Newham London

Newham Council's Domestic Homicide Review Panel

Executive Summary and Action Plan

One Stop Shop

Contents

1. Introduction

Name[1]	Age at the point of the murder	Relationship
Amolita[2]	29	Victim
Duhsambada[3]	46	Husband / perpetrator
Adult 2	37	Brother of perpetrator
Child 1	9	Daughter of victim and perpetrator
Child 2	7	Daughter of victim and perpetrator
Ms X	Unknown	Niece of victim

This domestic homicide review (DHR) report examines agency responses and support given to Amolita, a resident of Newham prior to the point of her murder on 5 July 2011. This is a condensed version of the homicide review. For a full version please see the Newham Community Safety Partnership (CSP) website.

Summary of the case

Amolita and Duhsambada were married in Bangladesh in November 2000. They moved to the UK in 2002. They had two daughters, one in 2001 and the other in 2003. In 2005, Amolita reported domestic violence (DV) to the police and went into a refuge, moving to permanent accommodation in Newham in 2006. Duhsambada petitioned for child contact and the case continued until June 2009. During this time, Amolita regularly reported instances of harassment and threats from Duhsambada to both herself and to members of her family in Bangladesh.

On 5 July 2011, the London Ambulance Service was called to Amolita's address where they found the dead body of Amolita. She had been strangled. Duhsambada was arrested on suspicion of murder.

Post mortem

On 6 July 2011, a Home Office pathologist carried out a post mortem at East Ham mortuary and gave the cause of death as "1A, asphyxia and 1B compression of the neck". His conclusion was that the compression was by hand.

Inquest

On 12 July 2011, Walthamstow Coroners Court opened and adjourned the inquest pending police inquiries.

Duhsambada was convicted at the Central Criminal Court and sentenced by a High Court judge. The coroner decided to record that verdict and sentence as the result for his records with no further coroner's hearings to take place.

Court dates

After an initial appearance at Newham Magistrates Court, Duhsambada appeared at the Central Criminal Court on July 2011 where an application for bail was refused. A trial date was set for February 2012. Duhsambada pleaded not guilty to the murder of Amolita but was found guilty in March 2012. He was jailed for life with a minimum tariff of 17 years.

Scope of the review

Amolita moved to Newham in March 2006 having been previously resident in a refuge in north London. This seemed an appropriate point at which to set the start of the scope for participating agencies. It should be noted that information gathered from interviews also covered earlier years. This means that the review considered agencies' contact/involvement with Amolita and Duhsambada from March 2006 until July 2011.

The individual management review (IMR) from the Metropolitan Police also helpfully included information about their involvement with both parties between June 2004 and December 2005 which provided further contextual information about the history of DV. NHS North East London and the City also provided information outside of the scope which helped to show the number of times that the family had moved to different addresses in London since their arrival in the UK.

Newham Council's children's social care were not made aware of the family until after Amolita's death, however, contributed relevant information they had learned from their involvement with the children and were proactive partners in the review, facilitating the children's engagement in it.

[1] The findings of this review are confidential and all parties are anonymous. For ease of reading, the victim and perpetrator have been allocated alternative Bengali names. Amolita means 'priceless' and was a choice approved by Ms X.
[2] Not her real name [3] Not his real name

1. Introduction

Terms of reference

The terms of reference for the review were to:

1. Review the involvement of each individual agency, statutory and non statutory, with Amolita and Duhsambada between March 2006 and 5 July 2011. In order to critically analyse the case, the terms of reference required specific analysis of the following:
    - Communication and co-operation between different agencies involved with either party
    - Opportunities for agencies to identify and assess risk
    - Agency responses to any identification of DV issues
    - The training available to the agencies involved on DV issues
2. 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 DV.
3. Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.
4. Involve Amolita's family in the review process.
5. Commission a suitably experienced and independent person to produce the overview report critically analysing the agency involvement in the context of the established terms of reference.
6. Commission a suitably experienced and independent person to chair the DHR panel, co-ordinating the process, quality assuring the approach and challenging agencies where necessary.
7. Establish a clear action plan for individual agency implementation as a consequence of any recommendations from individual management reviews.
8. Establish a multi-agency action plan as a consequence of any issues arising out of the overview report.
9. Provide an executive summary.

Chronology

Below are edited extracts of the most significant events.

Amolita and Duhsambada were married in Bangladesh in November 2000. She remained in Bangladesh where their daughter, Child 1, was born on 22 November 2001, while he travelled between Bangladesh and the UK. In April 2002 the family moved to the UK, and lived with his mother in north west London. On 13 October 2003 their second daughter, Child 2, was born.

In July 2005 Amolita left Duhsambada and went into a refuge in south west London, telling police at the time that she and her children had experienced DV from Duhsambada.

On 13 October 2005 Amolita reported that her brother in Bangladesh told her that Duhsambada had threatened to kill him unless she returned to him. She said that Duhsambada had rung her brother in Bangladesh and said: "If your sister comes back to me I'll leave you alone, otherwise I'll kill you."

1. Introduction

On 1 December 2005, following a call at the refuge from a third party claiming that Duhsambada was making threats about harming her, Amolita and her daughters moved to another refuge in north London for safety reasons. Duhsambada was given a first warning under the Protection from Harassment Act (1997).

In March 2006 Amolita moved to Newham to be closer to Ms X and her mother. On 1 June 2006 Amolita petitioned for divorce and an injunction was issued at Bow County Court on 12 June 2006 citing violence and harassment. This injunction expired on 22 June 2008.

On 9 July 2008 Amolita attended a Police Station to report a threat made by Duhsambada using his mobile phone from Bangladesh. On 18 February 2009, Amolita attended the offices of her solicitor and stopped divorce proceedings.

On 15 September 2009 Duhsambada reported a burglary at Amolita's home address that he discovered at 4am whilst preparing his breakfast, indicating that he was now living there.

Author's note: Almost all agencies who knew that Amolita had stopped divorce proceedings and that Duhsambada had moved into Amolita's house, assumed that reconciliation had taken place and, indeed, Amolita herself told Aanchal that she was trying to make it work for the sake of the children. However, information from Ms X indicates otherwise. Both she and her mother report that Child 1 had given Duhsambada a key and that he had simply taken up residence. These conflicting reports possibly reflect Amolita's own ambivalence.

Records from Aanchal and information from Ms X suggest that Amolita was under constant pressure from Duhsambada and the wider Bengali community to reconcile. Amolita seemed to make strenuous efforts to carve out a new and independent life for herself but was constantly undermined by this pressure as well as the inability of agencies to protect her family members in Bangladesh and lengthy court battles. It is easy to understand how she might have given Duhsambada a second chance since he claimed to have changed. As with many abusers, however, these new behaviours didn't last long and Amolita found herself trapped all over again.

Contributors to the review

DHR panel members were as follows:

- Aanchal Women's Aid, includes general DV advocacy and specialist south Asian women's support and advocacy service (NB: Aanchal does not provide refuge accommodation)
- Newham Council's community safety unit
- Newham Council's adult services
- Newham Council's children's services
- Newham Council housing
- London Probation
- Metropolitan Police Service
- Newham Action Against Domestic Violence (providers of the local independent domestic violence advocacy (IDVA) service)
- NHS North East London and City (a cluster of five primary care trusts)

All of the above were represented by senior staff and were all independent of the case. The panel contained a mixture of those who were IMR authors and those who were not.

In addition, interviews were undertaken with the following:

- Aanchal caseworker
- Amolita's solicitor
- Two teachers at the children's school
- A close friend and relative of Amolita (Ms X) – this interview also afforded the opportunity for a brief conversation with the relative's mother
- The two children of Amolita and Duhsambada (Child 1 and 2)

Dissemination

DHR panel members, Ms X and her mother and Newham Council's legal department have all received a copy of this report. A decision was made at one of the panel meetings that verbal and age appropriate feedback would also be given to Child 1 and 2 by their allocated social worker.

The DHR panel also agreed that a copy of the full report will be attached to the children's records in social services. The DHR panel wanted to ensure that if, in later years, the children wished to see the report that they would have access to it. Although this report was commissioned by the community safety partnership, it was felt that as social services will be retaining responsibility for the children's care until they reach adulthood as well as retaining records beyond that point, that it was most likely that if either child came looking for a copy, they would start with social services.

The chair also consulted with Larasi, chief executive of Imkaan and a national expert on DV regarding the wording in some paragraphs.

Independence of the chair

This report was written on behalf of the DHR panel by the independent chair of the review, Davina James-Hanman.

1. Introduction

Davina is the director of AVA (Against Violence and Abuse) which she took up following five years at the London Borough of Islington as the first local authority DV co-ordinator in the UK. From 2000-08, she had responsibility for developing and implementing the London DV strategy for the Mayor of London.

The review process

The DHR panel was initially convened on 23 September 2011 with all agencies that potentially had contact with Amolita and Duhsambada prior to the murder.

Agencies were asked to give chronological accounts of their contact with the victim and perpetrator prior to the murder and to complete an IMR in line with the format set out in the statutory guidance. Where there had been no involvement, agencies were asked to consider why that might be the case and what changes might be needed to make their services more accessible. The exception to this was Newham Council's adult services who having searched their records and found no contact, were not asked to complete an IMR since Amolita's circumstances fell outside their criteria for a response, even had she come to their attention.

Each agency's report covers the following:

- A chronology of interaction with the victim and/or their family
- What was done or agreed
- Whether internal procedures and policies were followed
- Whether staff have received sufficient training to enact their roles
- Analysis of the above
- Lessons learned
- Recommendations

Seven IMRs and one background report were completed. Four agencies responded as having had significant contact with the victim and/or perpetrator:

- Aanchal Women's Aid
- Cafcass
- Metropolitan Police Service
- NHS North East London and the City

Three of these agencies produced an IMR. In addition, a comprehensive background report was provided by Cafcass who declined to submit a full IMR on the grounds that 'Cafcass has no statutory functions in respect of the protection of adults and is not named in the Domestic Violence, Crime and Victims Act (2004) as a body that may be directed by the Secretary of State to participate in a DHR [4]'. As such, their report contains no analysis or recommendations.

Three agencies responded as having had no contact with either the victim or the suspect or with any children involved:

- Newham Council's children's services
- London Probation
- Newham Action Against Domestic Violence.

It should be noted that Newham Council's children's services did a full IMR with recommendations relating to events after the murder and thus outside the scope of this review. Nevertheless, these recommendations will be implemented. One agency, Newham housing, responded with information indicating some level of involvement with the victim although their contact was of no relevance to the events that led to the death of the victim.

[4] Letter to Chair 14.06.12

1. Introduction

Equality and diversity issues

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

Age: Amolita was only 19 years old when she married Duhsambada who was 16 years older than her. Duhsambada seemed to treat his wife as a child and became infuriated whenever she showed signs of independence.

Disability: Whilst not strictly a disability, many of those who had contact with Amolita commented upon her voice as being very soft and high pitched. There was some speculation from two of the interviewees that this may have been as a consequence of repeated strangulation attempts. As one said:

'I do believe that he had attempted to strangle her. I'm not a doctor of course but her voice was absolutely unique. You could tell that there was something very strange about her voice. It was very squeaky and very high pitched, as if her vocal chords had been damaged in some way.'

Another commented *'She had a very soft voice. It was almost like her voice was constricted all the time. You had to really strain to hear her*'. Information from her family suggests that Amolita was very embarrassed about her voice, feeling that it sounded like a whine. As she reported to her family, this inhibited her from speaking up, in particular in her dealings with Cafcass.

Marital status: Amolita's actions were shaped by the strong disapproval of parts of the Bengali community towards separated and divorced women.

Pregnancy: Amolita reported being assaulted while pregnant to both agencies and family members. This instilled in her a fear that Duhsambada was very dangerous and clearly willing to step outside social norms.

Ethnicity: Both victim and perpetrator were Bengali and the existence of an Asian women's organisation was important to Amolita in assisting her to establish independence after separating from her husband, albeit ultimately unsuccessfully.

Nationality: The case involved family members living outside of the UK (in Bangladesh) as powerful influences on Amolita's decision making and at critical points, Duhsambada was between the two countries. Duhsambada's ability to threaten crimes against Amolita's family members abroad with no consequences for him in the UK was a powerful control strategy.

Wealth disparity: While not a protected characteristic, the disparity in income between Amolita's family and Duhsambada was another significant influence on her decision making and on Duhsambada's ability to continue to intimidate and control her, even post-separation.

2. Key findings of the DHR panel

Amolita was married to Duhsambada for eleven years, from 2000 until the point of her death. He was violent and abusive to her from their wedding night and continued his attempts to control her even after she left him in 2005.

Amolita did engage with agencies but failed to find what she seemed to be seeking. She wanted 'back up' for her stance in refusing to be an 'obedient wife' as defined by Duhsambada. Cafcass correctly focused on the children, her solicitor focused on making his client appear 'reasonable' to the court, housing focused on supplying her with a tenancy, the police focused on evidence, health professionals focused on the clinical issues, Aanchal was asked for an intervention that they could not provide (a warning letter to Duhsambada) and some parts of the wider Bengali community muttered to her about family 'honour'.

Author's note: All of the above agency responses prioritised statutory duties, or agency and community agendas ahead of Amolita's needs, yet with the exception of the failures to refer to children's services, none can be fairly categorised as 'wrong'. The statutory remit of Cafcass is to focus on the children just as it is the statutory duty of the police to focus on investigating crimes. However, without close co-ordination between agencies, no-one has a complete picture and each agency is working in a silo, dealing with just one part of the picture. What it does demonstrate is the complexity of issues that require multi-agency responses. It is not simply a matter of agencies sharing information but also necessitates a refocusing of priorities if interventions are to be truly holistic and effective.

As a consequence of agencies not responding holistically and strengthened by Duhsambada's threats to her family abroad, Amolita never found the kind of help she wanted. Even with the benefit of hindsight, it is hard to see how this might have been achieved although it is possible that had each of the statutory agencies probed a little more and made her feel less judged, which is what she reported to her family, Amolita may have felt supported enough to pursue courses of action (injunctions, police reports etc) that she had come to doubt in terms of their effectiveness.

Conclusions and recommendations from the review

There no words more poignant than those written by Ms X:

"Blackmailed into marriage (he was rich, she was poor; he had friends in high places, her widower mother had no one and a large family to support), she was married in Bangladesh, brought to England, and abused from the day of her wedding. Enduring daily beatings, rape and broken ribs, it was only when her husband raised his hands against her daughters that she found the willpower to ignore the sometimes suffocating burden of 'family honour' and finally escape. From the day she entered the police station with her three words of English to the moment she breathed her last, she tried everything she could to secure three things: a divorce, sole custody of her children and acceptance in her community.

She died unable to accomplish even one of these goals. Because to divorce a man who wants to 'keep' you, and is rich enough to secure the best lawyers, one needs money (and legal aid, now demolished, is rarely enough). Nor did she have deep enough scars to convince the social workers or the judge in her custody trial of the dangers posed by the father towards her children. On top of all this, [Amolita] had to further ignore the sneers of distant family members or strangers in her community who felt they had every right to judge her for daring to 'leave' her husband."

3. Lessons learnt

Risk identification: This case demonstrates as many others before it, that leaving an abuser and having disputes over child contact are key risk factors for homicide. It also confirms research showing that the victim's assessment of the level of danger she faces is the most accurate [5]. Amolita reportedly told family members that Duhsambada would kill her and he did. A further issue which should have been recognised, but was not, was the longevity of the abuse. Seven years after leaving the relationship, Amolita was still being harassed by Duhsambada. This level of persistence should have been a warning sign.

Domestic violence services: Amolita did not seem to trust state agencies but she had a long and mostly open relationship with Aanchal. This demonstrates the importance of specialist DV services which are focused on providing a service to women from specific communities or ethnic groups. This provision is used to help women to form new social networks, rebuild their lives and resist community stigma.

It is possible, based on knowledge of community norms and some of the threats made by him, that Duhsambada feared losing his standing within the Bengali community if he appeared as a man who could not control his wife. Initiatives to challenge such beliefs, which extend far beyond parts of the Bengali community, are much needed.

Child contact: More than any other issue, this is the one where there was the most variety of opinions.

For example:

Amolita's solicitor: 'I realised she was starting to lose credibility with the court because instead of bringing up things that mattered, she for some reason which I can never quite work out, focused on things that were trivial like the point for the handover of the children. She wanted it to be near her home and he lived some distance away and wanted it to be near his home and it was little things like that which tended to reduce her credibility with the court.'

Amolita's caseworker: 'Child contact was holding her back. She knew his personality and at one point she did say that he sits at the Cafcass meeting and he tells lies and no one believes me but in the end she felt compromised and in a situation where she, no matter what happened, had to allow child contact. So she was distressed for nearly a year around those issues but there was no way out. She came, I think, she just came to a point of acceptance because she felt 'I can't fight'.'

Ms X: 'My mum accompanied my aunt to the courts so many times and I remember at one case my mum came home crying and I said 'what's wrong' and she goes 'the judge has actually called Amolita a stupid woman' for her fear of being killed. She actually warned the judge 'if you let him see the kids then that will be the end of me' and the judge said to her 'don't be a silly woman'.'

Cafcass: 'The contact centre supervising the father's contact provided detailed reports on each of the seven sessions that took place. These were provided to Cafcass. Some aspects of the father's attitudes and behaviour (e.g. asking the girls if they wanted to go to his house and who loved them more and requesting to take the girls outside of the centre contrary to the court order) may have been evidence of a manipulative personality. His unwillingness to share the cost of the mother's transport could also have been a sign of attempts to control the mother. Otherwise, the centre reported no evidence that the father attempted to intimidate or harass the mother.'

Amolita reported to both Aanchal and Ms X that she did not feel that Cafcass believed her version of events and seemed unconcerned at the ways in which Duhsambada was using child contact to exert control over her. Cafcass would like to make it clear that whilst they accept this was Amolita's view, it does not accord with theirs.

Communication and clarity of roles and responsibilities between agencies: Whilst it is unlikely that the confusion that Aanchal is not a refugee affected the course of events in this case, it does highlight how clear communication between agencies is essential to prevent clients losing faith or 'falling through the net'. Communication could also be improved both internally at NHS North East London and the City and there is clearly a need for more GP education about the dynamics of abuse.

Of particular concern is the lack of referrals by any agency to Newham Council's children's services. When interviewed after the murder, Child 1 described the way that her father treated her mother as 'torture'; a shocking word for a nine year old to use. Four agencies in contact with Amolita failed to notify children's services that the children were at risk of significant harm.

Community knowledge and views: Ms X and her mother provided much support to Amolita and her children but did not themselves know how to resolve the issues she faced. In addition, parts of the Bengali community shunned Amolita for being separated from her husband. Individual and collective notions of 'honour' impact on women's safety and decision-making and the existence and propagation of such concepts allows violence and abuse to continue with impunity. Work is thus needed at a community level to challenge these ideas, although it should be noted that they are not exclusive to the Bengali community or indeed views held by all Bengalis.

[5] Battered Women's Perceptions of Risk Versus Risk Factors and Instruments in Predicting Repeat Reassault D. Alex Heckert and Edward W. Gondolf (2004)

3. Lessons learnt

In the UK there has been much emphasis on improving agency responses which is, of course, essential. Much less attention has been paid to improving the awareness and understanding of the general public, or in ensuring that supportive friends and family members have the knowledge about where to find appropriate help.

Good practice: During the interview with the school attended by Child 1 and 2, two areas of good practice emerged that deserve highlighting although one falls outside the scope of the review.

The first example is that during the registering of any new child at the school, the parent is asked for details of all adults who are permitted to have contact with the child and also if there are any adults who are not permitted to have contact. They make it clear that in situations of DV, the school will do everything they can to protect the children and refuse permission for all adults to remove a child if it is someone no staff member recognises. When Amolita registered her children, this created 'permission' for her to disclose that she had moved to Newham as she was escaping DV.

The second example concerns the school's response after the murder. The teachers pro-actively made contact with the parents of the friends of Child 1 and 2 to let them know that that their child was supporting Child 1 or 2. Flexibility was permitted with regard to the timetable to allow Child 1 and 2 to spend additional time with their friends. This created a sense of safety and support for Child 1 and 2 and this thoughtful practice is to be commended.

4. Recommendations

In addition to those proposed by individual agencies, the panel agreed the following:

1. All agencies to have basic DV awareness training, supplemented by multi-agency training for relevant staff that includes an awareness of risk factors.

2. Raise community awareness of DV to:

    - ensure that concerned friends and family members have an awareness of where to go for help
    - challenge myths and stereotypes about DV.

3. All agencies to review their referral processes for children at risk of significant harm.

4. The panel originally wanted to recommend the following for Cafcass:

Where there are allegations of current DV and disputes over child contact, the local children's services should be routinely notified.

However, Cafcass rejected this recommendation stating:

'We did, in fact, do that as a matter of policy for a period of time but stopped. We receive over 45,000 private law applications per year. DV is a feature of about one half of these. Sending approximately 22,000 notifications to children's services per annum is not seen as good safeguarding practice by either us or children's services. Our child protection policy therefore directs staff to make child protection referrals to children's services where our information (including that derived from domestic violence) suggests that a child is suffering, or likely to suffer, significant harm (Children Act 1989).'

Consequently the panel, specifically supported by children's services, would now like to recommend that the government take up this issue nationally.

5. Government: Cafcass be made a statutory partner for DHRs, similar to their role in local safeguarding procedures.

6. Commissioners: Ensure that DV provision in the locality is not solely focused on risk but also offers opportunities for early intervention and counselling/resettlement support. Commissioners should also take account of the specialist nature of this work which is not easily replicated in generic provision.'

7. Newham housing: When applicants are referred from another borough, routine screening of DV should be done.

8. Explore ways in which solicitors might be included within local partnerships.

9. Police: When undertaking risk assessments, officers should ask for a history of abuse.

10. Newham adult services to consider referral pathways/ contract management of floating support services to ensure vulnerable women like Amolita do not fall through the gaps in provision.

11. Schools to share DV information with health. The school should have raised its knowledge of DV history, especially when it knew Duhsambada was once again residing with Amolita.

12. The family wished to recommend some form of action or policy which could address the issue of perpetrators abusing extended family members living abroad. While they accept that no country has resources enough to undertake extensive investigations overseas, they felt that agencies would have taken Amolita a lot more seriously had she felt able to report these 'overseas' incidents to them openly, and that Duhsambada may not have progressed to murder if police/agencies had begun to question him about them and warn him against any further such actions.

This is clearly beyond the authority of Newham CSP but the panel would thus recommend that the government explore this at a national level to explore the possibilities that may exist to move towards this outcome.

An action plan for taking forward these recommendations can be found in section 6.

5. Was this homicide preventable?

There is no obvious point at which the homicide could have been clearly prevented, in that there was no agency which did not fulfil its remit or follow its policy, with the exception of referrals to Newham Council children's services as described in this report. Nevertheless, it is easy to see how the protracted battle over child contact wore Amolita down and undermined her trust in the 'system' to protect her and her children, potentially deterring her from seeking further help.

It is also possible that had children's social services been notified by either health professionals, Cafcass, the police or Aanchal, then Amolita and her children may have received the support she needed. The panel also concluded that the focus on high risk in recent years has inhibited the development of multi-agency work for 'lower' risk victims. It is hoped that the nascent domestic violence champions project will provide more opportunities for professionals to informally create opportunities for intervention with victims not currently attracting a high risk rating.

This case highlights the unacceptable pressures placed on Amolita by some members of the community linked to individual and collective notions of 'honour'. This impacts on women's decision making and places women's lives at greater risk. The circumstances of this death highlights the critical need to carry out work on a community level to challenge attitudes that allow violence to persist with impunity. In the desire to uphold notions of family 'honour', a woman is dead, a man jailed for life and two children will now grow up without either parent as part of their lives.

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

6. Domestic Homicide Action Plan

Recommendation	Action
East London Foundation Trust (ELFT), Community Health Newham Directorate (CHN) and GP practices agree and implement the sharing of information in relation to newly registered/deregistered children under five years of age.	ELFT and NHS North East London and City (NELC) to continue their current work to agree a process and implement it across Newham.
ELFT and CHN put in place an action plan to ensure that children who transfer into Newham are visited and previous records requested within five days of being notified the family is of concern. Universal pathway transfer in visit to be completed within 28 days of notification. This latter timescale to be reviewed once health visiting numbers increase.	Recirculate Transfer in Pathway – Health Visiting (August 2011) and Procedure for action with regards to no access visits, failed contact and refusal of services (Health Visiting and School Nursing) – March 2011).
School nurses have a policy in place which follows up those children not known to health services at school entry. This needs to include pro-active work with families where they do not respond to school entry health questionnaires, as these will be the most vulnerable of children.	Complete draft for consultation in respect of reviewing four year questionnaire and school entry assessments at five to five and a half years protocols. To include section on failure to respond within two weeks of a liaison with school and GP and SW if child has a Child Protection (CP) or Child in Need (CIN) plan. Implement agreed procedure.
Exploration with GPs as to the best way to flag women who are/have been subjected to domestic abuse on the practice IT system and also have it identified within the children's records. The new General Medical Council (GMC) guidance for doctors highlights the need for family members to be linked. This is particularly important where the parents have different names and do not necessarily reside in the same house.	The lead GP for safeguarding children identifies the best way to flag families affected by DV within GP surgeries and implements this across Newham.
A rolling programme of DV awareness to be provided to the GP practices in Newham as part of their safeguarding training.	GPs receive training about domestic abuse and the impact on children as part of their child protection training.
Each refuge in Newham to have a named health visitor who will be responsible for the health needs of all the families within that refuge.	Produce a list of which refuge is covered by which health visiting team and identify named health visitors for the refuge to contact.
All agencies to have basic DV awareness training, supplemented by multi-agency training for relevant staff that includes an awareness of risk factors.	Develop and implement a training programme.

6. Domestic Homicide Action Plan

Raise community awareness of DV to: • Ensure that concerned friends and family members have an awareness of where to go for help • Challenge myths and stereotypes about DV.	Develop and implement a community awareness programme building on the work already undertaken by Newham Action Against Domestic Violence (NAADV).
All agencies to review their referral processes for children at risk of significant harm.	Agree and implement a review process.
Ensure that DV provision in the locality is not solely focused on risk but also offers opportunities for early intervention and counselling/resettlement support.	To be included as part of the new DVS strategy for the council.
To lobby government for: • Inclusion of Cafcass as an agency with a duty to participate in a DHR • A change in national policy to require referral of cases involving DV to the local children's services • An exploration of how to better respond to abusers that threatens and/or assault family members living abroad as a way to control their victim in the UK.	To formally write to the Home Office raising these issues as part of the DHR guidance review.
When applicants are referred from another borough, routine screening of DV should be done.	Develop and implement a new procedure.
Explore ways in which solicitors might be included within local partnerships.	Incorporated into the work plan of the new Newham DVS strategy.
Officers should ask for a history of abuse when undertaking risk assessments.	Implement a new procedure.
Consider referral pathways/contract management of floating support services to ensure vulnerable women like Amolita do not fall through the gaps in provision.	To be incorporated into the next commissioning process.
Schools to share DV information with health services.	Develop an information sharing protocol for schools.