

DOMESTIC HOMICIDE REVIEW- Report into the death of Elena

Action Plan

Recommendation	Scope of Recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
<p><b>Recommendation 1:</b> The Home Office to review funding arrangements for the provision of specialist and expert advocacy for the families of victims who reside outside of the UK.</p>	<p>National</p>	<p>Consideration of recommendation by Home Office</p>	<p>Home Office</p>	<p>Recommendation sent to Home Office for consideration</p>	<p>Completed</p>	<p>The Homicide Service would support a family bereaved by domestic homicide if they were a resident in England and Wales and the victim was a British national. This would apply if the homicide took place in another country but they wouldn't support a family where they themselves were resident outside of the UK. This is because funding for victims is only made available for residents of the UK. It would be for the country in which the family is resident in to offer them support. The EU directive stipulates all EU countries should provide support for victims of crime.</p>

DOMESTIC HOMICIDE REVIEW- Report into the death of Elena

Action Plan

<p><b>Recommendation 2:</b> The Safer Brent Partnership to review the local training offer to ensure all front-line practitioners have a good awareness of the barriers and support options for a person with NRPF.</p>	<p>Local</p>	<p>Consider commissioning of specialist training provider around support for victims with NRPF</p>	<p>Community Protection</p>	<p>Review of local training offer during development of new service spec for commissioned domestic abuse services</p>	<p>March – September 2021</p>	
<p><b>Recommendation 3:</b> The Home Office to ensure that there is consistent access to immigration and/or benefits advice, support and pathways out of destitution, for EEA nationals who are victims of domestic violence and abuse but have NRPF.</p>	<p>National</p>	<p>Recommendation sent to Home Office for consideration</p>	<p>Home Office</p>	<p>Recommendation sent to Home Office for consideration</p>		
<p><b>Recommendation 4:</b> The Safer Brent Partnership to work with the Brent LSCB and Safeguarding Adults Board (SAB) to ensure all front-</p>	<p>Local</p>	<p>The Safer Brent Partnership, Brent LSCB and Safeguarding Adults Board (SAB) commissioned a working group on</p>	<p>Joint with children’s partnership and Safer Brent Partnership.</p>		<p>July 2020</p>	<p>Report of the findings from this working group was finalised and presented to all three boards</p>

DOMESTIC HOMICIDE REVIEW- Report into the death of Elena

Action Plan

<p>line practitioners are aware of the signs and indicators of Modern-Day Slavery as well as the NRM.</p>		<p>modern slavery, including the NRM, coordinated by Anne Kitappa.</p> <hr/> <p>SAB to organise multi-agency learning events for the staff of its partner agencies on modern day slavery, drawing on this DHR and Safeguarding Adult Reviews on the subject, including “Drina” published by Barking and Dagenham SAB.</p> <hr/>	<hr/> <p>SAB.</p> <hr/> <p>SAB</p>		<hr/> <p>As soon as possible recognising Covid19 constraints</p> <hr/> <p>As soon as possible recognising</p>	<hr/> <p>A question regarding the level of Modern Slavery was also included in the Safeguarding Survey (May 2019) undertaken by both Brent LSCB and Safeguarding Adults Board (SAB). Approximately 20% of respondents said they had received training on this subject.</p> <p>Training and awareness of the subject is currently provided by signposting to the national Modern Slavery E- learning course.</p> <hr/>
---	--	---	------------------------------------	--	---	---

DOMESTIC HOMICIDE REVIEW- Report into the death of Elena

Action Plan

		Audits of case files to be considered by the SAB.			g Covid19 constraints	
<p><b>Recommendation 5:</b> WDP to work with its commissioners to ensure that female offenders can access a female member of staff as part of unscheduled 'drop-ins'.</p>	<p>WDP to continue to provide access to female staff members for all appointments and unscheduled drop-in</p>	<p>Management to ensure female staff members are on site</p>	WDP	<p>Devising staff rota in advance to ensure accessibility to female staff members</p>	Completed /ongoing	Completed/ongoing
		<p>Continue to encourage female services users, to access Women only mornings on site</p>	WDP	<p>We have identified x1 female and x1 male staff members to train as IDVA's for the service</p>	Completed	<p>27/11/19 – staff in post. awaiting IDVA training dates</p>
<p><b>Recommendation 6:</b> The Brent LSCB to undertake a case audit to explore the issues identified in this case (relating to the undertaking of a Pre-Birth Assessment and identification of domestic violence risk) and identify any actions required to improve performance.</p>	<p>Local Safeguarding partnership arrangements have now superseded the LSCB arrangements in Brent.</p>	<p>Consideration by the Brent Safeguarding Forum</p>	Partnership	<p>The new arrangements do not provide the capacity to undertaken such audits. A rapid review undertaken by the Strategic Partners in November 2019 regarding the death of a baby following a concealed pregnancy recommended improved dialogue between Midwifery services and Health Visitor services. The case review group have been assured that these services have made improvements. This case also prompted a serious</p>	Completed	<p>The case review group is assured that the London North West University Healthcare Trust has taken steps to ensure that appropriate action is taken to safeguarding vulnerable mothers and their unborn children.</p>

DOMESTIC HOMICIDE REVIEW- Report into the death of Elena

Action Plan

				incident review commissioned by London North West University Healthcare Trust, although the findings are not for public dissemination, the case review group is assured that the Trust has taken steps to ensure that appropriate action is taken to safeguarding vulnerable mothers and their unborn children.		
		Every DHR involving children will be flagged with the Children's Safeguarding Forum so a rapid review can be considered	Community Protection	Discussion between Community Protection and Children's Safeguarding Forum Chair regarding implementation in July 2020	August 2020	
<b>Recommendation 7:</b> Brent CYP to ensure that mandatory domestic abuse training is undertaken by all staff to ensure they are familiar with indicators of	Local	Identify front-line staff who required to undertake domestic abuse training.	Brent CYP	List of frontline staff who are required to complete training is agreed by senior managers.	31/7/2020	
		Determine whether e-learning training covers the point to	Community Safety	E-learning programme is reviewed.	31/7/2020	29/7/20 – Corporate e-learning covers the need to speak to victims on their own.

DOMESTIC HOMICIDE REVIEW- Report into the death of Elena

Action Plan

<p>domestic abuse, as well as the need to speak to people separately.</p>		<p>speak to people separately.</p> <hr/> <p>Mandatory programme of e-learning on Domestic Abuse to be rolled out to all identified staff in August 2020 with a 3 month window to complete and 1 month to push attendance.</p> <hr/> <p>Learning from the DHR to be incorporated into local learning reflective practice sessions on domestic abuse.</p>	<p>Brent CYP</p> <hr/> <p>Brent CYP</p>		<p>30/11/2020</p> <hr/> <p>30/09/2020</p>	
<p><b>Recommendation 8:</b> The Safer Brent Partnership to develop a comprehensive engagement and communications strategy. This should identify the actions the partnership will take to deliver both a sustained</p>	<p>Local</p>	<p>Deliver a communication and promotion campaign across the year and at key periods to highlight DA and VAWG.</p>	<p>Community Protection</p>	<p>16 Days of Activism</p> <p>International Women's Day</p>	<p>Ongoing</p>	<p>Ongoing - part of Safer Brent Partnership VAWG Action Plan</p>

DOMESTIC HOMICIDE REVIEW- Report into the death of Elena

Action Plan

awareness raising campaign and community outreach (including developing resources to meet the needs of Eastern European communities and ensuring access to interpretation where appropriate).						
<b>Recommendation 9:</b> The Safer Brent Partnership to scope the requirement for specialist provision for Eastern European communities in the borough.	Local	Consider additional commissioning of the Refuge Eastern European IDVA service	Community Protection	The Domestic Abuse Covid-19 recovery group are responsible for the review and recommissioning of local Domestic Abuse Victim Services	March – September 2021	
<b>Recommendation 10:</b> The Safer Brent Partnership to work with neighbouring boroughs such as Barnet and Harrow, and MOPAC, to develop sustainable specialist provision for Eastern	Local	Consider additional commissioning of the Refuge Eastern European IDVA service at a regional level	Community Protection	Domestic Abuse Covid-19 recovery group to consult with key stakeholders to explore joint commissioning of services.  New spec to be developed for commissioned domestic abuse service	September 2020 – March 2021  March – September 2021	

DOMESTIC HOMICIDE REVIEW- Report into the death of Elena

Action Plan

European communities at a regional level.						
<p><b>Recommendation 11:</b> The Safer Brent Partnership to review its existing strategy and action plans in relation to domestic abuse, to explicitly identify the actions it will take to ensure that the needs of Eastern European victims are met, including ensuring:</p> <ul style="list-style-type: none"> <li>• Staff can access single and multi-agency training, so they have appropriate skills and knowledge</li> <li>• There are robust pathways in place locally.</li> </ul>	Local	<p>Build links with Refuge Eastern European IDVA service to strengthen pathways.</p> <hr/> <p>Consider commissioning of specialist training provider to deliver training around supporting Eastern European victims for front-line practitioners in Brent</p>	Community Protection	<p>Domestic Abuse Covid-19 recovery group have key responsibilities around access and awareness of victims within Brent:</p> <ul style="list-style-type: none"> <li>- Enhance the service provided for victims of Domestic Abuse whilst making it easy for residents to access.</li> <li>- Mapping out service provision to include: Journey of a victim &amp; available Pathways</li> <li>- Increase awareness and understanding of Domestic Abuse in Brent</li> <li>- Review and recommission Domestic Abuse Victim Services</li> </ul>	<p>Ongoing</p> <p>July 2020</p> <p>Ongoing</p> <p>March – September 2021</p>	

DOMESTIC HOMICIDE REVIEW- Report into the death of Elena

Action Plan

<ul style="list-style-type: none"> <li>This recommendation should be implemented in consultation with the Brent LSCB and SAB.</li> </ul>						
<p><b>Recommendation 12:</b> The Brent LSCB to review the learning identified in the case and develop an interim policy and procedure to ensure that no case is closed by health or children’s social care without consideration of safety netting options.</p>	<p>Local Safeguarding partnership arrangements have now superseded the LSCB arrangements in Brent.</p>	<p>Consideration by the Brent Safeguarding Forum.</p> <p>The Brent Safeguarding Forum is now a consultative advisory group and no longer has the statutory powers of the LSCB to implement multiagency safeguarding policies.</p>	<p>Brent Safeguarding Children Partnership</p>	<p>In the new format of the Safeguarding Forum Case review Group, it is considering a number of serious safeguarding incidents which have been referred to the national panel. Some of these have identified shortcomings in information sharing between a number of agencies and the group continues to seek assurances that people are not falling through the gaps as described in the DHR. A recent rapid review led to a request for both the police and family front door to review the operating procedures of the Integrated Risk Management meeting and</p>		

DOMESTIC HOMICIDE REVIEW- Report into the death of Elena

Action Plan

		<hr/> <p>Brent Safeguarding Children Partnership Case Review Group will seek assurance from health and social care partners that there appropriate procedures in place.</p>		<p>a very recent case with further prompt a review of this information exchange meeting.</p> <hr/>	<hr/> <p>September 2020</p>	
<p><b>Recommendation 13:</b> The Brent LSCB to escalate the learning identified in this case to the national Serious Case Review Panel for consideration.</p>	<p>Local Safeguarding partnership arrangements have now superseded the LSCB arrangements in Brent.</p>	<p>Consideration by the Brent Safeguarding Forum</p>	<p>Partnership</p>	<p>At a local level, the case review group oversees any learning identified from these reviews and gives regular updates to the strategic partners.</p> <hr/> <p>A summary of learning from this DHR will be shared with London Safeguarding Partnerships Business Managers Network</p>		<p>This recommendation is not applicable as the national panel do not have such a function. The statutory partners forward all learning from rapid reviews commissioned by them to the national panel for their information and decision as to whether it necessitates a national review.</p>