through accessing the Framework I data base.

BRENT COMMUNITY SAFETY PARTNERSHIP

61. The Chair of Brent Community Safety Partnership should write to the Association of Chief Police Officers requesting a national review of:
    - approaches to investigating sexual offences including whether routine questioning of other family members should be introduced to assess whether they have also been victims;
    - approaches to bail conditions in sexual offences cases;
    - approaches to notifying other household members if an alleged sexual offender is bailed to their address including supporting household members to conduct their own risk assessment;
    - approaches to notifying Adult Social Care if an alleged sexual offender is bailed to an address where a person at risk of experiencing harm is known to live;
    - guidance and training of police officers in understanding models of sexual offending;
    - operation and effectiveness of the Police National Database.

62. The Chair of Brent Community Safety Partnership should write to the Home Secretary requesting that:

    - the Home Office should undertake a review of the operation of the enhanced disclosure scheme by the Police and Disclosure and Barring Service and whether the intent of the Bichard recommendations has been undermined by subsequent case law. The review should identify ways of ensuring that agencies training or employing health and social care professionals are aware of allegations of sexual and domestic violence, kidnapping and false imprisonment and sexual harassment when making decisions about whether to admit individuals to train or work in health and social care professions.
    - the Home Secretary uses her power under Section 9 of the Domestic Violence, Crime and Victims Act (2004), subsection 6, to amend Section 9, subsection (4) of the Domestic Violence, Crime and Victims Act (2004) by order and name all bodies in receipt of public funding as having a statutory responsibility to participate in domestic homicide reviews.
    - the Home Secretary reviews the legislation governing other statutory requirements to review and ensures that all bodies in receipt of public funding be required to participate if the review chair requests their involvement;
    - the Home Secretary reviews approaches to bailing alleged sexual offenders prior to charging and to communicating the nature of their alleged offences to others living at the same address and to Children's and Adult Social Care if a child or person at risk of experiencing harm is known to live at the address.

63. The Chair of Brent Community Safety Partnership should write to the National College of Policing recommending a review of training on rape and sexual offences.

64. The Chair of Brent Community Safety Partnership should write to the Home Secretary, Secretary of State for Education and Secretary of State for Justice requesting a review of whether possession of violent pornography should be included in risk assessments for domestic violence, safeguarding adults and children and sexual offences.

65. The Chair of Brent Community Safety Partnership should write to the University of West London requesting a review of procedures for suspending a nursing student including:

    - the University formally notifying the Trust responsible for the placement that the student has been suspended;
    - the University removing the student's uniform as part of the suspension process.

66. The Chair of Brent Community Safety Partnership should write to the Nursing and Midwifery Council requesting a review of the regulation of student nurses and consideration that student nurses should be required to register with their professional body in the same way that student social workers are.

67. The Brent Community Safety Partnership will monitor and review the action plan set out at Appendix 3.

SECTION 8 - GLOSSARY

A&E – Accident and Emergency
ACPO – Association of Chief Police Officers
AEI - Approved education institution
CCG – Clinical Commissioning Group
CRB – Criminal Records Bureau
CRIS - Crime reporting Information System
CSC – Children's Social Care
DBS – Disclosure and Barring Service
DHR – Domestic Homicide Review
DOLS – Deprivation of Liberty Safeguards
FWi – Framework-I social services casework management system/database
GP – General Practitioner
IMR – Individual Management Review
LB – London Borough
LSA – Local Supervising Authority
LSCB - Local Safeguarding Children Board
NMC – Nursing and Midwifery Council
PNC – Police National Computer
PND – Police National Database
SENAS – Special Educational Needs Assessment Service

Appendix 1 – Terms of Reference

SAFER BRENT PARTNERSHIP DOMESTIC HOMICIDE REVIEW (DHR) PENINA ROBINSON

DRAFT TERMS OF REFERENCE

Overarching aim

The over-arching intention of this review is to learn lessons from the homicide in order to change future practice that leads to increased safety for potential and actual victims. It will be conducted in an open and consultative fashion bearing in mind the need to retain confidentiality and not to apportion blame. Agencies will seek to discover what they could do differently in the future and how they can work more effectively with other partners.

Principles of the Review

1. Objective, independent & evidence-based
2. Guided by humanity, compassion and empathy with the victim's voice at the heart of the process.
3. Asking questions, to prevent future harm, learn lessons and not blame individuals or organisations
4. Respecting equality and diversity
5. Openness and transparency whilst safeguarding confidential information where possible

Specific areas of enquiry

The Review Panel (and by extension, IMR authors) will consider the following:

1. Each agency's involvement with the following family members between 1 January 2009, or in the case of Rizwan Ahad Ibrahim 1 January 2000, and the murder of Penina Robinson on 18 October 2013 (all resident at 57 Cairnfield Avenue, London NW2 7PH):

(a) Penina Robinson
(b) Rizwan Ahad Ibrahim
(c) Child 1
(d) Child 2

2. Whether, in relation to the family members, an improvement in any of the following might have led to a different outcome for Penina Robinson:

(a) Communication between services

(b) Information sharing between services with regard to the safeguarding of adults and children

3. Whether the work undertaken by services in this case was consistent with each organisation's:

(a) Professional standards

(b) Domestic violence policy, procedures and protocols

(c) Safeguarding adults policy, procedures and protocols

4. The response of the relevant agencies to any referrals relating to Penina Robinson, Child2 and Child 1, concerning domestic violence or other significant harm from 01/01/09 and any referrals relating to Rizwan Ahad Ibrahim concerning domestic violence or other significant harm from 01/01/00. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision-making and effective intervention in this case from the point of any first contact onwards.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

(d) The quality of the risk assessments undertaken by each agency in respect of Penina Robinson and Rizwan Ahad Ibrahim.

5. The training provided to adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done so as to safeguard and promote the welfare of children or vice-versa.

6. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.

7. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any special needs on the part of either of the parents or the child were explored, shared appropriately and recorded.

8. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

9. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

TERMS OF REFERENCE FOR THE CHILD'S ELEMENT OF THE DOMESTIC HOMICIDE REVIEW

10. In relation to this Review the children are not identified as victims as specified in paragraph 3.3, 3.4 and 3.6 of the DHR Guidance. The primary role of this element of the Review in relation to the children affected is to highlight any learning from this case which would improve safeguarding practice in relation to domestic violence and its impact on children.

11. In particular the Review should identify whether there is any learning in relation to effective communication, information sharing and risk assessment for all those children's services involved in Brent Council and also any other agencies and local authorities. It should also highlight any good practice that can be built on.

Panel Membership

Name/Job title	Role/Agency
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.

Family involvement and Confidentiality

The review will seek to involve the family of both the victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process.

We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

We will identify the timescale and process and ensure that the family are able to respond to this review endeavouring to avoid duplication of effort and without undue pressure.

Disclosure & Confidentiality

- Confidentiality should be maintained by organisations whilst undertaking their IMR. However, the achievement of confidentiality and transparency must be balanced against the legal requirements surrounding disclosure.
- The independent chair, on receipt of an IMR, may wish to review an organisation's case records and internal reports personally, or meet with review participants.
- A criminal investigation is running in parallel to this DHR, therefore all material received by the Panel must be disclosed to the SIO and the police disclosure officer.
- The criminal investigation is likely to result in a court hearing. Home Office guidance instructs the Overview Report will be held until the conclusion of this case. Records will continue to be reviewed and any lessons learned will be taken forward immediately.
- Individuals will be granted anonymity within the Overview Report and Executive Summary and will be referred to by an alias or by initials.
- Where consent to share information is not forthcoming, agencies should consider whether the information can be disclosed in the public interest.

Timescales

The review began on 4 December 2013. The aim is to conclude the review within six months. However this will be affected by the criminal trial and the review may be suspended pending any court case and resumed when any trial is concluded.

Media strategy

Until the conclusion of any criminal proceedings, all media queries will be referred to the Metropolitan Police. Following the conclusion of any trial, all media queries will be referred to Brent Council.

Appendix 2 – Combined chronology

(attached separately)

Appendix 3 – Action Plan

(attached separately)

Appendix 4 – Note on the Nursing and Midwifery Council (NMC) for the Brent DHR Panel

The Nursing & Midwifery Council (NMC) exists to protect the health and wellbeing of the public.

1. We register all nurses and midwives and ensure that they are properly qualified and competent to work in the UK.
2. We set the standards of education, training and conduct that nurses and midwives need to deliver high quality healthcare consistently throughout their careers.
3. We ensure that nurses and midwives keep their skills and knowledge up to date and uphold the standards of their professional code.
4. We ensure that midwives are safe to practise by setting rules for their practice and supervision.
5. We have fair processes to investigate allegations made against nurses and midwives who may not have followed the Code.

Our remit is set out in the Nursing and Midwifery Order 2001. The work of the NMC is governed by this and other associated legislation.

NMC's role in education

1. **Education standards**

We set standards for the length and content of all pre-registration nursing and midwifery education and training programmes in the UK. All programmes are approved by the NMC and provided by NMC-approved higher education institutions (universities (referred to as 'Approved education institutions' AEIs) in partnership with clinical placement providers.

(Guidance on professional conduct for nursing and midwifery students, http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Guidance-on-professional-conduct.pdf)

2. **Quality Assurance of education**

- We quality assure all NMC programmes of pre-registration nursing and midwifery education through robust processes of approval, self-assessment and reviews.
- We currently quality assure:
  - 79 educational institutions
  - Approximately 1,000 nursing and midwifery programmes

- From 1 September 2013, Mott MacDonald, an external contractor, will be delivering the quality assurance of education and local supervising authorities (LSAs) within a new framework.

(Further details here: http://www.nmc-uk.org/Educators/Quality-assurance-of-education/)

What we do

1. Set education standards, which shape the content and design of programmes and state the competences of a nurse and midwife.
2. Approve education institutions (universities) AEIs and maintain a database of approved programmes (courses).
3. Deliver quality assurance programmes.
4. Register nurses and midwives when they have successfully completed their courses.
5. Assess and ensure the quality of practice placements for students as their training consists of 50 percent theory and 50 percent practice

What we don't do

1. Educate or select students. This is done by the education institutions within the parameters in the NMC standards.
2. Set curricula. This is done by the education institutions within the parameters in the NMC standards.
3. Regulate students. If there are concerns about a student, this is dealt with by the education institution.
4. Assess practice settings' ability to support students' learning. This is done by AEIs.
5. Assess the quality of care in hospitals or the community. This is the responsibility of other regulators. These are: the Care Quality Commission in England, Healthcare Improvement Scotland, Healthcare Inspectorate Wales and Northern Ireland's Regulation and Quality Improvement Authority.

Good health and character guidance (2010)

This guidance helps both students and practising professionals understand what the 'good health and character' requirements are, including what we mean by reasonable adjustments and what must be done in case there is a chance of circumstances.

http://www.nmc-uk.org/Students/Good-Health-and-Good-Character-for-students-nurses-and-midwives/Reasonable-adjustments/

Following are some sections from the guidance relevant to this case:

Assessing good character

- When you apply for a programme you must declare any convictions, cautions, pending charges that might impact on good character.
- Programme providers should assess all applicants to decide what effect a caution or conviction might have on the person's ability to meet the NMC requirements for entry to a programme leading to registration. If you have a conviction or caution or pending charges, the relevance, seriousness, and circumstances in which the offence was committed must be taken into account.
- Programme providers should consider:
  - whether the conviction or caution was disclosed
  - the degree of risk posed to patients and service users
  - the length of time since the offence
  - whether there is a pattern of offending
  - how your situation has changed since the offence was committed
  - the circumstances surrounding the offence
  - your explanation of the offence
  - evidence submitted by you, or referees, of good character
  - your commitment to work safely and effectively upholding the trust and confidence of patients and clients.
- If a student is charged or has a conviction or caution during the programme -

If during your pre-registration programme you receive pending charges or a conviction or caution that may impact on your good character, you must notify the AEI immediately who should investigate in accordance with programme regulations. If necessary a local fitness to practise panel will meet to make a decision about your suitability to remain on the programme. This would apply if your attitude or behaviour is such that it is calls into question your good character.

- For further information about local Fitness to Practise panels see Good health and good character: Guidance for approved education institutions 2010.
- If you have a lengthy break in your programme your good health and good character should be assessed on your return. You should declare any changes to good health and good character to enable the programme provider to consider whether there is a need for further assessment and support.

Guidance for AEIs (2010)

http://www.nmc-uk.org/Documents/Guidance/nmcGood-HealthAndGoodCharacterGuidanceForApprovedEducationInstitutions.PDF

Pre-registration nursing education standards (2004) which also includes the standards for AEIs.

http://www.nmc-uk.org/Documents/Standards/nmcStandardsofProficiencyForPre_RegistrationNursingEducation.pdf

The NMC requires programme providers to ensure that processes are in place for assessment of an applicant's/student's good health and good character at admission to, during, and on completion of pre-registration nursing programmes.

Key points to note:

The 2004 Pre-registration nursing education standards (which were applicable at the time MY made his university application) state:

'Applicants must demonstrate that they have good health and good character, sufficient for safe and effective practice as a nurse, on entry to, and for continued participation in, programmes leading to registration with the NMC.'

and that -

'Approved educational institutions shall obtain evidence of the applicant's good health and good character as part of their selection, admission and ongoing monitoring processes.'

The 2010 version of the PRNE standards however specify that AEIs must require students to immediately declare any cautions and convictions they receive, including charges pending, before entering and throughout the programme. These tighter checks came into place only in September 2010 when Riwaz was already offered a provisional place in the programme based on the submissions he had done.

Appendix 5 – Email of 24 July 2014 from Disclosure and Barring Service

Subject: Domestic Homicide Review (DHR) - Request for Information from Disclosure and Barring Service

Davina

In relation to a request for information made to the DBS to assist a DHR, we received a further request to re-consider following our previous advice sent from Helen Ryan on 8th May and subsequently from Stewart Baxter on 18th June. We have done so in conjunction with both HO and DBS legal advisors and our response is contained below.

Response

We have considered further in conjunction with our legal advisors and we do not believe there is any specific legal provision to rely upon in order for DBS to provide the information requested. I have detailed our reasons below.

1. The first point to make is that the DBS has no statutory power to share information and without a statutory basis the DBS are unable to release information.

2. There is provision under the Protection of Freedoms Act 2012 (Para 14 of schedule 8) enabling the Secretary of State to direct the DBS in the exercise of its functions -

> *(1) The Secretary of State may give directions in writing to DBS in relation to the exercise of any of its functions other than a core function mentioned in paragraph 8(1)(a), (b) or (c).*

(2) The Secretary of State may vary or revoke any such directions.

(3) DBS must comply with any directions given under this paragraph

> However, 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's functions.

3. We also considered Para 18 of Schedule 8 of the Protection of Freedoms Act 2012 which states -

> *(1) In connection with the exercise of any of its functions DBS may—*

(a) enter into contracts and other agreements (whether legally binding or not),

(b) acquire and dispose of property (including land),

(c) borrow money,

(d) do such other things as DBS considers necessary or expedient. This is about doing those things that support the DBS in its function rather than supporting others in their functions so we do not believe this provision can be relied upon.

4. The Data Protection Act (DPA) applies to all information held by the DBS. In order to process personal information of a sensitive nature, as defined under the DPA, the DBS must comply with the principles of the DPA unless the circumstances fall within an exemption.

The first principle is that the processing, including disclosure of information, must be fair and lawful and fall within one of the conditions within both Schedules 2 and 3 of the DPA. Guidance from the Information Commissioner's Office is that disclosure of information from one organisation to another for use by that organisation, in the absence of express consent or full awareness at the time the information was provided as to the use that it would be put to, is not lawful or fair unless an exemption within the DPA applies. No such exemption applies to these circumstances.

One of the exemptions within section 35 DPA provides that - Personal data are exempt from the non-disclosure provisions where the disclosure is required by or under any enactment, by any rule of law or by the order of a court. There is no specific enactment requiring the disclosure of this information. The ICO guidance (Page 22) indicates that a court order or a witness summons are methods prosecutors may use to obtain criminal information but this is not under this category

I might be worth us setting up a tele-conference if that would be helpful so we can discuss this in more detail? We are trying to be helpful but do not want to breach any statute in doing so I think a discussion would be useful.

If we could understand how the information requested is relevant to the legislative functions and remit of the DHR and how the information will be used within those functions that may also assist us in re-considering the request. A suggestion may also be that if the individual is aware of the review, could they be asked to agree to disclosure of the information?

I am more than happy to discuss so please do contact me if you think it would be helpful to so.

Adele Downey
Corporate Services
DCEx & Director for Corporate Services
The Disclosure and Barring Service

Appendix 6 – Text of letter from DBS of 29 August 2014 explaining principles of disclosure process

Dear Davina

Further to my response of 27 August 2014, I would like to provide you with the answers to the three general questions posed in your letter of 23 August 2014, pending a final response in relation to the specifics of the person under consideration

The DBS has and will continue to cooperate with the review as far as it is legally able. We have sought legal advice and consulted with the Home Office, including its lawyers. The legal provisions enabling DBS to voluntarily share personal information with third parties are specified within the Safeguarding Vulnerable Groups Act 2006 and the Police Act 1997. Otherwise the DBS relies upon the powers provided to other bodies to require the provision of information by the DBS. Engagement with the Home Office has resulted in further consideration of wider legislative powers that may assist in this particular instance and the Home Office response is pending. Please find our response to each of the three general questions below.

What are the principles which underpin the enhanced disclosure scheme?

The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children.

The Disclosure and Barring Service (DBS) carries out criminal record checks for specific positions, professions, employment, offices, works and licences included in the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975.

A DBS certificate may be requested as part of an organisation's pre-recruitment checks following an offer of employment, including volunteering roles and applications for specific licences or for existing employees or volunteers or for licence renewals as part of ongoing safeguarding processes, (Individuals and the self-employed cannot apply for a check directly to the DBS.) Enhanced checks are predominantly carried out for roles or professions that work closely with the vulnerable (including children).

There are currently four levels of criminal record check available under the provisions of the Part 5 of the Police Act 1997. These are Basic, Standard, Enhanced and Enhanced with Barred List Check. The DBS does not provide Basic Checks yet and therefore the following information relates to the remaining three levels of checks,:

Standard checks – To be eligible for a standard level DBS certificate, the position must be included in the Rehabilitation of Offenders Act (ROA) 1974 (Exceptions) Order 1975.

A standard check will provide any convictions, cautions, reprimands or final warnings held on the Police National Computer. The DBS remove certain specified old and minor offences from DBS certificates in line with legislation introduced in May 2013.

Enhanced checks - To be eligible for an enhanced level DBS certificate, the position must be included in both the ROA Exceptions Order and in the Police Act 1997 (Criminal Records) regulations.

An enhanced check will provide any information prescribed by the legislation, that is information about a relevant matter that relates to the applicant, and held on the Police National Computer. Relevant matters are defined within the section 113A of the Police Act 1997, as amended following the recent case which determined that the disclosure of all cautions and convictions held of PNC was incompatible with a persons Convention Rights. Guidance is available on the DBS website and as an attachment to this letter.

Further the check will provide any information held locally by police forces and other data sources which the chief officer reasonably believes is relevant to the role or workforce applied for and in their opinion ought to be included on the certificate. The DBS does not have any role in determining whether the information held by the police force is relevant and ought to be disclosed. Section 113(B) of the Police Act 1997 set out the responsibilities of the DBS and limit the DBS functions to requesting that the chief officer make a decision in respect of whether any information is relevant to the application and ought to be disclosed. The DBS will then include the information disclosed by the chief officer in the certificate.

Enhanced checks with children's and/or adults' barred list check(s) – To be eligible to request a check of the children's or adults' barred lists, the position must be eligible for an enhanced level DBS certificate as above and be specifically listed in the Police Act 1997 (Criminal Records) regulations as able to check the appropriate barred list(s).

What process is followed by the DBS with regards to decisions made when an enhanced disclosure is requested?

The process that has been outlined below is in respect of the enhanced checks with children's and/or adults barred list check(s).

An enhanced check application with a check of both Adult's and Children's barred lists would go through the following process.

(i) The applicant will be asked to complete an application form by the person or organisation recruiting or employing them and must sign a declaration that their details are correct.

(ii) Once the applicant has completed the application form, an organisation, known as a registered body will verify the identity of the individual, provide details of the role or workforce the individual is looking to work/volunteer in and sign to say that they have the ability to request the check – known as answering the exempted question. This application is then countersigned and submitted to the DBS by the registered body – DBS will not accept applications directly from the applicant.

(iii) An enhanced check will include relevant matters held on the Police National Computer. The definition of relevant matter is set out in legislation (Police Act 1997 s113A(6) and includes: convictions, cautions, reprimands and final warnings. The DBS uses information provided on the application form to identify any potential matches to the PNC and where any such matches exist a job step

process will be followed to determine whether or not the record should be matched to the individual.

(iv) An enhanced check will also include any 'relevant information' which the police hold and consider ought to be disclosed on a certificate. The DBS uses the applicant's details to identify potential matches to any information held locally by police forces and other data sources and then asks the relevant chief officer to provide any information that they reasonably believe to be relevant to the role or workforce applied for and in their opinion ought to appear on the disclosure.

There is Statutory Guidance set out by the Home Office which makes reference to a Quality Assurance Framework which police forces use to support them in the procedural side of their decision making which aims to provide a consistent approach across all forces.

I have attached a copy of the Home Office Statutory Guidance and the Quality Assurance Framework which is produced by the DBS in agreement with the police forces.

(v) The DBS uses the applicant's details to search the relevant barred lists and determine whether or not the applicant is held on the list(s).

The certificate will contain details of relevant matters as they appear on the PNC – the DBS does not manipulate or amend any data, relevant information as it is provided by the chief officer – the DBS does not manipulate or amend the information and details of whether or not the individual is included on the relevant barred lists – where the individual is held on a list the details of the reason for barring are not provided.

In what circumstances would allegations of sexual offences, sexually inappropriate behaviour, domestic violence, kidnapping and false imprisonment or assaults be disclosed?

As described above, the DBS does not play a role in the determination of whether or not information is relevant to a role or workforce in respect of which the application is made; it is solely a decision for the relevant chief officer. On this basis I am unable to provide circumstances of when this information would be disclosed other than to reiterate it would be disclosed when provided to the DBS by the chief officer because he or she reasonably believes that the information is relevant to the role or workforce being applied for and in their opinion should be disclosed. The DBS is under a duty to place the information, which the chief officer has decided should be disclosed on the certificate.

I hope this answers your questions.

Yours sincerely

DCex and Director of Corporate Services, Disclosure and Barring Service

Appendix 7 - The Full Code Test

The Public Interest Stage

4.10 In 1951, Sir Hartley Shawcross, who was then Attorney General, made the classic statement on public interest: "[i]t has never been the rule in this country - I hope it never will be - that suspected criminal offences must automatically be the subject of prosecution". He added that there should be a prosecution: "wherever it appears that the offence or the circumstances of its commission is or are of such a character that a prosecution in respect thereof is required in the public interest" (House of Commons Debates, Volume 483, 29 January 1951). This approach has been endorsed by Attorneys General ever since.

4.11 Accordingly, where there is sufficient evidence to justify a prosecution or to offer an out-of-court disposal, prosecutors must go on to consider whether a prosecution is required in the public interest.

4.12 A prosecution will usually take place unless the prosecutor is sure that there are public interest factors tending against prosecution which outweigh those tending in favour, or unless the prosecutor is satisfied that the public interest may be properly served, in the first instance, by offering the offender the opportunity to have the matter dealt with by an out-of-court disposal. The more serious the offence or the offender's record of criminal behaviour, the more likely it is that a prosecution will be required in the public interest.

4.13 Assessing the public interest is not simply a matter of adding up the number of factors on each side and seeing which side has the greater number. Each case must be considered on its own facts and on its own merits. Prosecutors must decide the importance of each public interest factor in the circumstances of each case and go on to make an overall assessment. It is quite possible that one factor alone may outweigh a number of other factors which tend in the opposite direction. Although there may be public interest factors tending against prosecution in a particular case, prosecutors should consider whether nonetheless a prosecution should go ahead and for those factors to be put to the court for consideration when sentence is passed.

4.14 The absence of a factor does not necessarily mean that it should be taken as a factor tending in the opposite direction. For example, just because the offence was not 'carried out by a group' does not transform the 'factor tending in favour of a prosecution' into a 'factor tending against prosecution'.

4.15 Some common public interest factors which should be considered when deciding on the most appropriate course of action to take are listed below. The following lists of public interest factors are not exhaustive and each case must be considered on its own facts and on its own merits. Some common public interest factors tending in favour of prosecution

4.16 A prosecution is more likely to be required if: a) a conviction is likely to result in a significant sentence; b) a conviction is likely to result in an order of the court in excess of that which a prosecutor is able to secure through a conditional caution; c) the offence involved the use of a weapon or the threat of violence; d) the offence was committed against a person serving the public (for example, a member of the emergency services; a police or prison officer; a health or social welfare professional; or a provider of public transport); e) the offence was premeditated; f) the offence was carried out by a group; g) the offence was committed in the presence of, or in close proximity to, a child; h) the offence was motivated by any form of discrimination against the victim's ethnic or national origin, gender, disability, age, religion or belief, political views, sexual orientation or gender identity; or the suspect demonstrated hostility towards the victim based on any of those characteristics; i) the offence was committed in order to facilitate more serious offending; j) the victim of the offence was in a vulnerable situation and the suspect took advantage of this; k) there was an element of corruption of the victim in the way the offence was committed; l) there was a marked difference in the ages of the suspect and the victim and the suspect took advantage of this; m) there was a marked difference in the levels of understanding of the suspect and the victim and the suspect took advantage of this; n) the suspect was in a position of authority or trust and he or she took advantage of this; o) the suspect was a ringleader or an organiser of the offence; p) the suspect's previous convictions or the previous out-of-court disposals which he or she has received are relevant to the present offence; q) the suspect is alleged to have committed the offence in breach of an order of the court; r) a prosecution would have a significant positive impact on maintaining community confidence; s) there are grounds for believing that the offence is likely to be continued or repeated. Some common public interest factors tending against prosecution

4.17 A prosecution is less likely to be required if: a) the court is likely to impose a nominal penalty; b) the seriousness and the consequences of the offending can be appropriately dealt with by an out-of-court disposal which the suspect accepts and with which he or she complies; c) the suspect has been subject to any appropriate regulatory proceedings, or any punitive or relevant civil penalty which remains in place or which has been satisfactorily discharged, which adequately addresses the seriousness of the offending and any breach of trust involved; d) the offence was committed as a result of a genuine mistake or misunderstanding; e) the loss or harm can be described as minor and was the result of a single incident, particularly if it was caused by a misjudgement; f) there has been a long delay between the offence taking place and the date of the trial, unless: * the offence is serious; * the delay has been caused wholly or in part by the suspect; * the offence has only recently come to light; * the complexity of the offence has meant that there has been a long investigation; or * new investigative techniques have been used to re-examine previously unsolved crimes and, as a result, a suspect has been identified. g) a prosecution is likely to have an adverse effect on the victim's physical or

mental health, always bearing in mind the seriousness of the offence and the views of the victim about the effect of a prosecution on his or her physical or mental health; h) the suspect played a minor role in the commission of the offence; i) the suspect has put right the loss or harm that was caused (but a suspect must not avoid prosecution or an out-of-court disposal solely because he or she pays compensation or repays the sum of money he or she unlawfully obtained); j) the suspect is, or was at the time of the offence, suffering from significant mental or physical ill health, unless the offence is serious or there is a real possibility that it may be repeated.

Prosecutors apply Home Office guidelines about how to deal with mentally disordered offenders and must balance a suspect's mental or physical ill health with the need to safeguard the public or those providing care services to such persons; k) a prosecution may require details to be made public that could harm sources of information, international relations or national security. The views of victims or their families

4.18 In deciding whether a prosecution is required in the public interest, prosecutors should take into account any views expressed by the victim regarding the impact that the offence has had. In appropriate cases, for example, a case of homicide or where the victim is a child or an adult who lacks capacity as defined by the Mental Capacity Act 2005<http://pnld.westyorkshire.pnn.police.uk/docmanager/content/S932.htm>, prosecutors should take into account any views expressed by the victim's family.

4.19 However, the prosecution service does not act for victims or their families in the same way as solicitors act for their clients, and prosecutors must form an overall view of the public interest. 4.20 Where prosecutors have a responsibility to explain their decision to the victim, for example, when they stop a case or substantially alter the charge in a case, they must comply with the Code of Practice for Victims of Crime and all relevant CPS Guidance. Prosecutors must follow any agreed procedures, including abiding by any time period within which such decisions should be notified to the victim.

The Threshold Test

5.1 Prosecutors will apply the Full Code Test wherever possible. However, there will be cases where the suspect presents a substantial bail risk if released and not all the evidence is available at the time when he or she must be released from custody unless charged.

5.2 In such cases, prosecutors may apply the Threshold Test in order to make a charging decision.

When the Threshold Test may be applied:

5.3 The Threshold Test may only be applied where the prosecutor is satisfied that all the following four conditions are met: a) there is insufficient evidence currently available to apply the evidential stage of the Full Code Test; and b) there are

reasonable grounds for believing that further evidence will become available within a reasonable period; and c) the seriousness or the circumstances of the case justifies the making of an immediate charging decision; and d) there are continuing substantial grounds to object to bail in accordance with the Bail Act 1976<http://pnld.westyorkshire.pnn.police.uk/docmanager/content/S5.htm> and in all the circumstances of the case an application to withhold bail may properly be made.

5.4 Where any of the above conditions is not met, the Threshold Test cannot be applied and the suspect cannot be charged. Such cases must be referred back to the custody officer who will determine whether the person may continue to be detained or released on bail, with or without conditions.

5.5 There are two parts to the evidential consideration of the Threshold Test. The first part of the Threshold Test - is there reasonable suspicion?

5.6 First, the prosecutor must be satisfied that there is at least a reasonable suspicion that the person to be charged has committed the offence.

5.7 In determining whether reasonable suspicion exists, the prosecutor must consider the evidence which is currently available. This may take the form of witness statements, material or other information, provided the prosecutor is satisfied that: a) it is relevant; and b) it is capable of being put into an admissible format for presentation in court; and c) it would be used in the case.

5.8 If this part of the Threshold Test is satisfied, the prosecutor should proceed to the second part of the Threshold Test. The second part of the Threshold Test - will there be a realistic prospect of conviction?

5.9 Secondly, the prosecutor must be satisfied that there are reasonable grounds for believing that the continuing investigation will provide further evidence, within a reasonable period of time, so that all the evidence taken together is capable of establishing a realistic prospect of conviction in accordance with the Full Code Test.

5.10 The further evidence must be identifiable and not merely speculative.

5.11 In reaching a decision under this second part of the Threshold Test, the prosecutor must consider: a) the nature, extent and admissibility of any likely further evidence and the impact it will have on the case; b) the charges that all the evidence will support; c) the reasons why the evidence is not already available; d) the time required to obtain the further evidence and whether any consequential delay is reasonable in all the circumstances.

5.12 If both parts of the Threshold Test are satisfied, prosecutors must apply the public interest stage of the Full Code Test based on the information available at that time.

Reviewing the Threshold Test

5.13 A decision to charge under the Threshold Test must be kept under review. The evidence must be regularly assessed to ensure that the charge is still appropriate and that continued objection to the granting of bail is justified. The Full Code Test must be applied as soon as is reasonably practicable and in any event before the expiry of any applicable custody time limit or extended custody time limit.

Selection of Charges

6.1 Prosecutors should select charges which: a) reflect the seriousness and extent of the offending supported by the evidence; b) give the court adequate powers to sentence and impose appropriate post-conviction orders; and c) enable the case to be presented in a clear and simple way.

6.2 This means that prosecutors may not always choose or continue with the most serious charge where there is a choice.

6.3 Prosecutors should never go ahead with more charges than are necessary just to encourage a defendant to plead guilty to a few. In the same way, they should never go ahead with a more serious charge just to encourage a defendant to plead guilty to a less serious one.

6.4 Prosecutors should not change the charge simply because of the decision made by the court or the defendant about where the case will be heard.

6.5 Prosecutors must take account of any relevant change in circumstances as the case progresses after charge.

Appendix 8 – Draft List of Risk Triggers (in no particular order)

Poor mobility – reliance on aids/others to support mobility

Lack of capacity

If they are unable to communicate their wishes/needs clearly due to either capacity issues or physical health issues.

Social Isolation

The language they speak

Having a dependency on someone else to do something for them

Poor physical health/ short or long term

Mental Health issues

Cultural issues

Frailty

Learning Disability

Sensory issue

Substance misuse

Previous experience of abuse

Low self esteem

Social Isolation

Factors that staff should consider as raising potential concerns when occurring in relation to a vulnerable adult as above (in no particular order)

Consider the context of the referral (i.e. the context of this) did this raise any obvious concerns or unusual circumstances

If family answer on behalf of someone and do not let the person speak

Who the adult talks about and in what way i.e. positively or negatively

How the children etc speak about their parents i.e. positively or negatively

Family who are reluctant to maximise the adult's independence – not agreeing to rehab/equipment/supporting the adult to optimise their independence

The home environment being unkempt, sparsely furnished, cold, damp etc and there is support in place from carers or family in some capacity

Poor standard of hygiene and personal care of the adult if there are carers in place

If the carer is taking on a lot of responsibility and this seems to be too much and is likely to result in stress for the carer – how will they cope? May they harm the adult intentionally/unintentionally?

Are there any injuries on the adult?

Is there a change in presentation when someone else enters the room or is mentioned in conversation?

Changes in the adult's body language when certain issues are discussed

Eye contact of the adult when certain issues are discussed – either looking away/at the ground/ too intently at the worker/ or making regular eye contact with someone else appearing to seek authorisation/checking their happy with what they are saying

Negative comments made by the adult to describe them self

How does the adult/family/carer make the worker feel i.e. if the person is aggressive what impact does this have on the carer/family/adult

If the adult does not have access to main parts of the house and/or sleeps out of the bedroom?

If someone lives in the house but the adult owns it and they pay all the bills

How is the person's money managed? Is there a legal framework in place?

Who does the shopping? Is the adult happy with the food bought? Is there food in the house?

Adult has poor fluid and nutrition intake - Loss of weight? Dehydration?

Adult has poor sleeping pattern

Recurrent hospital admissions

Unexplained injuries/recurrent health issues linked to poor standards of care

The adult presents as anxious/stressed/frightened/tearful/nervous

Others not letting professionals gain access e.g. GP, Physio, District Nurses, Support Workers, Social Workers, carers etc

Adult is not motivated to express their opinion. Why is this?

Undue influence – are they feeling pressured into saying/doing something?

Neutralisation comments – "it is ok as she gets my shopping so I don't mind her taking money"

Adults declining support after they have agreed to it or declining it in general when this may place them at risk (important to consider positive risk taking)

Adult refusing support with personal care or becoming anxious distressed when this is being attempted

The adult is asking for someone to help their carer as they are not coping

The adult asking the carers to support them quickly and leave

The adult asking the carers to stay longer

Actions staff would take (in no particular order)

Raise an alert with the safeguarding team/family front door

Discuss concerns with your supervisor

Always speak to the adult alone – think about where this discussion should take place i.e. day centre (if they attend etc)

Ask the adult what they want to happen

Confirm/consider the adult's levels of capacity

Speak to the carer alone – they may say they are not coping

Consider support for the carer

Consider support for the alleged perpetrator

Who is the best person to have this discussion? May be a support worker/carer or district nurse. (a joint visit could be carried out)

Speak to other agencies/professionals to gather/verify/check information i.e. day centre/GP/district nurses/physio/OT/social worker etc

Consider any emergency action required – i.e. police, medical services, removal of the alleged perpetrator, emergency placement to safeguard the adult

Visit again

Ask direct questions – i.e. what is the bruise on your arm, are you frightened? As a carer are you feeling overwhelmed?

If someone discloses abuse, listen fully, reassure them you are listening

Be clear about boundaries of confidentiality

Ask about the family dynamics – consider who lives in the household, are there other children/adults? Are they at risk? Do any of these points relate to them?

Ask how the injuries occurred

Seek medical advice

Understand cultural issues

Offer advocacy

If there are language barriers then arrange for an interpreter and do not rely on the translation from family members

Never make assumptions – check referrals are made and actioned

Put a risk management plan in place if there are concerns

Ascertain if there are previous concerns

Explore the chronology of the case

Appendix 2 – COMBINED CHRONOLOGY

Date	Source of information	Family member	Event description, action and outcome
01/02/01	MPS Kilburn QK CRIS: 1903056/01 Kidnap/False Imprisonment	Rizwan	15 year old girl alleges that Rizwan kidnapped and falsely imprisoned her. Her uncle accompanied her to station and said suspect was Rizwan. Enquires with school and bus company, no corroborating evidence. Rizwan's home address visited. He was not there but his mother explained that the uncle had stolen items from her son. Victim challenged about her account, confirmed she did not wish for matter to be further investigated. Allegation closed, believed to be malicious, no further action taken.
26/04/02	Met Police and UWL IMR; letter from DBS	Rizwan	Caution for cannabis possession;
29/11/04	Met Police and UWL IMR; letter from DBS	Rizwan	Caution for possession of bladed item and fixed term notice for Using threatening, abusive or insulting words or behaviour
Dec 2004	Rizwan's personal statement to UWL CRB screening panel dated 22/03/10	Rizwan & Elizabeth	Rizwan and Elizabeth got married
Jul 2005	Medical records North West London Hospitals Trust (NWLH)	Twins	Birth of twins – premature resulting in ongoing health issues
24/07/06	MPS Kilburn QK CRIS: 1922697/06 Domestic Incident	Rizwan & Elizabeth	Police called by neighbours to domestic incident - argument between Elizabeth and Rizwan about a birthday cake (twins' 1st birthday on 23/07/06), Elizabeth threw away Rizwan's penis enlarging pills. Both

Date	Source of information	Family member	Event description, action and outcome
			said no violence, no further action
23/03/08	MPS Kilburn QK CRIS: 1906973/08 Common Assault MERLIN 08CTN 025517	Elizabeth & Rizwan	Police called to domestic incident, allegation that Rizwan assaulted Elizabeth following argument about him watching pornography on family computer, evidence of injury to Elizabeth, Rizwan arrested for common assault, made counter allegation that she assaulted him, scratches on him. Police decide no further action
Aug/Sep 2008	Brent Children's Social Care IMR	Rizwan	Rizwan began temporary employment at Willow nursery
05/11/08	Case recording of 5/11/08, Brent Children's Social Care records		Allegations by staff of inappropriate behaviour by Rizwan at Willow nursery where he worked - 'peeping' and 'masturbating' and 'flirting' with female staff in the toilets in the nursery. Elizabeth seen to hit Rizwan at nursery during argument about Rizwan having an affair with a 16 year old. Rizwan's temporary employment contract terminated
14/12/08	Brent Children's Social Care records	Elizabeth	Elizabeth tells a social worker that marriage is 'rocky' due to children's health needs. Parents referred to parenting classes and to apply for school places
06/01/09	Brent Children's Social Care records	Rizwan, twins	Rizwan came into conflict with Brent Early Years Service when he wanted his children to attend Willow nursery. It was fully subscribed at the time and twins not recongnised as disabled at the time. Rizwan referred to 'past incident' preventing allocation of place
28/01/09	Email printout, SALT service	Child 1, Child 2, Rizwan	Speech and Language Therapist seeing both twins at Wembley Centre clinic. Child 1 currently attending block of therapy but missed last 2 appointments due to ill health. Father phoned on both occasions to inform therapist.
02/02/09	GP record	Rizwan	2 year history of insomnia, secondary to twin's illnesses – short term hypnotic prescribed Temazepam. Return 2-3 weeks for review and discussion re longer term treatment.

Date	Source of information	Family member	Event description, action and outcome
12/02/09	Paper file, SALT service	Child 2, Rizwan, Elizabeth	Review appointment with Speech and Language Therapist for Child 2. Attended by both parents. Father said that Child 2's language had improved. Father asked about progress of request for Statutory assessment. Therapist had no information.
21/02/09	Medical records NWLH	Child 2, Elizabeth, Rizwan	Emergency presentation with acute breathing difficulties. Accompanied by both parents. Admitted to the ward Discharged home 21/02/2009
26/02/09	Copy of Referral form in paper file, SALT records	Child 2	Pro forma referral sent by Speech and Language Therapist to Brent Child Development Service requesting assessment by paediatrician. Child 2 referred for severely limited attention skills as well as disruptive behaviour and mildly delayed receptive language. Father also reported to have said that Child 2 gets upset when a routine is changed. Therapist reported that parents were "very upset" that twins were not welcomed into Uxedon Manor nursery and wanted a Statement so that the school would be able to handle them.
04/03/09	Community Services Brent records	Twins, Rizwan	Rizwan tells consultant paediatrician that family can't cope with twins' behaviour
07/03/09	Medical records NWLH	Child 2	Presented to the emergency department from home after running into a table and cutting the head Discharged Home 07/03/2009
19/03/09	Copy of Referral form in paper file, SALT service		Pro forma referral form sent to Brent CAMHS for both twins by Speech and Language Therapist, describing their aggressive and challenging behaviour. Twins reported to be "difficult to console and will have a tantrum that lasts over half an hour if they do not get what they want" and stating that "An appeal for a statement has been requested as no nursery or school will accept them until they get 1:1

Date	Source of information	Family member	Event description, action and outcome
			support".
17/04/09	GP records	Elizabeth and Rizwan	Attended GP saying they were having trouble controlling their anger which was resulting in physical aggression; referred for anger management to Brief Psychological and Counselling Service
21/04/09	Framework i, Brent Children's Social Care	Twins	Community paediatrician concludes that children not disabled, difficult behaviour considered to be due to inconsistent parenting
16/06/09	GP records	Elizabeth & Rizwan	Brief Psychological and Counselling Service rejected anger management referral; GP wrote to Rizwan suggesting RELATE
05/07/09	Community services Brent records	Twins, Elizabeth and Rizwan	Initial appointment at Brent Child and Family Centre. Both parents have given up work to focus attention on children (unclear since when)
19/07/09	Medical records NWLH	Child 2, Rizwan	Emergency presentation with acute breathing difficulties. Accompanied by father. Discharged home from the emergency department 19/07/2009
12/08/09	Copy of report in paper file, SALT service	Child 2	Speech and Language Therapist sent discharge report, stating that Child 2 has been discharged as "there are no longer any concerns regarding the speech and language skills".
22/08/09	Medical records NWLH	Penina, John	Arrival of Penina & John in Britain
22/08/09	Medical records NWLH	Penina	Penina admitted to Central Middlesex Hospital on arrival in Britain. Presenting problem confusion. Noted to have lost the ability to speak English. Blood tests noted AS to have latent syphilis a referral made to clinic of Genito urinary medicine. CVA diagnosed
Sep 09	Lyon Park school	Twins	Twins start at Lyon Park Infants

Date	Source of information	Family member	Event description, action and outcome
	records		
11/09/09	Medical records NWLH, GP	Penina (& Elizabeth & Rizwan)	Penina discharged to Elizabeth & Rizwan's address – expressive dysphasia, right sided weakness, loss of English speaking. Documented within the medical records that Penina was independent with self-care. Speech and language had not resolved. Patient discharge plan filed in the medical records had not been completed
07/10/09	GP letter uploaded on FWi Referral episode created on FWi	Penina	GP requests social care assessment for Penina
19/10/09	Medical records NWLH	Child 1	Reviewed by Respiratory team at the Royal Brompton and Harefield. Noted to be well and making very good progress from a respiratory point of view.
21/10/09	FWi, Brent Adult Social Care	Penina	Referral from the GP screened and allocated to Occupational Therapist Assistant for assessment visit within 28 days of referral.
24/10/09	GP records	Penina	Care package put in place following OT assessment
12/11/09	Medical records NWLH	Penina	Outpatient appointment with stroke team Noted to have made good improvements in mobility and self-care
17/11/09	Episode referral on FWi, Brent Adult Social Care	John (& Elizabeth)	Elizabeth requests social care assessment for her father
24/11/09	FWi, Brent Adult Social Care	Penina	OT visit to family home to complete specialist OT assessment of Penina Full functional assessment was completed and hand rail and bath

Date	Source of information	Family member	Event description, action and outcome
			board were recommended
03/12/09	GP record	Rizwan	A&E attendance, concerned he may have throat cancer
07/12/09	FWi, Brent Adult Social Care	Penina, John	Occupational Therapist Assistant review at family home of provided bath board and bath seat completed. Bath seat demonstrated to Penina. Occupational Therapist Assistant completed full functional assessment for John and recommended major adaptations to meet his needs
10/12/09	FWi documents	John	Housing Association turns down doing adaptations for John at Elizabeth and Rizwan's home saying he shouldn't be living there
24/12/09	Medical records NWLH	Child 2, Elizabeth	Emergency presentation with acute breathing difficulties. Accompanied by Elizabeth Discharged home from the emergency department 24/12/2009
06/01/10	FWi, Brent Adult Social Care	Penina	Penina's case closed to Occupational Therapist Assistant as no ongoing need or care is required
06/01/10	FWi, Brent Adult Social Care	John & Penina	Certificate of Visual Impairment received for John. John & Penina now living at new address. Unclear who, if anyone else, lives with them
15/01/10	Special Education Needs Assessment Services records	Twins	Start of statutory assessment of twins' special educational needs
16/01/10	Rizwan's student application, UWL	Rizwan	Rizwan applies for nursing training
24/01/10	Community Services Brent Paediatric medical	Rizwan & Elizabeth	CSB medical report says 'parents were reported to be both students in the NHS' and described them as warm and loving

Date	Source of information	Family member	Event description, action and outcome
	report		
26/01/10	Medical records NWLH	Child 1	Reviewed by the paediatric respiratory team at Northwick Park Hospital. Noted to be well and making very good progress from a respiratory point of view.
05/03/10	Rizwan's UWL student file	Rizwan	Rizwan brings copies of CRB disclosures from 2008 to nursing course Selection Day
08/03/10	Medical records, NWLH	Penina, Rizwan	Penina attended an Outpatient clinic appointment for assessment of speech and language. Accompanied by Rizwan. Medical history noted and full assessment undertaken. Plan made for Penina to have speech and language therapy.
11/03/10	Rizwan's UWL student file	Rizwan	Chair of UWL CRB screening panel writes to Rizwan re CRB disclosure
22/03/10	Rizwan's UWL student file	Rizwan	Rizwan responds to Chair of UWL CRB screening panel providing more info and a personal statement
April 10-March 12	Brent Adult Social Care records	Penina & John	Penina main carer for John who has dementia and is visually impaired
12/04/10	Rizwan's UWL student file	Rizwan	CRB screening panel decides to defer Rizwan's application pending further investigation, including a request for further information from Rizwan
16/04/10	Rizwan's UWL student file	Rizwan	CRB screening panel agrees to review Rizwan's file after Rizwan claims that his cautions were under review by the Information Commissioners Office. Letter informing him of this
28/04/10	FWi, Brent Adult Social Care	Elizabeth, John	Phone call referral from Elizabeth for her father, who has a visual impairment and dementia. Requesting an assessment to provide direct payments support
03/05/10	Medical records	Child 1	Review by Consultant Neonatologist

Date	Source of information	Family member	Event description, action and outcome
	NWLH		Making satisfactory progress
04/05/10	Medical records NWLH	Penina, Rizwan	Penina, outpatient appointment with orthopaedics. Attended with Rizwan who was used as interpreter. Complained of bi lateral knee pain. Noted as being an obese patient.
05/05/10	Lyon Park school records	Child 1 & Rizwan	Child 2 disclosed dad had hit them. Designated teacher took advice from social care (disputed by social care). Teacher spoke with dad who showed remorse. No further action taken
11/05/10	Rizwan's UWL student file	Rizwan	letter to Rizwan from CRB Screening Panel notifying him that application allowed to progress pending new CRB check
13/05/10	SENAS note on Tribal	Twins	Final statements of special educational needs issued for both children
24/05/10	Child development clinic file	Child 1	Multi-disciplinary assessment (Consultant Child Psychiatrist, Clinical Psychologist & Consult-ant Paediatrician) confirms diagnosis of ADHD
04/06/10	Medical records NWLH	Child 2	Emergency presentation with fever follows a booster injection some 3 days previous. No respiratory issues. Admitted to ward treated for infection Discharged home on 09/06/2010
06/06/10	Medical records NWLH	Child 1	Emergency presentation to Northwick Park emergency Department via London Ambulance with breathing difficulties. Accompanied by Elizabeth. Treated and discharged home on 08/06/2010
14/06/10	Framework i, Brent Children's Social Care records	Twins, Elizabeth	Telephone Contact from Elizabeth who confirmed that Child 1 has been diagnosed with ASD and ADHD (along with chronic lung disease) and Child 2 has been diagnosed with ADHD. Elizabeth would like to be assessed for Direct Payments (DP)

Date	Source of information	Family member	Event description, action and outcome
22/06/10	Medical records NWLH	Penina	Outpatients appointment with orthopaedics Left knee injected
03/07/10	GP records	Rizwan	Raised concerns with GP re erectile dysfunction. Prescribed drug. Several further contacts over the next month over this issue
05/07/10	Rizwan's UWL student file	Rizwan	University Administrator completes new CRB check application form for Rizwan
06/07/10	Framework i, Brent Children's Social Care records	Elizabeth, Twins	Elizabeth called wanting to know when assessment for Direct Payments would take place as both parents due to start university in September
26/07/10	GP records	Rizwan	Telephone contact re erectile dysfunction treatment. Given different drug
02/08/10	GP records	Rizwan	Telephone contact re erectile dysfunction treatment. Offered a different drug and option of referral to erectile dysfunction clinic. Turned down as Rizwan wanted to try medication first
10/08/10	Medical records, NWLH	Penina	Outpatient appointment seen by gynaecologist. MSU test taken for urodynamic assessment. Frequency urge and stress incontinence noted
13/08/10	FWi, Brent Adult Social Care records	John	Hospital requests social care assessment. John admitted due to a fractured neck of femur on 3rd July and will need a care package for discharge. Assessment took place in the hospital on 20 August, John discharged with a substantial care package on 24/08/10 Meetings to review John's care package held between Sep 10 and Mar 12
23/08/10	Framework i, Brent	Elizabeth, Rizwan,	Newly allocated social worker visits family home to start assessment

Date	Source of information	Family member	Event description, action and outcome
	Children's Social Care records	twins	for direct payments
23/08/10	GP records	Rizwan	Contact re erectile dysfunction. Agreed to seek referral to erectile dysfunction clinic from new GP as Rizwan moving house
24/08/10	Medical records, NWLH	Penina	Attended outpatient orthopaedic clinic regarding her arthritis
27/08/10	GP records	Penina	New registration check done. Basic demographic information obtained. Notes indicate patient from Fiji, speaks English poorly main language Rotuman. BMI 43.4. Regular medication noted. Advised re diet, health education given. Next of kin noted.
27/08/10 and 31/08/10	GP records	Twins, Rizwan	Twins and Rizwan attend new patient meetings.
06/09/10	Manor School records	Child 1	Child 1 starts at Manor School
Sep 10	Rizwan's UWL student file	Rizwan	Rizwan starts UWL training
30/09/10	Framework i, Brent Children's Social Care records	Elizabeth, Rizwan, twins	Resource Panel Decision: 2 hours per week Direct Payments awarded
19/10/10	GP records	Rizwan	GP consultation, Penile thrush, Canesten cream prescribed. Wife to be treated also
08/11/10	Medical records NWLH	Child 1	Review by Consultant Neonatologist Making satisfactory progress
26/11/10	Letter from DBS (12/09/14)	Rizwan	Enhanced CRB disclosure dated 26th November 2010 supplied to UWL. Matches information provided by Rizwan – cautions for cannabis possession and possession of a blade

Date	Source of information	Family member	Event description, action and outcome
03/12/10	MPS Kilburn QK CRIS: 1931653/10 Domestic Incident	Elizabeth & sister	Police called to domestic incident between Elizabeth and her sister; no evidence of any crime, no further action
10/12/10	Rizwan's UWL student file	Rizwan	Letter to Rizwan stating that CRB checks confirm information he supplied. Rizwan, formally admitted to nursing course
11/01/11	Medical records NWLH	Child 1	Review by Consultant Neonatologist Making satisfactory progress
02/02/11	GP records	Penina	Previous stroke (CVA) noted, CAT scan abnormal Nov 2009. Has swelling in left ankle discharged from orthopaedics yesterday – letter not received yet- daughter advises that they have suggested investigation / referral – chase up letter. Tramadol and paracetomol prescribed.
25/02/11	GP records	Rizwan	GP consultation. Headaches – reports allergy to aspirin, paracetomol and ibuprofen. Can only take Codeine phosphate. Requested prescription be faxed to the chemist – informed it is not a routine service – rang the chemist.
25/02/11	GP records	Penina	Penina reported continued lower limb pain
10/03/11	GP records	Rizwan	Reported difficulties with penile erection to his new GP
22/03/11	Manor School IMR	Rizwan & Child 1	School called Rizwan because Child 1 said that the father kicked the leg. Rizwan said that it had happened as the bus was arriving and he had nudged Child 1 with his foot and said come on. There was no mark or injury that was apparent. School explained to Dad that Child 1's autism diagnosis may cause the child to report information very literally and that may have interpreted this as a kick. An escort witnessed the event and confirmed that Rizwan did not kick the child.
03/05/11	Medical records NWLH	Child 2	Reviewed in paediatric clinic Good progress

Date	Source of information	Family member	Event description, action and outcome
05/05/11	GP records	Penina	Knee pain
18/05/11	Manor School Chronology	Child 1 & Rizwan	Child 1 said that when English was used at home to say “pardon” Dad had smacked them. School called Dad and Dad confirmed that he had smacked Child 1 on the bottom because he wants to use Arabic at home.
24/06/11	Special Education Needs Assessment Service records	Twins & Rizwan	Email request to LB Brent from Rizwan for both children to attend Gladstone Park Primary.
14/07/11	Child and Family Health Records RIO entry in files	Child 1	Speech and Language Service requested an urgent review assessment to be conducted as parents reportedly want Child 1 to attend a mainstream school from September 2011. School Occupational therapist and Speech and Language Therapist feel it is in Child 1’s best interest to stay in a special school provision. SALT Review assessment carried out in class followed by a discussion with class teacher.
15/07/11	Medical records NWLH	Child 2	Emergency presentation acute exacerbation of asthma. Accompanied by Elizabeth Discharged home 15/07/2001
18/07/11	Rizwan’s Student application file	Rizwan	Positive review at end of 1st year of study
01/08/11	Framework i, Brent Children’s Social Care records	Elizabeth, Rizwan, twins	Case de-allocated from Social Worker and held in duty folder in line with management of direct payments only cases
01/08/11	Special Education Needs Assessment Service records	Twins & Elizabeth.	Gladstone Park refuse to take twins. Special needs service inform Elizabeth who asks them to challenge decision
12/10/11	Special Education	Twins & Rizwan	Rizwan informs Special needs service that they no longer want Child

Date	Source of information	Family member	Event description, action and outcome
	Needs Assessment IMR		1 to move from Manor School
01/11/11	GP records	Rizwan	Requests GP to write mitigation letter to UWL re sleeping problems. Provided. Further request on 03/02/12 – told existing letter sufficed
07/11/11	GP records	Penina	Penina prescribed Tramadol for pain in her joints
25/11/11	GP records	Penina, Rizwan	Rizwan requests Tramadol for Penina
03/01/12	GP records	Rizwan	Reports flaky skin on penis after sex. Given cream and advised to go to GUM clinic if it did not resolve
10/01/12	Medical records NWLH	Child 1, Child 2	Child 1 reviewed by Consultant Neonatologist. Making satisfactory progress Child 2 reviewed in paediatric clinic. Good progress
22/01/12	SENAS records	Child 2	After some dispute between local auth and school, Gladstone Park admits Child 2 with funding for extra support
02/02/12	GP records	Rizwan	GP consultation. Penile rash – looks like lichen planus, complained of irritation after intercourse. GUM NAD – Aqueous cream.
13/02/12	GP records	Rizwan	Tells GP he is “unable to sleep at night, under stress and in turn unable to focus as much during my studies in class sessions and examination.” Requests further mitigation letter to UWL – told existing letter sufficed, advised to seek therapy for stress.
14/02/12	Medical records NWLH	Child 2, Elizabeth	Emergency presentation with asthma exacerbation. Accompanied by mother. Discharged same day.
08/03/12	Medical records NWLH, GP records	Penina	Out patients appointment, Neurology Carpel tunnel suspected, test arranged. She would benefit from a referral to an occupational therapist.
12/03/12	GP records	Penina	Requests more Tramadol

Date	Source of information	Family member	Event description, action and outcome
16/03/12	Rizwan's Student Application File	Rizwan	2nd Year, 1st placement review from Monks Park Primary Care Centre. The review noted Rizwan to have made good progress in his 2nd year and that he had met the professional standard expected for a 2nd year nurse.
18/03/12	GP records	John	John dies
09/04/12	Medical records NWLH	Child 2, Elizabeth, Rizwan	Emergency presentation with asthma exacerbation. Accompanied by both parents. Admitted. Discharged the following day.
10/04/12	GP records	Penina, Elizabeth	Daughter requests more Tramadol
11/04/12	GP records	Penina	Referral made for an occupational therapy assessment on the advice of the neurologist
15/04/12	GP records	Penina	Seen in neurology clinic
02/05/12	Rizwan's Student Application File	Rizwan	2nd Year, 2nd placement from Central Middlesex Hospital Gladstone 3. Review demonstrates Rizwan meets the expected standard of practice and behaviour for a 2nd year student nurse.
04/05/12	GP records	Penina, Elizabeth	Accompanied by daughter – sensible final year student nurse. Mum is awaiting cardiology opinion before GUM will treat syphilis, still awaiting results from neurophysiology tests two months ago. Plan to write to cardiologist and neurologist. Tramadol dose increased. Letter written 04.05.2012.
23/05/12	GP records	Penina	Attended with a cough for three days. Prescribed amoxycillin
24/05/12	GP records	Penina, Elizabeth	Call from daughter to say mother allergic to Penicillin - not coded on the system. Apologised and prescribed cephalexin instead if needed.
01/06/12	Medical records NWLH	Child 1	Child 1 presented to the emergency department with abdominal pain history of vomiting and a temperature On examination pain settled Paracetamol administered with good effect

Date	Source of information	Family member	Event description, action and outcome
			Discharged home the same day
07/06/12	GP records	Penina	Seen by a neurologist who suggested she needed carpal tunnel release
11/06/12	GP records	Penina	Fall (believed to be on 11/06/12)
13/06/12	GP records	Penina	Seen by GP re fall on 11/06/12. Examined, no evidence of major injury. For rehab to ensure safety mobilising – OT and Physio referrals made.
04/07/12	STARRS RiO records	Penina, Rizwan	First appointment following a referral from the GP on 14/6/2012. Assessment completed by Physiotherapist. The assessment record mentions that Rizwan is a nurse at Willesden Community Hospital
11/07/12	STARRS RiO records	Penina, Rizwan	OT STARRS assessment completed. Son-in-law present, refuses suggested adaptations saying the family is due to move in Sep
20/07/12	GP records	Penina, Elizabeth	Elizabeth requests repeat Tramadol
30/07/12	GP records	Penina, Rizwan	Son (believed to be recording error and to refer to Rizwan) requests repeat prescription. Repeat prescription process explained
23/07/12	Rizwan's student application file	Rizwan	2nd year 3rd placement review from Menzler Ward, Willesden Centre for Healthcare. Review demonstrates Rizwan meets the expected standard of practice and behaviour for a 2nd year student nurse.
20/08/12	GP records	Penina, Rizwan	Rizwan requests Tramadol prescription.
18/09/12	Medical records NWLH	Child 2, Elizabeth	Reviewed by Physiotherapist for ongoing cough, accompanied by mother
18/09/12	Framework i, Brent Children's Social Care records	Elizabeth, Rizwan, twins	Case reallocated for short break plan to be reviewed.

Date	Source of information	Family member	Event description, action and outcome
23/09/12	Framework i, Brent Children's Social Care records	Elizabeth, Rizwan, twins	Allocated s/w visits family to undertake review of short break
24/09/12	GP records	Rizwan	GP consultation. Sore throat advice and codeine phosphate prescribed.
24/09/12	Rizwan's student application file	Rizwan	Rizwan transferred to BSc in Adult Nursing
12/10/12	GP records	Penina, Rizwan	Requested Tramadol for headaches.
16/10/12	GP records	Penina, Rizwan	Request for repeat Tramadol for Penina, Recorded as from husband (now believed to be Rizwan)
25/10/12	STARRS records	Penina	Discharge letter sent as Penina did not make contact with STARRS team following several letters (in English) were sent to her
05/11/12	Framework i, Brent Children's Social Care records	Elizabeth, Rizwan, twins, Penina, Rizwan's sister	Home visit by social worker to review the short break plan. Children, Father, maternal Grandmother and paternal aunt seen at the family home, which was clean and tidy.
16/11/12	Medical records NWLH	Penina	Outpatients appointment, reviewed regarding her arthritis in both knees, and left ankle pain
23/11/12	Medical records NWLH	Penina	Outpatients appointment Orthopaedic upper limb clinic Referred to neurologist query carpel tunnel syndrome
10/12/12	GP records	Penina, Rizwan	Request for repeat Tramadol for Penina, Recorded as from son but believed to be Rizwan
10/12/12	Framework i, Brent Children's Social Care records	Elizabeth, Rizwan, twins, Penina, Rizwan's sister	Resource Panel Decision: Agreed to increase support from 2 hours to 4 hours per week.
28/12/12	GP records	Penina, Rizwan	Request for more Tramadol

Date	Source of information	Family member	Event description, action and outcome
Jan 13	Brent Children's Social Care records	Elizabeth, Rizwan & twins	Elizabeth phones Children's Social Care. She says Rizwan wants children to go to Islamic school but she is opposed.
25/01/13	GP records	Rizwan	Penicilin prescribed for inflamed throat and mouth
15/02/13	Medical records NWLH	Child 2, Elizabeth	Emergency presentation from school after the welfare worker noticed Child 2 looked blue. Arrived by private car. Accompanied by mother Treated and discharged home on 15/02/2013
19/02/13	Framework i, Brent Children's Social Care records	Elizabeth, Rizwan, twins	Case de-allocated (in line with management of direct payments only cases)
mid March 13	Herts Police records re Crime C4/13/955 Reported by victim to Herts police on 30/04/13	Rizwan	Rizwan meets Karen, a patient at hospital where he is a student; become friends and exchange phone numbers and texts
18/03/13	Medical records NWLH	Child 2, Elizabeth	Emergency presentation for acute exacerbation of asthma. Accompanied by mother Treated and discharged on 18/03/2013
19/03/13	Medical records, NWLH	Child 2	Emergency presentation for acute exacerbation of asthma. Accompanied by mother Treated and discharged on same day
20/03/13	GP records	Rizwan	Telephone consultation. Swollen tongue. Possible oral allergy
April 13	GP records	Penina	Largely self-caring until early April 13 (6 months before death)
05/04/13	Medical records NWLH	Penina	Presented to the Emergency department with a history of fall. Complained of right rib and arm pain. Limited information

Date	Source of information	Family member	Event description, action and outcome
			documented regarding assessment and care received during this presentation
08/04/13	GP records	Penina (& Elizabeth)	Fall, possible ministroke. Attended A&E then GP with daughter
12/04/13	GP records	Penina (& Elizabeth)	Fall, attended by community services then admitted to hospital; acting out of character, aggressive in hospital
16/04/13	Special Education Needs Assessment Service records	Twins & Rizwan	Child 1's annual review at Manor School states that "parents would like to move Child 1 to mainstream school where the other twin attends (Gladstone Park)"
16/04/13	Herts Police records re Crime J1/13/1416 Reported by victim via 999 on 30/04/13	Rizwan	Ruth admitted to hospital
16/04/13-23/04/13	Herts Police records re Crime J1/13/1416	Rizwan	Rizwan assists Ruth when she had medical incident in hospital toilets
22/04/13	GP records	Penina	Penina discharged from hospital
23/04/13	GP records	Penina	Penina readmitted to hospital – confusion, inappropriate sexual comments; treated for urinary infection
23/04/13	Herts Police records re Crime J1/13/1416	Rizwan	Ruth discharged from hospital
23/04/13	Herts Police records re Crime C4/13/955	Rizwan	Karen discharged from hospital

Date	Source of information	Family member	Event description, action and outcome
24/04/13	Medical records, NWLH	Penina	Lumbar puncture performed on Penina under general anaesthetic to rule out encephalitis
24/04/13	Herts Police records re Crime J1/13/1416	Rizwan	Rizwan visits Ruth (former patient) at her home with discharge papers; overfamiliar; returned that evening and got her phone number; frequent texts over next few days (while Penina in hospital; need to check if Child 2 also in hospital –dates for April 13 admission)
24/04/13 or 25/0413	Herts Police records re Crime C4/13/955	Rizwan	Rizwan allegedly orally rapes Karen
25/04/13	Medical records, NWLH	Penina	Security guards in place as Penina is aggressive on ward
26/04/13	Herts Police records re Crime J1/13/1416	Rizwan	Rizwan visits Ruth; allegedly kisses her against her will
27/04/13	Herts Police records re Crime J1/13/1416	Rizwan	Ruth tells her mother about Rizwan assault
30/04/13	Crime J1/13/1416 Reported by victim via 999 (Ruth) Crime C4/13/955 Reported by victim to Herts police (Karen)	Rizwan	Ruth reports sexual assault to Herts Police; tells her friend Karen who believes she has been targeted by same person; Karen reports sexual assault to Herts Police
01/05/13	Herts Police records re Crime C4/13/955	Rizwan	Karen makes written statement in hospital

Date	Source of information	Family member	Event description, action and outcome
01/05/13	Herts Police records, statements by NWLH staff	Rizwan	Police contact North West London Hospitals Trust re sexual assault allegations
02/05/13	Herts Police records, statements by NWLH staff	Rizwan	Rizwan arrested by police at Northwick Park Hospital and taken to police station; denied attending either victim's address; released on conditional bail until 27/06/13
02/05/13	Herts Police records	Rizwan	Rizwan vehicle and home address searched; Elizabeth hands over Rizwan's clothes to police
02/05/13	Herts Police records	Rizwan	Rizwan suspended by UWL
02/05/13	Emails between Deputy Director and Senior Practitioner; Interview with Senior Practitioner	Rizwan	Deputy Director of Nursing at NWLH notifies Senior Practitioner Adult Safeguarding Team, Brent Adult Social Care of alleged sexual assaults against former patients
02/05/13	Herts Police records	Rizwan	Hertfordshire Police made a referral to the Notifiable Occupation Scheme.
02/05/13	GP records	Penina	Penina discharged from hospital; discharge letter refers to out of character behaviour including frequent sexual comments
03/05/13	Medical records NWLH	Child 2	Outpatient appointment
14/05/13	Emails between Deputy Director and Senior Practitioner;	Rizwan	Email from and Senior Practitioner, Brent Adult safeguarding to Deputy Director of Nursing at NWLH requesting more detail re safeguarding alert

Date	Source of information	Family member	Event description, action and outcome
	Interview with Senior Practitioner		
15/05/13	Emails between Deputy Director and Senior Practitioner; Interview with Senior Practitioner, Statement of Deputy Director	Rizwan	Emails from Deputy Director of Nursing at NWLH to Senior Practitioner, Adult safeguarding: - confirming that she has asked matron from Northwick Park Hospital to forward Brent a safeguarding referral and that the perpetrator is due to go to court on 27 May 2013 - that no crime ref number but will forward it
31/05/13	GP records (under 05/06/13)	Penina	Unable to get out of bed alone
02/06/13-03/06/13	Medical records, NWLH; GP records	Penina	Fall on 2nd; seen in A&E on 3rd;
05/06/13	GP records	Penina & Rizwan	Rizwan requests home visit due to Penina's falls (4 in 3 days) and reduced mobility; treated for urinary infection; tramadol stopped; Rizwan says family struggling to cope
06/06/13 and 07/06/13	FWi, Brent Adult Social Care	Penina	Rizwan and STARRS make referrals for social care support for Penina on 6th and 7th respectively
06/06/13	Herts Police records re Crime C4/13/955	Rizwan	Karen withdraws support for prosecution due to ill health, stress and impact on marriage
10/06/13	District Nursing service record on RIO	Penina (& Rizwan?)	Referred by GP for a blood test. District Nurse visited but was informed that Penina was not at home, that she had gone to a hospital appointment.
12/06/13	FWi, Brent Adult Social Care	Penina	A reablement package of 3 calls with 2 enablers commenced with Health Vision

Date	Source of information	Family member	Event description, action and outcome
18/06/13	Continence Service - RiO Records	Penina	Continence assessment following a referral from the STARRS team on 10/04/2013
19/06/13	Herts Police records, NWLH records	Rizwan	Strategy meeting between Herts Pol, UWL and North West London Hospitals Trust re Rizwan
26/06/13	GP records	Penina (& Elizabeth)	Penina seen with Elizabeth at out of hours clinic and then A&E following further falls
27/06/13	FWi, Brent Adult Social Care	Penina (& Elizabeth)	Joint Reablement Review at Address 1, noted that Penina experienced confusion, query about dementia, right sided weakness, speech difficulties, expressive dysphasia, frequent falls
27/06/13	Herts Police records	Rizwan	Bail hearing rescheduled for 14/08/13 pending forensic and telephone evidence
28/06/13	FWi, Brent Adult Social Care	Penina	Home visit identifies potential for further reablement but limited due to Penina's cognitive needs
30/06/13	FWi, Brent Adult Social Care	Penina	Penina's care transferred to Gentle Care on the enhanced reablement service
01/07/13	FWi, Brent Adult Social Care	Penina, Elizabeth, Rizwan	Rizwan requests key safe (as he and Elizabeth returning to work) and pendant alarm due to Penina's falls
01/07/13	Medical records, NWLH, GP	Penina (& Elizabeth)	Penina seen in neurology clinic with Elizabeth – tends to be confused on waking, talks in sleep, excessively frightened if woken suddenly; likely to be developing significant subcortical cognitive impairment
02/07/13	Manor School records	Elizabeth & Child 1	Elizabeth tells Child 1's class teacher that family had moved house and that Penina had fallen ill and now lives with them; Elizabeth had less time for children. Grandma's needs change and this affects routines. Carers visit the home. Rizwan had started smoking and she was worried that this may have an effect on Child 1's asthma.
04/07/13	FWi, Brent Adult	Penina, Elizabeth	Elizabeth complains about new reenablement service

Date	Source of information	Family member	Event description, action and outcome
	Social Care		
08/07/13	FWi, Brent Children's Social Care	Rizwan	The Fostering Team received a request from Rizwan to be assessed as a foster carer for looked after children in Brent. Interviewed by a member of the fostering team and rejected from progressing any further
08/07/13	FWi, Brent Adult Social Care	Penina, Elizabeth, Rizwan	Review of care. Rizwan assisting with Penina's bathing. Penina's wishes not ascertained. Gentle Care to put morning bathing call on hold till new equipment delivered
17/07/13	District Nursing Service records on RIO	Penina	Referral from GP to District Nurse re sore on Penina's bottom
17/07/13	FWi, Brent Adult Social Care	Penina, Elizabeth	Joint visit re adaptations to home
18/07/13	District Nursing Service records on RiO	Penina & Elizabeth	District Nurse assessment; Penina visited by Community Staff Nurse following a referral from the GP on 17/7/2013 to assess the sore on Mrs Steven's bottom and pressure mattress. Full assessment carried out. Found to have pressure ulcers grade 1 (red areas) on sacrum. Daughter present. Advice given on management of pressure areas.
18/07/13	FWi, Brent Adult Social Care	Penina	Bathing assessment completed. Bathing assessment completed. Penina required a lot of prompting to safely use the bath board. The enablers needed to give assertive prompts to her. One enabler was due to go on holiday. Agreed that OT will return with the enablers the next day to watch the other enabler lead the session.
19/07/13	GP records	Rizwan	Referred to sleep clinic
19/07/13	FWi, Brent Adult Social Care	Penina & Elizabeth	Review of use of bathing equipment; bathing assessment aborted and strip wash attempted, Penina becomes unwell (due to UTI), ambulance called, taken to hospital. Elizabeth says Penina may move to Rizwan's mother's house whilst

Date	Source of information	Family member	Event description, action and outcome
			adaptations carried out
19/07/13	Medical records, NWLH	Penina	Penina presented to Emergency Dept. via London Ambulance Service following a collapse at home whilst using the toilet assisted by her carers. Presenting complaint confusing and falls. Elizabeth reported Penina had increased confusion, which was out of character for her, and reported to have offensive urine. Penina's care package was reviewed by the STARRS Team. The assessing nurse documented that Penina lived in a house alone, when in fact she lived with her daughter and son in law. Documented that Penina finding it difficult to follow simple commands Penina noted to have been discharged from the neurology clinic and had been referred to the mental health memory clinic services.
21/07/13	FWi, Brent Adult Social Care	Penina	Emergency Duty Team - Out of Hours Contact Adult; Penina discharged from hospital, Care package has restarted.
23/07/13	FWi, Brent Adult Social Care	Penina & Elizabeth	Joint OT and social care visit, unable to gain access, key removed from key safe. Elizabeth later explained that she had removed the key as she had washed Penina and did not want the enablers to enter and shower her again. Raised concern that morning calls are too late. Dangers of taking the key out of the key safe highlighted to Elizabeth who apologised. Key returned by lunch time and this never occurred again
23/07/13	FWi, Brent Children's Social Care	Rizwan	Deputy Director of Nursing at NWLH made a telephone call to the LADO regarding Rizwan's arrest in Hertfordshire for sexual offences
25/07/13	NWLH records	Rizwan	LADO form sent by North West London Hospitals Trust to Brent Council

Date	Source of information	Family member	Event description, action and outcome
25/07/13	Referral attached to email, Brent Children's Social Care records	Rizwan	LADO referral received from Deputy Director of Nursing, North West London Hospital Trust. Discussion between LADO and Deputy Director of Nursing. No further action taken or liaison between departments until after Penina's death. No record of conversations or liaison with Adults Services or feedback to referrer.
26/07/13	FWi, Brent Adult Social Care	Penina	Enhanced Reablement review - risk of falls on waking, behaviour issues following urinary tract infection, agitated towards enablers and family, Package of support from 1 carer 3 times a day with Priory Care to start 5th August
28/07/13	North West London Hospitals Trust records	Rizwan	Datix entry completed re patient safety concerns
29/07/13	District Nursing Service records on RiO	Penina & Rizwan	District Nurse visit. Rizwan present who stated that mother-in-law was found on the floor the previous morning and sustained a skin tear on her bottom. Examination found a skin tear of approx. 6 cm in length. Nurse applied dressing and gave advice on pressure area care
05/08/13	District Nursing records on RIO, GP records	Penina (Rizwan?)	District nurse is told (possibly by Rizwan) that Penina was at hospital appointment. Penina seen at Orthopaedic clinic (GP records); symptoms improving due to physio
05/08/13	FWi, Brent Adult Social Care	Penina	Priory Care start delivering services to Penina
12/08/13	GP records	Penina	Prescribed antibiotic for latent syphilis
12/08/13	Community Services Brent records	Child 1 & Rizwan	Specialist paediatric medical review

Date	Source of information	Family member	Event description, action and outcome
12/08/13	District Nursing records on RIO, GP records	Penina	Visited patient, checked all her pressure areas which were intact
14/08/13	Herts Police records	Rizwan	Bail hearing rescheduled pending forensic and telephone evidence
19/08/13	District Nursing records on RIO, GP records	Penina	Penina visited to monitor pressure area care. Discharged from DN care
28/08/13	Medical records NWLH	Penina	Penina due to attend Outpatients Falls clinic. Did not attend – Elizabeth cancelled this appointment due to transport issues and requested a home assessment
August 13	North West London Hospitals Trust IMR	Rizwan	Seen in hospital uniform at outpatient appointment for twins
02/09/13	FWi, Brent Adult Social Care	Penina & Rizwan	Rizwan requests further review as Penina falling frequently
03/09/13	Herts Police records	Rizwan	Police receive telephone evidence re sexual assault allegations
03/09/13	Special Needs Assessment Service records	Rizwan & Twins	Rizwan requests that both children are given places at Islamia School
05/09/13	FWi, Brent Adult Social Care	Penina	Review of care needs. Occupational Therapist to order Telecare sensors, Dali low bed, Crash mat, Tilt and space, Glideabout shower/commode and to increase door widths in bedroom and bathroom
06/09/13	FWi, Brent Adult Social Care	Penina, Rizwan	Rizwan reports that Penina has fallen again. Occupational Therapist agrees to order a hoist.

Date	Source of information	Family member	Event description, action and outcome
09/09/13	FWi, Brent Adult Social Care	Penina, Elizabeth, Rizwan	Hoist assessment. Issue was raised that the standing hoist was used to lift Penina off the floor when she fell over at the weekend. This use of standing hoist was referred to the Senior Practitioner who confirmed a mobile hoist would be required for this use
09/09/13	GP records	Penina & Rizwan	GP discusses OT concerns re Penina's falls with Rizwan; separately GP talks to STARRS
10/09/13	GP records	Penina & Rizwan	Follow up call from GP to Rizwan re community OT; Rizwan queried Penina drug and told it was for latent syphilis
13/09/13	FWi, Brent Adult Social Care	Penina	Equipment review completed; decision to increase care package
20/09/13	FWi, Brent Adult Social Care	Penina	Manual handling review; more equipment ordered
20/09/13	Manor School Chronology	Child 1 & Rizwan	Child 1 had a small scratch on the right side of the face. Rizwan said Child 1 was angry about having a shower and scratched themselves.
23/09/13	FWi, Brent Adult Social Care	Penina & Elizabeth	Elizabeth reports Penina's mobility further deteriorating. Different hoist ordered, agreed care to be increased to 2 carers from 25 Sep to enable use of hoist
25/09/13	FWi, Brent Adult Social Care	Penina	Care increased to 2 carers
26/09/13	FWi, Brent Adult Social Care	Penina	Review of use of hoist. Two carers from Priory Care present, report that Penina is able to stand at times. Consultation with senior practitioner – agreed to review transfers with senior practitioner
30/09/13	FWi, Brent Adult Social Care	Penina	Review of manual handling; Confirmed use of mobile hoist, all other equipment to be collected
02/10/13	FWi, Brent Adult Social Care	Penina & Elizabeth	Elizabeth requests equipment collection be put on hold; denied due to safety issues; joint visit planned for 21st October

Date	Source of information	Family member	Event description, action and outcome
09/10/13	Herts Police records	Rizwan	Police reinterview Rizwan who admits he attended victims' addresses when confronted with telephone evidence; claims relationship with Karen consensual, admits trying to kiss Ruth but denies any wrongdoing.
09/10/13	Herts Police records	Rizwan	Released on bail pending CPS charging decision
14/10/13	GP records	Penina	GP referral to District Nurse – skin infection on Penina's right thigh plus blood pressure and flu vaccine
14/10/13		Penina	Penina's birthday
18/10/13 (07:00)	FWi, Brent Adult Social Care	Penina, Elizabeth & Rizwan	Joint review, OT remarked on difference between this visit and the previous visit when Rizwan was present; carer responded that 'Penina is uncomfortable with personal care when Rizwan is around'
18/10/13 (12:55-13:55)	District Nursing records on RIO, GP records	Penina & Elizabeth	District Nurse visit following a referral from GP on 14/10/2013 to treat a wound infection on the back of the upper right thigh, give influenza vaccine and check blood pressure. Wound assessed and redressed. Daughter, present who stated that the wound may have developed due to friction. Influenza vaccine given. Blood pressure taken.
18/10/13 (20:00)	Met Police records	Penina & Rizwan	One of Penina's carers arrived at the family home to provide care to her. Rizwan and twins in the house. Carer found Penina bleeding heavily. Police and ambulance called. Penina taken to hospital and died later that night.
18/10/13 (21:05)	Met Police records	Rizwan	Rizwan arrested initially for assault, then murder
19/10/13	Met Police records, Herts Police records	Rizwan	Rizwan charged with murder Sexual assault file put on hold

Date	Source of information	Family member	Event description, action and outcome
08/11/13	Special Needs Assessment Service records	Elizabeth & Twins	Elizabeth confirms that the request for the children to move to Islamia School was done without her knowledge.
13/11/13	Herts Police records	Rizwan	Sexual assault file sent to CPS
10/12/13	Herts Police records	Rizwan	CPS advise that Rizwan should be charged with sexual assault against Ruth