

**LONDON BOROUGH OF TOWER HAMLETS
COMMUNITY SAFETY PARTNERSHIP**

**DOMESTIC HOMICIDE REVIEW
OVERVIEW REPORT**

MR AB AGED 79 YEARS

**KILLED IN TOWER HAMLETS
IN AUGUST 2015**

**REVIEW PANEL CHAIR AND AUTHOR
BILL GRIFFITHS CBE BEM QPM
2 MARCH 2018**

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OVERVIEW REPORT

INTRODUCTION

1. This report of a domestic homicide review examines agency responses and support given to Mr AB, a resident of the London Borough of Tower Hamlets prior to the point of his homicide in August 2015. Due to the circumstance that Mr AB was killed by his youngest son, Mr YZ, who was subsequently diagnosed with a serious mental health condition, the review also examines agency responses and support provided to him.
2. In addition to agency involvement, the review will also consider the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.
3. In the early evening of a Sunday in August 2015, police were called by the London Ambulance Service to a family house in Tower Hamlets where Mr AB aged 79 was found with fatal knife wounds. Arrested at the scene and subsequently charged with murder was his son, Mr YZ aged 31. Also injured by stabbing during the incident was Child C aged 11, and Child B aged 2. Mr YZ was charged also with the attempted murder of each child.
4. At the subsequent trial hearing in September 2016, the Judge directed the Jury to return a 'not guilty' verdict due to Mr YZ's diagnosed insanity and an order was made for Mr YZ to be detained under a Restricted Hospital Order within the provisions of sections 37 and 41 Mental Health Act 1983.
5. The review will consider agencies contact/involvement with Mr AB and Mr YZ from April 2010 to the day of the homicide in August 2015. Any relevant fact from their earlier life will be included in background information.
6. The key purpose for undertaking a Domestic Homicide Review (DHR) is to enable lessons to be learned from homicides where a person is killed because of domestic violence and abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.
7. One of the operating principles for the review has been to be guided by humanity, compassion and empathy, with both Mr AB and Mr YZ's 'voices' at the heart of the process.

TIMESCALES

8. The review began with a Panel meeting in January 2016. At the second meeting in February it was agreed that nothing useful could be undertaken pending the trial outcome that was concluded in September. A third meeting that considered an initial draft overview report was held in October.
9. The Panel then agreed that the overview could not be fully completed without the insight provided by an Individual Management Review (IMR) from Mr YZ's employers, a London Healthcare NHS Trust. Mr YZ was an employee and, other than through contact with

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Occupational Health Services, was not a patient of the Trust. This led to misunderstanding and protracted negotiation from November 2016, concluding a year later.

10. Chronologies from HR and Occupational Health (OH) were provided in May 2017 and the OH referral forms plus clinical notes from two OH doctors were disclosed in June. Panel meetings to find a solution for the lack of a full IMR were held in June and August. An IMR was eventually provided in November 2017, a delay that is subject of comment later in this review, and the draft overview report discussed in December before presentation of the final version of this report to the CSP Board in February 2018.

CONFIDENTIALITY

11. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.
12. The Government Protective Marking Scheme (GPMS) was adopted throughout with a rating of 'Official-Sensitive' for shared material. Either secure networks were in place (gsi, pnn) and adopted (cjsm) or papers shared with password protection. A copy of chronologies and IMRs was provided to all Panel members for review and discussion.
13. For ease of reference, all terms suitable for acronym will appear herein once in full and there is also a glossary at the end of the report. The family of both men made a request that code letters or numbers rather than pseudonyms be used in this review and these are included in the glossary for reference.

TERMS OF REFERENCE

14. Following discussion of a draft in the first Panel meeting, Terms of Reference (ToR) were issued on the same day (appendix 1) with a chronology template for completion by agencies reporting contact with Mr AB and Mr YZ and members of their family who were involved in the fatal incident. The ToR were shared, but not discussed, with family members as, unfortunately and for understandable reasons, they declined to have initial involvement in the conduct of this review. In the family discussions that were held with the Chair some two years later, they were offered the opportunity to comment and did not have anything to add.

METHODOLOGY

15. Under s9 Domestic Violence, Crime and Victims Act 2004, a Domestic Violence Homicide Review (DVHR) was commissioned by Tower Hamlets Community Safety Partnership and, on 30 November 2015, Bill Griffiths CBE BEM QPM was appointed Independent Chair of the DVHR Panel. Tony Hester supported him throughout in the role of Secretary to the Panel.
16. This review report is an anthology of information and facts from the organisations represented on the Panel, most of which were potential support agencies for both Mr AB and Mr YZ. From the table below, it may be noted that four agencies had limited contact, and only Mr YZ's GP and his employer held information relevant to the review.

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Table 1 – Agencies and records of relevant contact in the order that it occurred

Contact period	Agency	Summary of contact
04/05 to 07/15	Local General Practice Medical Centre	Provided GP services to family, including AB and YZ, during period of review
08/00 to 10/14	Metropolitan Police Service (MPS)	Various contacts with extended family, none relevant to the ToR for this review
10/12 to 12/13	East London Healthcare NHS Trust	Various contact with family, none relevant to this review
2010 to 07/15	London Healthcare NHS Trust	Occupational health services provided to YZ when employed at a Hospital within the Trust

17. An IMR was provided by an independent doctor from the Local General Practice and by the Deputy Director - Patient Experience for the London Healthcare NHS Trust.
18. This review was commissioned under Home Office Guidance issued in December 2016. Attention was paid to the cross-government definition of domestic violence and abuse and is included in the Terms of Reference (appendix 1).
19. The following policies and initiatives have also been scrutinised and considered:
- Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews published by the Home Office December 2016
 - Domestic Homicide Reviews: Key Findings from analysis of domestic homicide reviews published by Home Office December 2016
 - MPS Domestic Violence Investigation and Supervisors Toolkit issued in July 2013
 - Protecting Adults at risk: London multi-agency policy and procedures to safeguard adults from abuse (Social Care Institute for Excellence (SCIE) Report 39)
 - HMIC (Her Majesty's Inspectorate of Constabulary) Reports: 'Everyone's business: Improving the police response to domestic abuse' 2014 and 'The Metropolitan Police Service's approach to tackling domestic abuse' 2014
 - Tower Hamlets Council website: 'What is Domestic Abuse?' and the service directory published in March 2014
 - In addition, the Chair was provided with access to four prior DHR reports in the LB of Tower Hamlets, published and in progress, and there are no similarities or parallel lessons to be reviewed.

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INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

20. With the assistance of the police family liaison officer the family of Mr AB were invited by letter in advance of the trial to speak to the Chair with their concerns and input to the Terms of Reference. The Home Office explanatory leaflet was also provided. The family responded that they would keep the offer under review. Post the trial, the Chair made further contact and the family conveyed their desire to move on from this tragedy and declined to participate in the review and, initially, it was agreed that the family wishes should be respected.
21. Due to the extended passage of time, the Panel meeting in December decided that a further approach could be respectfully made and, thankfully, a positive response led to two meetings with a family representative in January 2018 when the draft content of the overview was shared by the Chair and comment invited. This enabled minor corrections to be made to the background information and pen pictures. The analysis, conclusions and lessons learned sections were discussed and input given to the recommendations. A copy of the 7th version of this report was provided to share and discuss with the wider family. The following text message was received: "My family have had a look at the report and are happy with it, thank you". There is a specific family request that pseudonyms are avoided, and random initial letters and numbers are used in the redacted version.
22. The family continue to support Mr YZ whom they accept was suffering severe mental impairment at the time of the attack on his father and other family members. They have endured multiple impacts from this tragic incident and the Panel offer their heartfelt condolences.
23. The Director of the local Mosque where the family worshipped was written to with a request for anything known or recorded there that may assist the learning and the Home Office 'friends' information leaflet provided. There was no response to the request and it is possible that this is connected to the family wishes; equally, there may not have been a record.
24. Mr YZ was not known to have friends with whom he socialised. Work colleagues at the Hospital where he worked in administration, declined a request through their Human Resources Manager to meet individually or in a focus group with the Chair on the grounds such a meeting would be too distressing.
25. The Panel debated whether, given his diagnosed mental health condition, it was appropriate to seek to interview Mr YZ. The Chair made a formal request for interview to him through the Consultant Psychiatric in charge of his care. There were no clinical grounds against such an interview in secure conditions, however, Mr YZ did not respond to the request.

CONTRIBUTORS TO THE REVIEW

26. An Individual Management Review (IMR) has been provided by the local General Practice Medical Centre, Tower Hamlets CCG with respect to Mr YZ. The MPS and the East London Healthcare Trust provided chronologies of their minor contact with the family and the Panel agreed that IMR's from these agencies were not necessary. Through the police, the Chair was provided with access to the written opinions of the Forensic Consultant Psychiatrists (CFPs)

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that were considered by the trial Judge in the determination that Mr YZ was insane at the time of the incident and not guilty of criminal charges.

27. Mr YZ's NHS employer provided two chronologies, from the Human Resources (HR) Department that investigated poor work performance and a grievance on the part of Mr YZ and from Occupational Health who responded to two referrals about him from HR. Protracted negotiations with the Trust to complete an IMR concluded in November 2017. An invitation to join the Panel was not taken up, however, the opportunity was provided to comment on the 5th draft overview report considered in December and the 7th version in January.

28. The Chair verified, and was assured, of the independence of both IMR authors.

THE REVIEW PANEL MEMBERS

29. The names of the Panel members, their agency, roles and job titles are set out below.

Table 2 – Review Panel members

Name	Agency/Role
Menara Ahmed	LBTH Domestic Violence and Hate Crime Team Manager
Kate Iwi	LBTH Positive Change Services
Alan Tyrer	LBTH Adult Social Care
Janet Slater	LBTH Housing Options
Stephanie Eaton	LBTH Domestic Violence Forum
Nadia Baksh	IDVA Newham Asian Women's' Project
Jane Callaghan	Barts Healthcare NHS Trust
Tracey Upex	East London Foundation Trust (provider of mental health service)
Tina Cicotto	Victim Support
Simon Dilkes	MPS LB Tower Hamlets
Ben Mott	MPS LB Tower Hamlets

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Janice Cawley	MPS Specialist Crime Review Group
Bill Griffiths	Independent Chair and overview report author
Tony Hester	Independent Administrator and Panel Secretary

AUTHOR OF THE OVERVIEW REPORT

30. Set out in appendix 2 are the respective background and ‘independence statements’ for Bill Griffiths as Chair and author and Tony Hester who managed the review process and liaison with the CSP and Panel.

PARALLEL REVIEWS

31. The Chair set up liaison with the Case Officer to ensure the judicial process was effectively managed, including the disclosure of material during the review. There are no misconduct allegations. The Coroner has determined that the trial outcome is sufficient to negate the requirement for an Inquest hearing. In the incident in which Mr YZ fatally injured his father, he also assaulted Child B age 11 and Child C aged 2 who are close family members. Tower Hamlets Children’s Safeguarding Board considered and decided against the need for a joint Serious Case Review.

EQUALITY AND DIVERSITY

32. Consideration has been given to the nine protected characteristics under the Equality Act in evaluating the various services provided. All concerned are Bengali by heritage and Sunni Muslim by faith. Mr AB was an ‘adult with care and support needs’¹ due to his age and dementia condition. The two surviving victims of the knife assault by Mr YZ are children. Given what was discovered about the state of Mr YZ’s mental health during the trial process, he also was an adult at risk. He made an allegation of racial discrimination by managers at his place of employment. Due to circumstances that will be outlined in the timeline below, an investigation into the allegation was not concluded. This review has not identified evidence of a differential service in respect of protected characteristics or evidence of a cultural barrier to engaging with mental health services.

DISSEMINATION

33. The intended recipients of copies of this report, once approved by the Home Office Quality Assurance Panel, are listed at the end of the review after the glossary.

¹ Formerly known as a ‘Vulnerable Adult’

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BACKGROUND INFORMATION (THE FACTS)

Family structure

34. The family is from Bangladesh and settled in Tower Hamlets where three sons and four daughters were brought up, the youngest sibling being Mr YZ. There are 12 grandchildren. On the day of the incident, eight family members were living or visiting together at the family home, a modern house on three floors with eight bedrooms in Tower Hamlets:

- Mr AB aged 79, the victim of homicide
- His wife
- Sibling 4 aged 36
- Sibling 5 aged 35
- Child A aged 13 of sibling 4
- Child B aged 2 of sibling 4
- Child C aged 11 of sibling 3 (who was not present)
- Mr YZ aged 31, sibling 7

Mr AB

35. Mr AB was born in Bangladesh and was orphaned as a child. He migrated with his family to the UK in 1963 and found work labouring and in a timber factory until retirement. He was a devout Muslim who attended the local Mosque. He used prayers for socialising and was a popular attender at the Mosque. In retirement, his passion was tending his garden.
36. Mr AB had been diagnosed with dementia a year prior to his death, initially at hospital and the treatment was carried forward by his GP. He was physically fit for his age and the dementia caused him to be confused in the mornings, but he was fine in the afternoons. He dealt well with his condition and just needed “prompting” from time to time, however, the medication he was prescribed made him very drowsy and in need of much sleep. The post mortem medical examination revealed that his brain showed signs of Alzheimer’s Disease.
37. Mr AB and his wife had seven children; Mr YZ was the youngest. Although several members of the family had their own homes they often congregated at their parents’ address. They are described as a very close family.
38. Sibling 5 provided a witness statement in the prosecution case and she reported that Mr AB and his youngest son were very close, and he depended on Mr YZ to accompany him on his medical appointments. The family all got on well and she knew of no arguments or antipathy between Mr AB and Mr YZ prior to the incident. Sibling 5 also met with the Chair and provided input to the review on behalf of the family.

Mr YZ

39. Mr YZ had lived almost all his life in the family home where the tragic events of August 2015 unfolded. He left school aged 15 with four grade ‘D’ GCSEs and then enrolled on an IT course at a North London College. He left after a year and then ‘took some time out’. In 2004, he returned to college to complete a youth and community course and intended to commence an ‘access to university’ course. This did not happen because he was worried he would have to

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do a presentation. He found jobs in retail and with postal delivery and also volunteered as a mentor in a charity for young people.

40. Mr YZ then worked for a London Healthcare NHS Trust in temporary positions via an agency between 2010 and 2014. He was regarded as a good worker and, when a substantive post became available, he applied and was appointed to a permanent position in administration based at one of the Trust Hospitals in January 2014. He told his family that he had found the job he wanted to do, despite it being quite a long daily commute to traverse Central London.
41. Following concerns about his work performance from about September 2014 and lengthy sickness absences due to stress at work, he eventually resigned in July 2015, three weeks before the homicide.
42. He was married in September 2014 and the couple lived at the family home. Sibling 5 recalls that, being a typical Asian wedding, there would be dozens of guests invited. Mr YZ made sure that a table close to the family table would be reserved so that the 10-12 colleagues he had invited from work could sit together and in a prominent position at the celebration.
43. The marriage did not work out and they separated in February 2015. In April 2015, Mr YZ met another woman through a Muslim dating site and they married in secret in July but did not live together. The two families did meet each other after the marriage had taken place.
44. Regarding his relationship with his family, he reported in the pre-trial interviews with clinicians that he loved his parents and never had any problems with them. He said his father was “more beloved” to him than his mother. He never fell out with Mr AB and got on well with him and all his family members.
45. Sibling 5 confirms that Mr YZ had a special relationship with his father as the youngest in the family. They shared similar sociable, outgoing and chatty attitudes with a kind and caring nature. They mischievously enjoyed sharing a cigarette from Mr AB’s bedroom window when neither was supposed to smoke when in the house.
46. Mr YZ’s family have provided strong and regular support to him since the homicide because they acknowledge and accept that he was very ill at the time.

Timeline of events leading up to the homicide

47. There are four perspectives available that provide a window on what was happening in Mr YZ’s life in the period leading up to the fatal attack on his father:
 1. The observations from family members
 2. The records held by the local General Practice (he was seen by 7 of the 12 GPs)
 3. His record of employment at the Healthcare Trust 2014-2015
 4. His own account provided in pre-trial interviews with two Consultant Forensic Psychiatrists (CFPs) on behalf of the Court. The strong caveat on this source of understanding for this review is the possibility for hindsight and outcome biases. The clinical information and assessment from this source was not available at the time to health professionals working at the General Practice and the Healthcare Trust.

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48. The joint psychiatric diagnosis for the Court suggests very strongly that what was happening at work from Autumn 2014 is inextricably linked to his motivation for the attack, in fact, it is believed to be one of two factors that triggered his mental health problems, the other being the breakdown of his marriage.
49. The following sequence of events is a composite from the four sources.
50. As early as September 2005 when aged 21, Mr YZ reported to GP1 that he was feeling paranoid that people were watching him, he felt worthless, hopeless and guilty and was suffering from panic attacks. He was not suicidal. He was prescribed citalopram and an appointment made to see a psychiatrist that he did not attend. GP visits and discussions about how to deal with anxiety continued until July 2007. Problems of this nature were not reported again until 2014.
51. Having worked for the Healthcare Trust on temporary assignments for four years, Mr YZ commenced a permanent position in January 2014. From June, his work performance at the Healthcare Trust deteriorated and his first line manager (LM1) met with him on several occasions over the following months to discuss concerns that included communication, accuracy of work, organisation of work, time management, non-completion of tasks, poor customer service skills, both in person and via telephone, and non-compliance with Trust policies. This was around the same time that a new second line manager (LM2) had started working at the Trust.
52. Mr YZ was seen by GP9 in early June for tiredness over the past six months and needing to urinate at night. Blood tests did not find a cause. It was noted that there were no problems with smoking, drugs or alcohol.
53. In October, Mr YZ met with LM1 under the Trust's Informal Performance Management process to discuss the matters identified in June. He raised concerns about the team and pressure in the working environment. LM1 agreed to provide additional training, structured workflow and organisational tools, in addition to regular face to face performance meetings in line with extant Trust policy. Written objectives were set for the following four weeks with weekly review meetings and a date in early November set for formal review. Mr YZ was told that if he failed to achieve the agreed objectives, then a formal performance management process was a possible outcome.
54. Just before that meeting was due, an additional meeting was held between LM1 and Mr YZ to discuss new issues with his behaviour in the workplace. These included excessive use of his personal mobile, time-keeping, absence from the workplace for extended periods of time, misuse of time in lieu arrangements and lack of communication with colleagues as to his whereabouts.
55. At that meeting, Mr YZ asked to take the following morning as annual leave to accompany his father to a medical appointment. LM1 asked him to submit an annual leave request form, but he did not do so and did not attend work the next morning. His absence was recorded as 'unauthorised with no explanation' and he was informed that a disciplinary investigation was being carried out. Mr YZ regarded this development as particularly unfair and it seems to mark the 'tipping point' for a burgeoning sense of grievance. Sibling 5 also recalls Mr YZ's

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exasperation at the time because he had submitted the leave request form, but it had been lost somewhere in the system.

56. LM1 met him again for the pre-arranged formal review (paragraph 53). Mr YZ was told that he had not met the required performance standards and that a formal meeting was to be arranged for later in November in line with the Trust's Poor Performance Policy. This was followed up in writing with the offer that he could be accompanied by a Trade Union representative, colleague or friend.
57. Mr YZ reported sick the next day and subsequently failed to supply his line manager with a GP certificate. After eight days and several unanswered emails, he was sent a letter informing him that unless the GP certificate was received then his absence would be considered unauthorised. A GP back-dated certificate was received citing 'stress at work' and signing Mr YZ unfit for work until early December.
58. The notes for the consultation with GP7 when this certificate was issued (the next GP visit logged after early June paragraph 52), record that Mr YZ reported he was being bullied at work by a new manager (LM2), had a disciplinary pending and was taking out a grievance. He felt stressed and was not sleeping so was provided with a GP certificate for work related stress.
59. In mid-November, Mr YZ attended an appointment with the Trust counselling service. He later disclosed in the CFP interviews that he found this session unhelpful. There were no follow-up appointments.
60. Four days later, Mr YZ reported to GP10 a low mood, anhedonia (disinterest in social contact) and poor sleep for which he was prescribed fluoxetine, an antidepressant. He discussed the option of looking for an alternative job. Seen again by GP11 ten days after that, he reported poor sleep and that the fluoxetine had not yet helped. He was encouraged to continue and given another certificate for work related stress to early January. [Note: He later told the CFPs that he only took fluoxetine for about two weeks because he did not like it].
61. About a week into December, LM1 sent a letter summarising the position, including arranging a meeting to discuss long term sickness and clarifying that the investigation into unauthorised absence was continuing. Three days later, Mr YZ replied via email with a copy to LM2:
²You are well aware of my condition, and your allegations have made my life worthless. I will not be coming in on the date stated and will be seeing my GP on the xx/12/14. To discuss my return to work you can contact me on 07xxxxxxx
62. LM1 contacted Mr YZ later that day and he requested that he be sent a copy of his employment contract and Job Description which was done. The sickness review meeting was re-arranged for the end of December, following the planned GP visit.
63. The next day Mr YZ attended his General Practice and was seen by GP12 to whom he alleged that he is under pressure to attend a meeting about phasing him back to work. This had involved consultants and the CEO. He asked the GP to make notes of this development. He is described as seeming mildly paranoid with a query that he is thinking too much and that it is stress related. He was encouraged to stick to one GP for pre-arranged appointments.

² All messages from Mr YZ in HR records shown herein are as written by him

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64. Mr YZ sent further emails to LM 1 and 2 during that month that included phrases such as:

I'm not well

I don't know where my mind is

I can't think straight

I don't know what I'm doing

I'm in a vegetative like state

65. In mid-December, Mr YZ submitted via email a grievance to a senior manager, LM3, with copies to the Divisional Director (DD) for his Department and the chief executive of the Trust. In the grievance, Mr YZ alleged racially-motivated bullying from LM1 and the next in line management, LM2. In his account to the CFPs, Mr YZ cited pressure from LM2 that affected his sleep and confidence and he felt depressed and anxious as a result. LM3 asked for an investigator to be appointed from outside of the Directorate to investigate Mr YZ's grievance upon his return to work.

66. Before this happened, LM1 left the Trust for another position elsewhere and the first line management role was taken over by another manager at the same grade, LM4.

67. At the pre-arranged appointment with GP11 near the end of December, Mr YZ reported that he had submitted a grievance through a lawyer and did not feel able to return to work. His family and friends had been supportive. He had stayed in his room for a week initially but is now active during the day and keen to keep well. The fluoxetine prescription had been helpful. He denied that there was anything similar in the past or in other areas of life. There were no other conflicts and no other persecutory thoughts. The Doctor noted there were no psychotic features and speech was normal in form and content, however, there was an intensity about him when talking about work. He was referred to primary care psychology.

68. GP11 saw Mr YZ again near the end of January 2015 when he reported that a phased return to work was taking place in another department. He was encouraged again to engage with psychology and the fluoxetine to continue.

69. Mr YZ complained to his family that he did not want to move to the other Department and could not see why it was necessary as he had been in his current Department for five years (including his time as agency staff).

70. Mr YZ returned to work in early February but was sending emails to senior clinicians³ alleging bullying. LM3 was concerned that Mr YZ's behaviour was erratic and asked LM4 to seek an urgent OH referral to review his mental health and well-being.

71. LM4 completed an OH referral form the next day. Of the eight possible reasons on the pre-formatted checklist, 'Long term absence (more than 4 weeks)' and 'Alleged work-related stress' were selected. 'Alleging harassment/bullying' was left blank. There is no mention of racial discrimination as an issue for Mr YZ.

72. In the section: 'guidance requested from workplace health and wellbeing', LM4 confirmed from another checklist of 11 that:

³ Mr YZ told his family that he had formed relationships with Department Consultants when agency working

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A full recovery is likely

Temporary or permanent adjustments to duties/days/hours will be required

Temporary or permanent re-deployment to another area or job role will be recommended

73. LM4 confirmed that this had been discussed with the employee and that Mr YZ was 'not currently absent' with the rider: 'Returned to work xx/02/2015 phased return until advised after occupation assessment'.
74. Under background information, LM4 provided these details:
"Mr YZ⁴ has been signed off for alleged work related stress. His certificate ends on xx/02/2015 and has been redeployed temporarily in XXX as a patient scheduler. Before Mr YZ's return to work I met with him on xx/02/2015 to discuss the support that we would provide during his transition back to work. Mr YZ appeared to be still stressed/tired and I am concerned that Mr YZ is returning too early and I am concerned this may have a negative impact on his state of health. He also showed signs of aggression and anxiety towards returning, I feel Mr YZ would benefit from an urgent occupational health assessment to support his return to work. He has contacted various members of staff during out of office work hours on personal mobile numbers, these messages range from inappropriate text messages, quotes and calling staff members during the weekend. A number of staff members have become concerned due to the amount of contact from Mr YZ while being signed off and are concerned for their own safety."
75. Seen by GP11 in mid-March, Mr YZ reported that, following a return to work, things had broken down again and he had been off since mid-February. He hoped to return in April and he was given a certificate until then. He appeared to be more withdrawn and mentioned problems in his marriage of six months which had broken down and his wife was back with her parents. GP11 discussed Relate counselling and referred him back to psychology⁵.
76. The OH appointment was arranged for mid-February and Mr YZ was seen by Dr1. Mr YZ reported that he had been redeployed to another Department, was pleased to be back at work and was looking forward to resolution of the problems, but he was finding it difficult to cope and he remains emotionally unstable. He expressed appreciation for the support he was receiving from LM3 and was also receiving appropriate support from his own doctor who had started him on treatment. He said he was bitter and angry about what had happened and felt that he had been subjected to bullying, harassment and discrimination.
77. Dr1's opinion was that a full recovery is likely if the issues at work are dealt with appropriately. To return to his former Department, Mr YZ will need to feel confident that he is being fairly dealt with by management. He disputes the allegations that have been made about his performance at work and is upset by what has happened which has led to an effect on his health and the sickness absence.
78. While pleased to be back at work, he is still recovering and his concentration remains impaired. Dr1 expected this to slowly improve over the coming weeks. Redeployment to the new area

⁴ Mr YZ's first name used throughout the OH request form

⁵ Mr YZ did not attend any of the psychology appointments offered by the Practice

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had been helpful in getting him back to work and it may need to be made permanent if the issues with management in the former Department are not resolved satisfactorily.

79. Dr1 concluded that Mr YZ: “Appears to be suffering from work related stress due to alleged bullying, harassment and discrimination and believed he will be fit to be back at work from the beginning of March on a phased return, if this is available, and slow improvement could be expected. Mr YZ appreciates the support that has been given to him for return to work but feels he needs a little bit more time off before he is ready to come back as he remains emotional. This will give his medication a little more time to take effect”.
80. No arrangement was made for a further appointment, but the offer was made to refer him back if any further problems or queries. Both Mr YZ and LM4 received a copy of the OH doctor’s report. Subsequently, Mr YZ informed LM3 that he did not wish to proceed with the grievance and just wanted to move forward. LM3 agreed to proceed no further.
81. The IMR author’s understanding is that Mr YZ’s manager was supporting members of the team that had raised concerns about their safety. LM4’s actions, to refer him to OH to assess and potentially address the root cause of his behaviour, seem reasonable. Furthermore, the Trust did take the grievance seriously in that an independent person from outside the directorate was asked to investigate. There were delays in the grievance investigation, primarily because of Mr YZ’s sickness absence, but these delays were excessive.
82. Mr YZ was late for an appointment with GP11 in early April so “not really seen”. He was still stressed at work with an expectation that he would be back at work on amended duties and a certificate was issued for two weeks to mid-April. Seen again by GP11 at that time, a further certificate was issued up to mid-May. In this consultation, it was noted that Mr YZ’s confidence had been knocked. He was encouraged to think of alternative employment. Mr YZ did not attend the General Practice again until late July.
83. Mr YZ later disclosed to the CFPs that, in April, following the end of his first marriage in February, he had been looking for a second wife. He believed that by finding a second wife he would feel better. He went on a dating site for single Muslims and he met a woman in who lived in another part of London and visited him in East London. They met secretly 10-15 times before marrying in secret at a local mosque in July. The marriage was consummated but they did not live together. Sibling 5 says there was one meeting between the two families in the two weeks after the second wedding and before the couple separated. Another meeting was planned but did not happen because the mother of the woman had to return to Bangladesh on an urgent family matter.
84. He went on to tell the CFPs that he returned to work in May although he did not want to return. His colleagues were surprised to see him. The same manager (LM2) was there and Mr YZ’s perception is that the manager was not talking to him and bullying him through other people. Sibling 5 recalls that Mr YZ described greeting LM2 with a “Good morning” on the day of his return and this was not responded to, so he felt rebuffed.
85. This return to work was negotiated with Mr YZ by LM4 in mid-May and commenced with reduced duties and hours four days later. LM4 was concerned that Mr YZ showed ‘signs of anxiety’ about the return and asked for a second appointment for Mr YZ to see an OH doctor. The original appointment offer was followed with a request from LM4 for an earlier day,

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indicating that the manager had identified some urgency in the request. When Mr YZ returned to work, he asked that his grievance be progressed again. Planning for this commenced, although the process was not completed.

86. An OH referral form was completed and the same selections were made under the 'Reasons' and 'Guidance' sections as before, this time with the rider: 'Returned to work from xx/05/2015 phased return until advised after occupation assessment'. Under background information, LM4 provided these details:

"Mr YZ has been signed off for alleged work related stress. His certificate ends on xx/02/2015 [sic] and will be returning to work on a stage return to the XXX clinic on a temporary basis.

Mr YZ has been signed off from xx/11/2014, he returned to work on xx/02/2015 and was signed off again 2 days later on xx/02/2015 until xx/05/2015.

Before Mr YZ's return to work I have spoken to him via phone on xx/05/2015 to ensure he was ready to return.

Mr YZ's GP has also agreed that he is fit to return. I have discussed support that we can offer on returning to ensure that Mr YZ is supported during this transition.

He also showed signs of anxiety towards returning, I feel Mr YZ would benefit from an urgent occupational health assessment to support his return to work"

87. Three weeks later, in mid-June, Mr YZ was seen by Dr2, a Consultant in Occupational Medicine. Mr YZ told him that he had been under considerable stress mainly due to perceived managerial issues at work. He feels bullied and harassed by the management and has been feeling low with lack of self-esteem and anxious. On completion of an 'Anxiety and Depression' questionnaire, Mr YZ scored 18/21 for anxiety and 21/21 for depression and Dr2's assessment was that he was suffering from significant symptoms of anxiety and depression.

88. In his note of this consultation to LM4 five days later, Dr2 advised that, based on the assessment, he is fit for duty with some adjustment. Dr2 wrote that it is important that the work issues need to be discussed and resolved and referred Mr YZ for counselling which should be helpful⁶. Dr2 also advised him that a stress risk assessment should be carried out to address the issues he perceives cause him stress regarding the perceived managerial issues and his workload and hours. Dr2 concluded with a request and invitation to meet with LM4 at a convenient time to discuss the case.

89. The day before, Mr YZ had re-submitted the December 2014 grievance to the DD and stated that:

I am back to XXX and I am getting know where with [LM3]. From day one [LM3] has not been supportive and recently stated that [LM3] supports [LM2⁷]. I am left with no option but to assume there is some serious nepotism going on

90. The DD asked a more senior manager who was the HR Business Partner (BP) from another Division to investigate Mr YZ's grievance, but when Mr YZ was contacted, he said that he wanted the BP to have nothing to do with the case and just to get on with work.

91. During this phase, Mr YZ asked to review a draft copy of the OH report from Dr2 before it was released to LM4. The finalised report was sent to LM4 and Mr YZ later in June, adding two

⁶ Mr YZ did not take up this offer

⁷ The manager against whom the racially motivated bullying complaint had been made

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weeks to the delay in the report arriving with LM4, so nearly five weeks in all from the initial request for an OH appointment. LM4 called OH to arrange the case conference but, due to an accident, Dr2 was by then on sickness absence, so the discussion did not take place and the risk assessment was not carried out.

92. In mid-July Mr YZ emailed the BP (he had earlier told not to investigate) seeking an update on progress of his grievance. The BP responded that there was a minor delay, but all was in progress, and Mr YZ thanked for the update. Later that day, Mr YZ called the BP asking to be moved from XXX. Mr YZ ended the call, in tears. He later texted the BP:

Please move me from this Dept

93. Two days later, Mr YZ was seen loitering in the lift lobby area outside the HR office. He explained that he was looking for the BP who happened to be leaving the HR office at that precise moment and introduced himself. They spent 30 minutes in the HR waiting room with Mr YZ clearly very upset and begging to be moved to another department. After Mr YZ left, the BP went directly to meet LM3 and LM4 to discuss moving him to another area whilst the grievance was investigated.

94. The next day, Mr YZ emailed LM3 and the BP saying that the fire alarm had gone off in his building and he was leaving immediately as he feared that LM2 was trying to burn the building down with him inside it. LM3 responded that it had been arranged that Mr YZ could work in another department at a different Hospital within the Trust from the following Monday and he should just report there. Given that Mr YZ was 'begging to be moved' in his meeting with the BP the day before, this strange reaction to the fire alarm was viewed as a further attempt to get himself moved from the building, rather than a paranoid reaction. There was no further discussion within HR about this episode or Mr YZ's state of mind.

95. Sibling 5 recalls this day because Mr YZ returned home earlier than expected. He relayed his view that the fire alarm at work suddenly went off and, "I needed to get out of there before the fire got me". However, he told the story in such a 'jokey' tone that they did not take it seriously.

96. Mr YZ did not attend the other department on the Monday as arranged and LM3 sent an email asking for his whereabouts. Mr YZ replied that he did not want to work anymore. The BP was notified and responded to Mr YZ not to make any decisions in haste and that the grievance would be fully investigated. Mr YZ replied that he wanted to drop the grievance, to which the BP responded to consider it overnight.

97. The BP then wrote to Mr YZ asking if he felt ready to talk. Mr YZ replied saying that he had made his final decision which was to leave his job. The BP offered support services, including OH, and would hold off submitting the Termination Form until the following Monday in case Mr YZ had a change of heart.

98. On that day, Mr YZ was seen by GP2 in his first appointment since April. He had returned to work but there was ongoing bullying, so he had left. He is now at home all day thinking about what happened and getting a bit paranoid that people are still out to get him and not sleeping as a result. In this consultation, there was no mention of the fire alarm incident from the week before. He had stopped taking fluoxetine in May. He was encouraged to restart fluoxetine and

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to self-refer to psychology. GP2 referred Mr YZ to the practice social prescriber⁸ so he could find voluntary work or study to rebuild his confidence and distract him from thinking all the time. He was also encouraged to exercise to become physically tired. He was prescribed diazepam to help him sleep and referred to the Health Care Advisor for help with smoking cessation. [Note: He told the CFPs that the diazepam did not help the sleep problem].

99. The next day, the BP wrote to Mr YZ confirming that the Termination would be processed unless he indicated otherwise. Mr YZ's response was:

Thank you very much for your help but I feel I need to move on

100. On a visit near the end of July, the social prescriber rated Mr YZ's 'Wellbeing Star' at 2/5. He is feeling work is against him and he has lost confidence. His family are supportive. He has a plan to do volunteering or a job helping people but feels unable to deal with the pressure yet. Relaxation/meditation techniques were explained and volunteering possibilities suggested.

101. Mr YZ was also seen by the practice nurse for help with smoking cessation and given nicotine replacement therapy on three visits, the latest two days before the fatal incident and the last time at the Practice.

102. In his account to the CFPs of the weeks prior to the homicide, it is noted that Mr YZ started to believe that his second wife was a spy sent from his place of work by LM2 to get him done in. He accused her of being a spy, that she denied, but he then stopped seeing her about two weeks after the wedding. During this time Mr YZ was having nightmares about the manager and thought he was coming to get him. This was a thought that came in to his mind and he was not hearing any voices.

103. In the two weeks prior to the homicide, Mr YZ spent most of his time in bed. Noise from building works nearby affected his sleep. He was scared to go out at night because he thought the manager had people working for him who were spying on him. He also thought his mobile phone had been hacked. He had racing thoughts of danger going through his head. When his sister made him a cake for his birthday on in early August, he later threw it away because he thought it was poisoned.

The day of the homicide

104. The following narrative is compiled from Mr YZ's account given to the CFPs and Sibling 5's recollection of the day. On the morning of fatal incident, Mr YZ woke up at about 1100 feeling a bit down. He remembers walking with his mother to the supermarket where he felt that people were watching him and that his phone was being hacked. Sibling 5 was also there, and she remembers thinking that maybe Mr YZ was recovering because he seemed more like his former outgoing self, for example, by waving to neighbours that he knew.

105. On return home, he had something to eat and then took a bath at about 1500, which is the normal time for him, and remained for about 45 minutes. He was feeling restless and anxious but had he had no thoughts of harming himself or anyone else at that point. After his

⁸ A support member of staff trained in counselling

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bath, he went downstairs and had some tea and biscuits with the family. The children were not there at that time.

106. Over the next hour Mr YZ recalls that he was feeling more anxious. He told his sister how he was feeling and she advised him to go for a walk in the garden on his own. As he did so he saw a plastic snake belonging to his nephew near the back door. The family were unaware that one of the children had been playing with the snake and other toys in a small portable sandpit that was in the garden and had no reason to be concerned it had been left there that day as it had been there for the children over the whole summer.
107. It was only when he saw the snake that Mr YZ realised that he and his family were going to be tortured and killed, having not had that thought before. He said that the snake signified human evil, not spiritual evil.
108. Later, following a family meal with his mother, two sisters and four of the grandchildren, he noticed people getting out of a car in the street outside the house and thought they were coming to get his family. In response to overwhelming fears, he took a knife from the kitchen with the intention of killing his loved ones to save them from torture. He believed they were all going to be crucified. After he killed them he was going to kill himself. He did not think it was the manager from work (LM2) who was behind it; he did not know who it was or why.
109. He went upstairs to his father first because he was the most vulnerable one and stabbed him through the chest. He then went after the children (Child B and Child C) because they were also vulnerable. Had he not been stopped by his sister (sibling 5) and Child A, he would have carried on killing his family members and then killed himself. When he called out "do it now", he was saying to his family to kill themselves before they were captured, tortured and killed.
110. From Sibling 5's perspective, after a normal family day where tea and biscuits were shared at about 1700 followed by prayers at 1730, she was witness to a sudden and unexpected aberration in her brother's demeanor.
111. She had started to prepare dinner and Mr YZ had called down to ask if he could do anything. She asked him to fold some sheets, which he did, and returned upstairs. After 10 minutes, she heard Child A screaming so she rushed upstairs to her mother's room. There she saw Child B and Child C lying on the bed. Child A was sitting on the bed and said that Mr YZ had a knife and had hurt the children but she did not observe any injuries at that point.
112. Mr YZ was kneeling at the foot of the bed with his arms at his side and was saying, as if he had to protect the children:
They're coming
They're coming to take [Child B] and torture him; they're going to make him suffer
They're coming to get us; there's no time
They will take them and torture them
113. She then noticed he had a knife so grabbed his arms from behind whereupon he started stabbing his own torso. Child A assisted her by taking hold of the handle of the knife. The

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mother also entered the bedroom and helped while Sibling 4 entered and took Child B from the room. Sibling 5 managed to seize possession of the knife and handed it to Child A who locked it in another room. She persuaded Mr YZ to go downstairs where she sat him on the sofa. He was heard to repeatedly say: "They are coming".

114. He then ran into the kitchen and picked up scissors, which were taken from him, followed by the food preparation knife that he used to stab himself. In the ongoing struggle to wrest this knife from him, Child A received a bite on the hand. An ambulance had been called and arrived at 1815. The paramedics assisted with the restraint of Mr YZ until the police arrived and detained him.
115. Mr AB was found upstairs with a chest wound and, despite being rushed to hospital, died from his wound while undergoing heart surgery later that evening. Child A had the bite to the hand inflicted in the struggle with Mr YZ; Child B was stabbed twice in the back and Child C twice in the chest. They both recovered from these wounds. The two knives used in the attacks by Mr YZ were retrieved as evidence.
116. In interview, Mr YZ admitted responsibility for the homicide and causing serious harm to Child B and Child C. He described having a 'funny feeling' that someone was coming to kill him and his family. He took a knife from the kitchen drawer and went to his father's room. He spoke to him for about five minutes, then stabbed his father in the chest. His father said: "You bastard, you've killed me!" He went on to confirm that he stabbed the children because he thought they would be killed by those coming to attack the family.

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ANALYSIS

117. In this review, there is no history or trail of domestic abuse of any kind between Mr YZ and his father Mr AB whom he killed and the two children whom he seriously assaulted at their family home. This was a sudden and unexpected intra-familial homicide committed by a young man who, undiscovered by anyone at the time, was suffering from paranoid schizophrenia.
118. His family had noted his depression and uncharacteristic loss of interest in socialising and knew this was related to problems with the job that he loved and the breakdown of his first marriage. The family simply provided loving support throughout this period and there was no reason for them to consider the state of his mental health. They do not blame anyone for what happened but they would like to know that learning will follow, so that the possibility of such a tragedy is minimised in future.
119. His mental health condition was apparently triggered some 12 months prior, in late 2014, by a combination of what was happening at work and the breakdown of his marriage. His GP medical notes contain a possible indication he was prone to mental illness when, between, 2005 and 2007, he reported feeling paranoid that people were watching him and was suffering panic attacks. Over several GP visits, he was advised how to deal with anxiety. Nothing else of relevance was recorded in clinical notes until June 2014.
120. All that can be ascertained about the marriage trigger comes from his account to the CFPs. It was an arranged marriage and his bride came to live with him at the family home in September 2014. They did not get on and this led to separation by February 2015. Following an introduction through a dating website in April 2015, a second marriage lasted for only two weeks after the wedding in July and they separated before the homicide occurred.⁹ It is noteworthy that Mr YZ had by then formed the belief that his second wife was in fact a spy sent by his manager (LM2).
121. A window on his work situation is provided from two perspectives: from the local General Practice where he was treated for work-related stress and from the Healthcare NHS Trust where Mr YZ was employed in administration. Both agencies provided a chronology of contact with an Individual Management Review. The Healthcare Trust also produced copies of two OH referral forms and two OH clinical assessments.

Local General Practice

122. From reflections in the local General Practice IMR, they were working with what Mr YZ told GPs about his situation, with no collateral information from the NHS occupational health service that may have had useful information by which a comparison of accounts could be made. It is acknowledged that it is not clear from the notes whether this information had been requested¹⁰.
123. From September 2014, he had frequent GP appointments which enabled him to be assessed by several doctors who might have felt that he was "paranoid" or preoccupied and

⁹ It has not been possible to ascertain more information about the marriage and the reasons for separation

¹⁰ There is no record of such a request within Trust files

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ruminating but did not feel he was psychotic. The importance of correct terminology in this context has been highlighted and the review considered that the symptoms observed were more consistent with that of a personality disorder or anxiety and it was unlikely that he was schizophrenic or schizoaffective when he was seen.

124. Some of the notes show that this was considered and excluded, though not all notes, and notably the last consultation with GP2 did not make mention of thought disorder or hearing voices while mentioning paranoia. The impression at the time was of rumination rather than psychosis but there is no evidence that a full mental state examination was done.
125. GP11, who had more contact with Mr YZ than others in the Practice was clearly intent on providing care and follow up, but Mr YZ came back more frequently than expected and therefore saw different GPs (7 of 12 practicing in this period). There could have been many reasons for this. One consultation suggested that he was in a low mood but did not record asking about suicide which would constitute better practice.

London Healthcare NHS Trust

126. The reflection from the Healthcare Trust is that Mr YZ's time as an employee was not straightforward. There were issues related to both his ability to perform his duties and his conduct. His managers had no choice but to address these, which they did in line with the organisation's poor performance and disciplinary policies.¹¹
127. This was clearly difficult for him as evidenced both by a lengthy period of sick leave and the grievance process he initiated. In his dealings with OH, his stress and anxiety related to the alleged bullying, harassment and discrimination is clearly documented. The allegations of bullying, harassment and discrimination were never investigated for the reasons outlined in the sequence of events above and therefore not proven one way or the other. However, the impact that this perception had on his health was clear.
128. The application of the poor performance management process was timely, appropriate and in line with extant policy. The aim of this process is to improve performance, which it often does, but in this case, it did not. The use of the disciplinary policy, to deal with some clear behavioural issues, also seems appropriate but when added to the already initiated poor performance policy may have added to Mr YZ's sense of feeling bullied.
129. In addition, there appear to have been delays in dealing both with the disciplinary issues and the grievance, which were driven primarily by his long period of sickness. Whilst it may not have been possible to eliminate these delays, they would have likely added to his anxiety.
130. Managing performance and behaviour issues is commonplace in large organisations such as the Healthcare Trust. It is felt that these processes were appropriately applied in this case, but they contributed to his anxiety.
131. His line managers were clearly concerned about his health and wellbeing and contacted him before his planned returns from sickness. Appropriate referrals were made to the trust

¹¹ There is no reference to Mr YZ's prior performance as a 'temp' in 2010-2014 as there are no HR records

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occupational health service to review his health and fitness to return to work. The advice following both reviews was that he was fit to return and ensured that the recommended arrangements, for a phased return with reduced duties and responsibilities, were implemented. He was appropriately referred to the trust counselling service.

132. There were some delays in getting him seen by OH and in getting the findings of the second review out to his manager, due in some part on his insistence that he approved the content. There is evidence that his line manager (LM4) contacted OH on a number of occasions to try and get his (second) return to work review brought forward. It is unlikely that these delays were significant as the advice given related to his return to work was in effect already in place: reduced hours and responsibilities. However, a delay of over four weeks from request to receiving a report is too long.
133. The recommendation for a case conference between Dr2 and LM4 did not take place because, within the latter period of the delay, Dr2 became unavailable due to an accident. The recommended stress risk assessment was not undertaken. The BP dealing with the second grievance investigation arranged for a move to another hospital site but this did not happen because Mr YZ tendered his resignation.
134. The OH records from his two attendances show that comprehensive assessments of his wellbeing were undertaken and the advice about returning to work was considered. It is noted that, whilst he was anxious and felt stressed, he was pleased to be back at work and grateful for the support of his manager
135. It is important to understand that the Occupational Health's function revolves primarily around determining fitness for work of the trust employees, both at the time of recruitment and when staff have extended periods of sickness. They do not provide a primary care function and would not be involved in the *treatment* of acute or chronic illness of staff. Whilst it would not always be necessary to have an information exchange between OH and the GP, it would have potentially been helpful in this case.

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Timeline of opportunities for Mr YZ’s General Practice (GP) and Healthcare NHS Trust (HT)

136. An integrated timeline of the two reviews (Table 3 below) provides an overview that identifies potential connections between the two agencies, with missed opportunities for the exercise of ‘professional curiosity’. The strong caveat on this aspect of analysis is that these connections and opportunities are identified through hindsight. Nonetheless, while the relationship between discreet events could be seen as only tenuous, the holistic perspective suggests more could have been done to exercise ‘professional curiosity’ and identify the underpinning causes of Mr YZ’s very evident distress with the situation at work.

137. *Table 3 – Opportunities for professional curiosity*

Date/ Source	Event	Comment
June-Nov 2014 HT	The instigation of a performance review of YZ’s duties and conduct in June led to additional training, structured workflow, organisational tools, written objectives and regular face to face meetings with LM1 in October and November. In early November YZ took ‘unauthorised absence’ to accompany AB on a medical appointment. More sanctions followed	With probing by the line manager about AB’s medical problems a better understanding may have emerged of the challenges YZ felt he was facing as a result
Nov 2014 GP	A meeting under the Trust’s Poor Performance Policy led to YZ reporting sick with work-related stress Three days later, he disclosed to GP7 that this was because he was being bullied by a new manager and had registered a grievance. He was then in further trouble for non-supply of a medical certificate for absence (backdated one provided) Seen by GP10 a week later, reported low mood and prescribed antidepressant medication Seen by GP11 a week later, reported poor sleep and that the medication had not worked. Certificate issued up to early January	Three GP visits in as many weeks. The cause of distress was clearly work related, hence the rationale for the medical certificates, and the discussion regarding alternative employment Could additional probing have assisted the diagnosis and remedy?
xx/12/14 HT	In response to a letter about the need to discuss long-term sickness, YZ wrote: “Your allegations have made my life worthless”. In other emails in December, he wrote that he did not know where his mind is and that he felt in a vegetative like state	It is felt that such language from an employee responding to a standard letter dealing with a phased return to work is uncommon and it merited reflection on his state of mind
xx/12/14 GP	YZ seen by GP12 and asked that this pressure to attend a phased work return meeting be noted	This unusual request is described as ‘mildly paranoid’ and YZ is thinking too much

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xx/12/14 HT	YZ submitted a written grievance to LM3 with copies to the DD and CEO alleging racially-motivated bullying by LM1 and LM2. LM appointed an independent investigator for when YZ returned to work	The difficulty with application of the extant grievance policy when there are earlier developments, such as the one above is acknowledged. A step back to view the connections between events may have been useful here
xx/12/14 GP	YZ told GP11 that the grievance had been submitted. There were no similar conflicts or persecutory thoughts in his life. There were no psychotic features but an intensity about him when talking about work was noted. Referred to primary care psychology	The reference to 'intensity' when talking about work is likely to have driven the primary care psychology referral A follow-up flag would have been good practice
xx/02/15 HT	YZ returned to work in a different department. LM4 (who had replaced LM1) concerned that, due to his sending of emails to senior clinicians about his allegations, YZ's behaviour is erratic; he remained stressed/tired and had returned to work too early which may have a negative impact on his health. He went on sick leave again within 3 days	LM4 was bringing fresh eyes to the problems presented by YZ, observed a different picture and developed a more 'professionally curious' concern for the impact on his health
xx/02/15 HT	<p>In the request for an urgent OH referral, LM4 describes YZ's "aggression and anxiety" toward returning and his harassment of colleagues to the point where they are concerned for their own safety</p> <p>There is no mention in the referral of the racially motivated bullying and harassment allegation which had been the subject of YZ's apparent pestering of colleagues This was picked up by Dr1 who cited YZ's grievance as the cause of the stress, and that he was being treated by his GP, but felt he needed more time due to his residual angry and bitter feelings He would need to feel confident that he was being treated fairly by management to return to XXX He appreciated the support from LM4.</p>	<p>In the experience of the Panel, such expressions in the HR lexicon are uncommon and could have triggered further inquiry</p> <p>This report was accepted without challenge but it appears that no actions followed to address the findings</p> <p>Contact by Dr1 with the General Practice at this point may have been illuminating and helpful</p> <p>Following the OH report, YZ withdrew his grievance, so this support may have boosted his confidence. However, there was a missed opportunity, albeit</p>

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		narrow, to speak to YZ informally about the bullying and discrimination allegations
xx/03/15 GP	YZ told GP11 that things had broken down following his return to work, coinciding with the breakup of his marriage. He was placed unfit for work until April	Probing the cause and the impact of the marriage breakdown may have provided further insight to his illness
April 2015 GP	YZ was late for his appointment, so “not really seen” by GP11 and a certificate issued for a week Seen again by GP11 and certificate issued for another week. Noted that his confidence had been knocked and he was encouraged to think of alternative employment [Note: YZ did not attend Practice again until late July, <u>after</u> he had resigned from work]	This was the last opportunity to probe the cause of the stress at work and possibly engage with OH Dr1, clinician to clinician [Note: It is not recorded that YZ mentioned the involvement of an OH Dr in any of the Practice notes]
xx/05/15 HT	YZ returned to reduced duties and hours in another department as part of a phased return at the end of May and requested that his grievance was progressed. LM4 submitted a second OH referral form stating that YZ’s GP had agreed he is fit to return to work	There is no action recorded that the grievance was progressed at this stage Reliance on the GP certifying YZ’s fitness to resume may have been misplaced The second, and ‘urgent’, OH referral repeated the omissions in the first (ie no specific reference to discrimination)
xx/06/15 HT	YZ seen by OH Dr2 and diagnosed with significant symptoms of anxiety and depression but fit for duty with some adjustment. A risk assessment and case conference were recommended. This did not happen because there was a delay whilst YZ approved a draft of the report and, by the time it had been received by LM4, Dr2 had been involved in an accident	Dr2 had substantially raised the risks and called for action, albeit the opportunity was not identified to speak to the General Practice Despite the unavailability of Dr2 for a case conference, LM4 could have initiated a risk assessment
xx/06/15 HT	YZ re-submitted his grievance alleging nepotism by LM3, favouring LM2 When an independent manager from another department (BP) contacted YZ, he did not want to take it further	This was the second time YZ had advanced his grievance and then changed his mind again Acceptance at face value was a missed opportunity to gain insight to the problems, as it was in February
xx/07/15 HT	YZ emailed the BP for an update on his grievance with a request to be moved from his department	Another change of mind about the grievance process could have prompted a conversation about why that was
xx/07/15	YZ encountered the BP in the lift lobby near his office and was interviewed. YZ was	This was supportive of YZ but, taken with the earlier text asking

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HT	upset and begged to be moved. The BP discussed the options for a move directly with LM 4 and LM3 whilst the grievance was investigated	to be moved from XXX, may have induced a mindset about his agenda
xx/07/15 HT	YZ reported by email his fears that the fire alarm test signified an attempt by LM2 to burn down the hospital with him inside. This was taken as part of his campaign to be moved and he was told to report for work at another hospital the following Monday He did not attend, was contacted by email, and responded that he did not want to work anymore. Several contacts were made by the BP to ensure that he did not want to continue with the grievance and wished to resign	On any objective view, this was bizarre behaviour, however, it seems to have been considered through a 'fixed lens' that YZ was a problem employee with an agenda to secure a move to a place of work other than his Hospital
xx/07/15 GP	YZ seen by GP2. His reason for leaving the HT was ongoing bullying and was now at home all day thinking about what happened and feeling paranoid that people are still out to get him. As a result, he was not sleeping and he was prescribed the antidepressant again and encouraged to self-refer to psychology and counselling. Exercise would help him sleep, as would the diazepam prescribed and he should find voluntary work or study to help rebuild his confidence and distract him from ruminating	There had been a 3-month gap since last seen at the Practice for work related stress and he had been back at work for most of that time The lingering theme of his feeling that work colleagues were still 'out to get him' could have prompted a full mental state assessment rather than relying on him self-referring to the Practice psychologist

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CONCLUSIONS, LESSONS LEARNED AND GOOD PRACTICE

Local General Practice

138. So far as the local General Practice IMR is concerned, Mr YZ was seen by fully qualified GPs (not trainees) in 2014-5 for work related stress symptoms and the diagnosis seemed clear. Two doctors picked up clues and wrote them down to raise the possibility of an alternate diagnosis but had reassured themselves first that this was very unlikely. The possibility of schizophrenia or psychotic depression was reviewed and there was a discussion about the use of the word paranoia in the notes and should this always raise alarm of psychosis or are there alternative causes such as anxiety or personality disorder.

139. There was very little to support the diagnosis of psychotic depression as Mr YZ's depression seemed mild. The lack of collateral history from the Healthcare Trust meant that the stress of work may have brought on, or been, schizophrenic delusions that it was not possible to detect, without details from his work or occupational health assessments.

London Healthcare NHS Trust

140. Mr YZ had been employed for four years on temporary contracts without any problems being recorded and he was regarded as a good enough prospect to be offered a permanent position. The HT IMR concluded that his relatively short tenure as permanent employee at the Healthcare Trust was complicated by genuine issues about his performance (not undertaking his duties as expected) and his conduct (failing to adhere to the expected behaviours).

141. The management of these issues potentially led to him feeling stressed and anxious and taking significant time off work. He felt that he had been treated unfairly and that he had been bullied and discriminated against. Although he raised a grievance, this process was never concluded so it is not possible to state whether his concerns were founded.

142. Advice from the OH service seems to have been sound and based on comprehensive assessments of his condition. Efforts were made to reintroduce him to the workplace in such a way that would provide the least stress possible. It is acknowledged though that these efforts did not result in the desired outcome. It seems that there was little surprise that he resigned from his post, but staff were shocked that he could go on to commit the acts that he did.

143. The OH clinical assessment from Dr1 in February 2015 does make specific reference to the support being provided to Mr YZ by his GP, but there was little cause for concern to drive contact with the Practice at that stage. The report from the Consultant Dr2 does not reference the GP involvement but, perhaps due to more obvious symptoms in June 2015, does call for a risk assessment and case conference.

144. It is an unfortunate circumstance that Dr2 was not available to see this recommendation to fruition before Mr YZ resigned from employment, because the assessment and/or conference discussion may well have generated an enquiry with the General Practice to compare notes.

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145. **Good practice** has been identified in that LM4 was very focused on Mr YZ's wellbeing and showed concern and due regard for this, for example, by calling him before he returned to work and making referrals to OH when not completely satisfied that he was ready to return. The OH health reviews seem comprehensive. The Business Partner who became involved with the grievance aspect in the latter stages made every reasonable effort to listen to Mr YZ's concerns and to ensure he had the opportunity to reflect carefully on his decision to resign his employment.

Panel conclusions

146. Mr YZ is part of a close, loving, family and there is no pattern of the domestic abuse described in the cross-government definition; this was a single fatal incident. Other than his obvious depression and unhappiness at work and with his marriage breakdown, there were no outward signs to alert family members to the approaching danger arising from his deepening mental illness. In fact, up to the day of the homicide, Sibling 5 had formed the view that her younger brother was on the road to recovery from his depression and was proactively trying to improve his situation.

147. The only possibility for a different outcome lay with the two sets of health professionals who were separately handling the indicators of his deteriorating mental health that, latterly, included strange behaviours such as his reaction to the fire alarm, in the nine months prior to the fatal incident. Nobody had the whole picture because there was no sharing of patient information and symptoms between Mr YZ's General Practice who saw him on numerous occasions and treated him for work-related stress, and the Occupational Health Doctors at the Healthcare Trust who twice interviewed him as an employee with long-term sickness absence and complaining of bullying, harassment and discrimination.

148. The line managers and HR professionals involved from the Healthcare Trust also had a duty of care to their staff member and there is evidence of concern for the impact on Mr YZ of the performance review and the disciplinary and grievance procedures that ran from October 2014 to July 2015, together with two sets of measures to support him with a phased return to full duties.

149. It is also apparent that he was viewed as a troublesome employee and the second OH assessment in June did not trigger the risk assessment and case conference (due to the unavailability of Dr2) that could have identified Mr YZ's underlying mental health problems. This was quite close in time to his last GP visit in July when a full mental health assessment also could have been considered.

150. Thus, it is feasible that Mr YZ could have been treated earlier for his paranoid schizophrenia had either source of observation been aware of the other perspective. It is not suggested that any professional or agency failed to follow extant policy or protocol or is in any way to blame for what happened. As intended by the legislation, lessons to be learned have been identified by each agency.

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Learning from the DHR process

151. A general learning point from this IMR process, unconnected to the events leading to the homicide, is the complication and delay caused by the route through which the request for an IMR was delivered to the Healthcare Trust, which was to a senior HR manager that had been a witness in the prosecution case, with this contact detail provided by the police investigation.

152. The agenda sits within the safeguarding function in the Trust and, had the request come directly to the safeguarding lead or the chief nurse, who is the executive lead for safeguarding, the misunderstanding as to what was required could have been resolved much earlier. Work has been done within the Healthcare Trust to ensure that if a request to contribute to an IMR comes in in future it will be sent without delay to the safeguarding lead who will co-ordinate the response.

153. Equally, there has been learning for the Chair and Panel in this review and a shared responsibility for delay in this process is acknowledged. Unwittingly, there is a benefit from the delay in that the family of Mr AB and his son decided to participate after all and their contribution has been invaluable.

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RECOMMENDATIONS

Local General Practice

154. The internal learning identified from the local General Practice IMR is to consider using words like 'paranoid' only in the paranoid delusional sense and remember to record suicidality if the patient is depressed. Record presence/absence of thought disorder and hallucinations if recording paranoid ideation and review taking a forensic history. This recommendation has been implemented by the Practice.
155. For wider consideration: in an organisation like the NHS, does the occupational health physician have responsibility to share information for the safety of patients and staff?

London Healthcare NHS Trust

156. The internal learning from the Healthcare Trust IMR questions whether delays in the OH service appear to have been related to the limited resources available to manage cases promptly. The Trust commissioned a strategic review of OH services which has recently been completed (November 2017). The Trust needs to consider the implementation of recommendations from this report. Managers need to ensure that conduct issues and staff grievances are dealt with promptly and effectively

Panel recommendations

157. This review has highlighted that the primary care and treatment of Mr YZ did not benefit from the wider picture available to the OH physicians working to support him as a member of staff in the same organisation, namely, the National Health Service; nor was it standard practice to reciprocate. This is a paradox that can only be resolved by NHS England issuing practice guidance that would provide clarity in the albeit unlikely event of a similar scenario in future. The family of Mr AB and Mr YZ have indicated this, with the recommendations above, would meet their expectations for this review.
158. Therefore, the recommendation from this review is:
That NHS England study the Domestic Homicide Review overview report into the death of Mr AB in Tower Hamlets in August 2015 to identify a policy and protocol for the sharing of information between NHS Occupational Health physicians and Primary Care Practices for the safety of patients and staff.
[As this is a national recommendation, there is no requirement for a local action plan]

Author

Bill Griffiths CBE BEM QPM

2 March 2018

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Glossary

CCG	Clinical Commissioning Group
CFP	Consultant Forensic Psychiatrist
cjsm	Criminal Justice Secure eMail
DA	Domestic Abuse
Dr	Doctor (Dr1 and Dr2 at the Healthcare Trust OH)
DV	Domestic Violence
DHR	Domestic Homicide Review
DVHR	Domestic Violence Homicide Review
GP	General Medical Practitioner (GP1 – GP12 at the local General Practice)
gsi	Government Secure Internet
HMIC	Her Majesty's Inspector of Constabulary
HR	Human Resources
HT	Healthcare NHS Trust
IMR	Individual Management Review
LB	London Borough
LBTH	London Borough of Tower Hamlets
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MPS	Metropolitan Police Service
NHS	National Health Service
OH	Occupational Health
pnn	Police National Network
ToR	Terms of Reference

Name references used

AB	Victim of homicide and father of seven children
YZ	Perpetrator of homicide and youngest son of AB (Sibling 7)
Sibling 4	YZ's sister and mother of Child A and Child B
Sibling 5	YZ's sister and witness to events on day of homicide
Child A	Child of Sibling 4, witness to events and slightly injured by YZ
Child B	Child of Sibling 4 and stabbed by YZ
Child C	Child of Sibling 3 and stabbed by YZ
LM1	YZ's first line manager at Healthcare Trust January to December 2014
LM2	YZ's second line manager from June 2014
LM3	Senior line manager who dealt with YZ's grievance against LM1 and LM2
LM4	Replaced LM1 as YZ's first line manager in December 2014
DD	Divisional Director at Healthcare Trust
BP	HR Business Partner at Healthcare Trust who undertook 2 nd grievance investigation

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Distribution List

Name	Agency	Position/ Title
Will Tuckley	LB Tower Hamlets	Chief Executive
Shiria Khatun	LB Tower Hamlets	Councillor for Community Safety; lead on domestic abuse
Charles Griggs	LB Tower Hamlets	Head of Community Safety Service
Menara Ahmed	LB Tower Hamlets	Manager of Domestic Violence and Hate Crime Team Manager
Janet Slater	LB Tower Hamlets	Service Manager, Housing Options
Lisa Matthews	LB Tower Hamlets	Safeguarding & MCA Coordinator, Adult Social Care
Racheal Sadegh	LB Tower Hamlets	DAAT Coordinator
Clare Belgard	LB Tower Hamlets	Interim Head of Service, Youth & Community Learning
Shazia Ghani	LB Tower Hamlets	Head of Community Safety
Dr Somen Banerjee	LB Tower Hamlets	Interim Director of Public Health
Dr Robert Dolan	North East London NHS Foundation Trust	Chief Executive
Jane Callaghan	Barts Health	Adult Safeguarding
Awaits	Imperial College Healthcare NHS Trust	Chief Executive
Karen Sobey Hudson	NHS England	Patient Safety Projects Manager (London Region)
Sue Williams	Metropolitan Police	Borough Commander
Janice Cawley	Metropolitan Police	Detective Sergeant Specialist Crime Review Group
Simon Dilkes	Metropolitan Police	Detective Chief Inspector
Euan McKeeve	Metropolitan Police	Homicide Command Investigating Officer
Clare Williamson	Victim Support	East Area Manager
Bill Griffiths	Independent Chair	Independent Chair/Author of the Domestic Homicide Review
Tony Hester	Director Sancus Solutions Ltd	Independent Administrator and Panel Secretary
Quality Assurance Panel	Home Office	-
Cressida Dick	Metropolitan Police Service	Commissioner
Sophie Linden	Mayor's Office for Crime and Policing	Deputy Mayor
Baljit Ubhey	Crown Prosecution Service	London Chief Crown Prosecutor

Terms of Reference for Review

1. To identify the best method for obtaining and analysing relevant information, and over what period of time [Note: Agreed on 12/01/16 as from 1 January 2010 to date of homicide with any relevant prior information to be summarised], in order to understand the most important issues to address in this review and ensure the learning from this specific homicide is understood and systemic changes implemented
2. To identify the agencies and professionals that should constitute this Panel and those that should submit Individual Management Reviews (IMR) and agree a timescale for completion
3. To understand and comply with the requirements of the criminal investigation, any misconduct investigation and the Inquest processes and identify any disclosure issues and how they shall be addressed, including arising from the publication of a report from this Panel
4. To identify any relevant equality and diversity considerations arising from this case and whether either victim or alleged perpetrator was an 'adult with care and support needs' and, if so, what specialist advice or assistance may be required. An initial discussion by the Panel has identified the following protected characteristics:
 - All the above-named are Bengali Sunni Muslim
 - AB is elderly and has dementia, so an adult with care and support needs
 - Child A and Child B are children
 - YZ may be an adult with care and support needs
5. To identify whether the victim was subject to a Multi-Agency Risk Assessment Conference (MARAC) or the alleged perpetrator subject to Multi-Agency Public Protection Arrangements (MAPPA) or Domestic Violence Perpetrator Programme (DVPP) and, if so, identify the terms of a Memorandum of Understanding with respect to disclosure of the minutes of meetings. [Note: Preliminary assessment is that none of these processes apply in this review]
6. To determine whether this case meets the criteria for a Serious Case Review, as defined in Working Together to Safeguard the Child 2013, if so, how it could be best managed within this review. [Note: It has been established that the Tower Hamlets Children's Safeguarding Board have taken the decision that a Serious Case Review is not appropriate in the known circumstances of this case]
7. To determine whether this case meets the criteria for an Adult Case Review, within the provisions of s44 Care Act 2014, if so, how it could be best managed within this review [Note: This will be kept under review in the light of information received from agency IMRs].
8. To identify how should family, friends and colleagues of the victim and other support networks (and where appropriate, the perpetrator) contribute to the review and how matters concerning them in the media are managed during and after the review¹².
9. To identify how the review should take account of previous lessons learned in Tower Hamlets and also from relevant agencies and professionals working in other Local Authority areas

¹² This version pending input from family, friends and others to be arranged through police family liaison

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10. To keep these terms of reference under review and subject of reconsideration in the light of any new information emerging

Operating Principles

- a. The aim of this review is to identify and learn lessons so that future safeguarding services improve their systems and practice for increased safety of potential and actual victims of domestic violence (as defined by the Home Office – see below)
- b. The aim is not to apportion blame to individuals or organisations, rather, it is to use the study of this case to provide a window on the system
- c. A forensic and non-judgmental appraisal of the system will aid understanding of what happened, the context and contributory factors and what lessons may be learned
- d. The review findings will be independent, objective, insightful and based on evidence while avoiding ‘hindsight bias’ and ‘outcome bias’ as influences
- e. The review will be guided by humanity, compassion and empathy with the victim’s voice at the heart of the process
- f. It will take account of the protected characteristics listed in the Equality Act 2010
- g. All material will be handled within Government Security Classifications at ‘Official - Sensitive’ level

Government Definition of Domestic Abuse¹³

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

- psychological
- physical
- sexual
- financial
- emotional

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

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

¹³ Updated and published in August 2013 by the Home Office

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Appendix 2

Independence statements

Chair of Panel

Bill Griffiths CBE BEM QPM was appointed by Tower Hamlets CSP as Independent Chair of the DVHR Panel and is the author of the report. He is a former Metropolitan police officer with 38 years operational service and an additional five years as police staff in the role of Director of Leadership Development, retiring in March 2010. He served mainly as a detective in both specialist and generalist investigation roles at New Scotland Yard and in the Boroughs of Westminster, Greenwich, Southwark, Lambeth and Newham.

As a Deputy Assistant Commissioner he implemented the Crime and Disorder Act for the MPS, leading to the Borough based policing model, and developed the critical incident response and homicide investigation changes arising from the Stephen Lawrence Inquiry. For the last five years of police service, as Director of Serious Crime Operations, he was responsible for the work of some 3000 operational detectives on all serious and specialist crime investigations and operations in London (except for terrorism) including homicide, armed robbery, kidnap, fraud and child abuse.

Bill has since set up his own company to provide consultancy, coaching and speaking services specialising in critical incident management, leadership development and strategic advice/review within the public sector.

During and since his MPS service he has had no personal or operational involvement within the Borough of Tower Hamlets, nor direct management of any MPS employee. He has been involved as Chair and author of two other DHRs in Tower Hamlets in 2015-16.

Secretary to Panel

Tony Hester has over 30 year's Metropolitan police experience in both Uniform and CID roles that involved Borough policing and Specialist Crime investigation in addition to major crime and critical incidents as a Senior Investigating Officer (SIO). This period included the management of murder and serious crime investigation.

Upon retirement in 2007, Tony entered the commercial sector as Director of Training for a large recruitment company. He now owns and manages an Investigations and Training company.

His involvement in this DVHR has been one of administration and support to the Independent Chair, his remit being to record the minutes of meetings and circulate documents securely as well as to act as the review liaison point for the Chair.

Other than through this and two other reviews, Tony has no personal or business relationship or direct management of anyone else involved.

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Appendix 3



Home Office

Public Protection Unit 2 Marsham Street London
SW1P 4DF

T: 020 7035 4848
www.gov.uk/homeoffice

Menara Ahmed
VAWG, DA & Hate Crime Manager
VAWG, Domestic Abuse & Hate Crime Team Safer Communities
Mulberry Place
5 Clove Crescent London, E14

17 September 2018

Dear Ms Ahmed,

Thank you for submitting the Domestic Homicide Review (DHR) report for Tower Hamlets to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 27 June. I am very sorry for the delay in providing the Panel's feedback.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded that this is a good review with appropriate findings based on the information presented. However, the Panel noted that the terms of reference are generic in nature and predominantly process-focused. The circumstances of each individual case should determine the terms of reference that are pertinent to the review and result in more tailored, specific questions in relation to what needs to be examined. It is the review panel's role to determine appropriate terms of reference for each individual review based on the circumstances of each case.

There were also other aspects of the report which the Panel felt may benefit from further analysis, or be revised, which you will wish to consider:

- There is no examination of barriers to the perpetrator accessing the support offered by the GP;
- Similarly, barriers to engaging with mental health services for cultural reasons are not explored which could have been expected in such a case and would be useful to inform learning;
- Risk and risk assessment, other than in the context of the perpetrator's return to work carried out by occupational health, are not considered;



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- The Panel noted the report mentions a review of the Health Trust's occupational health system was completed just before the DHR but the findings have not been included in this review;
- A representative from a mental health charity on the review panel may have been beneficial;
- The Panel noted an action plan to accompany this report was not submitted in line with the statutory guidance – in particular to include the recommendations for the GP practice and Health Trust;
- You will wish to note that there is a discrepancy in the status of the GP recommendation in the executive summary (marked as completed) with that in the overview report. In addition, the second GP recommendation in the overview report does not appear in the executive summary;
- The location of the homicide on the title page of both reports differ;
- The Panel understands the challenges of following family wishes in relation to anonymisation but felt that pseudonyms would humanise a review and allow a reader to more easily follow the narrative;
- The Panel noted the efforts made to engage the family in the review and suggested that, in future, you may wish to consider offering families specialist advocacy support to encourage their involvement in the DHR process
- There is a contradiction in the start date of the review period: terms of reference state January 2010; page 3 states January 2007;

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the Mayor's Office for Policing and Crime for information.

Yours sincerely

Charlotte Hickman

Joint-Chair of the Home Office DHR Quality Assurance Panel

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**Home Office letter extracts with responses from Bill Griffiths, DHR Chair and report author,
agreed by Tower Hamlets Community Safety Partnership**

Point	Letter extract	Response
1	The Panel concluded that this is a good review with appropriate findings based on the information presented. However, the Panel noted that the terms of reference are generic in nature and predominantly process-focused	The starting point for setting Terms of Reference is the generic Home Office guidance so as not to miss anything of importance. Ideally, the ToR would have been informed by the family of the deceased and his son, but their input was not gleaned until near the end of the process. It is acknowledged that the ToR could and should have been revised once the reports from the Consultant Forensic Psychiatrists had been accessed (some ten months after the beginning of the process). Nonetheless, as explained in paragraph 47 on page 10, these reports were highly informative to the Domestic Homicide Review which was not, in the end, process-focussed
2 (Bullet point list 1)	There is no examination of barriers to the perpetrator accessing the support offered by the GP	In paragraph 32 on page 8, the Panel concluded that there was no evidence of a differential service [from the GP Practice and the Health Trust] in respect of protected characteristics or evidence of a cultural barrier to engaging with mental health services. Thus, it can be safely concluded that the issues were discussed, however, it is a learning point that the Panel could have been more challenging in its examination of this aspect of the review
3 (2)	Similarly, barriers to engaging with mental health services for cultural reasons are not explored which could have been expected in such a case and would be useful to inform learning	See response above
4 (3)	Risk and risk assessment, other than in the context of the perpetrator's return to work carried out by occupational health, are not considered	It is acknowledged that specific reference to risk and risk assessment by the GP Practice has not been recorded. However, Table 3 at paragraph 137 on page 24 does set out the missed opportunities for both Trust and Practice to apply professional curiosity to identify the underpinning causes of Mr YZ's evident distress

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5 (4)	The Panel noted the report mentions a review of the Health Trust's occupational health system was completed just before the DHR but the findings have not been included in this review	Mr YZ was an <u>employee</u> of the Health Trust. In paragraph 135 on page 23, it is clear that the Trust was not providing Mr YZ with primary care, so he was <u>not a patient</u> in the conventional sense. Thus, DHR legislation did not apply to the Trust in this context. The Trust's internal review was a strategic one of OH services and informed the DHR Individual Management Review (IMR) that was voluntarily provided after much negotiation with the Chair. It has been very helpful to this review. The findings in the Trust IMR can be seen in paragraphs 126 -135, starting on page 22. An integrated timeline analysis of the opportunities for professional curiosity by both the Trust and the GP Practice has been included in Table 3 at paragraph 137. The conclusions from the Trust review are noted in paragraphs 140-145
6 (5)	A representative from a mental health charity on the review panel may have been beneficial	This has been accepted as a learning point
7 (6)	The Panel noted an action plan to accompany this report was not submitted in line with the statutory guidance – in particular to include the recommendations for the GP practice and Health Trust	The internal recommendation identified for the GP Practice has been implemented to the satisfaction of the Panel. The Health Trust recommendations relate to a strategic review of OH services and an internal matter for the reason explained above. An Action Plan would be retrospective in any case and it is felt that the work required to write up how something was implemented is not warranted, given that this report was submitted in March 2018 The Panel recommendation is a national one for NHS England and the Action Plan is a matter for them
8 (7)	You will wish to note that there is a discrepancy in the status of the GP recommendation in the executive summary (marked as completed) with that in the overview report. In addition, the second GP recommendation in the overview report does not appear in the executive summary	This discrepancy has been corrected in the overview – the last sentence from paragraph 154 on page 31 has been added to the Executive Summary. The second GP recommendation at paragraph 155 informed the Panel discussion and recommendation in paragraphs 157-158, and these are replicated in the final two

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		paragraphs of the Executive Summary
9 (8)	The location of the homicide on the title page of both reports differ	This error has been corrected in the Executive Summary version
10 (9)	The Panel understands the challenges of following family wishes in relation to anonymisation but felt that pseudonyms would humanise a review and allow a reader to more easily follow the narrative	The point that pseudonyms humanise a review is acknowledged and, when a family does not take the opportunity to choose one for their loved one, the Chair will discuss the suitability of random names with the Panel. Underpinning the specific family request for random initial letters in this review (see paragraph 21 page 6), was their concern that publication will have an impact on the younger family members through speculation on social media. They accept that publication is inevitable but consider the use of initials as helpful to reducing this impact. The Panel maintain the view that family wishes should be respected whenever possible
11 (10)	The Panel noted the efforts made to engage the family in the review and suggested that, in future, you may wish to consider offering families specialist advocacy support to encourage their involvement in the DHR process	The efforts to engage the family in the review are set out in paragraphs 20 and 21 on page 6. The advance letter from the Chair in September 2016 highlighted the content of the Home Office guidance leaflet where the pathway to specialist advocacy support is clearly set out. The Chair was not able to meet or converse directly with the family because they declined the offer. They are not compellable in this process and their stance was respected. When the Panel felt that their view may have changed due to the passage of time, the Chair repeated the offer and did meet with them in January 2018 when input was made and then provide them with a near complete copy of the review. Their reasons for not engaging in the beginning were made clear, and did not include the lack of advocacy support
12 (11)	There is a contradiction in the start date of the review period: terms of reference state January 2010; page 3 states January 2007	This is a typographical error (it should be 2010) and has been corrected in the redacted version to be published