DOMESTIC HOMICIDE REVIEW

Hammersmith & Fulham Community Safety Partnership

Report into the death of Senai - May 2020
Executive summary

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February 2022

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Domestic Homicide Review into the death of Senai[1]

Preface

The Independent Chair and the Domestic Homicide Review Panel members offer their deepest sympathy to all who have been affected by the death of Senai, and thank them, together with the others who have contributed to the deliberations of the Review, for their participation, generosity of spirit and patience.

The Review Chair thanks the Panel for their enthusiastic engagement with this process and the Individual Management Review authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies.

1. Introduction

1.1 Domestic Homicide Reviews (DHRs) came into force in April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). 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) A person to whom he was related or with whom he was or had been in an intimate personal relationship or

(b) A member of the same household as himself;

with a view to identifying the lessons to be learnt from the death.

The report uses the cross-Government definition of domestic abuse as issued in March 2013. At the time of writing this report, with some minor amendments, this was about to become a statutory definition.

1.2 The purpose of a Domestic Homicide Review (DHR) is set out in the statutory guidance but can be summarised as trying to establish what lessons can be learned from the domestic homicide to try to prevent domestic violence and homicide and to improve service responses.

1.3. In May 2020, Hammersmith & Fulham Community Safety Partnership were notified of the death of a male resident (Senai) allegedly killed by his brother (Amaris[2]).

1.4. The decision to undertake a DHR was made by Hammersmith & Fulham Community Safety Partnership in May 2020 in consultation with local partners and specialists. The Home Office was duly informed a few days later. An independent Chair was appointed in August 2020 and the Panel met for the first time in August 2020 where Individual Management Reviews (IMRs) were commissioned, and agencies advised to implement any early learning without delay. These actions ran alongside the ongoing criminal investigation and

[1] Not his real name
[2] Not his real name

proceedings. Three further meetings of the Panel were subsequently held at which point the process was suspended until criminal proceedings had concluded.

1.5. In March 2021, Amaris was acquitted of all charges. In light of the only incident of abuse being the fatal one which a jury had accepted was an accident, the Community Safety Partnership (CSP) then sought guidance from the Home Office as to whether a DHR was still required.

1.6. In June 2021, the Community Safety Partnership was informed by the Home Office that a proportionate DHR would be required. Unfortunately, this coincided with a period of unavailability on the part of key individuals, and it was not until the end of September that the Panel could meet again.

1.7. The process concluded in February 2022.

2. Overview

2.1. Persons involved in this DHR

Pseudonym used	**Who**	**Age at the time of the incident**	**Ethnicity**
Senai	Victim	33	Eritrean
Amaris	Brother of victim	35	Eritrean
Adult 1	Cousin / Flatmate of Amaris	N/K	Eritrean
Adult 2	Cousin / Flatmate of Aramis	N/K	Eritrean
Adult 3	Unknown male present in the flat at the time of the incident	N/K	N/K
Adult 4	Unknown male present in the flat at the time of the incident	N/K	N/K
Janet	Former partner of Senai and mother of his two children	33	White British

2.2. Amaris also had child from a former partner. None of the brothers' children were present during the fatal event.

2.3. Background context

2.3.1. Amaris and two other adult men (adult 1 and adult 2) all lived together in a one-bedroom flat (address 1). His brother lived separately but visited him regularly. Both Amaris and Senai had children by previous partners and both brothers suffered from mental health conditions. At the time of the incident, Amaris was on antipsychotic medication which was administered by a monthly depot injection. He received his last injection two weeks before the incident.

2.3.2. Adult 1 was present at the flat when the stabbing took place, and he witnessed the incident. Two other men were also present at the time of the stabbing (Adult 3 and Adult 4). Both of these men fled the scene before the police arrived and declined to co-operate when approached for a statement.

2.3.3. According to Adult 1, the two brothers usually got on well. They both drank alcohol and smoked cannabis, but toxicology tests would rule out any consumption of either drug by Amaris on the day of the incident. Senai had not consumed alcohol but had consumed cannabis which may possibly have still been influencing him at the time of the incident.

2.3.4. The Panel wish to make it clear that even if drugs had been consumed, these are not a causal factor for domestic abuse.

2.4. Summary of the incident

2.4.1. Adult 1 told the police that he had returned home from work to find Adult 2 already there, but asleep. Adult 2 woke at around 3 pm before leaving for work.

2.4.2. Adult 1 went to sleep but later awoke to hear an argument between the two brothers. Initially, he thought the argument was '*normal'*, but he stated it quickly became much worse and both men were very angry. Adults 3 & 4 were also present.

2.4.3. Adult 1 thought that the brothers were arguing about a girl but couldn't be sure. He said he thought Senai appeared to be the more aggressive of the two. Adult 1 was unclear how Amaris came to have the knife but was able to identify it as a kitchen knife that was in regular use in the flat. He described how Amaris was saying to Senai, '*get out of my house'* to which his brother repeatedly replied*, 'come and make me'*.

2.4.4. It seems at this point, Amaris grabbed the knife and attempted to stab Senai 2-3 times. Senai immediately said, '*I am leaving, I am leaving'* and left the flat. Adult 3 and Adult 4 ran out of the flat. Amaris followed them.

2.4.5. Adult 1 went to collect his own jacket when there was a knock at the front door. He assumed that Amaris must have locked himself out of the flat when he followed Senai out. However, when he opened the door, he saw Senai lying on the ground with Amaris kneeling over him, distressed and crying. He was on the phone to the Ambulance Service and followed their instructions until they arrived. The 999 call was made at approximately 19.45.

2.4.6. The Ambulance Service contacted the police and on arrival, they were met by Amaris on the ground floor, coming out of the lift. As he approached the police, Amaris held out his hands in a stacked cuff position and said, '*I just stabbed my brother, I did it out of anger*'. This interaction was captured on the police officer's body worn camera.

2.4.7. Other police officers who arrived at the scene made their way to the 5th floor of the building, where they found Senai unconscious on the ground outside address 1. The Ambulance Service arrived shortly afterwards but despite their best efforts, they were unable to save Senai.

2.4.8. This incident took place approximately six weeks after the first lockdown, which resulted from the Covid 19 pandemic, began.

2.4.9. Amaris was arrested and charged with murder to which he pleaded not guilty. In March 2021, he was acquitted of all charges by a jury.

3. Methodology

3.1. Early enquiries with agencies soon established that no agency held any history of domestic abuse disclosures or professional suspicion of domestic abuse between the two brothers. The only incident was the fatal one.

3.2. Agencies which had prior contact with the subjects of the review were asked to complete a report detailing their involvement, along with any recommendations for changing future policy and practice to learn from the tragedy and to improve the Partnerships response to domestic abuse. These reports were scrutinised by the DHR Panel, and their recommendations are now being taken forward.

3.3. The table below shows which agencies had contact with either Senai or Amaris.

	Had involvement with Senai	**Had involvement with Amaris**	**Completed an IMR for the DHR Panel[3]**
West London NHS Trust	Yes	Yes	Yes
London Borough of Hammersmith & Fulham Family Services (CSC)	Yes	No	Yes
Victim Support	Yes	No	Yes
Metropolitan Police	Yes	Yes	Yes
London Borough of Hammersmith & Fulham Housing Management	Yes	No	No
The Guinness Partnership	No	Yes	Yes
Imperial College Healthcare NHS Trust	Yes	No	Yes
Mind	Yes	No	No
Mapesbury Medical Group	No	Yes	No
H&F Adult Social Care	Yes	Yes	No
London Ambulance Service	No	Yes	No
Cassidy Medical Centre	Yes	No	No

[3] In some instances, contact was insignificant and not relevant to the circumstances of the death, so the contacts and circumstances were shared but a full IMR with analysis was not requested.

3.4. However, all Panel members were asked to complete a 'snapshot' report. This asked a range of questions about their agencies response to domestic abuse such as if they had a recently reviewed domestic abuse policy, what percentage of their staff had received domestic abuse training in the past two years, what local domestic abuse partnerships they were involved in and so on. A copy of this questionnaire can be found at appendix A.

3.5. This report is an anthology of information and facts gathered from:

- The reports detailed above
- The Police Senior Investigating Officer
- The criminal trial
- DHR Panel discussions

4. Domestic Homicide Review Panel

The DHR Panel was comprised of the following:

Name	**Job Title**	**Organisation**
Davina James-Hanman	Chair & report author	Independent
Annabel Moores	Victim Programmes Co-ordinator, then Ending Violence Against Women & Girls Lead	London Borough of Hammersmith & Fulham
Benn Keaveney	CEO	MIND
Carol Tye-Coleman	Quality Assurance Manager, Safeguarding, Reviewing and Quality Assurance Team	London Borough of Hammersmith & Fulham
Chantal Foster	NW Area Manager	London Community Rehabilitation Company
Felicity Charles & Beth Morgan	Community Safety Manager	London Borough of Hammersmith & Fulham
Fola Agboola	Designated Nurse Safeguarding Children (Hammersmith and Fulham)	North West London Clinical Commissioning Group
Hannah Candee	DHR Team Manager	Standing Together Against Domestic Abuse
Helen Rendell	Helen Rendell, Specialist Crime Review Group (SCRG), Metropolitan Police	Helen Rendell, Specialist Crime Review Group (SCRG), Metropolitan Police
Helene Berhane	DHR Support Officer and Expert Adviser on Eritrean Issues	Standing Together Against Domestic Abuse
Jo Baty	Assistant Director Mental Health, Learning Disability and Provided Services	London Borough of Hammersmith & Fulham

Lauren Tucker	Tenancy Enforcement Team Manger	The Guinness Partnership
Len Ramchelawon	Patient Safety Adviser	West London NHS Trust
Linda Stradins	Service Manager	West London NHS Trust
Lucy Bird	Graduate	London Borough of Hammersmith & Fulham
Margie O'Connell	Deputy Director of Quality	North West London Collaboration of Clinical Commissioning Groups)
Nicci Wotton	Head of Safeguarding,	Imperial College Healthcare NHS Trust
Peter Hannon	Head of Neighbourhood Services	London Borough of Hammersmith & Fulham
Rachel Nicholas	Head of Service - London Victim Witness Service and Domestic Abuse Services	Victim Support
Prashant Patel	G.P.	Mapesbury Medical Group
Shabana Kausar	Violence Against Women and Girls Strategic Lead	London Boroughs of, Hammersmith and Fulham, Westminster and Kensington and Chelsea
Shaun Hare	Interim Head of Operations for Community and Recovery Mental Health Service	West London NHS Trust
Shazia Deen	Safeguarding Lead, Adult Social Care	London Borough of Hammersmith & Fulham
Simone Melia	Head of Homelessness Prevention	London Borough of Hammersmith & Fulham
Victor Nene Linda Katte Joy Maguire	Adult Safeguarding & Clinical Quality Manager	North West London Collaboration of Clinical Commissioning Groups

4.1 Wayne Jolly, Senior Investigating Officer, Metropolitan Police attended the first Panel meeting.

4.2. Expert advice was provided on domestic abuse (Standing Together), mental health (Mind) and Eritrean culture / customs (Standing Together)

5. Independence

5.1. The author of this report, Davina James-Hanman, is independent of all agencies involved and had no prior contact with any family members. She is an experienced DHR

Chair and is also nationally recognised as an expert in domestic violence having been active in this area of work for over three decades.

5.1.2. This has included a variety of roles at local, regional, national, and international levels including advocate, campaigner, conference organiser, crisis counsellor, policy officer, project manager, refuge worker, researcher, strategy writer, trainer and writer. She has published innumerable articles and three book chapters and formerly acted as the Department of Health policy lead on domestic violence (2002-03). She was also a Lay Inspector for HM Crown Prosecution Service Inspectorate (2005-10). From 2000-08, she had responsibility for developing and implementing the first London Domestic Violence Strategy for the Mayor of London and acted as the Specialist Adviser to the Home Affairs Select Committee Inquiry into domestic violence, forced marriage and 'honour' based violence (2007-08). She is an Expert Adviser to NICE, a Special Adviser to Women in Prison and a Trustee of the Centre for Women's Justice.

5.2 All Panel members and Individual Management Review authors were independent of any direct contact with the subjects of this DHR and nor were they the immediate line managers of anyone who had had direct contact.

5.3. One of the agencies who attended was Standing Together Against Domestic Abuse. The Panel Member did not have any direct contact with any of the subjects of this Review. However, she did prepare the papers for the Multi-Agency Risk Assessment Conference (MARAC) meeting where the case involving the victim and his former partner was discussed as the usual co-ordinator was on annual leave. This MARAC meeting was not an event which directly related to the death.

6. Terms of Reference and Scope

6.1. The full terms of reference can be found in the main report. The key lines of inquiry were as follows:

For anyone with relevant information:

- What do we know about the brothers' arrival in the UK and their process of seeking asylum? At what point in their lives did they first receive a mental health diagnosis? What – if anything – might this tell us about the support Eritrean men in the UK may need?
- What do we know of the brother's substance use?

For specific agencies:

- Establish a clear picture of the offending history of both brothers (MPS)
- Were the Guinness Partnership aware of the sub-letting and was this with their approval? If not, what mechanisms might need to be put in place to identify (what appears to be) statutory over-crowding? (TGP)
- What were the results of the toxicology tests? (MPS)
- Establish where Senai was living (agency records are contradictory) (Housing / Homelessness)
- When and why was a care co-ordinator first assigned to Amaris? Why did Senai not have a care co-ordinator? (WLNHS TRUST)

- Review the brothers' mental and physical health care plans/risk assessments and risk management plans to establish whether they met their overall needs. (WLNHS TRUST and ICHT)

For all agencies:

- Establish the sequence of events for both Senai and Amaris, leading up to the death in May 2020 from January 2005 with any relevant previous events summarised).
- Establish whether there was effective and appropriate communication and liaison within and between agencies
- Consider whether policies and protocols were in place, whether they were followed and if these were fit for purpose – in particular whether staff readily consider family abuse and not just partner abuse.
- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- Were responses sensitive to the ethnic, cultural, linguistic, and religious identity of the brothers and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?
- Were senior managers or other agencies and professionals involved at the appropriate points?
- Are there any implications for ways of working, training, management, and supervision, working in partnership with other agencies and resources?
- Did any restructuring during the period under review and / or the pandemic have an impact on the quality of the service delivered?
- How accessible were the services for the brothers?
- Consider whether any actions taken in this case give rise to serious concerns about the way in which local professionals and/or services worked together to safeguard adults at risk.
- To highlight and learn from any positive practice.

6.2. The time frame under review was set as being from 2014 onwards. This was when Amaris was first admitted to hospital with mental health issues. Information prior to that date has been summarised.

7. Summary chronology

7.1 From the available information, it seems that the brothers were generally close, often relying on one another for care and support during times of mental ill-health. Although they lived separately, they seemed to spend much of their free time socialising together. No professional, friend or family member was able to identify any history of abuse between them.

Senai

7.2. Senai was 32 at the time of the incident. His parents separated when he was a small child, and his father remarried. He and his family left Eritrea and sought political asylum in

the UK due to the civil war. Senai had four brothers and one sister, but only one brother, Amaris, shared the same biological parents. His biological mother moved to the USA, and he met her once at aged 18 years. Senai and Amaris did not find out that their stepmother was not their biological mother until Senai was 17 and Amaris was 15.

Domestic abuse history

7.3 In July 2011, Senai was reported for domestic abuse against his girlfriend Janet and was later arrested and charged with common assault. Other non-domestic abuse related contacts with the police followed. These included violent disorder and cannabis possession.

7.4 Senai was reported again for domestic abuse assaults against Janet in September 2016, when she was six months pregnant with their second child, again in March 2017 and then in September 2017. DASH risk assessments were undertaken, and appropriate referrals made each time including to Children's and Young People's Service (CYPS) who undertook further assessments. Senai was arrested after both incidents in 2017 but neither incident led to a criminal prosecution. After the final incident, the case was referred to MARAC and discussed at a meeting in October 2017. There were actions for West London NHS Trust to explore relationships with him and if any abuse or concerns were disclosed by Senai, to offer a referral to the local perpetrator programme and the Respect phone line for perpetrators. This did not happen until mid-March 2020.

Allegations of family abuse

7.5. In January 2015, Senai attended Hammersmith Police station to report an allegation of non-recent abuse against his father. He told police that his father had physically assaulted him, hit him with a belt, burnt him with a lighter and locked him in cupboards without food or drink. His father was arrested and interviewed in the presence of a solicitor and an Eritrean interpreter. He denied all the allegations. Amaris was contacted by the Investigating Officer who stated that he had not witnessed his father or his stepmother assaulting his brother. No further action was taken due to insufficient evidence although Senai was referred to Victim Support for support. They managed to have one phone call with him but were unable to establish further contact after this initial call.

7.6. A week later, Senai reported feeling depressed to his GP. He stated that the reason for his low mood was his girlfriend's pregnancy. He did not mention the events described above. He was prescribed anti-depressants. There is no record of any enquiry about domestic abuse.

7.7. At the end of January 2015, Senai's father contacted the police to report that Senai had contacted him demanding that he and Senai's uncle convert to Islam and threatening to kill them if they didn't. Senai denied this when he was arrested and interviewed. Nevertheless, he was charged with threats to kill and bailed to appear at Hammersmith Magistrates Court with conditions not to contact his father or uncle.

Mental health history

7.8 In April 2015, Senai was reported missing by his girlfriend Janet, who was heavily pregnant. He had been at her address, and she became worried about his mental health. He had burnt his hands with a lighter and left the address. She reported that his mental health had deteriorated over the last two weeks with him constantly talking about God and the angel of death. He hadn't slept for two weeks and had stopped looking after himself. Later that day, police received calls about a man behaving erratically in a children's playground. On arrival, this proved to be Senai and he was conveyed directly to hospital where he was

sectioned under the Mental Health Act. He was later diagnosed as having drug induced psychosis. He was discharged two weeks later into the care of the Crisis Resolution Team who were supervising his medication in the community. A referral was also made to the FIRST team (First Incidence of Psychosis Team), to manage Senai's longer term care needs in the community.

7.9 In February 2016, Senai's mental health worsened again. He engaged with Hammersmith and Fulham Crisis Assessment & Treatment Team (CATT) who agreed to monitor the risks and monitor his medication. On 9th March 2017 he was assessed and taken on by CATT.

7.10 In March 2018, Senai was given a diagnosis of Paranoid Schizophrenia along with a differential diagnosis of Borderline Personality Disorder and possible Post Traumatic Stress Disorder. Psychology was offered but Senai only engaged with this sporadically so in June he was discharged from the CATT back to his GP.

7.11 In July 2019, his GP referred him to the Single Point of Access after Senai reported that he was experiencing some paranoid symptoms. The GP re-started his medications. Attempts by the triage team to contact Senai proved unsuccessful, so they discharged him back to his GP.

7.12 Towards the end of September, Senai presented to the Emergency Department with acute mental health symptoms. He reported that he was hearing voices telling him to jump from his flat, which was situated on the 17th floor. He also reported that he was fearful of being there, had no bed and no cooker. He also mentioned that he had not seen his children for three weeks. He stated that he was being abused and controlled financially by others but declined to give any further information on this despite being asked. He denied using cannabis. He was informally admitted to hospital.

7.13 In mid-October, he was discharged from the ward to Amaris's accommodation. Arrangements were put in place to ensure that Senai's flat was furnished with essential home appliances.

7.14 Senai's mental health continued to decline. In early November 2019 he was assessed by the Transitions Team after he presented with hearing voices 'telling him to do things. He also claimed to be the victim of financial abuse again but again was unwilling to provide any further details. Senai had also moved in with Amaris out of fears for his safety in his own flat but was concerned about the potential impact this would have on both their mental states.

7.15 Senai continued to receive input from West London NHS Trust Mental Health services and by December 2019, they made the decision to allocate him a care co-ordinator. This never happened before Senai's death. He was due to have an appointment in March, but this was re-scheduled by West London NHS Trust. Two voice mail messages to Senai did not result in any response and he died before any further appointments took place.

Amaris

7.16 Amaris was 30 at the time of the incident. He first appeared in agency records in 2009 when he completed a homeless application. He advised the London Borough of Hammersmith & Fulham that he was currently homeless as his brother – with whom he was residing – had given him a Notice to Quit. Prior to this, he had been living with a girlfriend in Edinburgh, but this relationship had broken down. Before this, he had been in prison for one year, for drug dealing. For a variety of reasons, Amaris would not secure stable accommodation for another decade.

Involvement with the Police

7.17 In the time frame under review. Amaris was stopped and searched by the police on four occasions on susicion of having drugs. Nothing was ever found. On a separate occasion in 2010, Amaris was stopped by Police after throwing the contents of a bottle over a police car. When spoken to, he became verbally aggressive and violent and attempted to bite an Officer. He was arrested in relation to Public Order offences and was issued with a Fixed Penalty Notice. There was a further incident in August 2012, when he was arrested for drug offences in Portsmouth. It was later confirmed that he had been supplying drugs.

Mental health history

7.18 In August 2011, Amaris was admitted into hospital due to mental illness and released in October. He was released to short-term supported accommodation. In March 2013, he was placed on Section 48/49 and admitted to hospital. He was diagnosed with paranoid schizophrenia and mental and behavioural disorders due to multiple drug use. He was discharged in January 2014 to the London Borough of Hammersmith & Fulham Early Intervention Service but in May, he was once again detained under Section 2 of the Mental Health Act 1983, and subsequently under Section 3. This was for non-compliance with medication and reduced engagement. He was subsequently allocated a care co-ordinator and discharged in September 2014.

7.19 In January 2015, Amaris travelled to Ethiopia for religious purposes[4]. Upon return, he was living with his step-mother who evicted him in June 2015 stating her property was overcrowded and she could not cope with his mental illness. Amaris then went through a period of living in various temporary accommodation hostels. Permanent re-housing was proving difficult due to past problems with running up rent arrears.

7.20 In December 2016, Amaris informed the Recovery Team at West London NHS Trust that he was contacted by the police regarding an investigation. The victim was a mutual friend, and he was, therefore, living outside of the borough, at an undisclosed address to stay safe. A meeting between the Metropolitan Police and the Recovery Team resulted in the police agreeing to fund the out of borough accommodation until the following week. It was agreed that he required re-location, and on-going engagement for at least six months with mental health services.

7.21 In September 2017 however, the alternative out-of-Borough accommodation provider complained that Amaris had abandoned the property. This was disputed by Amaris. There then followed a long period of disengagement from mental health services and not attending for his depot injections.

7.22 Amaris moved back to the London Borough of Hammersmith & Fulham in January 2018, albeit into further temporary accommodation. In March 2019, he was finally offered permanent accommodation at address 2 which he accepted. Amaris gave Senai as his emergency contact and next of kin.

7.23 In the one-year period leading up to the incident there appears to be only routine agency contact relating to Amaris but no significant changes in circumstances. His

[4] Further detail was not available. However, the Panel were advised that sometimes if people have a mental or physical health issues or if they feel like their life is not going well, they sometimes go to Ethiopia to go to specific monasteries to speak to religious leaders and to complete certain religious rituals to help them get better.

attendance for his monthly depot injection was slightly erratic in the latter part of 2019, but then stabilised in 2020.

7.24 In September 2019, Amaris attended his last Care Programme Approach (CPA) meeting, at the Claybrook Centre, with his allocated Consultant Psychiatrist and care co-ordinator. He reported he had been working evening shifts at a pizza kitchen. He said he had mended relationships with his family. He had a history of substance misuse but at this time he stated he wasn't using any substances. He expressed that he would like his medication reduced. However, he did state that he can be quite forgetful (with regards to medication for example). He reported an erratic sleep pattern and advised he was not experiencing suicidal ideation, or psychotic symptoms. He provided Senai's contact number as next of kin. The plan was to offer a treatment review in three months' time, and an Outpatient's Appointment in six months' time. There was a consideration for referral to GP because of his stability. The impression was that he was in remission from psychosis with medication, but that he needed to improve medication management.

7.25 Two weeks before the incident, Amaris had his last recorded agency contact when he attended for his monthly depot injection. There was no evidence of psychosis and he stated he was not experiencing any symptoms. He was well-groomed; he appeared calm and made occasional eye-contact. He explained that he was not suffering any side-effects of medication. He did not express any sleep or eating problems. He reported that he was not undertaking any social activities due to COVID-19, was handwashing and maintaining social distancing.

8. Key findings by the DHR Panel and recommendations

The findings and recommendations below arose from panel discussions and analysis. Additional findings were made by IMR authors who made their own recommendations.

Finding 1: The snapshot exercise (paragraph 8.4) revealed that although domestic abuse training is undertaken across participating agencies, in some instances, this lacks a focus on the different issues and dynamics for family violence rather than partner abuse.

Finding 2: Domestic abuse training is undertaken across participating agencies but in some instances, is subsumed under general safeguarding training. This approach does not allow for sufficient time to be allocated to the specifics of domestic abuse. The outcome is that whilst practitioners may know how to make a referral, they may continue to lack the knowledge to undertake sensitive routine enquiry and / or to identify domestic abuse indicators.

Recommendation 1: Hammersmith & Fulham CSP to develop a collective module on family violence for use across the multi-agency partners.

Recommendation 2: Hammersmith & Fulham CSP to formally write to the Royal Colleges to suggest that domestic abuse training be afforded a separate intercollegiate document that would detail how domestic abuse training should be delivered and to whom within heath care settings and that such training should become a mandatory requirement for all health staff (as recommended by NICE in 2014).

Recommendation 3: Working with the Local Safeguarding Boards, Hammersmith & Fulham CSP to develop a systematic tracking of staff training across the relevant multi-agency workforce.

Finding 3: This is the second family violence death in the London Borough of Hammersmith & Fulham in the past 18 months. It is not only training which needs to consider family violence but also all the other domestic abuse tools. Although a domestic abuse risk assessment was never carried out for the brothers, had it been done at any point it would have been the DASH. This is very intimate partner focused.

Recommendation 4: Hammersmith & Fulham CSP to produce a briefing paper of guidance on how to better assess risk in family violence cases. For example, professionals might need to apply different considerations when using professional judgement or ask supplementary questions for family violence cases.

Recommendation 5: Hammersmith & Fulham CSP to share the above document with the Home Office, recommending DASH be reviewed to establish what changes might be needed to make it more suitable for identifying risk in family violence cases.

Recommendation 6: The Home Office to produce a briefing paper of guidance on how to better assess risk in family violence cases.

Finding 4: Not all risk assessments undertaken in this case were sufficiently holistic.

Recommendation 7: Hammersmith & Fulham CSP to remind all relevant services that risk assessments should not only assess risk to self, partners, and children, but also to other members of a household.

Finding 5: The brothers were born in Eritrea, coming to England as children. In Panel discussions, it became clear that knowledge of the Eritrean community was low, in part, perhaps, because they are relatively new to the UK, relatively small and do not have Commonwealth links.

Recommendation 8: As part of its work, the Panel received an informative presentation on the Eritrean and Ethiopian community, their journey to the UK and where domestic abuse 'sits' within this culture and its customs. It is recommended that Hammersmith & Fulham Business Intelligence Team undertake a strategic needs assessment of the Eritrean and Ethiopian community living in the Borough of Hammersmith & Fulham and widely circulate this when complete.

Finding 6: Both brothers experienced mental health issues and whilst there was one, one-off contact with Mind there was no evidence in any other records of any attempts to put either brother in touch with any other kind of community support.

Recommendation 9: West London NHS Trust and local CCGs to encourage social prescribing for patients in receipt of mental health services.

Finding 7: In common with many young black men in London, both brothers had been subjected to multiple stops and searches. The victim had been stopped 17 times and the other brother on four occasions. It is acknowledged that on six occasions, the victim was found to be in possession of small amounts of cannabis. Nothing was ever found on Amaris. When each incident is viewed in isolation, it may seem as if the stop and search was justified, and it is certainly true that each individual incident was correctly recorded with a reason provided. Nevertheless, when viewed cumulatively, it seems unlikely that Senai and

Amaris experienced them as justified and that it probably felt as if they were being – and may even have been – racially profiled.

The Metropolitan Police reported that they were already undertaking significant work on Stop and Search following the publication of the IOPC report in October 2020. As such, the Panel originally determined not to make any additional recommendation here. However, the publication of further research In November 2021 showing that little had changed meant that the Panel was now unable to reassure itself that action was being taken and the gap narrowed.

Recommendation 10: The CSP will formally write to the Borough Commander and request anonymised data set for H&F from 2017-22 that largely matches the publicly available data set at data.police.uk but with a unique ID based on an individual's name and D.O.B. and which flags cases where an individual has not provided a name or D.O.B. – we, as officers, would seek a meeting with the lead Superintendent, and relevant analyst(s) to explore the parameters of data available and the abilities to obtain such data to help influence understanding in the future.

Finding 8: Rigid application of DNA policies meant that the brothers were not always engaged with consistently.

Recommendation 11: West London NHS Trust and Victim Support to review their DNA policy to include a more flexible approach, to consider checking contact details are accurate at each successful contact and / or to attempt more assertive outreach on the third attempt.

Single agency recommendations

The following recommendations arose from the relevant agencies IMR and are included here to demonstrate the additional learning that has been identified over and above the DHR recommendations. Individual agencies are responsible for progressing these recommendations and in most instances, have already been completed.

West London NHS Trust

- Staff should follow the Trust Clinical Risk Assessment and Management Policy in that risk plans must be updated when moving between services and relevant factors clearly identified
- Clear processes must in place to obtain forensic risk assessments and guidelines as to referral to assessment timelines made available.
- The Trust should review its commitment improving awareness of, and engagement with, relatives and carers involved in the care of a service user.
- The service raise awareness of the importance of safeguarding adults and actioning recommendations made by external agencies such as MARAC.
- The appropriate MDT (Multi-Disciplinary Team) function should be engaged in considering and progressing housing requirements of service users.
- The service ensures patients requiring care coordination are appropriately allocated as soon as is practicably possible. Capacity issues should be escalated to relevant commissioners.
- The service complies with the Trust Care Programme Approach policy including making sure staff understand the threshold for managing patients with mental disorder under the Care Programme Approach. This will also serve to enhance care planning.
- Recovery teams to offer family intervention and individual CBT to all patients with schizophrenia in line with the NICE guideline on psychosis and schizophrenia. If the

service is not funded to be able to provide this, this is to be brought to the attention of the commissioners.

- Medical vacancies within the service should be filled and appropriate mechanisms in place with the Medical HR department of the Trust to ensure that recruitment strategies are in place to reduce vacancies. The Training Programme Director should also be sighted on trainee gaps.
- There should be in place the following, understood by all healthcare professionals of the service:
    - Operational policy for transitions team including referral process
    - Operational policy for recovery services including assessment of referrals in
    - Roles and responsibilities re duty function
    - Clear understanding of zoning. If any professionals have concern in relation to the safety of the service, for whatever reason, there should be appropriate escalation protocols in place.
- The service should adhere to a DNA policy that is understood by all members of staff that outlines clearly, expectations in relation to follow up of patients who Do Not Attend (DNA) appointments (to include nursing, medical, psychological and/or social work appointments

Children's and Young People's Service (CYPS)

- CYPS to ensure front line managers and staff participate in Safe and Together on-line training in 2020 and 2021.
- Managers in CYPS to ensure that staff explore wider family relationships in assessments of domestic abuse, including maternal and paternal family members.
- CYPS to explore opportunities with Adult Social Care for joint training for social workers on parental mental health.

London Borough of Hammersmith & Fulham Housing Management:

- DV training to be updated to include familial DV. To be delivered by all housing management staff by April 2021

Victim Support:

- Review of internal DA training to include training module on family violence and child to parent violence. This will be undertaken by Victim Support's Training and Development team with the assistance and oversight of the Independent Domestic Violence Adviser Community of Practice. Date for inclusion January 2021.
- Victim Support's Training and Development team to track changes to learning packages in the same way that policy and procedure is tracked and reviewed. This is to ensure full understanding of when staff would need to have refresher training. Date for action December 2020.
- Recommendation 3: Audit of case reviews in DA cases both for those allocated to Independent Domestic Violence Advisers and Independent Victim Advocates. Due April 2021.

Mind

- To develop a specific domestic abuse policy and training for staff

Imperial College

- All handovers between Liaison Psychiatry Service and Imperial College Healthcare NHS Trust should be clearly documented in patient record, detailing whether this was

able to take place face to face, or via telephone, and who spoke with whom. This is currently the agreement although formal Standard Operating Procedure to be drawn up. This will be drawn up and then agreed at the next Mental Health Governance group (December 2020)

- All new psycho-social assessments, or those carried out in the Emergency Department, whether by psychiatry or triage, especially where a person has a history of domestic abuse (whether as victim / survivor or alleged perpetrator) should include an overview of where the person is staying, who is there with them and any relevant information about their current residence.

Appendix A: Snapshot questions

Do you have:

A separate domestic abuse policy? Yes / No

If yes, when was this last reviewed?

A policy into which domestic abuse is subsumed (eg safeguarding)? Yes / No

If yes, when was this last reviewed?

Domestic abuse training for staff? Yes / No

If yes, what percentage of staff have attended training within the past two years?

If yes, is the training: 1-3 hours / 4-7 hours / more than 7 hours

If yes, does training include a focus on family violence as well as intimate partner violence?

Do you attend local domestic abuse partnerships? Yes / No

If yes, please specify: