LUTON COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the homicide of Farah

May 2016

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Associate Standing Together Against Domestic Violence

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1. Preface

1.1 Introduction

1.1.1 On an evening in May 2016, Mona called the police to her family home in Luton. She informed them that there had been a break in to the house and she had found her sister, Farah, in a pool of blood. Farah was found to have died from stab wounds. Mona initially stated that an intruder had entered the family home and killed her sister. The police commenced a murder enquiry and it was established that Mona had been having an extra marital affair with her sister Farah's husband. In the days before the death, Mona had researched methods of killing and had purchased the murder weapon. On the night of the incident Mona had lured her sister back to the family home and killed her. Mona was charged and later convicted of murdering her sister.

1.1.2 As Farah was a close family member the incident was considered a domestic homicide. Luton Community Safety Partnership (CSP) commissioned a Domestic Homicide Review (DHR) as required by Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.1.3 This report provides an overview of the DHR process. The review process examined the experience of Farah, together with interaction with agencies and support provided to her as a resident of Luton prior to her murder at her home in May 2016.

1.1.4 The review considered agencies contact or involvement with Farah and her sister Mona over a two-year period, from May 2014 to the date of Farah's death in 2016.

1.1.5 In addition to agency involvement, the review also examined the past to identify any relevant background information or evidence of abuse before the homicide. This included, whether support was accessed within the community and whether there were any barriers to accessing support. In examining as much information as possible the review sought to find ways of making the future safer for others.

1.1.6 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for learning to be developed as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such crimes happening in the future.

1.1.7 This review process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

1.1.8 The Review Panel expresses its sympathy to the family, friends and colleagues of Farah.

1.2 Timescales

1.2.1 The Luton CSP commissioned this DHR in accordance with the March 2013 Multi-Agency Statutory Guidance for the Conduct of DHRs. The Home Office were notified of the decision in writing on 30 June 2016.

1.2.2 Standing Together Against Domestic Violence (Standing Together) was commissioned to provide an independent chair for this DHR in August 2016. Whilst the review was conducted in accordance with the 2013 Guidance, the revised Home Office guidance was published in December 2016. Wherever possible, this report considers the revised guidance. The completed report was handed to the Luton CSP on 6 June 2018.

1.2.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. There was an initial delay in the commissioning process also, Standing Together from the point of being commissioned had to identify the agencies that needed to be at the panel and allow these agencies sufficient time to search and secure their records. Therefore, the first panel meeting was held in November 2016. The panel was able to gather information and complete reports for the consideration of the panel. The panel considered that it would be necessary to complete the review after the criminal trial had taken place. This decision would allow an opportunity for the panel to consider interviews with the perpetrator, family and colleagues without interfering with the criminal justice process. It was agreed with the prosecuting authorities that the witnesses would not be approached until after the trial. The trial concluded in October 2017. The chair maintained contact with the family through the Victim Support (VS) Homicide Worker. The main point of contact with the family was the victim's husband. Whilst the husband was made fully aware of the DHR process, terms of reference and charities offering support, he declined to speak to the chair. It was noted at an early stage that the victim's parents were acting in a supportive role to the perpetrator and up until the plea of guilty the perpetrator was maintaining a legal position that she was not guilty of her sister's murder. Given the circumstances of the case it was felt important to provide the perpetrator with an opportunity to be interviewed. The interview process took several months to arrange, with planned interviews being cancelled by the perpetrator. The chair eventually spoke to the perpetrator in April 2018 and she declined to be interviewed. Finally, the chair needed to ensure adequate time was provided to family and friends to review and comment on the final report before submission to the CSP.

1.3 Confidentiality

1.3.1 The findings of this report are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. Information is available only to participating officers/professionals and their line managers.

1.3.2 This review has been suitably anonymised in accordance to the 2016 guidance. The specific date of death has been removed, and only the independent chair and DHR Panel members are named.

1.3.3 To protect the identity of the victim, the perpetrator and family members the following anonymised terms have been used throughout this review:

1.3.4 The victim: Farah

1.3.5 The perpetrator: Mona

1.3.6 The victim's husband: Osman

1.3.7 The victim's five-year-old child: Child A

1.3.8 The victim's four-year-old child: Child B

1.3.9 The victim's two-year-old child: Child C

1.3.10 The victim's 11-month-old child: Child D

1.3.11 The perpetrator's boyfriend; Hamza

1.3.12 The names of all persons listed have been anonymised. Pseudonyms have been selected that are culturally appropriate and a copy of the report has been provided to the husband of the victim to consider whether the names could cause any concern or distress to the family. Approval will be confirmed before publication.

1.4 Equality and Diversity

1.4.1 In conducting the review, the Chair of the Review and the DHR Panel considered all the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

1.4.2 The panel considered the local characteristics, in that the Luton area has a significant population of British Pakistani origin and the family were part of that demographic.

1.4.3 Farah was 34 years old at the time of her death and Mona was 26. Both were heterosexual. They were not known to have any disabilities. Both were Muslim. There was no information revealed in the review to show that religion had an influence on the relationship.

1.4.4 Farah and her sister, Mona, were both Dutch nationals and it is believed that they entered the United Kingdom around 1997. Consideration was also given to the overlap between Farah's status as a Pakistani Muslim in the UK and her sex.

1.4.5 Domestic abuse is a gendered crime and most victims are female. Whether the crime is Interpersonal Violence (IPV) or Adult Family Violence (AFV) perpetrators are most commonly male. This case was unusual in that it was a case of AFV, committed by a female on her female sibling. Special consideration was given to that fact when examining procedures and protocols to consider whether they take into account this type of abuse.

1.4.6 At the initial meeting consideration was given to involvement of leading members of the Muslim Faith. Up until the date of the trial there had been no public confirmation that the perpetrator had been involved in a sexual relationship with the victim's husband. It was considered by the panel that whilst the facts were not in the public domain that it would not be fair to the family to involve wider community members. It should be noted that during the process the Chair sought advice from the SAFE (Safety Across Faith and Ethnic) Communities Project Coordinator at Standing Together and she was invited to the join the panel.

1.4.7 It has been agreed by the CSP that this report will be shared with a local Community Senior Imam, based within the Ghousia Trust. At the time of writing the chair is liaising with the Imam and will be discussing the draft report and recommendations. The report will be subject to update, following this consultation.

1.5 Terms of Reference

1.5.1 The Terms of Reference are included at **Appendix 1**. This review aims to identify the learning from this death, and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported. The Terms of Reference were drafted and agreed under the 2013 Home Office guidance.

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

1.5.3 At the first meeting, the DHR Panel shared brief information about agency contact with the individuals involved. As a result of this enquiry it was agreed that the time period to be reviewed would be from May 2014 to the date of the homicide in May 2016. The rationale for this time span was decided upon once the initial scoping had established there were no incidents of abuse reported by Farah. The period

would also adequately cover the incidents where Mona had reported to statutory agencies. It was considered that extending the review beyond two years not be appropriate. Agencies were asked to summarise any relevant contact they had had with Farah or Mona outside of these dates.

1.5.4 This review was set up under the Home Office Guidance of 2013. The DHR Panel considered the “generic issues” as set out in 2013 Guidance. The issue of the victim and perpetrator’s nationality, and experience as migrants to the UK, was considered from the outset.

1.5.5 In order to give due consideration to the specific circumstances it was noted that there had been engagement with the local mosque. It was decided that there would not be any formal involvement of the mosque until the criminal trial was completed and the report was at draft stage.

1.5.6 The issue of substance misuse was not apparent at the outset of the review and there was no information uncovered during the review process to suggest this was an area of concern.

1.6 Methodology

1.6.1 Throughout the report the term ‘domestic abuse’ is used interchangeably with ‘domestic violence’, and the report uses the cross-government definition of domestic violence and abuse as issued in March 2013 and included in the Terms of Reference for the review at **Appendix 1**.

1.6.2 This review has followed the 2013 statutory guidance for Domestic Homicide Reviews issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. This review was commenced before the revised 2016 Guidance was implemented. On notification of the homicide; agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with victim, perpetrator and the victim’s children. A total of 14 agencies were contacted to check for involvement with the parties concerned with this review. Of all the agencies contacted, four agencies confirmed that they had had no contact with either party. The remaining 10 agencies completed chronologies and IMRs.

1.6.3 *Independence and Quality of IMRs:* The IMRs were written by authors independent of case management or delivery of the service concerned. The majority of IMRs received were comprehensive and enabled the panel to analyse the contact with the victim. Where there were gaps in information and analysis these matters were discussed and clarified at panel meetings. Any single agency recommendations highlight in an IMR are included at the end of this report.

1.6.4 *Documents Reviewed:* In addition to the IMRs, documents reviewed during the review process have included:- letters on levels of safeguarding training provided by East of England Ambulance Service NHS Trust (EEAST); Care Quality Commission (CQC) Reports for Hospital, EEAST and Farah's employer; and Luton Borough Council Homelessness Application Forms.

1.6.5 The author also referred to Sharps-Jeffs, N., and L. Kelly, *Domestic Homicide Review (DHR) Case Analysis*, (Standing Together, 2016) http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf (last accessed 2 February 2018).

1.6.6 At the time of commencing the review there had been no other DHRs in the Luton area.

1.6.7 *Interviews Undertaken:* At the time of writing there have been no interviews with family, friends, colleagues or the perpetrator. The key point of contact with the family has been the husband of the victim. The chair has maintained liaison with the husband through his victim support homicide worker. To date he has declined to meet the chair of the review he has also declined any telephone contact. Farah's husband has agreed to consider the case again once the report had reached draft status. It is known that there has been an allegation made that a close relative of Farah assaulted her husband shortly after the criminal case completed. The review was unable to find any personal friends of Farah to assist the review. The police provided contact details for three work colleagues for Farah and Mona, this included their work manager. All three were written to by the chair to be interviewed. To date these colleagues have not agreed to be interviewed.

1.6.8 The chair made a formal approach to interview the perpetrator in prison. The perpetrator agreed verbally to meet the chair and a visit was booked. When the perpetrator was asked to sign consent forms, before the interview took place, she declined. The chair persisted in an attempt to interview the perpetrator. This led to a telephone call being arranged between the Chair and the perpetrator in the presence of her offender manager. During this phone call Mona did not discuss the case and declined to take part in an interview or contribute to the review.

1.7 Contributors to the Review

1.7.1 The following agencies were contacted, but recorded no involvement with the victim or perpetrator:

- Community Rehabilitation Company
- East London Foundation Trust
- Luton Borough Council - Adult Social Care
- Luton Borough Council - Community Safety

- National Probation Service

1.7.2 The following agencies contributed IMRs reports to this review:

- Bedfordshire Police
- East of England Ambulance Service NHS Trust (EEAST)
- Cambridge Community Services (CCS) NHS Trust Luton Locality
- Luton and Dunstable University Hospital
- Luton Education Services
- Luton Borough Council – Children's Social Care (CSC)
- Luton Borough Council – Housing Services
- Luton Clinical Commissioning Group (CCG) – General Practice
- Luton Multi-Agency Risk Assessment Conferences (MARAC)
- Victim Support

1.8 The Review Panel Members

1.8.1 The review panel members are listed below

Agency represented	**Review Panel Members**
Bedfordshire Police	John Murphy - DCI – Crime Management and Victim Satisfaction, Bedfordshire Police Mark Ross – Review Officer, Major Crime Unit
Cambridgeshire Community Services NHS Trust Luton Locality – 0-19 Healthy Child Programme	Nicola Ayres – Named Nurse for Safeguarding Julie Darkin – Named Nurse for Safeguarding
Community Rehabilitation Company – Northamptonshire, Cambridgeshire & Hertfordshire	Doug De-St-Aubin - Director
East of England Ambulance Service (EEAST)	Anna Price – Named Professional for Safeguarding
East London Foundation Trust (ELFT) – Mental Health	Dinh Padicala – Safeguarding Team

Luton Borough Council – Adult Social Care	Maud O'Leary – Service Director
Luton Borough Council – Children's Social Care (CSC)	Rhona Freeman – Service Manager Glen Denham – Service Manager
Luton Borough Council – Community Safety Team	Emma Colclough – Community Safety Officer (Partnerships)
Luton Borough Council - Housing	Darren Alexander – Head of Housing Needs Ian Cartmell – Housing Services Manager
Luton Borough Council – Legal Services	Clive Tobin
Luton Borough Council – Public Health	Yvonne Jackson – Public Health Officer Gerry Taylor - Corporate Director Public Health, Commissioning & Procurement and Strategic Lead for Domestic Abuse
Luton Clinical Commissioning Group (CCG)	Chris Harvey – Head of Quality Abdullah Khan – Named GP for Safeguarding Adults and Children
Luton Community Safety Partnership	Vicky Hawkes – Service Manager (Public Protection)
Luton and Dunstable University Hospital NHS Foundation Trust	Mary McCaffrey – Named Nurse for Safeguarding Karen Radley – Risk and Governance Department Bernadette Rigoulay – Sexual Service Manager
Luton Education Services	Kathy Sears – Safeguarding in Education Manager
Luton MARAC	Deborah Lawson – MARAC Coordinator Joanne Nelson – Acting Team Leader, Community Safety and Civil Protection
Luton Women's Aid	Jane Firmin - CEO
National Probation Service	Alison Harding – Head of Bedfordshire Local Delivery Unit

Standing Together Against Domestic Violence	Huda Jawad - SAFE Communities Project Coordinator Mark Yexley – Independent Chair
Victim Support	Joy Leighton – Senior Operations Manager Carlie Banks – Operations Manager IDVA Service

1.8.2 *Independence and expertise*: The agencies involved in the review were represented on the panel by persons with appropriate levels of experience and expertise. The panel members and IMR authors were independent from those persons within the agencies who had contact with the family concerned. It was agreed at the outset of the process that local faith organisation would be consulted at the draft stage of the review. The chair also invited the Standing Together SAFE Communities project coordinator to join the panel and provide advice throughout the process.

1.8.3 The Review Panel met a total of three times, with the first meeting of the Review Panel on 23 November 2016. There were two subsequent meetings on 8 February 2017 and 15 February 2018.

1.8.4 The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.9 Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

1.9.1 Initially, the Luton CSP notified the family of Farah in writing of their decision to undertake a review on 4th July 2016. The letter was sent via the police Family Liaison Officer. The chair initiated contact with the victim's husband through the Victim Support Homicide Worker in September 2016. At the time of first contact the homicide worker had already provided the victim's husband with the Home Office leaflet for families involved in DHRs. The Chair of the Review and the DHR Panel acknowledged the important role Farah's family could play in the review. From the outset, the Review Panel decided that it was important to take steps to involve the family, friends, and work colleagues. There were concerns that a criminal investigation and trial were ongoing for a long period of time during the review. The panel decided it would not be appropriate to approach the family and colleagues who could be considered prosecution witnesses. The panel decided that the key point of contact would be the victim's husband who was receiving support from the Victim Support Homicide Worker. The chair ensured that he was provided with a letter of introduction that explained the process and a copy of the Home Office

DHR leaflet for families in Urdu. The VS Homicide worker also provided him with information on the support charity Advocacy After Fatal Domestic Abuse (AAFDA). The victim's husband has received a copy of the terms of reference and he has agreed to read a copy of the report with his Victim Homicide Support Worker.

1.10 Involvement of Perpetrator

1.10.1 The Review Panel appreciates the value that gaining an understanding of the perpetrator's view can add to a DHR. Wherever possible the chair would try to engage with Mona to formally contribute. Steps were taken to encourage Mona to take part in the review.

1.10.2 After the conclusion of the trial the chair took steps to ascertain if Mona would be willing to be interviewed. Enquiries were made with the Offender Management Unit Case Worker at Mona's prison. Mona finally agreed to interview in January 2018. Shortly before the planned interview Mona cancelled the meeting as she did not feel able to talk about the incident. Due to the particular circumstances of the case the chair felt it was important to continue to engage with Mona.

1.10.3 A telephone conversation was arranged between the chair and Mona, facilitated by her offender manager. On 9 April 2018 the chair spoke to Mona by phone. He explained the DHR process and it was apparent that Mona was reading the Home Office information sheet during the call. The chair explained that the process aimed to make recommendations to help victims and perpetrators in the future. Mona expressed concerns about publication of the report. The anonymity of the report was explained and so was the use of pseudonyms. Mona was not sure if she felt ok to talk about events at that time. It was explained, to Mona, that the details of what happened do not need to be discussed and an interview could focus on the surrounding circumstances. She was also told a copy of her interview could go on her offender management file. The chair reassured Mona that any concerns could be examined and addressed face to face. Mona said she would think about things and let her offender manager know. The offender manager later informed the chair that Mona did not want to be interviewed as part of the DHR.

1.11 Parallel Reviews

1.11.1 *Criminal trial:* The homicide investigation was conducted by the Bedfordshire, Cambridgeshire, and Hertfordshire (BCH) Major Crime Unit. The SIO attended the first meeting of the DHR panel and provided a briefing on the circumstances of Farah's death. The SIO was consulted on the drafting of the Terms of Reference. The chair also offered to work directly with the police Disclosure Officer on any issues arising from the DHR. The panel agreed that interviews, to support the review, would not be conducted with any witnesses until after the criminal trial process had concluded.

1.11.2 The criminal trial concluded in October 2017. Mona pleaded guilty to the murder of her sister on the opening day of her trial. She was sentenced to life imprisonment with a recommendation that she serve 22 years.

1.11.3 *No parallel reviews:* The Coroner decided no investigation was required and therefore, no inquest held. Consequently, following the completion of the criminal investigation and trial, there were no reviews conducted contemporaneously that impacted upon this review.

1.12 Chair of the Review and Author of Overview Report

1.12.1 The chair and author of the review is Mark Yexley, an Associate DHR chair with Standing Together. Mark has received Domestic Homicide Review Chair's training from Standing Together. Mark has chaired and authored ten DHRs. Mark is a former Detective Chief Inspector with 35 years' experience of dealing with domestic abuse. He was the head of service-wide strategic and tactical intelligence units combating domestic violence offenders, head of cold case rape investigation unit and partnership head for sexual violence in London. Mark was also a member of the Metropolitan Police Authority Domestic and Sexual Violence Board and Mayor for London Violence Against Women Group. Since retiring from the police service he has been employed as a lay chair for NHS Health Education Services in London, Kent, Surrey, and Sussex. This work involves independent review of NHS services for foundation doctors, specialty grades and pharmacy services. He currently lectures at Middlesex University on the Forensic Psychology MSc course.

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

1.12.3 *Independence:* The chair has no current connection or past connection with the Luton area or agencies mentioned in the report.

1.13 Dissemination

1.13.1 The following recipients will receive copies of this report:

- Family members of Victim
- Local Faith Leader
- Luton CSP

- Panel members
- STADV DHR Team

Once approved by the QA Panel, it will be published on Luton CSP website.

2. Background Information (The Facts)

2.1 The Homicide

2.1.1 *Homicide:* At the time of her death Farah was living with her husband, Osman, and their four young children in her parent's house in Luton, Bedfordshire. Also living in the house was Farah's younger sister Mona. For about a year before the homicide, Osman had been having an extra-marital relationship with his sister in law Mona. As far as is known, Farah was not aware of the relationship. Farah had made an application to local housing services to leave the family home with her husband and children. It is believed that this potential move was bringing an end to the relationship between Osman and Mona.

2.1.2 In the weeks before the homicide Mona had sent a series of 'bitter' text messages to Osman about the state of his marriage. The text messages were discovered by the enquiry team. An examination of Mona's internet history later revealed that she had searched on topics including how to buy a poisonous snake and how to hire a killer. Four days before the murder Mona bought the murder weapon, a large chef's knife, from a supermarket.

2.1.3 On the date of the murder, the adults were away from the house, some at a funeral and Farah at work, leaving Mona at home with Farah's four children. Mona called her sister home from work on the pretence that one of the children was unsettled. On her return home Mona attacked her sister in the hallway with the knife and killed her. Mona then removed her blood-stained clothing and protective gloves, placing them in a bin liner in an upstairs room. Mona then showered and contacted her family and the emergency services. She telephoned the police and informed them that there had been a burglary and that she had found her sister in a pool of blood.

2.1.4 The East of England Ambulance Service (EEAST) received a 999-call concerning an assault. They attended and found Farah with wounds to her neck and arm, with significant blood loss. She was pronounced dead and was not conveyed to hospital, the scene was preserved.

2.1.5 Osman was interviewed by the police. Osman told the police that he had been involved in a sexual relationship with Mona for over 12 months. He stated that he had recently told Mona that he intended to move out of the address with his wife and children. This was planned for two days after the date Farah was killed. Mona

told Osman that he had ‘broken her life’, once he had moved out she did not want him to return to the house and she would not see him again.

2.1.6 Mona was interviewed by the police and denied any involvement in the murder. It was put forward that the crime was committed by an intruder.

2.1.7 Mona was charged with the murder of her sister and pleaded not guilty. Mona’s initial defence was that her sister had been killed by a burglar. Mona later said that she had killed her sister, stating that this was due to loss of control coupled with mental health issues. Mona was subject to court mental health reports and that defence was later withdrawn. It should be noted that there was no information presented to the panel that Mona had any mental health concerns.

2.1.8 *Post Mortem*: A post mortem examination was conducted by a Home Office Pathologist. Farah was found to have suffered multiple stab wounds and the cause of death was recorded as ‘multiple incised wounds’.

2.1.9 *Criminal trial outcome*: Mona eventually pleaded guilty to murder at the Central Criminal Court in October 2017, where she was sentenced to Life Imprisonment with a recommendation that she should serve a minimum of 22 years.

2.2 Background Information on Victim and Perpetrator (prior to the timescales under review)

2.2.1 *Background Information relating to Victim:* Farah was 34 years old at the time of her death. Enquiries show that Farah’s father was registered as living in the UK in 1995 and her mother was believed to have moved to the UK in 2000. Farah was of Pakistani origin and she came to the UK from Holland and her nationality was Dutch. She was of Muslim faith. Farah’s first language was Urdu but all communication with her and agencies was in English. Farah was married to Osman a 39 year old male, the date of the marriage was not known. They had four children, Child A born in Holland in 2008, Child B born in Holland in 2012, Child C born in Luton in 2014 and Child D born in Luton in May 2015. Whilst her first child was born in Holland, it is known that Farah had registered with a GP in Luton in 1997. All of the children had English as a first language. Community Health Records show that Farah and her children moved into the Luton area, as a family, around December 2012. Farah worked for a local private care provider, contracted to provide services for the NHS.

2.2.2 *Background Information relating to Perpetrator:* Mona was 26 years old when she killed Farah. She is of Pakistani origin and she came to the UK from Holland and her nationality is Dutch. Mona was first registered with a GP in the UK in 1997. She is of Muslim faith. She is single and lived in a house with her parents, her sister Farah and brother-in-law and their four children. She was known to have previously had a boyfriend. Mona also worked for the same local private care provider as her sister.

2.2.3 *Synopsis of relationship with the Perpetrator:* Farah and Mona were sisters living in their parents' house. Also living in the house were Farah's husband and children. It is known that Mona sometimes helped mind her sister's children. There were no incidents of reported violence or abuse between any members of the household.

3. Chronology

3.1 Chronology from May 2014 to May 2016

3.1.1 In May 2014 Farah's five and half year old child, Child A, was seen at a GP paediatric clinic. Farah attended the appointment with her sister Mona. Farah had reported previous concerns on falls and she had visited the hospital Emergency Department (ED). This was followed by further appointments where Farah was concerned over her child's chronic thigh pain. The falls had mostly taken place at school. The child later had an ultrasound scan and results were normal. A vitamin D deficiency was later confirmed, this was an ongoing concern and reported in later GP appointments.

3.1.2 On 15 July 2014, Mona reported to Bedfordshire Police potential harassment by her ex-boyfriend. No offences were disclosed in the investigation.

3.1.3 On 21 July 2014, it was noted that Farah and husband did not respond to an invite for a two year developmental review of Child B. He was later seen by health visitor and development was normal with no parental concerns.

3.1.4 On 15 August 2014, Mona reported to Bedfordshire Police that she was being stalked by her ex-boyfriend. The suspect was arrested, and no further action taken on CPS advice. A referral was also made to the Luton IDVA and MARAC at the same time. After numerous attempts to contact the IDVA spoke to Mona in September 2014.

3.1.5 On 23 September 2014, a MARAC meeting was held and an action plan was established. The IDVA was to liaise with police, report any further concerns and to help Mona obtain a Non-Molestation Order if required. Information from the meeting was disseminated to other agencies and Luton and Dunstable Hospital notified. By the end of September, Mona had told the IDVA that support was no longer required, and the case was eventually closed in November 2014.

3.1.6 On 19 January 2015, Farah was seen by the midwife at her GP practice. She was around 23 weeks pregnant and it was noted that this was a very late booking. A full set of blood tests and an ultrasound was booked. It was noted that the midwife raised concerns and requested that Farah's record at Luton and Dunstable Hospital be flagged with appointment attendance to be monitored. All new maternity patients are subject to 'Routine Enquiry' concerning domestic abuse and

no concerns were recorded. A scan was carried out and all findings were normal, with a due date at the end of May 2015.

3.1.7 At the end of January and start of February 2015, Farah's children were all seen by the GP practice nurse and given travel advice and vaccinations. The destination of travel was not documented. This was followed by Farah visiting the GP for a flu vaccine and travel advice, as she was due to travel to Pakistan for five weeks.

3.1.8 On her return to the UK in March 2015, Farah was followed up by the GP antenatal services. Farah told the health visitor that it was an unplanned pregnancy, but she was happy to be expecting a new baby. She was asked to consider contraception after the birth, as she did not want any more children.

3.1.9 On 31 March 2015, Farah attended the housing offices at Luton Borough Council and informed them that her father had issued her family with a Notice to Quit (NTQ) the family home. She stated that she was pregnant and due to give birth in May. The NTQ points were removed from the housing register in October 2015, as it had expired and was no longer valid.

3.1.10 On 10 April 2015, Child C was taken by her mother to the Children's Centre for a one year health visitor review. There were no medical concerns raised and no concerns from the parent.

3.1.11 On 8 May 2015, admin staff at Mona's GP practice recorded that Farah had been rude and aggressive towards them when asking for a prescription, when she had lost her previous prescription for iron tablets.

3.1.12 Farah took all three children to the GP for appointments for minor health concerns during May 2015.

3.1.13 At the end of May 2015, Farah's fourth child was delivered by elective C section. The child, Child D, was healthy and Farah was discharged home after two days. She was followed up at home by health visiting services.

3.1.14 On 3 June 2015, Farah was seen at home by the health visitor where she was given a new birth assessment. Among a number of subjects Farah was asked about domestic abuse, housing, and mental health issues and no concerns were recorded.

3.1.15 Farah was seen again by the health visitor on 15 July 2015 for the six to eight week assessment on her new baby. There were no concerns on mental health, there were no concerns on domestic abuse, the home was described as clean and comfortable and Farah was seen to have bonded well with her baby.

3.1.16 In September 2015, Child C started a new school.

3.1.17 On 11 October 2015, Mona reported to the police that she had been assaulted whilst working as a care worker. She had been involved in a driving altercation over parking and punched and kicked by the driver and passenger from another

car. Mona provided police with an index number for her attacker's car, but this was not found to be correct by the police and there was no CCTV coverage of the incident. After she had reported to the police Mona attended the ED of Luton and Dunstable Hospital with a facial bruise and an injury to thumb, having been assaulted by a man and a woman. Mona was diagnosed as having soft tissue injury and letter was sent to the GP.

3.1.18 In October, November and December 2015 Farah's children were seen at the GP practice and Hospital Emergency Department (ED) with skin infections, chest infections and breathing problems.

3.1.19 On 4 January 2016, Child B was seen by the GP. The child had sustained a small burn having touched an iron that was on the floor. It is not known who attended with the child. Non accidental injury was not considered.

3.1.20 On 6 January 2016, an off duty police officer had seen six month old Child D left alone in their mother's car in a supermarket car park. The off duty officer observed the baby alone in the car for five minutes and then called 999. The baby had been left in the car with a mobile phone left on and open to be used as a baby monitor, with the adults taking another phone with them whilst they went shopping. Police called the EEAST to the scene and forced entry to the car to recover the baby. The smashing of the window did not alert Farah over the open telephone line. The baby was taken to Luton and Dunstable Hospital ED where they were found to be well with no injuries. Both Ambulance, Police and Hospital completed timely telephone safeguarding notifications, followed up by written referrals.

3.1.21 Farah was arrested for child neglect by Bedfordshire Police. When Farah was being booked into police custody there were no issues with her ability to speak English. She confirmed that she was not suffering from any mental health condition. She was risk assessed as not requiring any medical attention. There were concerns that she was not eating and drinking whilst in custody. She had five examinations by healthcare professionals during her detention and there no concerns regarding her health or mental state. She was later released on bail. Enquiries revealed that the baby had been left alone in the car for 20 minutes. The police report was later classified as "No Crime" and no further action was taken against Farah. There was early consultation between Police, Children's Social Care (CSC), and the Hospital Safeguarding Team. A strategy meeting was held on the day of the incident with a decision being to complete a single assessment. Further contact came from Health Visitor to coordinate with the single assessment.

3.1.22 Attempts were made by CSC to arrange a single assessment visit with Farah. This eventually took place on 25 January 2016. The meeting was at 10am in the family home with Farah, her baby and two other children. The family home was in the process of being refurbished and the environment was very busy. It was noted that the father works nights and was upstairs asleep. Mona was upstairs in bed. A maternal uncle was visiting from Holland and also upstairs in bed.

3.1.23 A further health visitor follow-up took place on 28 January 2016, three days after the CSC visit. Present at the home were Farah with her baby and two older siblings. Also present was an aunt (possibly Mona). A good bond was noted between baby Child D, her mother and aunt. CSC were informed of the visit.

3.1.24 On 1 February 2016, CSC attempted to make an appointment to meet the child's father Osman to complete the single assessment, a voicemail was left, and Osman was unable to attend on the date suggested. A further attempt was made to see Osman on 3 February 2016 and he was not present, but the eldest child was seen by CSC. Further direct work was undertaken with Child A in the company of aunt, Mona. The relationship was noted to be positive and warm.

3.1.25 On 9 February 2016, the EEAST received a call from the family home to a female who was unconscious and faint. The Ambulance crew attended and saw the female, who was identified as Mona. Mona was not observed to be unconscious by the ambulance crew, or in later examination at hospital. Mona was conveyed to Luton and Dunstable Hospital, and she walked into the ED.

3.1.26 On 16 February 2016, a meeting was held between CSC and Farah's husband, Osman. He was not concerned about the incident at the supermarket and saw it as 'an oversight'. Farah was also present at the meeting. Osman commented that Farah was a good mother and both seemed comfortable in each other's company.

3.1.27 The CSC Single Assessment was completed and submitted for review at the start of March 2016 and returned to the writer a month later. The report recommended that work was to be done with the family through the Early Help Team. There were no immediate safeguarding concerns. It was recognised that the family needed some help in managing their children's' needs and this could be done through the early help team. CSC closed the case in April 2016. Farah was seen at home to be informed of the decision and that a parenting course was recommended. She did not see the point of the course and was keen for the meeting to end.

3.1.28 On 11 April 2016, Farah was seen by her GP practice nurse for recurrence of skin problems, she attended alone. On the same date Mona was seen by the practice nurse for an unconnected condition, Farah was present with her sister.

3.1.29 On 27 April 2016, Farah made an application for housing to Luton Borough Council Housing department. She informed the housing officer that she had been issued with an NTQ by her father. The application included her husband and four dependent children. It included details of health conditions of eczema and back pain, and a lack of space in the home. The homeless legislation was explained to Farah and she was unhappy with the prospect of being placed in temporary accommodation. Farah informed the housing team that she would discuss an extension to the NTQ with her family and let them know if temporary accommodation was still required. The housing application form had a section to record any domestic abuse and there were no concerns noted.

3.1.30 A week before her death Farah cancelled a visit from CSC as work was being done on her driveway at home.

3.1.31 Three days before the death Mona cancelled a scheduled GP appointment.

3.1.32 After the discovery of the death of Farah there was liaison between Police and CSC. The children were place with emergency foster carers under a Police Protection Order. There was an immediate notification to the GP and the housing services were informed.

4. Overview

4.1 Summary of Information from Family, Friends and Other Informal Networks:

4.1.1 At the time of writing this report there is limited information forthcoming from the family. The police investigative team carried out enquiries into the background of the victim and perpetrator. They were unable to provide any details of friends to support this review. Contact information was provided for some work colleagues of the victim.

4.1.2 *Interview with family:* It was apparent during the review that the parents of the victim were acting in a supportive role to the perpetrator Mona. It was decided not to approach them at an early stage and make enquiries through Farah's husband at the conclusion of the trial. The chair of the review maintained contact with Farah's husband through the Victim Support Homicide Worker. The victim's husband declined to be interviewed. At the time of writing it has been left that a further offer of interview is made after the report has been agreed and a copy is available to him.

4.1.3 *Interview with Colleagues:* Both victim and perpetrator worked for a company providing care to people at home. The panel identified three work colleagues for Farah and Mona, this included a manager. The chair wrote to all three colleagues explaining the review and providing copies of the Home Office DHR leaflets. The letter informed them of the value that they could add to the review, but also added that they would not be required to talk about the matter if they did not want to. There was no response to the letters and the chair followed this up with text messages and calls to two of the colleagues and there was no response. The chair spoke to Farah's manager on the telephone and she asked that he communicated by email. An email was sent to the manager and there was no reply. A further email was sent, and the manager stated that they would not speak to the chair without authority of her seniors, the chair then emailed and sought further

permission from the manager's seniors. At the time of writing there has been no further reply from the manager or her company.

4.2 Summary of Information from Perpetrator:

4.2.1 In conducting DHRs the views of the perpetrator can provide a valuable insight. In this case it seemed particularly pertinent to obtain an account of the relationship from Mona's point of view. When Mona was arrested she gave an account that her sister had been killed by a burglar. Whilst she later admitted her guilt to the court, there is no detailed account from Mona's point of view available to the panel. After Mona was convicted in October 2017 the probation services supported the chair in making contact with her prison offender manager. Mona was sent a letter of introduction, a copy of Terms and Conditions and the Home Office leaflet on DHRs. The chair of the DHR made a formal request to Mona inviting her to be interviewed and contribute to the review. Mona agreed to be interviewed and an interview was booked for February 2018. When Mona was asked to sign consent forms in advance of the interview she then declined to be interviewed. The Standing Together DHR team persisted in attempts to arrange an interview with Mona. They worked with Mona's Offender Manager at her prison. In April 2018 Mona finally agreed to speak to the chair by telephone to discuss whether she would consent to an interview. During the phone conversation the chair explained the DHR process. It was made clear by Mona that she had read the papers supplied about the case. Mona said that she did not want to be interviewed and she was concerned about publication of the report. She was informed that publication was part of the process for helping prevent other similar crimes and she could provide an insight to help in the future. Mona declined to be interviewed. It was left that she would contact the chair if she changed her mind.

4.3 Summary of Information known to the Agencies and Professionals Involved

4.3.1 Bedfordshire Police: The police had contact with Mona from May 2013 when her boyfriend, Hamza, suspected that she was due to be taken to Holland for an arranged marriage. Mona was seen and there were no substantive offences identified by the police. Later that year Mona reported to police that she had ended her relationship with Hamza in May 2013 and after that he had been harassing her by text message and sending her letters. A police information notice was served on Hamza and the case was closed.

4.3.2 Mona reported to police that Hamza had been stalking her again in July and August 2014. Hamza was arrested and no further action taken, on advice of the CPS, due to lack of evidence. Mona was referred to an IDVA and to the local MARAC. She was assessed under Domestic Abuse Stalking and Honour-based

Violence (DASH) risk assessment as being of 'high risk'. A warning marker was placed on Mona's home address.

4.3.3 The police IMR also identified that Farah had reported a theft of her mobile phone from her home in October 2014. There had been 15 family and friends at the home at the time and there was insufficient evidence to identify a suspect.

4.3.4 In October 2015 police conducted an investigation into the allegation of assault by Mona after an altercation over parking. The matter was fully investigated, and the suspects were never identified.

4.3.5 The incident where baby Child D was left alone in the car by her mother on 6 January 2016 was investigated by the Bedfordshire Police Safeguarding Team. Police interviewed Farah and liaised with CSC. The Police IMR author confirmed that the investigating officers conducted an interview with Farah in English and there were no concerns recorded on her ability to read and understand English. Farah was known to be breast feeding at the time and it was thought to be in her child's best interests to release her on bail whilst CSC conducted a single assessment. Farah was bailed with conditions not to have unsupervised contact with a child under 18. The case was later closed by police as there was not enough evidence to prove wilful neglect.

4.3.6 In considering the murder of Farah the investigation team found no evidence to show that any other person, apart from Mona and Osman knew of their intimate relationship. The investigation has not revealed that Mona had made any form of threat to Farah or any threats to Osman about his wife. The extensive investigation team found no evidence of collusion between Farah and Osman that would suggest a risk to Farah.

4.3.7 The police IMR author has made internal recommendations concerning the processes on DASH risk assessments and recording processes.

4.3.8 East of England Ambulance Service: There was limited information known to the ambulance service. The main incident of note was the call to the supermarket on 6 January 2016. This resulted in the ambulance crew taking the victim's baby to the hospital ED and making a safeguarding referral. The referral was made at the appropriate level. Whilst there were concerns on matters of child protection, there is no evidence that there were any indicators of potential abuse between the victim and perpetrator.

4.3.9 The ambulance service also provided information on a call to the service on 9 February 2016. This concerned a female patient who had been reported as unconscious and taken to the hospital ED. The IMR did not show the name of the patient. Checks with hospital records show that this patient was Mona.

4.3.10 The ambulance service IMR makes no reference to being notified of the MARAC concerning Farah.

4.3.11 There were no internal recommendations from EEAST.

4.3.12 Cambridge Community Services (CCS): This service is the commissioned Trust for providing NHS community care for children in the Luton area. The Trust saw Farah's children under the 0-19 Healthy Child Programme and were responsible for developmental checks. There were no concerns noted and all children were developing normally. Farah was noted to have appropriate attachment to her children.

4.3.13 The first involvement with the service came on 3 December 2012 when Farah was seen at home on a planned home visit. At this appointment Farah was asked about her mental health and if there had ever been any form of domestic abuse. There were no concerns raised by Farah or the healthcare professional. Farah was also informed of the services that would be available to the family.

4.3.14 The IMR notes some occasions as significant to child safeguarding and that required following up. Prior to May 2014, Farah's eldest child, Child A, had frequent attendances at the Hospital ED and GP concerning frequent falls and accidents. There were also a number of missed appointments for the child over a three-month period. Whilst the management of the individual appointments was appropriate there does not appear to be any oversight or analysis of the series of events.

4.3.15 It was also noted that there were other occasions of missed appointments for Farah's children. The IMR author considers that these could have been due to Farah's family and work commitments. It was established that Farah's first language was Urdu, but she spoke in English with NHS staff. There were no recorded communication issues and Farah's understanding was documented. It was noted that Farah was asked about domestic abuse and mental health when she was alone, and staff took care not to raise matters in the presence of other family members. There were no recorded concerns about Farah's emotional or mental wellbeing. There was no evidence to indicate the presence of domestic abuse and no known threats to Farah's safety. There were no concerns on referral pathways or appropriate communication with other agencies. There were no internal recommendations from CCS.

4.3.16 Luton and Dunstable University Hospital: The Hospital provides ED services for the area where the victim lived. All hospital staff have been appropriately trained in line with Royal College of Paediatrics and Child Health (RCPCH) Intercollegiate Document 'Roles and Competencies for Health Care Staff' (2014). Safeguarding training includes the area of domestic abuse. All staff are trained to 'Think Family' and consider the impact of domestic abuse on children. The Trust also has a dedicated safeguarding team.

4.3.17 Records show that Farah was recorded as 'British Pakistani'. It was noted that although English was not her first language, that she spoke and could understand

English. This was clearly documented in Farah's hospital notes on two occasions. It should be noted that the Trust has a clear policy of using professional interpreters when dealing with safeguarding assessments, unless staff speak the first language of the patient.

4.3.18 Records show that Farah first became a patient at the hospital for maternity care until the birth of her baby, Child C, in January 2014. The IMR noted that the next significant contact came from March 2014 when Child A was seen on four occasions in the ED. No safeguarding concerns were raised, and injuries were consistent with accounts given. All attendances were shared with the GP.

4.3.19 In September 2014, the Trust recorded that Mona had been subject of a MARAC meeting and information was appropriately stored on the patient information system.

4.3.20 The Trust records show that midwives had raised concerns that Farah had booked late at 21 weeks when she was pregnant in 2015. There was close monitoring of all appointments thereafter and she gave birth to a healthy baby girl.

4.3.21 When Mona attended the hospital ED with a head injury on 11 October 2015 she reported being assaulted but did not identify the assailants. The IMR author considered that Mona should have been asked if the assailant was her ex-boyfriend, as the Trust was already aware of the previous MARAC referral. They considered this a missed opportunity. As a result of this the IMR author has made internal recommendations, which are shown below.

4.3.22 When Child D was brought to the ED by ambulance, after being found unattended in the car, it was noted that Farah was not present because she had been arrested for neglect. The child was healthy and released into the care of Mona and the maternal grandmother. The Trust made all appropriate safeguarding referrals to CSC and the GP.

4.3.23 There is documented evidence within medical notes that there was 'Routine Enquiry' on domestic abuse during both of Farah's pregnancies. Consideration was also given to the use of an interpreter. It should also be noted that one of Farah's named midwives spoke Urdu.

4.3.24 Education Services The IMR was conducted independently of the education providers by the Safeguarding in Education Team at Luton Council. The review considered the education of Farah's two eldest children Child A and Child B. The review covered two educational establishments, although it was established that Child A did not start at the second school until after the review period outlined in the terms of reference. The review found that all staff were trained to appropriate safeguarding levels and that policies were in place.

4.3.25 Child A was shown to be an outgoing and confident child and achieving well at school, with no concerns relevant to this review.

4.3.26 Child C settled well into their nursery school. They had no problems making friends, described as ‘sociable’, with good language skills.

4.3.27 The IMR noted that when Child B was reported to have a burn on their hand that it was not recorded and documented in line with safeguarding policy.

4.3.28 The IMR author also noted that the single assessment undertaken by CSC when Child D was abandoned was not known to education providers. This showed a lack of cross agency commination that could ensure good safeguarding provisions for children. Enquires with wider education providers suggest that it was not unusual for education to be missed in single assessments, at that time. It is believed that education providers could have provided valuable information to CSC when assessing parenting skills.

4.3.29 Children’s Social Care: During the period under review CSC provided statutory services and intervention on safeguarding services through the Rapid Intervention Team (RIAT). That team became a Multi-Agency Safeguarding Hub (MASH) in October 2016.

4.3.30 Following the incident where Farah left her baby alone in a vehicle, the RIAT received notifications from hospital, ambulance and the police by telephone and writing within 24 hours. A strategy meeting took place and it was established that the family were not previously known to CSC. It was decided to undertake a Single Assessment under s.17 Children Act 1989.

4.3.31 The assessment was undertaken by a student Social Worker who carried out the work over a period of nine weeks. Contact was made with the family GP and Health Visitor, but the IMR author states that the assessor was unable to get a response to her request for information. It was considered that there could have been further liaison with housing over the over-crowding in the family home. The worker considered that there was a lack of response to the advice on safety of the children and the case concluded with a referral to the Early Help Team. Farah showed reluctance to engage further with services offering support. When the case was closed the report was written before the final meeting with Farah and did not reflect her views on the Early Help referral.

4.3.32 The IMR author noted that there was no information to indicate that domestic abuse formed part of the family dynamics, but also considered that the parents were not interviewed separately and were not given an easy opportunity to disclose. The IMR author was unable to establish whether the potential for domestic abuse was a factor in the Single Assessment, and there were no supervision records available for review.

4.3.33 There is no record of the need for or use of an interpreter by CSC.

4.3.34 The author of the CSC IMR made internal recommendations on the completion of the report and these are included below.

4.3.35 Housing Services: Farah first registered her family with the housing department in 2012. After supplying further documentation she was accepted onto the housing register in March 2013. Farah was offered temporary accommodation but did not want to move away from the area. Farah provided a letter giving Notice to Quit (NTQ) from her father at the start of 2014. That NTQ later expired. Farah continued to inform the housing service of her family circumstances. A new NTQ was provided April 2016.

4.3.36 The Homelessness Application Form used at the time was reliant on a member of the housing department staff interviewing the applicant and identifying domestic violence. There was a simple tick box check list, with a reason for breakdown in relationship being recorded as 'violent' or 'non-violent'. There was no indication noted by the housing office interviewer that any parties were at risk from violence. The housing application linked to this new notification had the domestic violence question unchecked. There was no mention in the housing applications for the need of an interpreter. It was also clear that Farah wanted to remain in Luton near her children's schools. There were no other family pressures recorded. All contact appears to have been instigated by Farah.

4.3.37 At the time of the homelessness application there was a clear protocol for a multi-agency response if a case of domestic violence was revealed. Since the death of Farah the Housing Department has changed to a new Applicant Declaration for Homelessness form. The form now has a whole page focused on risk of violence within the household. The form does not focus solely on intimate partner relationships and the questions posed provide an appropriate opportunity for disclosure of abuse. The form also mandates that the Housing Officer records what action they take in referrals. This new process should be considered as good practice.

4.3.38 CCG - General Practice: There were a number of appointments with the GP over the start of the review period. It was noted that on one occasion Child C was brought to the practice by his aunt, however, the records do not state if the aunt was Mona.

4.3.39 Records show that Farah was seen by her health visitor on 1 April 2015 as part of her pregnancy care and the visit included discussion on the presence of domestic violence. The IMR comments that he did not know if Farah was of the impression that domestic violence only related to her husband and not the wider family. It is impossible to state what the victim's impression was. The IMR expressed concerns that the reason for Farah missing midwife appointments was not recorded, as pregnancy can be seen as a time when a woman is vulnerable.

4.3.40 Records also show that Farah's husband had taken children for GP appointments.

4.3.41 It was noted that Farah was aggressive and rude to staff in May 2015 and this was a missed opportunity to capture any problems concerning the home or mood disturbances.

4.3.42 It is clearly documented that Farah was screened for domestic abuse and maternal mental health problems during her health visitor appointment in June 2015, with no concerns being recorded. This screening was repeated in July 2015, again with no concerns recorded.

4.3.43 Mona was rarely seen by GP services, but there were no mental health or chronic health problems recorded. When she was seen at the hospital ED on 11 October 2015 there was no attempt by the GP or hospital to follow up the reason for the injury.

4.3.44 When Child B was seen by the GP in January 2016, it was not documented if a Non-Accidental Injury was considered. There was also no note of who attended with the child.

4.3.45 The medical records make reference to the occasion on 6 January 2016 when Child D was left alone in the car. The GP was informed of the incident on the day. The GP records show that a Health Visitor appointment took place on the 28 January 2016 following a notification of a CSC investigation. The IMR author believed that this was a missed opportunity to discuss the reason for not leaving the child in the car and no reference to Farah's mental health. There is no record of any information being passed back to CSC.

4.3.46 There are no references to Farah's language needs and whether she required an interpreter. There is no evidence that the GP practice were informed that Mona had been subject of a MARAC.

4.3.47 The CCG IMR made a number of internal recommendations and these are recorded below.

4.3.48 MARAC: The IMR from the MARAC service focuses on the one referral made in August 2014 by Bedfordshire Police. It was made on concerns from Mona's then boyfriend that Mona was going to be taken to Holland for an arranged marriage. It transpired that no marriage took place, but the boyfriend had begun to stalk Mona. It was shown that police had flagged Mona's address. The MARAC referral was from the IDVA. The police criminal investigation closed, and Mona did not require any further support.

4.3.49 There is no information to show whether any other agencies apart from the police were formally notified for records to be noted of the MARAC. There were no internal recommendations.

4.3.50 Victim Support: Victim Support provide the locally commissioned IDVA service for Luton. Mona was referred to Victim Support in August 2014 by the police for IDVA services. This was due to concerns that she was being stalked by an ex-boyfriend.

After several attempts to contact Mona the IDVA eventually spoke to Mona. Mona agreed to meet the IDVA but the meeting did not go ahead. There was a further attempt to contact Mona and the case was closed in November 2014 due to Mona's failure to engage. It appears that the closure process was not adhered to as it would require at least three attempts at contact before a case is closed.

4.3.51 The IMR author stated that there have been substantial changes to the service and practice since 2014. These include mandated management review before cases are closed. The service was reviewed in November 2016 and awarded "Leading Lights' reflecting that the IDVA service runs to best practice standards. There were no internal recommendations made.

4.4 Any other Relevant Facts or Information:

4.4.1 There was no evidence from the enquiries generated by the review that Farah or Mona had any mental health problems prior to the homicide. During the criminal case Mona raised a defence that she lost control and had mental health issues. That defence was later withdrawn and there is no material available to the review panel to support any suggestion that she had mental health problems.

4.4.2 There was no evidence to suggest that any party subject to this review had any substance misuse problems.

5. Analysis

5.1 Domestic Abuse/Violence and Farah

5.1.1 The circumstances of Farah's death and the conviction of her sister, for murder, clearly show that Farah was subject to an incident of domestic violence on the day that she died. There was no evidence gathered by the review that indicates that Farah was subject to any form of domestic abuse or harassment before the date of her death. Whilst Mona's attack on her sister can be seen as pre-planned, with the purchase of the murder weapon and internet searches for methods of killing, there is nothing to show that any other person was aware of that planning.

5.1.2 The fact that Farah was known to be pregnant from January 2015 ensured that she was subject to 'Routine Enquiry' by healthcare professionals on whether she was or had been a victim of domestic abuse. This enquiry took place through a number of meetings between the victim and the midwife and health visitor between January 2015 and July 2015. Farah is recorded as being alone with the healthcare professional at the time of the interview. There was nothing revealed by Farah that would have led professionals to believe that there was the need to consider a risk assessment. This shows that she would have had the opportunity to disclose any risks to her safety.

5.1.3 It is clear that Farah was keen to be rehoused by the local authority. The presence of domestic abuse in a housing application would highlight an area of risk for the

authority to consider. There was no mention of the presence of domestic violence in Farah's application for housing and it was not given as a reason for moving. At the time of completing the housing application there was limited opportunity for considering the various forms of domestic abuse that can take place. There was a tick box option to record whether a breakdown in a relationship was 'violent' or 'non-violent'. It is not known whether Farah was experiencing any abuse at the time at home. There would have been opportunity to inform council staff if this was an issue. It was apparent to housing staff the process of housing application could have been improved to more fully address risks around domestic abuse. A new application form has since been introduced and focuses on violence within the household, linking to risk assessment and appropriate support referrals. The use of the new form should be considered as good practice.

5.1.4 There was no evidence to indicate that Farah was subject to coercive or controlling behaviour. There was no evidence that Farah was subject to any form of financial abuse.

5.1.5 At the heart of this DHR process is the victim Farah and the review should aim to look at the interaction from her point of view. In this case it has been challenging to get a good sense of Farah and to view things from her perspective. From agency contact and observation at Farah's home she was seen to be a good mother with a close bond to her children. There were no outward signs of tension between Farah and her sister or husband. From the information gathered by the review there is no evidence to suggest that Farah was subject to any form of abuse from any family member before the date of her death.

5.1.6 There is no information to suggest that Farah was subject to domestic abuse in her home prior to being killed. This is based in the information currently available to the review panel. Consideration was given to whether Mona was subject to any form of controlling behaviour from her family, but she declined to be interviewed. There was no evidence in the criminal case that Mona was subject to abuse or acting under any duress. The panel was informed that there was an historic report that Mona was going to be subject to a forced marriage. This allegation was made by an ex-boyfriend, and that boyfriend was later reported by Mona for stalking her. Whilst the panel has had an opportunity to review the steps taken to deal with the stalking behaviour of Mona's ex-boyfriend, this was never connected to the murder of her sister. There can be no causal link between the earlier reports of stalking and harassment and the homicide.

5.2 Analysis of Agency Involvement:

5.2.1 This review has brought to light the management of reported domestic abuse to the perpetrator and safeguarding concerns for the victim's baby during the two years leading up to the victim's death. These matters have been examined by the

agencies concerned and whilst there are some lessons to be learned and single agency recommendations, it is not believed that the incidents can be linked to the homicide. They cannot be seen in any way to be predictive or indicators of domestic abuse towards Farah. These incidents are mentioned briefly in the analysis, so that all agencies can consider the learning.

5.2.2 Mona as victim of domestic abuse: The perpetrator Mona had some contact with statutory agencies during the period under review and had been a victim of harassment and stalking by her ex-boyfriend. There was no causal link established between any of those events and her actions in killing her sister. There was no evidence that any agencies dealing with Mona could have predicted in any way that she would ultimately murder her sister. Those investigations have revealed some procedural errors in the closure of the case by the IDVA. New management processes have been implemented and established since that time and there is no need for further action. This will not be discussed further in the analysis of the case, however internal recommendations from the learning from the management of Farah's report of harassment are included for information at the conclusion of this report.

5.2.3 Safeguarding Concerns for Osman and Farah's children: This review has also allowed the panel to examine safeguarding children procedures from the family's interaction with statutory agencies. Whilst this is not directly linked to the death of Farah it has revealed issues with protocols between agencies.

5.2.4 In dealing with the incident where Farah left her child in the car, the investigation was child focused. There was a prompt response focusing on the safety of Child D after an off-duty police officer had found the child left alone. Police, Ambulance and Hospital all made timely Safeguarding referrals and there was a coordinated response focusing on the welfare of the child. There was an immediate strategy meeting.

5.2.5 There were some concerns in the follow up to the case. The CSC Single Assessment was undertaken by a student social worker. In making that assessment there appears to have been no liaison with the school of Farah's other children. There is also some concern on communication between CSC, Health Visiting and GP. The CSC file shows that there was no response from the GP and Health Visitor and yet it appears that a Health Visitor did meet with the family as a result of being notified of the safeguarding concern. There is no evidence that the information on the Health Visitor meeting was passed back to CSC. It also appears that the Single Assessment was closed without ensuring that there was input from primary care, housing or education. From examination of the CSC case file, it is not clear who had oversight at a more senior level.

5.2.6 There appears to be little acknowledgement of the pressures on Farah and her mental health. The health visiting services made routine enquiry into her mental

health at various stages of pregnancy this was in line with protocols. However, there appears to have been no consideration of assessing Farah's mental health after she had left her child unattended in a car. It became apparent during the review that Farah had made an application to be rehoused and that this was a concern for her. The consideration that Farah may well have been suffering from stress, depression or other illness is not evident in the IMRs of police, CSC, or CCS. It has been established that Farah was seen by several medical practitioners whilst in police custody. The GP IMR recognises that this was a missed opportunity to screening Farah for mental health problems.

5.2.7 The Murder of Farah: In considering the death of Farah this review has examined opportunities that she may have had for disclosure of any form of abuse. It is clear that there are embedded procedures and protocols. There are some areas of Good Practice.

5.2.8 From the date that Farah made a late report of her pregnancy it is clear that she was seen by her Midwife and Health Visitor and asked questions as to whether she was at risk of domestic abuse. This process is known as routine enquiry and should be considered Good Practice. Farah was screened for domestic abuse during her pregnancy. This process started in January 2015 and she was asked about domestic abuse at least twice after the birth of her baby in the summer of 2015.

5.2.9 In the month before Farah was killed she made an application for rehousing. The housing application template includes a reference to Domestic Violence. This section was unchecked. It is not known if this indicates that no questions were asked about DV or that it was not present. It should also be considered that if Farah was experiencing any form of abuse from her family at this stage then she could have referred to this in making her housing application. There was no mention of abuse at this point.

5.2.10 One area that needs to be considered is the definition of Domestic Abuse in safeguarding protocols. The author of the GP IMR was uncertain that existing protocols specifically highlight Adult Family Violence (AFV) as a form of domestic abuse. Whilst the protocols in primary care and housing include screening and routine enquiry for abuse, it is not known if questions asked by professionals are sufficient to ensure that service users fully understand that AFV is domestic abuse.

5.2.11 A key purpose of a DHR is to look at the way in which local professionals and organisations work to safeguard victims. Consideration has been given to the involvement of agencies in the lives of Farah and her family. In this case there was a significant level of contact between Farah and her family and statutory agencies in the two years before her death. There is no evidence to suggest that there was

any form of unreported domestic abuse towards Farah in this case. Given the apparently secretive nature of the relationship between Farah's sister and her husband this is not surprising.

5.2.12 The attack on Farah was an act of extreme violence. The act appears to have been secretly planned by the perpetrator and there is no evidence to show that any member of close family was aware of any intention by Mona to cause her sister harm. Given the particular circumstances of this case it is impossible to see how any agency contact could have been aware of the potential for such a violent act.

5.3 Equality and Diversity:

5.3.1 The Review Panel identified the following protected characteristics of Farah as requiring specific consideration for this case; European Citizen of Pakistani origin, sex and marital status.

5.3.2 Consideration was given to Farah, as a Pakistani woman and an immigrant to the UK. From the information available to the panel it appears that she did not have friends outside of her family or a network where she could express concerns about difficulty at home. The majority of agency contact with Farah indicates that she was able to express herself and access services. However, the late reporting of her last pregnancy was one case where she did not access services straight away. It has been difficult to gain a good understanding of Farah as a person and how she engaged outside of her family.

5.3.3 It is known that Farah's first language was Urdu, she also spoke English. Farah's interaction with Health services, Housing services and the Police have shown that she was able to effectively communicate during interviews. There appears to be limited formal acknowledgment of Farah's first language and there is no formal record that she was happy to communicate with agencies in English.

5.3.4 It needs to be considered that the length of time that a person lives in a country can greatly influence a person's knowledge of specialist support, civil, and criminal justice options available to victims of crime. During her four to five years in the UK Farah had a number of interactions with support agencies. Her contact with primary care services included routine enquiry into domestic abuse. It is not known whether these interactions can compensate for the exposure to the dialogue around domestic abuse that has been growing in UK education and society in recent decades. It should also be considered that Farah came to the UK from a European country where equality and the rights of women are well recognised and established.

5.3.5 The fact that Farah was married appears to have had an impact on this case, as her husband's ending of an extra-marital relationship with her sister was a key

factor. The review process has however shown that the marital status of Farah had no impact on the statutory services provided to her. It is appreciated that the status of Mona as a single woman having a relationship with her sister's husband may have affected her ability to discuss her circumstances with family or friends. It has not been possible to explore any particular pressures on Mona as she has declined to be interviewed and her employers will not support this review.

6. Conclusions and Lessons to be Learnt

6.1 Conclusions (key issues during this Review):

6.1.1 This case demonstrates a case of adult family violence where there were no known indicators that the victim was at risk. The perpetrator and the victim's husband were involved in an intimate relationship. A thorough police homicide investigation and individual management reviews of ten separate agencies has not uncovered any evidence that any party, other than the perpetrator and victim's husband, knew of the relationship.

6.1.2 Even knowledge of the relationship could not be reasonably expected to predict that Mona was planning to kill her sister. It is not been shown that Mona expressed any feelings that would indicate that she could harm her sister and there had been no previous violence between the two.

6.1.3 There was no evidence of the perpetrator having any issues or problems affecting her mental health at the time of the attack. The review has considered all medical records and takes into account that the perpetrator pleaded guilty to murder and did not seek to rely on a defence linked to her mental wellbeing.

6.1.4 On the information available to the panel and after considering a thorough criminal investigation, it can only be concluded that Farah died as a result of a pre-mediated and calculated attack at the hands of her sister.

6.1.5 This was an extremely tragic case and the panel recognises the sad loss to the family of Farah.

6.1.6 The review process has examined the family's interaction with statutory agencies over the two years leading up to the death. The CSP area has shown some examples of good practice with well embedded procedures and protocols. Whilst those protocols are established services can always learn and improve. Whilst there is no established connection between those areas and the death of Farah, this review has provided the opportunity to make recommendations to improve services in the future.

6.1.7 The key issues revealed in examining the agency involvement in this case have been shown to be: -

(a) Recognition of Adult Family Violence as part of a spectrum of domestic abuse.

(b) Clearly recording the language needs of clients by agencies and in information sharing.

(c) Interagency communication on safeguarding referrals.

6.2 Lessons to Be Learnt:

6.2.1 This review has shown that, even when there are well established safeguarding systems to protect people from abuse, there are some cases where the potential for violence is well hidden. The threat of violence was hidden from the agencies with a duty to protect and from those closest to the potential victims.

6.2.2 Whilst the panel recognises the secretive and private nature of the threat to Farah, the review has revealed ways in which services can be improved. The agencies involved in this review have identified a number of areas for single agency learning and those are reflected in their recommendations below.

6.2.3 Farah's experience as a Dutch Pakistani woman living in the UK was a factor in this case. Whilst the majority of agencies show that Farah had no problems with the English Language, it is important to ensure that the language needs of a service user are fully recorded. It is also important to ensure that inter-agency communication records any language needs of service users.

6.2.4 The key area for learning in this case is that the potential for Adult Family Violence can be present in what appear to be the most stable family environment. All professionals should be aware that AFV is domestic abuse and subject to the established safeguarding protocols.

6.2.5 This case also provides a valuable opportunity to ensure that the public are aware that family violence is abuse and there are services available to support and protect families from all types of abuse.

7. Recommendations:

7.1 IMR Recommendations (Single Agency):

7.2 Bedfordshire Police Recommendations:

▪ Following a DASH 'high risk' assessment relevant warning marker(s) to be placed immediately.

▪ A Force policy to be implemented for the use of CATS (Running log of domestic abuse investigation).

7.3 Luton and Dunstable University Hospital Recommendations:

▪ The new Domestic Violence and Abuse Policy 2015 will continue to be rolled out in key areas and the Risk Assessment Pathway will be made available on the intranet and in hard copy, and promoted in training. Timescale for action completion - March 2017

▪ Safeguarding Adults and Children Training to be updated to include a scenario of Domestic Abuse that involves abuse or violence between sisters or in-laws and family members over 16 years, to ensure staff understand that DV is not confined to current or former intimate partners. Timescale for action completion - March 2017

7.4 Children's Social Care recommendations:

Management Oversight

▪ Where a student's Practice Educator is 'off-site', any case discussion, should be recorded and sent to the team manager for inclusion in the child's file.

▪ Direct case supervision to be undertaken within the teams where the work is allocated, in addition to the reflective practice supervision by the Practice Educator by 1st February 2017.

▪ Current lead in the Centre for the Development of Social Care Practice Unit at Bedfordshire University to meet with Team Managers to agree a format for the discussions and a timescale for provision of each by 1st February 2017.

▪ Direct Team supervision to be agreed at Extended SMT on 24th January 2017

▪ Where a single assessment is completed education and children centre provisions should be contacted as part of that process.

Interviewing of family members separately

Family members to be seen separately in Single Assessments wherever possible.

To ensure that the potential of Domestic Abuse is directly considered and explored in each Assessment, which requires those being interviewed to be seen separately, at least once. To review training and procedures to ensure this is expressly noted.

7.5 Education recommendations:

▪ Where a single assessment is completed education and children centre provisions should be contacted as part of that process.

▪ There should be regular staff training to support staff members working with victims and perpetrators of domestic violence. Training should incorporate the routine enquiry, responding, recording, reporting, multi-agency working etc. Training should be centrally coordinated and offered to ensure there is a clear pathway offer and to enable providers to know what would best suit their organisation.

▪ All staff should be aware of the need to record injury information in line with the school's safeguarding procedures.

▪ Where records or information is held in different places this should cross reference and it should be noted who has had the information and addressed any concerns raised by it.

7.6 Housing Service Recommendations:

▪ Greater transparency and integration within the IT system i.e. in the form of alerts created between the Housing Register module and the Homeless module will require exploration – March 2017.

▪ Review of ASC and Housing Protocol – February 2017

7.7 CCG recommendations:

Screening for domestic abuse

▪ GP practices to screen for and identify domestic abuse for those patients over 16 years at their new patient medical appointment for new patient registrations.

▪ GP practices to screen for and identify domestic abuse when seeing patient for pregnancy booking, antenatal care and post-natal care appointments.

▪ GP practices to screen for and identify domestic abuse when seeing patients who have previously attended Accident and Emergency with accidental injuries.

Documentation and information sharing:

▪ GP practices to ensure medical note keeping is detailed and that information sharing of important information is through the task system which links the alert to the patient record and flags this to all users of System One.

Late booking of pregnancy

▪ GP practices and community midwives to liaise and share information with regards to late booking of pregnancy and consideration to be given to the reasons for this and whether this is a sign of a family struggling or having problems.

Mental health screening

▪ GP practices to screen for and identify mental health concerns for those patients over 16 years at their new patient medical appointment for new patient registrations.

▪ GP practices to continue to screen for and identify domestic abuse when seeing patient for pregnancy booking, antenatal care and post-natal care appointments

Inter-agency working

▪ GP practices to establish or continue multiagency/disciplinary team meetings on a regular basis to review those families subject to a safeguarding child or adult investigation to assess if further support or vigilance is required.

▪ GP practices to establish close links with multiagency professionals to ensure person to person handover or dialogue is encouraged.

Safeguarding adults against domestic abuse

▪ GP practices to take part in regular safeguarding adults training which incorporates domestic violence training. All training to be disseminated to all staff working in the practice.

▪ GP practices to ensure awareness amongst staff that domestic abuse can be between any adults co-habiting.

7.4 Overview Report Recommendations:

7.4.1 The recommendations below should be acted on through the development of an action plan, with progress reported on to the Luton Community Safety Partnership within six months of the review being approved by the partnership.

7.4.2 **Recommendation 1: That all agencies domestic abuse training and protocols are reviewed to ensure that all variations of intimate partner and inter-familial relationships are considered and the potential abuse between adult family members is highlighted.**

7.4.3 **Recommendation 2: That Luton Community Safety Partnership review domestic abuse awareness campaigns to ensure that the subject of adult family violence is highlighted.**

7.4.4 **Recommendation 3: That all agencies should review their procedures to ensure that records show a clear record of a client's language and interpretation needs. All should ensure that a person's understanding of English and interpretation needs are clearly documented in safeguarding protocols and are recorded in any inter-agency referral.**

7.4.5 **Recommendation 4: That Luton Children's Social Care and Education Services audit and review information sharing protocols to ensure that education services are included in the Single Assessment framework.**

APPENDIX 1

Domestic Homicide Review Terms of Reference: Case of Farah

This Domestic Homicide Review is being completed to consider agency involvement with Farah and Mona following the death of Farah in May 2016 (edited). The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

1. Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.

2. To review the involvement of each individual agency, statutory and non-statutory, with Farah and Mona May 2014 (edited).

3. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.

4. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.

5. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.

6. The Independent Chair will:

a) chair the Domestic Homicide Review Panel;

b) co-ordinate the review process;

c) quality assure the approach and challenge agencies where necessary; and

d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

7. To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.

8. On completion present the full report to the Luton Community Safety Partnership.

Definitions: Domestic Violence and Coercive Control

9. The Overview Report will make reference to the terms domestic violence and coercive control. The Review Panel all agree that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The Review Panel understand and agree to the use of the cross-government definition as a framework for understanding the domestic violence experienced by the Victim in this DHR.

The cross-government definition of domestic violence and abuse (amended March 2013) definition states that domestic violence and abuse is:

“Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”

This definition, which is not a legal definition, includes so-called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

Ethnicity, Equality and Diversity

10. The Review Panel will consider all protected characteristics of both Farah and Mona (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any local area protected characteristics to consider (e.g. armed forces, carer status and looked after child). The following are local area protected characteristics to consider: gender and consideration of origin.

11. The Review Panel identified the following characteristics of Farah and of Mona as requiring specific consideration for this case; gender and consideration of origin.

12. The Review Panel will invite the head of the local Mosque to the panel as an expert/an advisory member to the chair to ensure they are providing appropriate consideration to the identified characteristics.

Membership

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

14. The following agencies are to be on the Panel:

a) Clinical Commissioning Group

b) Community Health Services (e.g. health visiting)

c) General Practitioner for the victim and [alleged] perpetrator (through CCG)

d) Hospital

e) Luton Adult Social Care Services - (included on panel list but not necessarily at meetings)

f) Luton Children's Social Care (CSC) Services

g) Luton Community Safety

h) Luton Education Services and/or School(s)

i) Luton Housing services

j) Luton domestic violence specialist service provider e.g. Women's Aid / IDVA

k) Mental Health Trust – (included on panel list but not necessarily at meetings)

l) NHS England

m) Bedfordshire Police

n) Probation Service

o) Substance misuse services

p) Victim Support

15. There were no other areas of expertise considered relevant at the start of the review. The panel will give consideration for the need for any expert advice throughout the process.

16. Parallel Reviews: The panel is not aware of any parallel reviews.

17. Role of Standing Together Against Domestic Violence and the Panel:
STADV have been commissioned by the Luton CSP to independently chair this DHR. STADV have in turn appointed their Associate Mark Yexley to chair the DHR. STADV DHR team consists of an Administrator and Manager. STADV DHR team Administrator will provide administrative support to the DHR and the STADV DHR Team Manager will have oversight of the DHR. STADV Manager may at times attend a panel meeting as an observer. STADV DHR team will quality assure the Overview Report before it is sent to the Home Office. STADV DHR team will liaise with the CSP around publication. The contact details for all on the STADV team will be provided to the panel.

Collating evidence

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

19. Chronologies and IMRs will be completed by the following organisations known to have had contact with Farah and Mona during the relevant time period, and produce an Individual Management Review (IMR):

20. Further agencies may be asked to complete chronologies and IMRs if their involvement with Farah and Mona becomes apparent through the information received as part of the review.

21. Each IMR will:

a) set out the facts of their involvement with Farah and/or Mona

b) critically analyse the service they provided in line with the specific terms of reference

c) identify any recommendations for practice or policy in relation to their agency

d) consider issues of agency activity in other areas and review the impact in this specific case

22. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Farah and Mona in contact with their agency.

Analysis of findings

23. In order to critically analyse the incident and the agencies' responses to Farah and/or Mona, this review should specifically consider the following points:

a) Analyse the communication, procedures and discussions, which took place within and between agencies.

b) Analyse the co-operation between different agencies involved with Farah /Mona [and wider family].

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

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

e) Analyse organisations' access to specialist domestic abuse agencies.

f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.

As a result of this analysis, agencies should identify good practice and lessons to be learned. The Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.

Development of an action plan

24. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the Community Safety Partnership on their action plans within six months of the Review being completed.

25. Community Safety Partnership to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Liaison with the victim's family and perpetrator

26. Sensitively attempt to involve the family of Farah in the review, once it is appropriate to do so in the context of on-going criminal proceedings. The chair will lead on family engagement with the support of Victim Support Homicide Service.

27. The Review Panel have discussed the involvement of children in the DHR at the 1st Panel Meeting and have decided it inappropriate for this review. The panel has considered the following factors; age, proximity to the homicide and view of Children's Social Care of child/children's needs. If there is any future need for contact with the children, this will be facilitated by the police and Victim Support Homicide Services.

28. Invite Mona to participate in the review, following the completion of the criminal trial.

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

30. Coordinate with any other review process e.g. those concerned with the child/ren of the victim and/or alleged perpetrator.

Media handling

31. Any enquiries from the media and family should be forwarded to the Community Safety Partnership who will liaise with the chair. Panel members are asked not to comment if requested. The Community Safety Partnership will make no comment apart from stating that a review is underway and will report in due course.

32. The Community Safety Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

33. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

34. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

35. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Documents to be password protected.

Disclosure

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

37. The sharing of information by agencies in relation to their contact with the victim and/or the alleged perpetrator is guided by the following:

a) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).

b) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:

i) It is needed to prevent serious crime

ii) there is a public interest (e.g. prevention of crime, protection of vulnerable persons)

Appendix 2: 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
What is the over-arching recommendation?	*Should this recommendation be enacted at a local or regional level (N.B national learning will be identified by the Home Office Quality Assurance Group, however the review panel can suggest recommendations for the national level)*	*How exactly is the relevant agency going to make this recommend ation happen?* *What actions need to occur?*	*Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?*	*Have there been key steps that have allowed the recommendation to be enacted?*	*When should this recommendation be completed by?*	*When is the recommendation and actually completed?* *What does the outcome look like?*
Recommendation 1: That all agencies domestic abuse training and protocols are reviewed to ensure that all variations of intimate partner and inter-familial relationships are considered and the potential abuse between adult family members is highlighted.	Local	Lead for each agency commission review and report back to CSP. CSP to consider	CSP			

		common themes and ensure that protocols are established. Guidance then agreed by lead agencies and new protocol plus training is established if required.				
Recommendation 2: **That Luton Community Safety Partnership review domestic abuse awareness campaigns to ensure that the subject of adult family violence is highlighted.**	Local		CSP Lead			
Recommendation 3: That all agencies should review their procedures to ensure that records show a clear record of a client's language and	Local	All agency representatives	CSP Lead			

interpretation needs. All should ensure that a person's understanding of English and interpretation needs are clearly documented in safeguarding protocols and are recorded in any inter-agency referral.						
Recommendation 4: That Luton Childrens' Social Care and Education Services audit and review information sharing protocols to ensure that education services are included in the Single Assessment framework.	Local		Education Services Lead CSC Lead			