Watford Community Safety Partnership

Main overview report of the Domestic Homicide Review Panel into the death of Shaily.

October 2014

Chair: Timothy Beach

Report writer: Elizabeth Hanlon

Main overview Report

Section 1: Introduction

Appendices

Section 1: Introduction

1.1 Background

1.1.1 Watford is the most diverse District in Hertfordshire. According to the 2001 Census, there are over 16600 people in the town who belong to an ethnic minority group, representing almost 20% of all people in Watford. Almost 4500 of these people are children, representing almost 25% of this age group in Watford.

1.1.2 The Schools Census in 2007 saw an even more diverse picture: 4677 of the 11730 pupils at school in the Borough, almost 40%, are from an ethnic minority background.[1]

1.1.3 The school roll is currently 1,700 pupils, of which 41% are from an ethnic minority background.

1.2 The commissioning of the review

This overview report has been commissioned by the Watford Community Safety Partnership concerning the death of Shaily that occurred in October 2014. The independent chair for this review is Timothy Beach who is a retired senior police detective who has several years' experience in carrying out reviews. He is independent to Watford Community Safety Partnership and all agencies associated with this overview report. He has written three independent overview reports in relation to a previous domestic homicide and is currently chairing the Suffolk Safeguarding Adults Board. This report has been written by Elizabeth Hanlon, who is also independent of Watford Community Safety Partnership and all agencies associated with this overview report. She is a former (retired) senior police detective who has several years' experience of partnership working and involvement with several previous domestic homicide reviews, partnership reviews and serious case reviews. She is currently chairing and writing three domestic homicide reviews for Essex. She has also recently taken over as the independent chair for the Hertfordshire Safeguarding Adults Board. She took this position after the start of the review process and as such has made sure that all recommendations have been analysed independently by the Hertfordshire Domestic Homicide sub group.

1.2.1 It is important to understand about what happened in this case at the time, to examine the professionals' perspective at that time within the context although it is likely as a consequence that hindsight will be encountered. This will be rationalised by taking key matters forward in order to broaden professionals' awareness both for the future and to ensure that best and current practice is embedded and that any learning is maximised both locally and nationally.

1.2.2 The death of any person in circumstances such as examined herein is a tragedy. Family members and friends have been consulted during the review process and any of their views have been commented upon accordingly within the document. Contact with the

[1] The Schools Census is not necessarily an exact indicator of the ethnicity of children living in the Borough – data from the National Census shows there are over 18000 dependent children who live in Watford, yet the Schools Census only records those who attend school or nursery in the Borough. Many children may not be of school age or may not attend school, and will not be recorded in the Schools Census, and many pupils may cross District boundaries to attend school.

family was made by the independent report writer through the Police Family Liaison Officer. The overview author is grateful for this input and the information obtained as a consequence of this contact at this very difficult time.

1.2.3 The Home Office were notified by Watford Community Safety Partnership on 3rd March 2015 of their intention to carry out a Domestic Homicide review. The Hertfordshire Coroner was also notified that a Domestic Homicide Review was taking place. The review was started on the 25th March 2015 when the first meeting took place. A press statement was produced by the chair of the Watford CSP following consultation with other partner agencies. This will be amended prior to any publication of the report. Chronologies were requested from the Hertfordshire Constabulary, NHS England, Hertfordshire Community NHS Trust, Children's Services, School, Royal Brompton and Harefield Hospital Trust, Watford Borough Council, West Herts Hospital Trust, Adult and Social Care Services. The chair and report writer met with the Senior Investigating Officer in the case with Hertfordshire, Bedfordshire and Cambridge Major Crime Unit and also had discussions with the Crown Prosecution Service and the Barrister in the case. A decision was made that it may be detrimental to the court case to proceed with the Domestic Homicide Review and therefore the review was put on hold until the completion of the court case. The Home Office were notified by the chair of the CSP of the delay in conducting the DHR. The review again started on 6th January 2016 when members of the review panel met. During this meeting all chronologies were reviewed and Individual Management Reviews (IMR's) were requested from the Police, School and GP practice.

1.2.4 The findings of each individual IMR are confidential. At the beginning of the meetings of the review panel, attendees were asked to sign a confidential agreement.

1.2.5 The author of the Police's Individual Management Review is a retired Police Senior Investigating Officer, formerly of the Cambridgeshire Constabulary. The author has in excess of 36 years' experience of policing in major crime, including the investigation of child deaths and homicides, homicides, complex criminal investigations and domestic homicides. He is a nationally accredited review officer and maintains his PIP 3 homicide Senior Investigating Officer, SIO, accreditation to the national standard.

1.2.6 He is currently a review officer for the strategic alliance of the Bedfordshire, Cambridgeshire and Hertfordshire Major Crime Unit (BCHMCU) and has several years' experience as the author of Individual Management Reviews in areas such as LSCB Serious Case Reviews, Domestic Homicide Reviews, Vulnerable Adult Reviews, Multi Agency Public Protection Agency Reviews and Mental Health Reviews. His work also includes examination of historical 'cold cases' and other specialised roles.

1.2.7 The author of the NHS review is qualified as a Registered Adult and Sick Children's nurse (RGN and RSCN) in 1981, initially working in children's physical healthcare, and in lead safeguarding roles since 2004. From 2007 she was the Safeguarding Named Nurse for the secure Adolescent Service (mental health and learning disabilities) for a national independent sector mental health provider, and later the organisation wide Safeguarding Lead. She has been directly involved in the management of allegations made against staff and contributing to serious case reviews and whilst working within the Risk Management

team was involved in investigation and report writing for serious incidents, including safeguarding events. She is a qualified management trainer, has a BSc (Hons) Degree in Healthcare, and is a CQC Safeguarding specialist advisor.

1.2.8 The author of the IMR for the School is an Independent Health and Social Care Consultant who has had no prior involvement with the case.
Her recent work includes conducting Serious Case Reviews using both traditional and systems methodology. She has completed IMR's for a learning disability service, investigated poor practice by a dentist under whistle blowing policy and conducted root cause analysis for six deaths in custody in prison settings. She has also undertaken CQC inspections.

1.2.9 At the beginning of the review School was represented by the head of safeguarding. A decision was later made by the chair that it was not appropriate for her to remain on the panel due to her close involvement in the case. At that time her place was taken by the chair of governors of the school who it was felt was impartial of the initial involvement. The governor was present at the review panel when the schools IMR was presented and discussed.

1.3 The Review Panel

Name	**Position/Organisation**
Timothy Beach	Independent Chair
Elizabeth Hanlon	Independent Report writer
Alan Gough	Head of Community and Customer Services, Watford Borough Council
Michelle Mulvaney	Named Nurse for Safeguarding Children, West Hertfordshire Hospitals NHS Trust
Ross Williams	Head of Family Safeguarding (East), Hertfordshire County Council
Tracey Cooper	Head of Adult Safeguarding, Hertfordshire Valleys Clinical Commissioning Group, East and North Herts CCG.
Kerry Clarke replaced by Jim Sowerbutts on 04/05/16	School, Bushey, Hertfordshire
Sarah Taylor	Programme Manager, Domestic Abuse, Stalking and Harassment, and Hate Crime – County Community Safety Unit
Samantha Allen	Programme Support Officer(Vulnerable people) County Community Safety Unit
Ruth Dodsworth	Detective Chief Inspector, Domestic Abuse Investigation and Safeguarding Unit, Hertfordshire Constabulary
Dawn Bailey	Lead Nurse Safeguarding Adults, West Hertfordshire

	Hospital Trust
Sue Darker	Operations Director, Learning Disabilities and Mental Health and Community Services
Dee Harris	Named Nurse Safeguarding Children
Anna Price	Named Professional for Safeguarding, East of England Ambulance Service NHS Trust

1.4 **Reasons for conducting the review**

1.4.1 A Community Safety Partnership (CSP) has a statutory duty to enquire about the death of a person where domestic abuse forms the background to the homicide and to determine whether or not a review is required. In accordance with the provisions of the Domestic violence, Crime and Victims act 2001, Section 9, Domestic Homicide Reviews (DHRs) came into force on 13th April 2011. The act states that a DHR should be a review:
Of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by –
A person to whom he/she was related or with whom he/she was or had been in an intimate relationship with, or
A member of the same household as themselves, held with a view to identifying the lessons learnt from the death.

1.4.2 The purpose of a Domestic Homicide Review (DHR) is to:
a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
b) identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result;
c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

1.5 Terms of reference

1.5.1 Scope

The Domestic Homicide Review Panel set the scope of the review for all agency involvement with the victim Shaily and her two sisters Roslin and Sadia, from **1st September 2011 to October 2014.**

1.5.2 These dates above were set by the panel as this was the date of the first significant reported involvement of any agency outside of the guardianship process.

1.5.3 Internal Management Reviews were requested from Police, GP practice and School however all other agencies were also requested to identify any significant information which may have indicated that the children were not happy or there were concerns raised, regarding them being placed with their brother and sister in law. A special guardianship order was granted to Sumon and Sharina in 2010.

1.5.4 The panel made the decision that the review would be extended to incorporate the other two young sisters within the household. This decision was made so the panel could try and establish if the victim Shaily was singled out for treatment or whether this was extended to all the female siblings within the family. A decision was also made not to include Rafsan, the elder sister in the family, in the scope of the review at it appeared, from information, that she had moved out of the family home and had set up home with a local male and had therefore been shunned by the family during the majority of the timeframe of the review.

1.5.5 Purpose of the review is to:

- To gain an understanding of what domestic violence, both physical and emotional, Shaily, Roslin and Sadia suffered, if any, within the family environment.
- Establish the appropriateness of agency responses to Shaily, Roslin and Sadia - both historically and immediately prior to Shaily's death.
- If and how agencies assessed risks within the family household.
- Establish whether single agency and inter-agency responses to any concerns about Shaily, Roslin and Sadia were appropriate.
- Identify, on the basis of the evidence available to the review, whether the deaths were predictable and preventable, with the purpose of improving policy and procedures within the various agencies areas of responsibility.
- To identify good practice that was in place.
- To establish how well agencies worked together and to identify how inter-agency practice could be strengthened to improve the identification of, and safeguarding of, vulnerable adults where domestic violence is a feature.

1.5.6 The Review will exclude consideration of who was culpable for the death of Shaily as this is a matter for the criminal investigation.

1.5.7 Key issues
Information:
Did the agencies comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?

1.5.8 Did the agencies have policies and procedures for risk assessment and risk management for domestic abuse victims or perpetrators and were those assessments correctly used?

1.5.9 Did the agencies have policies and procedures in place in relation to identifying children at risk within the family environment and were these adhered to?

1.5.10 Contact and support from agencies:
Were practitioner's sensitive to the needs of the victim and their family?
Did actions and risk management plans fit with the assessment and decisions made?
Were appropriate services offered or provided?

1.5.11 Any additional information considered relevant:
Any additional information would be brought to the attention of the panel and a decision would be made as to its inclusion within the review.

1.5.12 Key Lines of Enquiry:
The Panel for this DHR has determined broad aims, which could have been amended as information was gathered. No additional information was brought to the panel during the review and therefore the terms of reference were not changed.

1.5.13 specifically, the Panel wished to determine:

- What disclosures Shaily, Roslin and Sadia made to agencies and the circumstances behind them coming into contact with them?
- If and how agencies assessed risks to Shaily, Roslin and Sadia.
- Were the agencies' responses good practice and proportionate concerning their knowledge?
- Whether relevant agencies discharged their duties properly?
- Could this homicide have been prevented?
- Was this homicide predictable?
- Lessons to be learned for the future?
- Good practices that were in place.
- The effectiveness of inter-agency communication.
- Any difficulties agencies encountered when working with Shaily and her family that impact on the case.
- The accuracy of records and information imparted

1.6 Details of parallel reviews/processes

1.6.1 The three younger sisters were the subjects of this review process. Although Sadia was a child at the commencement of the homicide investigation and subject of relevant protection measures for a period of several months, there was no ongoing child protection processes in respect of her. Shaily, Roslin and Sadia were the subjects of Special Guardianship Orders in 2010. A Special Guardianship Order (SGO), is a court order, which says that a child will live with someone who is not their parent on a long term basis. In Shaily, Roslin and Sadia's case they were placed with their elder brother Sumon and his wife Sharina, following Sumon's's application to the court for a Special Guardianship Order. This was granted by the court, as the three sisters natural mother was deemed unfit to look after them due to serious neglect and evidence of the children being malnourished whilst in her care.

1.6.2 The birth father had been shunned by the family some time previously and had no contact with the family. A decision was made by the review panel, following consultation with the Head of Family Safeguarding that they would not look into the guardianship and that the review would start at a later date, however the terms of reference were widened to incorporate any concerns agencies had regarding the legal guardianship process. There was no available information to suggest that the guardianship process was not conducted to the required standard and no issues were raised by any agency.

1.7 Subjects of the review

1.7.1 Shaily was one of 7 children, who was initially brought up by her parents who originated from Bangladesh. She had 4 brothers and 3 sisters and she was the second youngest family member. Shaily's biological father was convicted of a sexual assault on a non-family member in the UK in 1999 and was a registered sex offender (under the respective legislation at that time). As a consequence of his conviction he was effectively ostracised by the family and has remained so since then.

1.7.2 As a result of the Special Guardianship Order in 2010 the three siblings moved into the home with Sumon and Sharina in accordance with the guardianship order.

1.7.3 Of the three principal subject's, Roslin lived between the two addresses, whereas Shaily and Sadia lived with Sumon and Sharina. Why is not entirely clear, but this may be associated with the bedroom space available although the three subjects tended to share a bedroom as Shaily was forced to sleep on the floor when all of them were present as Roslin and Sadia would share the single bed.

1.7.4 One of the older sisters Rina had moved away from the family following her more 'westernised' attitude and her relationship with a local man. Although she had spent some time away from the family she had recently started to spend time back with them.

1.8 Objectives of the review

1.8.1 The purpose of Domestic Homicide Review (DHR) is to give an accurate as possible account of what originally transpired in an agency's response to Shaily, to evaluate it fairly, and if necessary to identify any improvements for future practice. Chronologies were requested from several agencies however Internal Management Reviews (IMRs) were only requested from three agencies, Hertfordshire Constabulary, School and GP practice.

1.8.2 This overall report is based on the information obtained from those IMR's. These reports were written by professionals who are independent from any involvement with the victim, family, friends or the perpetrators. Should actions be necessary by any of the agencies, the maintenance of, and strategic ownership of any action plan will be the overall responsibility of the Watford Community Safety Partnership. It is essential that any resulting ownership and recommended activity is addressed accordingly. The overall action plan will also be reviewed and monitored by the Hertfordshire Domestic Homicide sub group which reports to the Hertfordshire Domestic Abuse Partnership Board.

1.8.3 Whilst key issues have been shared with organisations the report will not be disseminated until appropriate clearance has been received from the Home Office Quality Assurance Group. In order to secure agreement, pre-publication drafts of this overview report are shared by the membership of the Review panel, commissioning officers and members of the Watford C.S.P. The associated reports from agencies will not be individually published.

1.8.4 Relevant family members of the victim will be briefed about the report in accordance with policy and practice of the CSP and such consultation will take place prior to the publication of the report.

1.8.5 As a part of this review process the panel wished to explore the possibility of whether this was an Honour Based murder. At the time of the investigation the Police liaised with Karma Nirvana[2], who are a registered charity supporting all victims of Honour Based Abuse and Forced Marriage, their advice at the time was that they didn't feel that the murder fitted the criteria of honour based abuse. The panel wished to view any psychiatric report relating to Sharina to explore any further information relating to honour based violence but neither the defence nor prosecution requested any assessments. The leader of the local mosque, which the family attended, was also spoken to during the investigation but no additional information was obtained.

1.8.6 Honour based violence (HBV) is defined as:
"An incident or crime which has or may have been committed, to protect or defend the honour of the family or community".
HBV can be distinguished from other forms of abuse, as it is often committed with some degree of approval, and/or collusion from the family and/or community members.

1.8.7 The review panel made the decision that family members who have been convicted of offences surrounding the death of Shaily would not be interviewed during the course of this review. This decision was taken due to the complexity of the investigation and following advice from the police regarding any appeals process. However, two of the sister's Sadia and Rina had not been subjected to any criminal charges and were therefore contacted regarding contributing to the review process. These interviews were arranged and took place through the Family Liaison Officer (FLO) within the police who had built up a good relationship with them. Both Sadia and Rina were contacted and advised that a DHR was taking place and were invited to contribute to the review. Rina initially agreed to be a part of the process and then withdrew as she felt unable to talk again about the circumstances. Sadia stated that she wished to be a part of the review and was spoken too by the author in the presence of the FLO and her foster carer.

1.8.8 Two friends of Shaily and one of their parents were also contacted and participated in the review process.

1.9 Diversity considerations

1.9.1 The chair of the review and the review panel considered whether the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation were relevant to this review.

1.9.2 Shaily was a British Muslim female who was born in England. The three eldest children were all born in Bangladesh and were brought up in the city of Sylhet in the North-East of the Country. The family is understood to have migrated to the United Kingdom in 1989/90 where the four younger children were born. Sadia described the family as traditionally Bangladeshi and that they attended the mosque for prayers usually every week. She described them as moderate in their religious views but stated that although her

[2] Karma Nirvana is a charity who support victims of honour crimes and forced marriages since 1993.

two elder brothers had had arranged marriages there was no suggestion that marriages would have been arranged for the girls in the family.

1.9.3 The family, including Shaily dressed in westernised clothing and although she was restricted from attending certain events and locations this does not appear to be due to religious reasons. Diversity considerations are discussed throughout the report.

1.9.4 Shaily and the other female children were all treated as 'second class' within the family. They were not allowed to have an outside life of their own and were restricted in what they were able to do. It was the position of the men within the household to go out to work and the females were expected to look after the house and their welfare at home. Sharina was identified as the head of the household and as such she made all the decisions within both households.

Section 2: The Facts

2.1 Case specific background

2.1.1 An ambulance was called to a residential address following the report of a female in cardiac arrest. The emergency call was made by members of the family themselves including Sharina.

2.1.2 On arrival the attending paramedics found a woman who was identified to them as being Shaily lying unresponsive on the bathroom floor. The victim had evidence of vomit on her clothing and in her hair. Attempts were made to revive her however she was declared as deceased.

2.1.3 The attending healthcare professionals were concerned that there appeared to be extensive bruising to the deceased, in particular about her face, head and her upper torso, which were the areas of her body exposed during the resuscitation attempts. In addition, there was an apparent concern that the circumstances surrounding the discovery of the deceased by the family did not 'add up' and the attending police officers were notified accordingly of those concerns. Consequently, the police officers declared the location as a crime scene and as a result a homicide investigation was commenced.

2.1.4 When the victim's body was later formally examined, Shaily was found to have in excess of 50 separate bruise marks present to her entire body area, significantly these were to her upper torso and chest area including what appeared to be defensive injuries. She also had recent bruising to her facial area in particular around her eyes. The forensic pathologist concluded that the victim appeared to have been subjected to what must have been a severe and sustained assault by blunt force trauma to her head whereby she had lost consciousness and had consequently died as a result of inhaling (aspiration) gastric matter.

2.1.5 A total of eight members of her immediate family, with whom she resided with or had close and consistent contact with were arrested in connection with her death either at the time or as the investigation progressed, although some were initially dealt with as significant witnesses. As the investigation progressed over a period of a number of weeks and months, more information was uncovered by the investigation and further arrests of some of those close family members

were made. As a consequence, a total of seven family members were subsequently charged with offences in connection with the victim's death including that of murder, familial homicide and perverting the course of justice. Six were convicted at the subsequent trial in November 2015.

2.1.6 The resulting police investigation established that the victim had been subjected to an extensive history of abuse and neglect at the hands of her family with whom she lived and that she was effectively controlled within the home where her movements and contact with others was principally strictly dictated by Sharina, the wife of the eldest sibling Sumon. In effect Shaily had not been permitted to be outside of the home unless it was to attend school or when she was being escorted by a member of the family. Other than this she had little 'footprint' outside of that strictly limited social contact.

2.1.7 Although Sumon was nominally the head of the family, the investigation identified that in fact his wife Sharina was the matriarch and the dominant member of the household and the family network.[3] The investigation also uncovered in the region of 50 hand written notes and letters that had been written by Shaily or her siblings, which were recovered during searches of the homes and which contained descriptions of life within the household where instances such as force feeding, assaults and punitive treatment featured as part of everyday life for them. Many of the letters pleaded for the forgiveness of 'Afa', which transpired to be Sharina's family/cultural name for which she was frequently referred to by Shaily, Roslin and Sadia.

2.1.8 The family owned two properties in Watford which were in relatively close proximity of each other. Both properties were owned by and mortgaged by Sumon. The family utilised both addresses although one address was the property that the family would appear to spend most of their time and was most frequently used as the location where they would congregate for meals.

2.1.9 Despite that fact that Shaily was taken on a family visit to Bangladesh in 2012 where she was escorted by the family throughout, it was discovered that she rarely left the house. She had no mobile telephone, no internet access and no bank account or other apparent financial means. She had not made any benefit claim since leaving school and she did not work nor had she sought any work after leaving school. Shaily did not appear on the voters register for either of the address. Essentially, Shaily had a very limited citizen footprint.

2.1.10 The victim was effectively prevented from having any connection with the world outside of her home. By comparison, Roslin and Sadia were afforded a little more freedom than Shaily although they frequently had to seek permission from Sharina before using their phones and game systems. All appear to have had a very limited number of friends and none of these friends were allowed into either of the homes. Their social footprint revolved mainly around their schooling and the immediate family.

2.1.11 Evidence emerged that Shaily had been repeatedly force fed, was not allowed to use the toilet or bathroom which on occasions, led to her defecating and urinating in other rooms in the house whereby she was then forced to clean up after herself. It was admitted in evidence that on

[3] The origins of the family are from Bangladesh and it has been confirmed by independent advisors to the criminal investigation that in the region from which the family originates it is customary for the head of the household to be the eldest female whether a direct relative or one of that by marriage.

occasions she was forced to eat her own vomit and lick the toilet pan as punishments for her 'failings'. She was not the only one to have experienced similar humiliating treatment.

2.1.12 It emerged that Shaily was refused water to such an extent that she (and her siblings) were forced to conceal water in containers that purported to hold other liquids such as moisturisers and these were hidden in their room and amongst their personal belongings. Sometimes the contents of those containers were discovered by Sharina and they would be punished as a consequence.

2.1.13 The punishments were all at the behest of Sharina who sometimes administered the physical punishments herself, but would also frequently 'delegate' these to others and would watch and give instructions to the others. The evidence in the case showed that Sharina was responsible for the horrific injuries suffered by the victim prior to her death. There can also be no doubt that the assaults on Shaily were repeatedly dealt out and that other family members could have prevented and spoken up for her, but never did. There were opportunities for them to have reported this to the police, but this failed to occur.

2.1.14 There can be no doubt that Shaily suffered the most out of all of the siblings and that her life was intolerable and as she grew through her teenage years the treatment she received became more and more vindictive and violent, culminating in the beating that ultimately caused her death.

2.1.15 Looking at the other two siblings, there was evidence presented that identified some significant text messaging between Sharina and them. For example, in a text message recovered from a mobile phone that was attributed to Sharina, an incoming message from a mobile phone attributed to Roslin on the 19th December 2013, reads: "*Afa, I beg you please can I go to the toilet. I am not disobeying you, I am awake please afa listen to me once I promise I will never argue again*". This perhaps typifies the fact that the abuse was not short lived and had been ongoing for some considerable time and such revelations clearly identify that the three youngest siblings were subject of a daily routine of torment and punishment. The environment within the household led to the siblings turning against each other, where the weakest of them suffered consistent abuse and retribution. There is no doubt that the weakest and most vulnerable was Shaily. Evidence indicated that Sharina had a particular hatred for her and described her to other members of the family as *"a disease".*

2.1.16 The criminal investigation revealed a web of lies, deceit and denial by those on trial and following Shaily's brutal murder, it was established that the family had immediately conspired to hide the truth concerning the events preceding her death. When the paramedics arrived at the address and were shown Shaily's body in the bathroom it was apparent that not only had Shaily died some hours beforehand, but that this had probably taken place in a bedroom and efforts had then been made to disguise the actual scene by moving her to the bathroom. It is likely that Shaily was in fact dead before her body was moved.

2.1.17 Moreover, it was discovered some 48 hours into the police investigation that one family member, identified as Sadia, was actually unaccounted for. The family had kept silent about her and it was discovered that that immediately following the death of her sister she had been removed from the house by Jitu under instructions from Sharina. Sadia was told what to say by

Sumon and was then 'hidden' in a car for up to 17 hours and kept away from the unfolding events. This perhaps goes some way to emphasise the control that Sharina exercised over all the family and the extent that she was prepared to go to in order to deflect blame.

2.1.18 Early life

The family had originally come to the attention of the Local Hertfordshire Social Services in 2000 when Shaily was just 5 years old. Shaily, along with a number of her other siblings were placed in foster care and were subject of a child protection plan until 2001. Shaily's school attendance became sporadic and by the age of 8 she was losing weight and had been observed to be having dental problems.

2.1.19 In 2008, Shaily contacted the police reporting that she and her sister were being hit by their mother, Samarun. The issues between the younger siblings and their mother continued and by 2009 an 'agreement' was drawn up by Social Services for her mother not to physically chastise her. This agreement was however never signed by her mother. Much of this background was probably the catalyst to the eventual breakdown of the parent's relationship and consequently the family unit which by 2010, had progressively led onto Sharina and Sumon's guardianship of Shaily and her siblings. The three siblings moved into the family home with Sumon and Selma in accordance with the guardianship order.

2.2 Family composition

Name	Relationship	Ethnic Origin
Sumon	Brother	Bangladeshi
Jahid	Brother	Bangladeshi
Sharina	Sister-in law	Bangladeshi
Rafsan	Sister	Bangladeshi
Jitu	Brother	Bangladeshi
Laboni	Sister-in law	Bangladeshi
Tahmid	Brother	Bangladeshi
Roslin	Sister	Bangladeshi
Shaily	Victim	Bangladeshi
Sadia	Sister	Bangladeshi

2.3 Individual Management Reviews

2.3.1 The aims of the Individual Management Reviews (IMRs) are to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working;
- Identify whether the homicide indicates that changes to practice could and should be made;
- Identify how those changes will be brought about; and Identify examples of good practice within agencies.

2.3.2 The independent chair and overview report writer met with the IMR writers on 12th February 2016 and talked the authors through the process for the development of the IMR, as follows:

- Securing agency records;

- Commissioning IMRs;
- Gaining consent to view records;
- Drawing up a chronology;
- Conducting a desk-based review which investigates the agency's involvement relative to the agency's policies and procedures; relevant partnership / multi-agency policies and protocols (e.g. those of the Hertfordshire Domestic Abuse Partnership); professional standards and good practice; and national and local research and evidence-based practice;
- Conducting interviews with relevant staff;
- Writing the IMR including analysing the information and making recommendations;

- Ensuring the report is quality-assured through the process of counter-signing by a senior accountable manager; the same guidance includes advice on:
- Conducting parallel investigations of disciplinary matters and complaints which will not be reported which are internal agency matters;
- Providing feedback and debriefing to relevant staff;

2.3.3 Implementing the recommendations from the DHR within the Agency.

IMR authors were informed of the primary objectives of the process, which is to give as accurate as possible an account of what originally transpired in the agency's response to Shaily, Roslin and Sadia and to evaluate it fairly, and to identify areas for improvement for future service delivery. IMR authors are encouraged to propose specific solutions which are likely to provide a more effective response to a similar situation in the future. The IMRs have also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of, or experiencing domestic abuse.

Agencies each prepared a chronology of their agency involvement and significant events during the specified time period. This was merged into a comprehensive, integrated chronology which was compiled and analysed by the Review panel.

2.3.4 IMR authors produced a first draft of their reports which were quality assured within their own organisations through the signing-off process. These IMRs were then analysed by the Review panel and discussed with the authors at the meeting on 4th May 2016. Copies of IMRs had been circulated to all the panel members and this meeting was able to cross-reference significant events and highlight missing information. Authors then reviewed their IMR's which were again supplied to the review panel. Authors then produced final reports.

2.3.5 Key event analysis of involvement from the IMR's

The author has addressed the terms of reference as part of the analysis of involvement in order to address the key points.

2.3.6 What disclosures were made to agencies and the circumstances behind them coming into contact with them?

Hertfordshire Constabulary

This is an unusual case in that very little was known of the victim and her siblings after 2011 following on from when they were subject of the SGO. The majority of the information concerning

the victim and her siblings has been established during the homicide investigation which, taking into account what appears to have been known about the family by third parties, does not appear to have been evaluated or examined in any significant manner by any agency between the guardianship order and the date of the homicide. There was no significant information held by the police concerning the core family members that identified any indication of neglect, abuse or domestic abuse against the victim, Roslin or Sadia.

Taking into account the fact that the investigation revealed that Shaily and her siblings had been subjected to a regime of abuse and assaults, there can be little doubt that the violence and abuse remained hidden, moreover due to fear and intimidation. The indications are that the abuse did not start immediately after Sharina and Sumon took on the parental responsibility for the children, but was in fact a 'slow burn' that gathered momentum relative to the control that Sharina exercised over the wider household. Without detailing in full the harrowing accounts of Sadia, she was frequently forced to eat her food, but not only that would be punished if she failed to be 'lady like' at the dinner table. Members of the family would sit behind each of the subjects and punish them by beating them if they failed to consume the vast amounts of food that they were given, usually traditional Bangladeshi foods accompanied with rice.

It was not until after she was arrested in connection with the murder that Roslin claimed that Shaily was "mentally ill" and she repeatedly claimed that Shaily struck herself although on admission she agreed that she had never actually witnessed this occurring. She also claimed that Shaily regularly threw herself onto the floor and would bang her head against the wall, but again when challenged gave little provenance to such claims. Roslin, out of all of the siblings was clearly heavily influenced by Sharina in respect of what she should say and how she and her siblings should behave in the household.

What little was learned of Roslin was that she too did not work, have any independent source of income and she relied on the family to provide for her, as with Shaily and Sadia, being subservient to the rest of the family. She spent the majority of her time with Shaily and confirmed that neither of them went out of the house much and had no outside friends other than those made at secondary school with who they were not allowed to have in the home and with whom they no longer associated with.

An indicator of the events leading immediately up to Shaily's death appear to indicate that Shaily had thrown away her lunch on the previous day and that this had been brought to Sharina's attention principally by Roslin amongst other family members.

2.3.7 GP practice

There does not appear to be any records indicating any abuse within the family relating to any of the girls. All GP and hospital records have been checked and there are no documented reports of any concerns being raised at the time of any visits.

2.3.8 School

During the time frame there were two reported disclosures made about how Shaily was treated at home. Neither of the disclosures were made by Shaily or Sadia. The first disclosure was made by two of Shaily's friends in September 2011, when she had failed to return at the start of the 6th Form. They told the deputy head that they were worried that Shaily wanted to return to the 6th Form and ultimately wanted to be a teacher but that her brother will not let her. They had been unable to contact Shaily and were concerned that she may be in Bangladesh against her wishes. They also said that the family are very 'closed'

and traditional and that Sadia may be vulnerable. They also reported that Shaily used to talk about being force fed and hit by her brother.
The deputy head made further enquiries with the head of 6th form and ascertained that Shaily did have a place to study one A level and Applied Business Studies and was due to start on the 23rd September after a period of authorised leave. On her return to school, the deputy head met with Shaily on the same day. Shaily assured the deputy head that the holiday was planned and that her friends had no reason to be worried. She was adamant that Sumon and Sharina were very kind and that they were well looked after at home. Shaily was totally dismissive about the concerns that had been raised and said that she chose not to contact her friends rather than being stopped from doing so. A week later the deputy head met with Sumon to discuss concerns, he was reported to be annoyed that the deputy head seemed to believe that Shaily and Sadia had married whilst in Bangladesh.
The deputy head acted appropriately by following up the concerns about both Sadia and Shaily. She had met individually with both of the girls to ask them about how things were at home. At the time both Shaily and Sadia reported that all was well at home.
The two girls who had made the disclosure asked for some feedback in October 2011. They were told that Shaily said that they were lying and that she had never said any of this. Again the deputy head took this opportunity to meet with Shaily who became very angry and insisted that she should be left alone.
The second disclosure to the school was in October 2012; again the information was second hand. A parent made an appointment to see the head teacher on Friday evening after her daughter (Sarah) had returned from school and said that Shaily was 'force fed' at home, is only allowed to go to the toilet when given permission, is not allowed to do her homework since 'education is not for women'. In the past she had also been made to lick the toilet. She had contacted Karma Nirvana who advised her that they would be willing to speak with Shaily by telephone at the school. It was also reported that Sumon and Sharina present as very charming and convincing people which is very different from the true situation. It was also reported that Shaily is not allowed to have a mobile phone, and described the situation as an 'extreme emotional and physically abusive situation". The meeting was followed up with an email to the head teacher laying out her concerns.
The head teacher shared the information with the deputy head via an email later that evening. The deputy head informed him that she had already spoken to Shaily on two occasions and she denied that anything was wrong and that her family 'loves her dearly' and her friends are making it up. The plan was to speak with the head teacher on Monday before taking any further action. This seemed a reasonable decision given that they needed to talk to both the girls before agreeing what should be done.
The deputy head saw Shaily on the Monday to discuss her concerns but Shaily again denied that she had ever said these things. Shaily became very angry at the deputy head that she would believe that Sumon and Sharina would do such things. She continued to shout at the deputy head and pulled out a mobile phone and said she chose 'not to use it for people at school'.
Over the weekend of the disclosure Shaily had her 18th birthday. The deputy head spoke at length with Shaily on the Monday saying that she could talk to people outside the school environment and that she didn't have to carry on living at home if she was unhappy. Shaily responded by saying 'she had nothing to say to anyone because everything was fine' and that it was a waste of time calling anyone. Shaily stormed off and the deputy head then asked the head of 6th form to speak with her, she continued to deny that anything was

wrong. Following this meeting Shaily did not speak with the deputy head and avoided eye contact if they happened to pass in the school corridor or playground.

2.3.9 Establish the appropriateness of agency responses to each of the above named - both historically and immediately prior to the victim's death.

Hertfordshire Constabulary

Nothing was known of Shaily, Roslin and Sadia by the police after the guardianship order of 2010 and then it was only as a documentary record of the order as the guardianship process was conducted by the Social Services as a single agency, without any involvement by the police. There are no child protection records held by the Hertfordshire police relevant to the three subjects from 2011. The investigation identified that an incident which possibly occurred during either 2010 or 2011, which was attended by the police, started following what had been a significant disagreement between Sharina and Shaily. However, the report to the police, which was made by Sadia, identified that the dispute was in fact between two of the brothers. There was an additional report to the police concerning a domestic dispute but this was between Rafsan the eldest sister and her brother. This appeared to be a dispute between siblings and appears to have been dealt with appropriately.

The author wishes to point out the practice and policy and force structure to dealing with Domestic Abuse incidents has changed over the period under review, for example the Hertfordshire Police now has an integrated MASH team with other statutory agencies which was not in existence in 2011. The processes for dealing with any incident reported as a domestic occurrence has layers of review and supervision built into the 'journey' of an incident that commences at the 'front line' and continues so that all crime and non-crime related domestic abuse incidents are investigated, reviewed and supervised to ensure a consistent approach across the Constabulary and partnerships.

2.3.10 GP practice

The NHS IMR indicates that there was no significant contact with the girl's subject to this review which have had any impact on the review. It has been identified, however, that when the children did present for appointments that there is no record of whom they attended with or any record of their general health or appearance. Lessons have been identified in relation to presentation at surgeries of children who were previously or currently subject to a child protection plan. It must be identified by professionals that children who were at risk can often be at risk in the future and as such this should be bourn in mind at all visits.

2.3.11 School

At the time of her first disclosure Shaily was 16 years old and turned 18 over the weekend of the second. Young people aged 16 or over are entitled to consent to their own treatment, like adult's young people (aged 16 to 17) are presumed to have sufficient capacity to decide. The adult working with the young person should assess the maturity and understanding on an individual basis and ensure that the nature, purpose and possible consequences of refusing to give consent are fully understood. It is always a difficult balance when working with adolescents to support them in making informed decisions but at the same time considering whether the decision that they have reached is a safe one. Shaily was very clear that there was no substance to the reported disclosures by her friends and refused to speak

to anyone about home life, as 'there was nothing to say'. The advice from Karma Nirvana was that they could speak to Shaily confidentially whilst she was at school she refused this offer. The fact that Shaily refused to give consent left the deputy head in a difficult position, if a referral was made it would be without the consent of Shaily and the agency receiving the referral would be unlikely to take the referral. Given that she was now 18 a referral would need to be made to Adult Social Care, if it was considered that she was a vulnerable adult. The fact that Shaily became very defensive and angry when questions were asked about her home life should perhaps have been explored further.

Although Shaily had not given her consent for a referral to be made; during the course of this review and in discussion with the DSP a referral to Hertfordshire Children's Social Care should have been made. It is difficult to determine whether there would have been a different outcome but the concerns and disclosures made would have been shared with another agency.

Schools are often at the forefront of safeguarding but do not receive Child Protection Supervision or an opportunity to reflect and discuss individual cases. Staff can become 'fixed' in the way that they view the family and see it as the normal pattern of behaviour.

2.3.12 If and how agencies assessed risks within the family household.

Hertfordshire Constabulary

In respect of the two domestic related incidents referenced above where risk was assessed by the police, in each case the risk assessments were based on the facts as presented. In the view of the author, there is no reason to question the manner with which both incidents were addressed at the time and based on the information and circumstances as was established by the reporting officers.

What didn't occur however was that, specifically in respect of the July incident in July 2011, the attending and reporting officer did not obtain details of the other occupiers of the premises at that time by names and age details. This is not a pre-requisite and officers should base their assessment on the facts as presented which is clearly what occurred, however this may be a gap in process that requires addressing.

The author has been unable to establish whether or not Shaily, Roslin and Sadia were actually at the premises at the time of the police attending or their presence to the officer was apparent in the incident of July 2011, however as it was reported late on a Sunday evening, on that basis it is more than likely that Shaily, Roslin and Sadia were at the address.

2.3.13 GP practice

There is no evidence recorded in the records of Shaily, Roslin or Sadia that any risk assessments were made by any of the GP's who came into contact with the girls at consultation. There is no evidence to suggest that a risk assessment was indicated.

2.3.14 School

The School use the Risk Assessment and Management Plan (RAMP)[4]. RAMP is a sustainable early identification and intervention process designed to improve the wellbeing and access to learning opportunities for at risk students. Neither Shaily nor Sadia posed a risk to other pupils or to themselves at school and therefore the deputy head did not feel that a RAMP was appropriate.

On questioning the deputy head about whether she had considered if there were any safeguarding concerns following the second hand disclosures by friends of Shaily and consequently taken up by one of the parents. Her response was that 'of course she had, but felt that given Shaily's age and her refusal to consent to a referral it would be unlikely that Adult Social Care would have accepted and acted on the referral.

2.3.15 Were the agencies responses good practice and proportionate concerning their knowledge and did agencies discharge their duties properly?

Hertfordshire Constabulary
There are no recorded incidents where the author would anticipate any referrals being made to other agencies based on the fact that those incidents as reported and recorded as being standard risk DV incidents with none of the subjects recorded as being present.
The police did not attend any incidents where Shaily, Roslin or Sadia were the subject(s) of the report or otherwise identified as being at risk and consequently there are no reports raised or referrals made by direct reference to any of them.

2.3.16 GP practice
During the period of the review professionals responded to the presenting medical problems appropriately. There is nothing to suggest that any other actions were required.

2.3.17 School
Sadia had been subject to some unwelcome comments from two boys in her maths class when she returned a week late to school in September 2011. They questioned her about why she had been away from school and was it because she had got married. Sadia didn't reply to any of the questions and remained quiet but the boys continued to make jokes at her expense and laughing. Sadia was moved to another class and the boys were spoken to.
In January 2012 Sadia's dance teacher raised concern about her personal hygiene. The deputy head spoke directly with Sharina who refused to accept that Sadia smelled. The deputy head was very clear with Sharina that Sadia did smell and asked Sharina to check that Sadia is washing and wearing clean clothes.

On the 9th March 2012 Sadia is reported to have said 'what would you do if all your life you had been bullied and no one liked you?' She had thought about killing herself and jumping off the science block. She had been crying throughout the day and on more than one occasion had said that she was so sad and unhappy about people telling her that she smelled. Sadia later had an altercation with another girl and ended up fighting. Statements were taken from all the girls involved, this is good practice.

[4] Child Protection Schools Liaison Services, Hertfordshire Children's Services.

The school followed their Anti-bullying policy and attempted to work with Sumon and Sharina, their legal guardians to resolve the ongoing issues.
With regard to Sadia's mental health and wellbeing the deputy head met with Sharina at the school and discussed the situation, she was offered both support through a Muslim mentor and counselling at school but this was turned down. Sharina was advised to take Sadia to see her GP, Sharina stated that she didn't think that Sadia was suicidal but she just wanted the bullying to stop. Both Shaily and Sadia were placed on the weekly bulletin list for staff to keep a watchful eye and were discussed at the monthly meetings.

The school supported Shaily and Sadia and encouraged the girls to be open and honest about their family and home situation. Shaily as a young adult, for whatever reason chose not to talk to the teachers who were concerned for her general welfare. As previously discussed it is a difficult balance to manage when young people refuse to consent for any referrals to be made. At the time when the disclosures were made by other pupils, and then ultimately by the mother of one, there was nothing to suggest that Shaily was in immediate danger. The deputy head did consider making a safeguarding referral but felt that if she did the case was unlikely to be accepted as Shaily was 18 and was adamant that all was well. On reflection the deputy head felt that it would have been helpful to use the Consultation Line run by Hertfordshire Children's Social Care (HCSC).

Schools have access to The Child Protection Schools Liaison Officers (CPSLO) part of Children's Services: Safeguarding and Specialist Services. The role of the team is to support schools to effectively safeguard children from harm, abuse and neglect. They also provide as part of their service a Consultation Line to schools.

The school and in particular the deputy head, worked well with Shaily and Sadia to support them in school and made sure that she saw them on their own so that they had the opportunity to talk openly about any issues.

2.3.18 Identify, on the basis of the evidence available to the review, whether the death was predictable and preventable, with the purpose of improving policy and procedures within the various agencies areas of responsibility.

Hertfordshire Constabulary

Such little was known about the family from the police perspective that the question cannot be addressed within the context of what has become known since the conclusion of the investigation and the trial process in order for there to be no hindsight bias. The author would comment that had the 'information and intelligence' from the school friends been addressed by referral, that the issues of potential neglect would possibly have been looked at from a joint agency perspective. Whether this would have revealed anything of consequence at that time is speculative, given Shaily's reluctance to speak out when the third party concerns were raised through the school.

2.3.19 GP practice

There is no evidence from the GP records alone that this tragic event was preventable. Each consultation during the review period was centred on a tangible concern. For Shaily this was an ear infection where discharge was seen. Previous to that Shaily had seen the GP for medication. Roslin presented with normal health problems.

There is no evidence that any of the sisters sought GP support in clusters nor attended with symptoms that were not seen on examination, as had been the case in younger years when accompanied by their mother.
There is no record of observation in the consultations with Shaily, Roslin or Sadia that suggested any violence or coercion within the family. There is no record of any sister being accompanied by a responsible adult which may have given some evidence regarding the relationship between the girls and other adult family members.
Therefore, it can be concluded that on the evidence available, it is felt by the IMR writer that this event was not predictable or preventable.
[

2.3.20 School

Given that Shaily and Sadia had left the school in the summer of 2013, some 14 months before the fatal assault it is difficult to comment on whether it could have been prevented. However, a safeguarding referral after the second disclosure should have been made.
The author of this IMR is of the view that this homicide was not predictable or preventable.

2.3.21 To identify good practice that was in place

Hertfordshire Constabulary

In view of the lack of background to this case there is no actual good practice to be identified, in retrospect, there was a vast amount of information held by fellow pupils and that the opportunities for partnership to explore key areas of potential vulnerability was present.

2.3.22 GP practice

In relation to the Practice it has been noted that they were able to offer continuity in care of the sisters. The same names of GP's were seen in all the notes reviewed which shows consistency. The notes however were identified as being very practical in their nature and were lacking any general comments regarding how the girls presented themselves at the time of their appointments.

2.3.23 School

The School has a very strong pastoral care ethos underpinned by robust policies and guidelines in line with legislation and best practice. During this review it was noted that some of the policies on the school website were due for review in January 2016. The policies have been ratified by the school governors but there was a delay in the policies then being uploaded onto the school website. This work has now been completed. Staff have access to on-going training and development and all staff are up to date with Safeguarding training. The school has a safeguarding repository for additional material and articles to help support staff.
The school is divided into four Houses and they are designed to give a sense of identity and belonging to students within the larger school community. Each student remains in the same House and Tutor Group throughout their time at school. The school also provide a wide range of support services and covers a wide range of subjects during assemblies. Some of the subjects were delivered by outside speakers; including The Samaritans and members of the Bushey Neighbourhood Team (Police). In the academic year 2011-2012 themes

covered included: drugs, peer pressure, hate crime, school values and friendship. In 2012-2013 the themes included: feeling alone, diversity, supporting others and eating disorders. The pupils attend assemblies in year groups as well as in their individual Houses. The 6th form has weekly assembly and the year assembly is 1:5 weeks. A weekly meeting of the student support team takes place each Monday. The team will review and discuss any issues and concerns about individual students and review vulnerable children on a monthly basis. During the time that Shaily and Sadia attended school the structure was one Designated Senior Person with two deputies. Following the death of Shaily the school appointed three more deputies. The structure is now one DSP and five deputies, one deputy for each House (the school has four houses: Drake, Auden, Newton and Sutherland) and one for the 6th form.
The school had supported Shaily and Sadia during the period when Sumon and Sharina were being considered for 'Special Guardianship'. Once this was agreed by the court in 2010 it appeared to have influenced how the school responded to any issues that were raised.

2.3.24 Lesson to be learnt for the future

Hertfordshire Constabulary

As indicated, the most substantial learning point was not what little was known of the subjects by agencies but how much was in fact known by the subject's peers and friends that was not brought to the attention of professionals. It is perhaps a sad indictment that had some of those whom knew and understood the trauma's that the subjects alleged and had told them that they were exposed to, that a more informed and broader picture of what was occurring in the household would probably have emerged for professionals.
It is felt that there is scope for appropriate 'information and awareness' interventions to be used in educational environments, particularly those of the more mature students to highlight issues such as domestic violence. A national campaign to address Child Sexual Exploitation has featured prominently nationally recently and is topical given the recent convictions for CSE across the UK. Although that is a separate issue altogether, that campaign has highlighted vulnerability, in particular teenagers and is designed to make others think about how their friends are or may be being treated and domestic abuse and vulnerability should receive a similar input.
The IMR author has sought to establish if, when officers attended the respective incidents at either of the two relevant addresses, whether their scope for intervention could have been more incisive by the police.
Officers attended the report of a domestic dispute between brothers in July 2011. This was, on the face of the incident responded to by the police, the background to the call. It is of note that the occupiers of the address are not all identified individually and on reflection probably did not make themselves known at the time. The incident appears to have been dealt with effectively based on the facts as known and understood at that time. In consideration of the outcome on that basis, the officer attending recorded and classified the incident according to practice and policy as a Standard Risk Domestic Assault incident. The review identifies that at this time that according to the investigations research, there was nothing to indicate that Shaily was at significant risk, although the actual substance to the background to the call was possibly commenced as an issue between Sharina and Shaily, this was not apparent and such facts appear to have been concealed by the family. There is no record of Shaily, Roslin or Sadia being present at the time of the dispute.
In February 2014, Officers attended the home address following a report of dispute between Rafsan and Tahmid as brother and sister. On the basis of the information as examined in this case the incident appears to have been dealt with effectively based upon the facts as known at that

time. This was recorded in accordance with policy and practice as a Standard Risk Domestic Assault incident.
Looking at both incidents and linking them for the purpose of this review, there is an argument that more information *could* have been obtained by the officers, however that is with hindsight and based on the facts as presented on each occasion and with there being no apparent history to either address location or the individuals involved, the officers acted professionally and reported the incidents appropriately.

2.3.25 GP practice

When the children, who then became adults, presented themselves at the surgery there is very little evidence to suggest that any questions were asked regarding their current welfare and there are no entries recorded that suggest that these questions were asked. Where a professional has engaged in an interaction with a child patient, they should record the name/relationship of the accompanying adult or if they attended alone. They should also record any interaction that there was between the child and the appropriate adult. The practice was aware of the previous neglect issues and the legal guardianship to the brother and sister in law and as such this should have been in the back of their mind when speaking to the children.
In families that have a change in parental responsibility all professionals should take the opportunity to ask the question 'How are things at home?' and record the verbal and non-verbal response.

2.3.26 School

When disclosures are made to the school by other pupils or parents they should be advised about what action the school is able to take and what they as individuals can do, and how to make a referral if they are concerned. Safeguarding is everyone's responsibility. It appears in this case that the school were looked upon as being the lead for safeguarding and therefore responsibility was passed to them. This responsibility also lies within the household and family members and it is uncertain as to why the family members did not feel that they could call on other agencies for support. It was identified that Shaily made a referral to social services when she was young concerning abuse so was aware that there were mechanisms in place in relation to reporting.
The deputy head felt at the time that on both occasions that the threshold for a referral was not met and therefore did not contact any agencies for advice. The school were aware of the advice line but chose not to use it at this time. This may be due to past experience but following this review all staff members should be made aware of the Consultation Line that is available via Hertfordshire County Council and should use the line to explore any case giving rise to concern and agree a plan. Shaily had also contacted the school when she was young to report neglect by her mother and was therefore aware of the help that was available.
The school are advised to keep clear and contemporaneous records including future planning and actions taken. This should be achievable with the introduction of CPOMS (Child Protection On-line Management System) in April 2016.
The school needs to consider how the DSP and deputies can be given protected time during the school day to deal with issues and concerns about children within the school. This should also include mentoring and 1-1's to be given to all safeguarding trained staff throughout the school where cases can be discussed and the best plan of action agreed.

The decisions regarding safeguarding should not be left to one individual as this can sometimes cause complacency and the failure to see the bigger picture or to look for different solutions.

2.3.27 The effectiveness of inter-agency communication

Hertfordshire Constabulary

There does not appear to have been any inter-agency communication in this case in respect of the three key subjects during the relevant period under the terms of reference of this review. There was no information to suggest that the Police visits to the address were anything other than minor disputes between family members and there does appear to have been any triggers to have raised any concerns.

2.3.28 GP practice

There is no evidence of inter-agency communication during the period in the review. There is no reason documented for this to have needed to occur. The letter regarding residency of the children at the time of the guardianship was copied to all three sets of notes. This highlights that the GP's were all aware of the guardianship and therefore should have displayed more professional curiosity at the time of the children being presented to them. It does not appear, however, that there was anything which raised any concerns to the GP's at their appointments but would be good practice in the future.

2.3.29 School

During the timeframe of this review there was no communication from other agencies. The School Matron was contacted by The Royal Brompton Hospital when Shaily was diagnosed with QT Syndrome[5] there was no further contact from the hospital. (It should be noted that this fell outside the time frame of the review). The school were aware of certain issues regarding Shaily and Sadia throughout an 18 month period. There were several causes for concern regarding allegations of bullying against Sadia and incidents where she has appeared to have been upset or depressed. These, together with the concerns raised by Shaily's school friends should have resulted in certain questions being asked or information being shared with other agencies. It appears that although the school did try and deal with all the issues and obviously took them seriously there was no contact with other agencies for advice or support.

2.3.30 Any difficulties agencies encountered when working with Shaily and her family that impact on the case.

Hertfordshire Constabulary

Hertfordshire Constabulary attended two incidents of a domestic nature surrounding family members but these appeared to have been of a minor nature and as such would not have necessitated any referrals to other agencies. When Police attend addresses where children live who are classed as 'at risk' an intelligence marker is placed on that address to highlight to officers attending that particular attention must be made to any children at the address. In these cases, reports would be sent to Children's Social Care of their attendance. However, at the time of the police attendance the children had already gone through the special guardianship order process

[5] A disorder of the heart's electrical activity

and therefore were not deemed to be at risk. Critically, there is no record of any interaction with the victim within the specified review period.

2.3.31 GP practice

There are no difficulties documented with other agencies during the review period**.** There is nothing to suggest that any concerns were raised by any family members whilst presenting and therefore there would have been no need to make referrals to other agencies.

2.3.32 School

School had a considerable amount of contact with family members throughout several years. Five of the eight children had attended the same school. Although out of the timeframe scope of the review it is worth noting that the deputy head was very involved in the issues of neglect of the children when they lived with their natural mother. The deputy head spent a considerable amount of time speaking to their mother and had a great deal of interaction with the girls and social services prior to them moving to live with their brother and sister in law. The school showed strong pastoral care in relation to their dealings with the family and followed all child protection procedures.

The school generally had a good relationship with Shaily and Sadia initially and that the girls trusted the deputy head as she was the one they contacted when things were bad at home with their natural mother. It is unsure why the girls did not discuss any of their concerns with the school even though they were asked on several occasions if there were any problems at home. It shows that there was a breakdown in trust between the girls and the school and when speaking to Sadia she stated that both she and Shaily thought that if anything was raised at the school then it would automatically get back to their family which would make the situation worse.

The deputy head met with Sumon and Sharina, as the Special Guardians for Shaily and Sadia, when necessary and although they were not always in agreement with what was being said, they did continue to work with the school. It appears that the family were not always easy to deal with and could be confrontational on occasions. It should be noted that aggression is often used as a barrier and was something that was used by Shaily on several occasions when she was spoken to the school about her friend's allegations.

2.3.33 The accuracy of records and information imparted.

Hertfordshire Constabulary

The records held by the Hertfordshire Constabulary are adequate and fit for purpose but have not been shared with other agencies although it appears that there was very limited information and no necessity to share that information with other agencies.

2.3.34 GP practice

The records are medically led and do not make reference to social circumstances as previously indicated.

2.3.35 School

The author has reviewed the records and documentation held by the school on Shaily and Sadia. The key events are documented but it was not always clear about what the plan and follow up was. Writing and keeping contemporaneous records is a challenge for most professionals but within a very large and busy school this becomes more difficult during the

school day. The author found evidence that emails and writing records falls outside the normal working day; emails were often written late at night. The author recognises that the staff were very committed and 'went the extra mile'. However, the school needs to review how staff can be better supported to allow time in the working day to complete records. The School has recognised that that record keeping needs to improve and have purchased the Child Protection On-line Monitoring System (CPOMS). This is a secure system that is accessible to all staff at pre-determined levels. It can be used to record a wide range of pastoral and welfare information including: incident reporting, bullying notes, safeguarding and child protection. It allows schools to track referrals to external agencies and is designed to save time and reduce administrative time. The system was installed in April 2016 and is now in use within the school.

Section 3: Friends and family

3.1 Family and friend's involvement and perspective

3.1.1 The author would like to thank family members and friends of Shaily who contributed to the review process. The panel understands that this must be a very difficult time for those who were close to Shaily and wishes to express their condolences in this case.

3.1.2 The author spoke to the younger sister, Sadia in the presence of her Foster Carer and the Police FLO. During the interview Sadia spoke about her relationship with her natural parents and the background to moving to the guardianship of her brother and sister-in-law. She stated that she had spoken to Social Services and was happy with the guardianship order and the way it was dealt with. Sadia stated that they had all been happy staying with their brother and sister in law and that arguments had only started between them after they had lived there for about 3 years.

3.1.3 Sadia described the family as traditionally Bangladeshi and that they attended the mosque for prayers usually every week. She described them as moderate in their religious views but stated that although her two elder brothers had had arranged marriages there was no suggestion that marriages would have been arranged for the girls in the family.

3.1.4 Sadia stated that Shaily was the most outspoken of the girls within the family and that she and Sharina had clashed. She said that Shaily always answered Sharina back and wasn't always happy to accept her authority within the family. Sadia explained that it was traditional for husband's mother to be the head of the household but in this case due to the guardianship it then fell to Sharina to take on that role. This was accepted within the family.

3.1.5 Sadia stated that she had had a lot of problems whilst she had been at School, mainly surrounding bullying from other pupils. She stated that she hadn't had a very happy time at school and struggled to make friends. Sadia expressed concerns in relation to the way the school had dealt with these issues and believed that she had been let down by the school. Sadia stated that although the school had taken certain steps in relation to the bullying it hadn't stopped. The school had contacted her family who had come into the school to discuss the bullying on two separate occasions. At one point Sadia had told another school friend that she was so unhappy that she wanted to 'kill herself', again she felt that this wasn't taken seriously by the school.

3.1.6 Shaily is described as being popular at school whilst she was in year 9 and that she had a good friendship group, although when she went into year 10 Sharina told Shaily that she wasn't happy with her having friends at school as they were a bad influence on her and after that Shaily and Sadia started hanging around together. Sadia wasn't aware of what being a bad influence was but believed that Sharina believed it was causing Shaily to be more outspoken within the family.

3.1.7 Sadia stated that neither she nor Shaily trusted the school and that every time they had tried to speak out the end result was that the school would contact her brothers and sister in law who would then come into the school.

3.1.8 School friends

The author spoke to two of Shaily's school friends, Julie and Louise. Julie stated that she had been friends with Shaily since secondary school from about 13 years. She stated that Shaily was quite open within her friendship group about what was happening at home. Shaily had spoken about being made to 'lick the toilet' and being made to eat until she was sick. She stated that on occasions Shaily had asked to copy her homework because she told her she wasn't allowed to do homework at home. Julie described Shaily as being very feisty and fiery and was someone who would stand up for herself within their peer group. Shaily wasn't allowed to socialise with them outside of school and at one point was told that she could not hang out with them at school. Julie stated that Shaily wasn't allowed to go into the town centre or have friends around to her house or visit friends after school. Julie stated that when she returned to school after the summer holidays at the beginning of the Sixth form (September 2011), she was aware Shaily had not returned to school. She went to speak to the deputy head as she was concerned about Shaily knowing that she had gone to Bangladesh over the summer holidays. Julie informed the school that Shaily had disclosed to them that she was being forced fed at home and was also being hit by her brother. Julie believed that her concerns weren't taken seriously by the school and was made to feel that she was meddling. Julie stated that she felt that a door had been shut in her face and that she wasn't taken seriously regarding her concerns about Shaily. When Shaily came back into school she was called into see the deputy head and as such became angry with her friends for telling on her. Shaily stated that her brother and sister in law had been called into the school as a result of their concerns which had made things worse. Julie describes feeling inadequate and having to assume an authority that was out of her jurisdiction and not knowing what else to do. Julie feels that she should have been given more support in relation to what she was saying and believed that she wasn't being taken seriously by the school.

3.1.9 Julie continued to be concerned regarding Shaily throughout the year but believed that having already spoken to the school that the school thought that either Shaily or she were lying so she didn't go back to the deputy head again to re raise her concerns. However, a year later she felt so concerned regarding what Shaily was saying was happening at home that she told her mother when she came home from school.

3.1.10 A parent was spoken to by the author who stated that her daughter, Julie, had come home one Friday evening in October 2012 expressing serious concerns regarding Shaily and

what was happening at home. She was so concerned about the disclosures that she tried to contact the school. Due to the time no one answered but due to her high level of concern she drove to the school and managed to speak to the head teacher who advised her that he would contact the deputy head, which he did. She also made contact with Karma Nirvana for advice and was told that due to her age (18yrs) that they would need to speak to Shaily herself and that they would be more than happy to speak to Shaily on the phone from the school. She sent an e-mail to the Head teacher expressing her concerns, including her concerns that 'Shaily appears to be of the opinion that her sister and brother in law present a very charming convincing denial of the true situation'.

3.1.11 The parent stated that she received a telephone call from the deputy head the following week who wished to speak to Julie because she was absent from school, not being very well. She states that during the telephone call she was told that the school believed that Shaily was fabricating what was happening at home because she was psychologically disturbed and that her family were lovely.

3.1.12 Another friend of Shaily was spoken to, Louise who was friends with Shaily for several years due to them being in the same form group. Louise stated that it was a 'open secret' within their friendship group about what was happening at home and that Shaily would openly speak about her 'punishments'. She said that Shaily described her family as being very tough and controlling. She was aware that Shaily used to throw away her lunch as she was made to eat a large meal when she got home and was even made to continue eating if she was sick. Louise described in detail some of the punishments that took place within the family home, including being made to lick the toilet and to drink toilet water as she was so thirsty. Louise stated that when Shaily didn't come back to school after the GCSE's for Sixth form that herself and a friend went to speak to Connexions[6] who were based within the school. They were advised to go and speak to the deputy head regarding their concerns. Louise stated that the Connexions worker told her that she was aware of the family situation and gave her Shaily's home address stating "don't tell anyone I've given you this, but have a walk past her home address and make sure that she is ok". She was advised that "Shaily had a reputation for making things up in the past but it would be looked into".

3.1.13 Louise stated that she felt very let down by the school and she felt that she wasn't believed. She stated that she was made to feel silly and was made to doubt herself.

3.1.14 Karma Nirvana

The author would like to thank Karma Nirvana for their help and time during the writing of this report. During the Police investigation into the death of Shaily the Police liaised with Karma Nirvana who upon being presented with the information in the case formed the view that they did not believe that the murder was 'Honour Based', although they identified that the non compliance and cover up afterwards was.

[6] Youth Connexions is a matrix accredited organisation providing high quality youth work, information, advice, guidance and support for young people through One Stop Shops, outreach in community and schools and colleges.

3.1.15 Honour Based Violence is "an incident or crime which has or may have been committed to protect or defend the honour of the family or community". Karma Nirvana records an average of at least 12 honour killings in the United Kingdom each year[7]. Their national helpline received 8,268 calls in 2014 and over 45,000 since inception in 2008 and between 2010 and 2014 recorded reported 11,744 incidents to the police involving honour based abuse. The motivation behind honour based abuse lays in relation to protecting the honour of the family. This might involve controlling decisions some family members take and limiting them in the choices that they make, such as what to wear, what friends to have, where to study or if to study and who to marry. The importance of 'family respect' can relate to both males and females within the family although it is believed that females carry more of the weight of honour on their shoulders.

3.1.16 Whilst the family members were initially interviewed as significant witnesses[8] prior to being arrested, there was very limited information received regarding the family's perspective of honour within their specific family. Due to the lack of information received from family members and other members of the community, Karma Nirvana stated that it was very difficult for them to make an educated response as to whether this fitted the criteria for honour based abuse. There are a great many examples of the way Shaily was made to live within the family environment which indicated that she was under a strict regime, however it appeared that Shaily was also given a certain amount of freedom. All of the girls within the family attended school and Shaily went on to stay at sixth form and was looking at some sort of higher education. It was suggested that they weren't allowed access to computers or mobile phones; it is believed that Shaily received a mobile phone for her 18th birthday. It is noted that the other females within the households were allowed access to computers and other electrical equipment. It appears that although Shaily lived within a Muslim household who held moderate views, the abuse she suffered was more to do with personality clashes than specifically honour based.

3.1.17 It is difficult to establish why other members of the household didn't intervene in what was happening within the home and were also complicit to the abuse that was taking place. This might have been that they were protecting the honour as set down by the matriarch of the household, Sharina, or that they were too afraid of her to go up against her. The panel believed that although several of the incidents which took place within the household were possibly of an 'honour nature' they did not believe that there was sufficient information to show that the murder itself was 'honour based'. The panel also felt that although this was something they needed to consider within their review it was not something that had had an impact on the way agencies worked either individually or together. It appears that for some reason Shaily was singled out by Sharina within the household as a target. This might be that Shaily was the most outspoken female within the family and would question Sharina's position as head of the household; she was described by her sister and friends as being feisty and not afraid to express her views.

3.1.18 Karma Nirvana having checked their records record having a conversation with a friends of Shaily's mother regarding Shaily and concerns regarding what was believed to be

[7] Cowan 2004

[8] The author would like to thank the police for allowing her to have access to the significant witness statements and interviews of family members and also the Judges summing up at the trial.

happening at home. They stated that due to Shaily's age they would need to speak to her directly but advised that the best course of action was for their details to be passed to her and for a safe call to be facilitated. They state that they hadn't however received any calls from Shaily herself or the school.

3.2 Analysis

3.2.1 Hertfordshire Constabulary

The Police IMR writer identified an incident which possibly occurred during either 2010 or 2011, which was attended by Police. The reason this was raised by the writer was that the initial report to the police appeared to be about an argument that was taking place between Sharina and Shaily, however, the report to the police was made by Sadia identifying that the dispute was in fact between two of the brothers. It appears that the dispute had escalated to being between the two brothers, possibly as one of the brothers was protecting Shaily. This is perhaps of significance in this particular case that if the background was actually a dispute between Sharina and Shaily, the family appear to have covered up the real reason behind the occurrence. It is also perhaps indicative of the relationship between Sharina and the other family members from around that time which is when, it is suggested by Sadia in particular, that Sharina's domineering behaviour manifested itself and she was able to manipulate the attention away from the root cause by coercing others. This was recorded as being a 'Standard Risk Domestic Assault Incident'[9] The background to the incident suggests that it was a dispute over finance. There was no arrest made and on the basis of the information reviewed, the matter was dealt with in accordance with policy and practice.

The overview writer agrees that this might have been of significance; however, there was limited information available at the time and no indication from officers who attended the scene that this was anything more than a low level domestic incident. There would not have been any addition information available from other partners at this time which may have raised any addition concerns to the officers.

The police attended a further domestic incident at the other address owned by the family which turned out to be between two siblings not subjected to this review. There is no record of other persons present at the time of the dispute and on the basis of the information viewed the author of the IMR is satisfied that the incident was dealt with in accordance with policy and procedures. Looking at both incidents and linking them for the purpose of this review, there is an argument that more information *could* have been obtained by the officers, however, that is with hindsight and based on the facts as presented on each occasion and with there being no apparent history to either address location or the individuals involved It is this author's view, that the officers acted professionally and reported the incidents appropriately. The police do attend a number of incidents that involve Rafsan and her partner however these incidents are not in any way connected to the two principal addresses or the three subjects of this review, although the attendance is in respect of domestic violence incidents between the two of them. It is known that Rafsan used the family address from time to time and in particular when she was on bail for an alleged serious assault against her partner in July 2013, as this address was deemed as suitable for her bail. When Rafsan was granted bail for GBH and went to her 'family' address in July 2013, were there enough suitability checks made to establish whether that bail address was appropriate? On the basis that it was the family home, there is a view that this was appropriate,

[9] Where no independent record of a domestic related dispute was created other than as linked to the incident in view of the minor nature of the occurrence. Should a further incident occur within 12 months a record would be created at a higher classification of medium risk or higher.

however what may not have been considered is details of the other occupiers and if there were other potential vulnerabilities as a consequence.

3.2.2 GP practice

Shaily, Roslin and Sadia all presented to the GP during their younger years with childhood illnesses.
The records for all three girls demonstrate that they were seen by a small group of GP's at the surgery. It is clear that the practice was able to maintain consistent staffing during that period of time. The family were known by the GP practice to have been removed from the Child Protection Register in 2001 as recorded in the notes of Sadia. There is an absence of observations recorded about the general appearance of the girls, their relationship with their mother or other family members or who accompanied the children to the doctor for their appointments. Each girl has been referred to the appropriate Specialist Consultant at Watford General Hospital and Royal Brompton and followed up by the GP as required.
It is noted that the girls tended to attend 'Urgent Appointments' and were reminded on occasions to book routine appointments for some complaints.

3.2.3 School

3.2.4 The eldest brother, Sumon and his wife Sharina became the legal guardians for Roslin, Shaily and Sadia in 2010. Five of the family had attended the same School and the family circumstances and background were well known by the school. It appears that the school had involvement with Sadia in relation to bullying that was going on throughout her school years. The author believes that the school acted appropriately in relation to the bullying that was taking place within the school involving Sadia. The school followed their anti-bullying policy and attempted to work with Sumon and Sharina, their legal guardians to resolve the ongoing issues.

3.2.5 During this period Sadia spoke to a friend stating she was so unhappy that she wanted to die. With regard to Sadia's mental health and wellbeing the deputy head met with Sharina at the school and discussed the situation, she was offered both support through a Muslim mentor and counselling at school but this was declined. Sharina was advised to take Sadia to see her GP, Sharina stated that she didn't think that Sadia was suicidal but she just wanted the bullying to stop. Both Shaily and Sadia were placed on the weekly bulletin list for staff to keep a watchful eye and were discussed at the monthly meetings. It does appear to the author that due to the school's disclosures to both Sharina and Sumon, in relation to the bullying that was going on, that this may have caused a loss of trust in the school in relation to Shaily.

3.2.6 On the first occasion in 2011 Shaily's friends went to the deputy head regarding their concerns re Shaily not being at school and highlighting the possibility of an arranged marriage. They also told the deputy head that Shaily had told them that she had been force fed and also hit by her brother. It is unclear how Sumon and Sharina became aware that the school had spoken to Shaily and Sadia but as a result Sumon attended the school to speak to the deputy head annoyed that both Sadia and Shaily had been spoken to about the fact that they might have gotten married in Bangladesh. This may have reinforced any concerns that the girls might have had regarding a lack of confidentiality and that any allegation of abuse

they raised would get straight back to their brother and sister in law, who were later identified as the perpetrators.

3.2.7 The Forced Marriage policy is on the Hertfordshire educational website and Hertfordshire's grid for learning which is updated by Hertfordshire County Council, and the subject of Forced Marriage is discussed during religious studies. The multi-agency statutory guidance for dealing with forced marriages was first published in March 2013 and was last updated in March 2016. It is felt that the initial disclosure by the school friend of Shaily was a missed opportunity and the focus had been on the possibility of an arranged marriage and not on the allegations of abuse that had been made against Shaily by her family. The allegation of abuse mentioned by the friends appears to have been overlooked at this stage. The girls went back to the deputy head a short while later to get an update and were told that Shaily had been spoken too and denied anything was going on at home and had told the deputy head that they had been lying. The deputy head did however speak to Shaily again regarding her friends concerns but she continued to deny that anything was wrong.

3.2.8 It might have been a consideration for the school to have a discussion with all of the girls together in relation to getting to the bottom of what was happening, this would have made it harder for Shaily to have stated that the girls had lied. At this point Shaily was 16yrs old; consideration should have been made by the deputy head with regard to making a safeguarding referral in relation to the concerns raised. If a referral had been made it would have been without the consent of Shaily and it is the belief of the deputy head that the referral would not have been acted upon.

3.2.9 Two friends stated that around this time they went to speak to Connexions who were based at the school regarding their concerns. As previously highlighted they were advised to go and speak to the deputy head, which they did. The author has tried to obtain records in relation to this meeting and the advice given but unfortunately has been unable to trace the person that the girls spoke to. The Connexions manager has spoken to two Youth Connexions personnel advisers who were working at the school in 2011. Neither can recall having had such a conversation with Sarah or Louise and both are quite firm that they would have reported it (to the school in the first instance) and through their line management if they felt that it was not being picked up and both are quite firm that they would not have made a suggestion to the young women to 'go pass the house and see'. The room used by connexions within the school is also used by other staff members to speak to pupils privately. Louise, however, is certain that it was a connexion worker that she spoke to regarding her concerns for Shaily.

3.2.10 In March 2012 Shaily and Sadia attended the deputy heads office advising that her brothers, Jitu and Tahmid were outside in the car and they wanted to speak to the deputy head in relation to the bullying that was going on surrounding Sadia. Shaily was asked to go and get her brother but refused to leave Sadia alone with the deputy head. Eventually Jitu and Tahmid turned up for the meeting instead of Sumon. The brothers were very angry and accusing the deputy head of not dealing with the bullying of Sadia. The author believes that the deputy head should have considered asking further questions as to why Shaily was reluctant to leave Sadia alone in the office with her whilst she went outside to get her brothers. This should have raised some concerns or at least some discussion. In October

2012 a parent attended the school and spoke to the head teacher regarding concerns raised by her daughter. These concerns were followed up with an e-mail to the school. The head contacted the deputy head and forwarded the email. The deputy head advised the head that that she was aware of the allegation but that she had already spoken to Shaily about them who had denied that they had happened and told her that her family loved her dearly. These allegations had been reported nearly a year previously and should therefore have been dealt with as a new allegation. Consideration should have been given as to why these concerns were still being raised by separate girls at the school over a long time period.

3.2.11 The parent states that she received a call from the deputy head on the Monday wishing to speak to Sarah as she wasn't at school due to being ill. During the conversation the deputy head informed her that she believed that Shaily was fabricating the allegations due to being psychologically disturbed and that her family were lovely. This conversation is denied by the deputy head and there is no record of a conversation taking place in the note keeping. As this conversation is disputed it is very difficult for the author to make judgements regarding its contents, however if it had taken place it raises concerns regarding the seriousness with which the school took the allegations and whether they had known the family for such a long time, and had helped them through the previous child protection concerns, that they felt that the abuse could not be happening within a family that they knew so well.

3.2.12 Again, although Shaily turned 18 years over the weekend, consideration should have been given to making a safeguarding referral or at least contacted the appropriate services for advice. The author feels that the parent believed that she had passed on any concerns to a 'professional body' and therefore there was no need to take any additional action herself. Safeguarding is the responsibility of everyone and advice should have been given that if she was concerned then she could have made a safeguarding referral. It is felt by the author that this is another missed opportunity.

3.2.13 In March 2013 Shaily went to the school matron as she had a sore ear, which was later identified as a serious ear infection caused by a bite whilst on holiday in Bangladeshi. Shaily was asked whether she had been to see her GP but told the matron that her name had been taken off of the GP's list. No discussion took place with Shaily as to why her name had been taken off of the list and contact was made with Sharina as per policy when a pupil is treated at school.
During the police investigation a significant amount of information was revealed from the school friends of the victim and also friends of the victim's siblings that was not actioned despite approaches made by pupils and on one occasion, the parent of one of the friends that significant information was disclosed to. There was an opportunity for the school to have shared the information with social care by referral or to at least have contacted the school for advice.
The school, however, appears to have acted in the best interests of the child at that time, who, denied that there were any issues at home. If there are any lessons to be learned in this regard is the fact that had the information been shared outside of the educational environment by either the school or friends of Shaily, alarm bells might have been raised if more than one referral had been made regarding these concerns and that the concerns had been made over a period of time and from different people/organisations.

3.2.14 It should be noted that the deputy head spoke to Shaily on several occasions regarding concerns about what was happening at home and giving Shaily an opportunity to speak to either herself or an independent person, i.e. Karma Nirvana. On all occasions Shaily reacted very robustly and aggressively towards the deputy head stating that all was fine at home, even producing a mobile phone when she was told that she wasn't allowed access to communication. The deputy head was not to know that she had only been given that phone over the weekend for her 18th birthday.

Section 4: Conclusions and Recommendation

4.1 Conclusions

4.1.1 This review looks into the tragic death on a young person at the hands of her family. The family were known to several agencies which started when the young children in the family became subject to child protection arrangements following concerns relating to their natural mother and father. During the time, when the subjects of the review were very young, a special guardianship order was given to the eldest brother and his wife in relation to the younger children in the family in 2010. This DHR review did not look at the special guardianship process in depth, only to reassure themselves that it had been carried out under the correct processes and that the children subjected to the guardianship had been consulted and were happy with the process and the ultimate decision of the courts. This was established to have been the case.

4.1.2 The panel also made the decision to extend the review to include all three of the youngest girls within the family to see if opportunities were missed in relation to them, where professionals could have gained access to the family. The panel also wanted to look at the dynamics of the family to establish whether the abuse which occurred within the family was restricted to the victim or extended to the other females within the family.

4.1.3 It appears from family reports that all was well within the household for several years but that things started to change. This might relate to the timings of Sharina having problems in conceiving which is well documented in the police reports. During the police investigation it appears that Sharina went to considerable lengths to conceive to the point of using the other male members of the household for that purpose.

4.1.4 There is no significant information held by the Police or GP practice concerning the core family members that identified any indication of abuse, neglect or domestic abuse against Shaily, Roslin or Sadia.

4.1.5 Five of the family had attended the same school and the family circumstances and background were well known by the school. The school had a considerable amount of contact with the family since 2008 when Sumon, as the eldest brother, contacted them concerned regarding the care the younger children were getting at home. At this time the head and deputy head held a meeting at the school with Sumon and passed on the phone number of Children's Services and advised them to make a referral as a matter of urgency. It appears that the deputy head took an interest in the children and gave a considerable amount of support to the family during this time. This may have had an impact on the decision making process at a later stage by the school as they felt that they had' saved the

children' from their natural mother and helped them go into the care of their brother and sister in law.

4.1.6 The school were aware of allegations of bullying against Sadia throughout a large amount of her time at the school. It appears that the school followed their policies regarding bullying and tried to deal with each incident as it arose. The policy advices consulting with family members to try and resolve issues which took place on several occasions. The brother and sister in law attended the school when requested to in relation to hygiene problems leading to bullying and also indications by Sadia of unhappiness and thoughts of suicide.

4.1.7 It is felt that due to this contact with the family and the request for their attendance at school this might have placed barriers up between Sadia and Shaily as they may have believed that anything they said would get back to the family and result in further punishments. Consideration could have been made for other members of staff to speak to Shaily over the friend's allegations to keep them sterile from the person dealing with the family over bullying. At the time School had very limited DSP's which would have made this difficult but now this has been increased this may be a consideration for the future.

4.1.8 It is documented that over the 2 year period when Shaily returned to sixth form there were concerns raised by different pupils and a parent on three separate occasions. The school appears to have tried their best to speak to Shaily regarding these allegations but these concerns were received with anger and resentment by her. The deputy head tried to speak to Shaily on numerous occasions but received the same response.

4.1.9 It is the belief of the author that there were several missed opportunities in relation to the allegation made concerning Shaily which should have been acted upon. Whether the outcome would have been any different is debatable, as it is unknown what responses would have been made regarding the information, as at that time there was no further information from other agencies.

4.1.10 There is significant information received from the police during the investigation that the other members of the households were believed to be initially compliant in the abuse and then more instrumental in carrying out the abuse. This might be self-preservation by those family members that if the abuse was being aimed at Shaily then they would be safe. It is not clear to the panel why the abuse was not reported outside the family. It appears that the family were aware of the route for protection as it was Shaily herself who contacted the police in 2008 to report that she and her sisters were being abused by their mother which started the care process. The schools also had a significant amount of involvement at this time and worked closely with the eldest brother to help resolve the issues. The Hertfordshire County Community Safety Unit has a varied program in relation to the ethnic communities within Hertfordshire. The County Community Safety Unit (CCSU) is an integrated Hertfordshire County Council (HCC) and Hertfordshire Constabulary Partnership Unit that was formed in June 2010. The unit provides additional support and expertise to reduce crime and fear of crime, anti-social behaviour, substance misuse and re-offending rates whilst increasing public safety and confidence under four priority work streams:

Offender Management
Drugs Strategy
Safer Communities including the Alcohol Strategy and Anti-Social Behaviour
Vulnerable People including Domestic Abuse (including HBA/FM/FGM), Home Safety and Hate Crime

It was noted throughout the review that different agencies had different spellings for each family member and that these varied through the time of any interaction with them. The variation not only occurred throughout agencies but also differed within the same agency throughout their involvement with the family. It is good practice for all names to be taken down correctly by agencies and for spelling to be clarified.

Was the homicide either predictable or preventable?

4.1.11 The author believes that there were several missed opportunities during agencies interaction with Shaily however she does not feel that the death of Shaily was predictable or preventable in this case.

4.2 Recommendations

4.2.1 Hertfordshire constabulary

On a number of occasions, the names of the victim and suspects have been misspelt within the police documents/records. Care needs to be exercised by officers ensuring the accuracy of the names for record keeping in accordance with both Data Protection and to ensure the integrity of record keeping. This is further supported by the need to ensure accurate cross referring to partnership agencies as misspellings can lead to inaccuracies in those others' records.

Recommendation 1.

Officers should be encouraged to check and verify reliable identity documents, such as passports, birth certificates and driving licences in order to confirm and verify identification.

Although there will be occasions when officers are unable to effect powers of entry, these occasions are relatively few and far between and in accordance with the Operation Oak, domestic abuse policy, officers should be reminded of the need to establish, wherever possible, all occupiers of the premises in particular when it is a multi-occupied household. This applies in particular to households where there are children present irrespective of any involvement with the domestic related incident as safeguarding should remain a priority.

Recommendation 2.
Officers are to be reminded of the need to establish the identity all occupiers of premises at the time of attending all domestic related incidents. This should be re-enforced under the Operation Oak dynamic operational policy. This is an agency specific recommendation.

When bail is granted by the police following charges for a recordable offence, suitable enquiries should be made of the intended bail address of the subject to ensure that there is no potential safeguarding conflict. Officers should address this by ensuring that a local intelligence item is created that can be referenced at both a local and PND enquiry level. If there are children present at the address a record should also be created on the relevant CAIU database.

Recommendation 3.

Appropriate cross referenced records for bail should be created when persons are granted bail to a separate address where other occupiers include children or where there is a potential safeguarding conflict.

4.2.2 GP practice

The records for all three girls demonstrate that they were seen by a small group of GP's at the surgery. It is clear that the practice was able to maintain consistent staffing during that period of time. The family were known by the GP practice to have been removed from the Child Protection Register in 2001 which is recorded in the notes of Sadia. There is an absence of observations recorded about the general appearance of the girls, their relationship with their mother and other family members or who accompanied the child to the doctor.

Recommendation 1.
The Clinical Commissioning Group are requested to advice GP's that during consultations they record who a child is accompanied by.

Recommendation 2
The Clinical Commissioning Group are requested to advice GP's that in cases where children are known to be or have been in need of protection it is good practice that the general appearance of the child/young person should be recorded in every consultation.

When presenting for an appointment the surgery is to see that patient as part of a family and to consider relationships in the home environment, especially where there have been previous child protection concerns. When questions are asked all verbal and non-verbal responses are to be documented as part of every consultation.

Recommendation 3.
The Clinical Commissioning Group are requested to advice GP's that whilst carrying out patient interviews to record social relationships as well as the presenting medical complaint especially in those families where there has been concerns regarding the family dynamics.

4.2.3 School

Schools are often at the forefront of safeguarding but do not receive Child Protection Supervision or an opportunity to reflect and discuss individual cases. Staff can become 'fixed' in the way that they view the family and see it as the normal pattern of behaviour.

Recommendation 1
School should consider available options in providing Child Protection supervision to the DSP and deputies on a regular basis.

The School has recognised that record keeping needs to improve and have purchased the Child Protection On-line Monitoring System (CPOMS). This is a secure system that is accessible to all staff at pre-determined levels. It can be used to record a wide range of pastoral and welfare information including: incident reporting, bullying notes, safeguarding and child protection. It allows schools to track referrals to external agencies and is designed to save time and reduce administrative time. The system was installed in April 2016.

Recommendation 2
School to undertake a records audit following the installation of CPOMS.

4.2.4 Additional recommendations

Recommendation 1 – Hertfordshire Schools
Advice to be issued to all Hertfordshire school regarding the Consultation line that is available via Hertfordshire County Council and the need to use this line to explore cases, which fall outside safeguarding, giving rise to concerns and agree a plan.

Recommendation 2 – School
The school needs to consider how the DSP and deputies can be given protected time during the school day to deal with issues and concerns within the school.

Recommendation 3 – School
The school should look at ways of implementing a mentoring system for DSP's and their deputies within the school to include 1-1 conversations.

Recommendations 4 – Hertfordshire Safeguarding Children's Board
The Hertfordshire Children's Board should consider carrying out a S11 audit within educational premises across Hertfordshire in relation to their compliance to safeguarding

children.

The school also provide a wide range of support services and covers a wide range of subjects during assemblies. Some of the subjects were delivered by outside speakers; including The Samaritans and members of the Bushey Neighbourhood Team (Police). In the academic year 2011-2012 themes covered included: drugs, peer pressure, hate crime, school values and friendship. In 2012-2013 the themes included: feeling alone, diversity, supporting others and eating disorders. The pupils attend assemblies in year groups as well as in their individual Houses. The 6th form have weekly assembly and the year assembly is 1:5 weeks.

Recommendation 5 – School
The school to review and update their 'information and awareness' campaigns to make sure that safeguarding is highlighted and that safeguarding is every one's responsibility and the importance of making referrals to the appropriate agencies if concerned and that the school is not classed as the only responsible agency.

Recommendation 6 – Hertfordshire County Council (Connexions)
Connexions to review their Safeguarding policies and to make sure that all workers are up to date on their safeguarding training to including adult safeguarding.

Recommendation 7 – Hertfordshire Safeguarding Adults Board
To consider carrying out an audit within schools that have sixth forms to reassure themselves as a board that all educational staff are aware of adult safeguarding procedures and are aware of what to do when concerns are raised about an adult (18yrs) within their school.

Recommendation 8 – Hertfordshire Community Safety Unit
To review and evaluate domestic abuse advice which is specifically aimed at minority groups /hard to reach communities within Hertfordshire to make sure that the right audiences are being targeted and are aware of what domestic abuse within the family is and how to make a referral.

Recommendation 9 – All Agencies

Staff across all agencies are to be encouraged to gain the correct spelling and dates of births and to check consistency across records and paperwork.

4.2.5 Judges summing up comments

When Shaily died she was 19 years old, just a few days short of her 20th birthday. She died in her own home in circumstances which none of you have had the humanity and common decency to explain. I am quite sure that all of you know the true circumstances in which she died. The steadfast refusal of all of you to reveal those circumstances is a shocking, selfish and disgraceful perversion of family loyalty which dishonours the memory of your dead sister.

Appendix A- Key events timeline

Date	Source Document	Relevant event, significant details of contact	Action	Comment
05.01.11	Children Services	Special Guardianship Order granted	Children placed in the care of Sumon and Sharina	
10.07.11	Hertfordshire Police	Non crime Domestic Violence incident between Sumon and Jahid	Incident recorded but no further action required	
08.09.11	Email	Sumon sends email to head teacher informing him that Sadia is still in Bangladesh and will return on 15.09.11 Enquired whether Shaily had obtained a place in the 6th form.	Head teacher responds that the absence will be recorded as unauthorised as had been given leave of absence 15-22 July to travel to Bangladesh. Advised to contact Head of 6th form re Shaily.	
16.09.11	School record	Two boys made comments to Sadia and asked if she had got married? Continued to laugh and make jokes at her expense. Absent from school on the Monday but seen by deputy head on return. Sadia cagey	Reported by Maths teacher Moved to different Maths class. Boys given detention	History of bullying Sadia moved to a different class. Boys spoken

		about time spent in Bangladesh. Asked about home and Sadia reported that they were fine.		to.
21.09.11	School record	Two girls in Yr. 12 disclose to deputy head that they are worried about Shaily. They have been unable to contact her. Also said that Shaily talked about being force fed and hit by her brother.	Deputy head contacted head of 6th form. Advised that Shaily was on authorised leave and would start on the 23.09.11. Shaily to be seen by deputy head on her return.	
23.09.11	School record	Shaily reassured deputy head that the holiday was planned and that her friends had no reason to be worried. Shaily was adamant that Sumon and Sharina were very kind and she was well looked after. Shaily was dismissive about the deputy heads concerns and said that she chose not to contact her school friends and she was not stopped from contacting them.		Shaily asked directly about home life and if all was well?
29.09.11	School record	Sumon met with deputy head. Sumon annoyed that she		Multi –agency Statutory guidance for

		had spoken with Shaily about her late start to Yr. 12 and that she seemed to believe that Shaily and Sadia may have got married in Bangladesh		dealing with forced marriages, first published in March 2013 and last updated in March 2016.
Oct 11	School record	The two Yr. 12 girls asked for an update from the deputy head about the concerns that they raised. Advised that Shaily said that she never said this and are lying.	Deputy head spoke with Shaily again but she refused to speak and became very angry insisting that she should be left alone	
09.03.12 reported on the 12.03.1212	School record	Sadia very unhappy and had asked a member of her form 'what would you do if all your life you had been bullied and no one liked you?' Sadia said that people pretend to like her and she had thought about killing herself and jumping off the science block. She didn't stop crying all day and on more than one occasion told two girls that she was so sad and unhappy and that she felt like killing herself There was also an altercation between Sadia and another	Shaily and Sadia were absent from school on the 12.03.12. The deputy head called home and various contact numbers for the family. A message was left for Sharina.	

		girl when she asked if Sadia was all right, Sadia stuck her fingers up at her and they ended up fighting.		
15.03.12	School records	Sadia and Shaily return to school Shaily requests a meeting between the school and Sumon and Sharina to discuss bullying.	Meeting arranged for the 16.03.12 at 3pm. Sadia completes a student statement about the incident on the 9.03.12	
16.03.12	School records	Shaily and Sadia attend the deputy head's office at 3pm and reported that their brother was outside in the car park. Shaily was asked to go and get her brother but refused to leave Sadia alone with the deputy head. Eventually Jahid and Tahmid turned up for the meeting instead of Sumon. The brothers were very angry and accusing the deputy head of not dealing with the bullying of Sadia.	The brothers were asked to leave as they refused to listen to concerns about Sadia's mental health. They were asked to get Sumon to make contact, as he was who the deputy head was expecting. They said that he was abroad.	Further explanation of why Shaily was reluctant to leave Sadia alone in the office with the deputy head should have happened
21.03.12	School	Deputy head	Advised	Followed up

	records	contacted Sharina and she agreed to come to the school to discuss Sadia. Sharina does not believe that Sadia is suicidal but she wants the bullying to stop.	Sharina to take Sadia to her GP, as she had wanted to end her life. Advised that Sadia must report incidents to the teachers so that they can investigate	evidence of discussion at weekly meeting, bulletins etc.
12.10.12	School record E-mail from Mrs Mortimer	Julie's mum came into school late Friday afternoon to speak to the head teacher about concerns regarding Shaily. concerns were followed up in an e-mail later that evening. The concerns were: Shaily is force-fed, is only allowed to go to the toilet when given permission, is not allowed to do homework since 'education is not for women' In the past she has also been made to lick the toilet. She is not allowed a mobile phone. Shaily appears to be of the opinion that her brother and sister-	The head teacher sent an email to DSP who responded saying that when Shaily is asked she denies that anything is wrong. Will talk in person on Monday. The parent advised that she had contacted Karma Nirvana who would be willing to work with social services and the police	The head teacher didn't advise her make a referral to Social Services, which they could have done. Decision made to discuss further on Monday.

		in-law present as very charming and convincing, denying the true situation.	and they would talk to Shaily on the phone at school. SS would not institute child protection because of Shaily's age	Shaily had her 18th birthday over the weekend
15.10.12	School record	Deputy head met with Shaily to discuss her disclosure to Julie. Shaily denied ever saying these things and that Julie was lying, the deputy head said that she didn't believe that Julie was lying and that she felt that things were not right at home. Shaily became angry and started shouting 'how dare you', 'my brother loves me' 'you above all people know what	Advised Shaily that she would like her to speak to someone from outside the school if she didn't want to speak to the teachers. Even though she was 18 there were people that could be contacted and she didn't need to	Shaily is now an adult, she refused to give consent for any referrals to be made to other organisations. Shaily did not talk to the

		good people they are'. When asked about a phone Shaily pulled a phone from her pocket 'look I've got no phone have I? I do but I just choose not to use it for people at school'. She became angry and aggressive and said she had nothing to say to anyone because everything was fine and that it was a waste of time to call anyone. Shaily stormed off	carry on living at home if she was unhappy. The deputy head spoke with Head of 6th form who attempted to speak with Shaily but she continued to deny anything was wrong.	deputy head or even look at her when they passed one another in the corridor or playground.
09.01.13	School record	Shaily did not return to school straight after Christmas	Telephone call to home, Sharina reported that she had flu.	
10.01.13	School record	Shaily returned to school and was seen by both Head of 6th form and deputy head separately. Shaily was adamant that she had been very ill but was fine and everything was good at home. She was angry that she		Good practice to follow up absence and give Shaily an opportunity to talk to the deputy head on a one to one basis.

		was being questioned again		
09.03.13	School record	Shaily went to see the school matron as she had sore ears. Shaily was asked if she had been to see her GP but was told that her name had been removed from the list.	Ear cleaned and cream applied Matron contacted Salma who said that she had made an appointment with the GP for next week and that Shaily was constantly picking at her ears.	No discussion with Sharina as to why Shaily had been removed from the GP list.
27.06.13	School record	Sadia seen by deputy head as reported to be looking very low in mood by her maths teacher. Sadia stated that she was fine	Advised Sadia to come back tomorrow or any day if she does need to tell the deputy head anything.	Attending school for exams only
End of June 2013				Sadia completed Y11 (GCSEs) and Shaily Y13 (A Levels).
13.02.14	Hertfordshire Police	Non crime Domestic incident between brother and sister regarding sister still being asleep at 4pm.	Incident between Rafsan and Tahmid.	No further Police action required.

Appendix B
Role of Designated Senior Person with safeguarding lead within Hertfordshire.

Role of the Designated Safeguarding Lead
Governing bodies and proprietors should ensure that the school or college designates an appropriate senior member of staff to take lead responsibility for child protection. This person should have the status and authority within the school to carry out the duties of the post including committing resources and, where appropriate, supporting and directing other staff.
The broad areas of responsibility for the designated safeguarding lead are:

Managing Referrals
Refer all cases of suspected abuse to the local authority children's social care and: The designated officer(s) for child protection concerns (all cases which concern a staff member), Disclosure and Barring Service (cases where a person is dismissed or left due to risk/harm to a child); and/or Police (cases where a crime may have been committed).
Liaise with the head teacher or principal to inform him or her of issues especially ongoing enquiries under section 47 of the Children Act 1989 and police investigations.
Act as a source of support, advice and expertise to staff on matters of safety and safeguarding and when deciding whether to make a referral by liaising with relevant agencies.
Training
The designated safeguarding lead should receive appropriate training carried out every two years in order to: Understand the assessment process for providing early help and intervention, for example through locally agreed common and shared assessment processes such as early help assessments.
Have a working knowledge of how local authorities conduct a child protection case conference and a child protection review conference and be able to attend and contribute to these effectively when required to do so.
Ensure every member of staff has access to and understands the school child protection policy especially new or part time staff who may work with different educational establishments.
Ensure each member of staff has access to and understands the schools or college's child protection policy and procedures, especially new and part time staff.
Be alert to the specific needs of children in need, those with special educational needs and young carers.
Be able to keep detailed, accurate, secure written records of concerns and referrals.
Obtain access to resources and attend any relevant or refresher training courses.
Raising Awareness
The designated safeguarding lead should ensure the school or college's policies are known and used appropriately: Ensure the school or college's child protection policy is reviewed annually and the procedures and implementation are updated and reviewed regularly, and work with governing bodies or proprietors regarding this.
Ensure the child protection policy is available publicly and parents are aware of the fact that referrals about suspected abuse or neglect may be made and the role of the school or college in this.

Link with the local LSCB to make sure staff are aware of training opportunities and the latest local policies on safeguarding.
Where children leave the school or college ensure their child protection file is transferred to the new school or college as soon as possible. This should be transferred separately from the main pupil file, ensuring secure transit and confirmation of receipt should be obtained.

Appendix C

CV Independent Chair Tim Beach

Suffolk Constabulary November 1979 – November 2009, police officer in various roles outlined below, including Area Commander, Ipswich (Chief Superintendent) and Detective Superintendent with responsibility for all areas of Public Protection which included Safeguarding Children, Vulnerable Adults, Hate Crime and Domestic Abuse Services.
I was a nationally accredited Senior Investigating Officer (SIO) for Major Crime until my retirement and a Firearms Commander for a number of years.
Independent Chair of Safeguarding Children Board, Barnet, London (August 2009 to November 2013)
Chair Domestic Homicide Review (DHR) Cambridge shire County Council/ Constabulary 2009/10
Overview Report Writer, DHR East Hertfordshire (2012/13)
Overview Report Writer, DHR Watford BC (2013/14)
Member of London Safeguarding Children Board, (representing Chairs 2010 to October 2013)
Chair of London Independent Safeguarding Chairs Group, (2010 to October 2013)
Independent Serious Case Review Report Writer for East of England for Multi Agency Public Protection Arrangements (MAPPA) 2010.
Local Government Association Peer Review - Cornwall Children Services – November 2011 and Cambridge shire October 2013
Review of MAPPA arrangements - State of Jersey – 2011/12
MAPPA Serious Case Review – Jersey - July 2014
Independent Investigations with regard to complaints under Children Act 1989/2004 and Adult Services (Suffolk County Council - 2010 to 2014)
Fostering Panel (National Fostering Agency - 2011 to present)
Vice Chair Ipswich Umbrella Trust (Homeless and Vulnerable Persons Charity – 2007 to 2015)
Chair Suffolk Safeguarding Adults Board – September 2014 to July 2016
Review of Child Protection arrangements and processes,
Suffolk Constabulary - November/ December 2014

CV Independent Report writer Elizabeth Hanlon

During my employment with Hertfordshire Constabulary I was a part of the Hertfordshire Major Investigation Department which investigated murders and other complex crimes within Hertfordshire. I was the Senior Investigating Officer (SIO) for numerous complex and sensitive investigations including domestic homicides.
I have been the Police lead for Hertfordshire as a part of the Serious Case Review Board and the Police representative on all Partnership Case Review's, Domestic Homicide Review's and Multi Agency Serious Incident Review's that have taken place both within and outside Hertfordshire. I had the responsibility of implementing the Domestic Homicide Review process within Hertfordshire and briefing all the Chief Executives on the process and responsibilities. I have successfully completed training in relation to conducting DHR's and writing the overview reports.

am currently employed as the Independent chair for the Hertfordshire Adult Safeguarding Board
I am chairing and report writing two Domestic Homicide Reviews which occurred in Maldon and Clacton, Essex. I am also chairing a further Domestic Homicide Review in Epping Forest, Essex.
BSC (Hons) Police and Police studies
Detective Constable Investigation Course
Detective Sergeant Investigation Course
ABE Interview Course
Interview Investigation Course
Child Death Course
Senior Investigators Course
Senior Investigators Course for the professional standards department within Hertfordshire
Media Course
Review Officers Course
SCIE reviews

Appendix D
Glossary

CSP	Community Safety Partnership
FLO	Family Liaison Officer
SIO	Senior Investigating Officer
IMR	Internal Management Reviews
MAPPA	Multi Agency Public Protection Agency's
CQC	Care Qualify Commission
SGO	Special Guardianship Order
GP's	General Practitioners
RAMP	Risk Assessment Management Plan
DV	Domestic Violence
HCSC	Hertfordshire Children's Social Care
DSP	Designated Senior Person
CSP	Child Sexual Exploitation
CPOMS	Child Protection On-line Management System
GBH	Grievous Bodily Harm

Appendix E
School assembly themes

AUTUMN		SPRING		SUMMER	
Changes	2011-12	**Our school values**	2011-12	**Voice**	2011-12
	2011-12	**Jealousy**	2011-12	**Fairtrade**	2011-12
Thinking of Others	2011-12	**Talents**	2011-12	**Local History**	2011-12
Drugs	2011-12	**Persecution**	2011-12	**Staying Positive**	2011-12
School Council	2011-12	**Trust**	2011-12	**Diamond Jubilee**	2011-12
Hate Crime	2011-12	**Peer pressure**	2011-12	**Determination**	2011-12
Leadership	2011-12	**Chinese New Year**	2011-12	**The Titanic**	2011-12
Veganism	2011-12	**Making mistakes**	2011-12	**Blood**	2011-12
Poppies	2011-12	**Cancer**	2011-12	**The Olympics**	2011-12
Non-Uniform Day	2011-12	**Science & Engineering**	2011-12	**Victims**	2011-12
Doing the Right Thing	2011-12	**The Earth**	2011-12	**Memory**	2011-12
World Aids Day	2011-12	**Resurrection**	2011-12	**Population**	2011-12
Friendship	2011-12			**Goodbyes**	2011-12
The Media	2011-12				
Generosity	2011-12				
Aiming High	2012-13	**Watch What You Eat**	2012-13	**Mental Health**	2012-13
Litter	2012-13	**Lifeboats**	2012-13	**Duty**	2012-13
Challenges	2012-13	**Crime**	2012-13	**Museums**	2012-13
Old Age	2012-13	**Standing Out From The Crowd**	2012-13	**The Red Cross**	2012-13
Black History Month	2012-13	**Mothers**	2012-13	**Passover**	2012-13
Making A Difference	2012-13	**Eating Disorders**	2012-13	**Walk To School Week**	2012-13
Personal Safety	2012-13	**Supporting Others**	2012-13	**The School Environment**	2012-13

Youth Work	2012-13
Climate Change	2012-13
Enterprise	2012-13
Making A Stand	2012-13
Learning For Life	2012-13
Anger	2012-13
Being Considerate	2012-13
Light In The Darkness	2012-13

Self Denial	2012-13
Consumerism	2012-13
Brain Power	2012-13
Diversity	2012-13
World Health Day	2012-13
Feeling Alone	2012-13

Child Labour	2012-13
Difficulties	2012-13
Drug Abuse	2012-13
Sports Relief	2012-13
Holidays	2012-13

New beginnings	2013-14
Looking ahead	2013-14
Making amends	2013-14
Languages	2013-14
Black History Month	2013-14
Reading	2013-14
Health	2013-14
Volunteering	2013-14
Remembrance	2013-14
Embracing Failure	2013-14
Courage	2013-14
Disability	2013-14
Rights	2013-14
The Christmas spirit	2013-14

Resolutions	2013-14
Relationships	2013-14
Faith	2013-14
Holocaust	2013-14
Reviewing	2013-14
Charity	2013-14
Sacrifice	2013-14
Caring	2013-14
Knowledge	2013-14
New life	2013-14
Time to Talk	2013-14

Spring	2013-14
Depression	2013-14
Turn Off The TV	2013-14
RSPCA	2013-14
Revision	2013-14
Community	2013-14
Walking	2013-14
Being active	2013-14
Lift Sharing	2013-14
Motor Nuerone Disease	2013-14
Communicating	2013-14
Activities Week	2013-14
Looking back	2013-14
Moving On	2013-14