LONDON BOROUGH OF TOWER HAMLETS
COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

ABDUL AGED 36 YEARS

FOUND MURDERED IN TOWER HAMLETS
IN SEPTEMBER 2015

REVIEW PANEL CHAIR AND AUTHOR
BILL GRIFFITHS CBE BEM QPM

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FOREWORD

"Death ends a life, not a relationship"

Mitch Albom

It is incredibly sad that the two brothers in this case fought each other, resulting in the homicide of one and the incarceration for murder of the other. For the surviving family of six sisters, their grief is compounded firstly by their belief that their younger brother should have been acquitted on the grounds of self defence, secondly by the loss of their disabled mother shortly after the incident. Our deepest sympathy goes out to them.

There had been a history of friction between the brothers since their mother was afflicted with a stroke and was bed bound at the home they shared together. Daily visits by care workers and district nurses to attend to their mother's needs must also have been disruptive to their own daily lives. It is apparent that excessive alcohol consumption and cannabis use increased during this time and, in respect of the victim, this may have contributed to the paranoia disorder from which he suffered.

There had been relatively minor domestic incidents recorded between the brothers, also involving their sisters on occasion, going back to 2007 including possibly two instances of throat grabbing on each other, which perhaps foretell the manner in which Abdul met his death. However, there was nothing known to anyone in authority that could have foreseen the violent end to the discord between them. As intended by the legislation, the review has surfaced some missed opportunities and lessons to be learned as well as good practice to be shared.

This independently chaired review into the circumstances leading to the death of Abdul has been well supported by Tower Hamlets Community Safety Partnership and the agencies and specialist advisers that participated in the review. I am very grateful to the members of the Panel for their hard work to support the review and also for their wise and expert counsel during discussions. My understanding of the issues and appreciation for the work they do in the field of domestic abuse has been greatly enhanced.

I should also place on record my grateful thanks to Tony Hester and Sancus for the invaluable management support to this review.

W Griffiths CBE BEM QPM
Independent Chairman
15 January 2018

OVERVIEW REPORT

INTRODUCTION

1. This report of a domestic homicide review examines agency responses and support given to Abdul, a resident of the London Borough of Tower Hamlets prior to the point of his homicide on or before the discovery of his body in early September 2015. He and his brother were carers for their disabled mother, Minu, and the review also examines agency responses and support provided to her as an adult at risk.

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 early September 2015 at about 1700 police were called to a second floor flat in Tower Hamlets, London, E1 where Abdul aged 36 was found deceased from strangulation. His body had lain in situ for at least a week. His brother, Yunus aged 29 was arrested as the result of enquiries and charged with murder. There is a history of known domestic incidents between the brothers since 2007. At the Central Criminal Court in February 2016, Yunus was sentenced to 12 years imprisonment for the murder of his brother.

4. The review will consider agencies contact/involvement with Abdul, Yunus and Minu from January 2007 to the day of the homicide in August 2015. Any relevant fact from their earlier life will be included in background information.

5. 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.

6. One of the operating principles for the review has been to be guided by humanity, compassion and empathy, with Abdul and Minu's voices at the heart of the process

TIMESCALES

7. The review began with a Panel meeting on 12 January 2016. Further meetings to consider and debate the chronology of events known to safeguarding agencies, the Individual Management Reviews (IMR) provided and the analysis, lessons learned, conclusions and recommendations were held in February, May and June. There was a delay to allow for a prison interview with Yunus. The fifth version of the overview report was agreed by the DVHR Panel and then presented to the Community Safety Partnership Board and the Adult Safeguarding Board in October.

8. A redacted version of the final report was submitted in November (in the format required prior to new guidance issued in December) to the Home Office Quality Assurance Panel. This was considered at a meeting in July 2017 and the result notified in a letter dated 26 September 2017 (appendix 1 attached). An additional Panel meeting was held in December to consider the issues raised in the letter and the responses to the points raised are shown in a table below this letter, with cross-reference to any new paragraph numbers that arise due to restructuring of the report in line with new guidance.

CONFIDENTIALITY

9. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.

10. 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.

11. 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 deceased will be referred to as Abdul and his brother as Yunus. Reference will also be made to their disabled mother who lived with them at the flat, as Minu. The six daughters in the family will be allocated numbers in the order of their age.

TERMS OF REFERENCE

12. The first Panel meeting was held on 12 January 2016 with the membership and agencies represented as shown in Table 2 below. Following discussion of a draft, Terms of Reference were issued on the same day (appendix 2).

METHODOLOGY

13. 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 Abdul, Yunus and Minu. From the table below it may be noted that five agencies have records of relevant contact with the deceased and his brother from 1 January 2007 (date identified by Panel) up to the discovery of Abdul's body in early September 2015. An integrated timeline to aid the reader can be found at appendix 4.

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

Contact period	Agency	Summary of contact
13/09/07 to 03/09/15	Metropolitan Police Service (MPS) in LB of Tower Hamlets	Police were called to eleven domestic abuse incidents between Abdul and Yunus and their sisters prior to the homicide, two of which included a minor assault by Yunus and one by Abdul

		Abdul also on sex offenders register since 08/10 for indecent assault on a female bus driver
02/01/08 to 03/09/15	A Health Centre, Tower Hamlets CCG	Provided primary health care to Abdul, mainly for anxiety with depression, and to Yunus, mainly for alcoholism
29/04/08 to 06/03/15	London Borough of Tower Hamlets (LBTH) Adult Social Care (ASC)	Provided adult social care to Muni following a stroke and aware of tensions between the brothers from 07/13 onward Concerns raised by care workers for Muni in 02/15 that Abdul exhibiting mental health symptoms, Safeguarding Meeting held and referred to Community Mental Health Team (CMHT)
15/12/08 to 03/09/15	Barts Health NHS Trust	Provided a community nursing service to Minu following her stroke Safeguarding concerns raised by district nurses to Minu in 12/14 No contact with either Abdul or Yunus found in acute health services records
22/11/11 to 11/03/15	East London Foundation Trust (ELFT)	Provided mental health services to: Abdul from 08/12 to 03/15 in which diagnosed with paranoid personality disorder associated with alcohol and increasing cannabis use. Did not attend follow up appointment in 04/15 Yunus from 01/14 to 04/14 for anxiety and depression associated with alcohol and cannabis consumption

15. This review was commissioned under Home Office Guidance issued in December 2016. Close attention was paid to the cross-government definition of domestic violence and abuse and is included in the Terms of Reference (appendix 2).

16. 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

17. There have been six DVHR cases reported in the London Borough of Tower Hamlets since the legislation and prior to this case. Two have been published and three are close to completion, with the sixth case near in time to this review. Particulars have been provided to the Chair who has concluded that, in the circumstances of this review, there are no parallels to be drawn.

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

18. The deceased and the perpetrator are brothers to six sisters, aged between 50 and 29 at the time of this homicide, and several attended the trial at the Central Criminal Court. In the course of the trial, they became concerned that the police investigation and Crown Prosecution had jointly pursued the murder charge and not accepted their position that Yunus had acted in self defence. This culminated in them ceasing dialogue with the family liaison officer and so would not meet with the DHR Chair who was present, saying at the time: "It won't alter anything and nothing will change".

19. In anticipation, the Chair provided a letter of invitation, with the Home Office Domestic Homicide Review Information leaflet attached, to Defence Counsel for Yunus for personal delivery to the sisters who were present. A further request to meet via text message some six months later was acknowledged, and considered at a family meeting, but also declined.

20. Contact was successful with friends of Abdul who had known him through a shared interest in horticulture and had planted a tree in his memory nearby and they have contributed to this review.

CONTRIBUTORS TO THE REVIEW

21. Each agency listed in Table 1 has provided an Individual Management Review (IMR). In preparation for this submission, ELFT undertook a full Serious Incident Review at level 1b of all the known episodes of care provided to Abdul and Yunus, using the Root Cause Analysis methodology. A number of other local agencies involved with the response to domestic abuse have checked their records and have found no trace of any of the parties involved in this review.

22. An enquiry was made with the establishment where Yunus is serving his sentence and, with the support of his offender manager, the Chair interviewed him in August 2016 and his perspective is illustrated in the report.

THE REVIEW PANEL MEMBERS

23. Table 2 - Review Panel Members

Name	Agency/Role
Menara Ahmed	LBTH Domestic Violence and Hate Crime Team
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 Woman's' Project
Jane Callaghan	Barts Health
Tracey Upex	East London Foundation Trust
Tina Cicotto	Victim Support
Simon Dilkes	MPS LB Tower Hamlets
Ben Mott	MPS LB Tower Hamlets
Euan McKeeve	MPS Homicide Command
Janice Cawley	MPS Specialist Crime Review Group
Bill Griffiths	Independent Chair
Tony Hester	Independent Administrator and Panel Secretary

AUTHOR OF THE OVERVIEW REPORT

24. Under s9 Domestic Violence, Crime and Victims Act 2004, a Domestic Violence Homicide Review (DVHR) was commissioned by Tower Hamlets Community Safety Partnership and in November 2015, Bill Griffiths CBE BEM QPM was appointed Independent Chair of the DVHR Panel and author of the overview report. Tony Hester supported him throughout in the role of Secretary to the Panel. Their respective background and 'independence statements' are attached at appendix 3.

PARALLEL REVIEWS

25. 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.

EQULITY AND DIVERSITY

26. Consideration has been given to the nine protected characteristics under the Act in evaluating the various services provided. All concerned are Bengali by heritage and Sunni Muslim by faith. Consideration has been given to whether either or both brother meets the classification of 'adult at risk'[1]. It is accepted that Minu was an adult at risk due to her medical condition.

[1] Formerly known as a 'Vulnerable Adult'

BACKGROUND INFORMATION (THE FACTS)

Family background

27. Minu and her husband had eight children, six daughters and two sons who are victim and perpetrator in this review. The family originated from Bangladesh and most of the children were born in the UK. Their father died from cancer in 1994. Their mother, Minu, had been diagnosed with schizoaffective disorder, then suffered a stroke in April 2008 and was later bedridden as a result at the privately leased family home, a four-bedroom apartment on the second floor of a purpose-built block of flats in Tower Hamlets that she shared with her two sons.

28. Sister 6, who is the youngest sibling, was the last sister to be married and leave the family home in August 2013. Regular visits to their mother were also undertaken by sister 3, sister 4 and sister 5. Abdul and Yunus remained living at home each occupying their own bedroom at the flat.

Abdul

29. Abdul was aged 36 at the time of his death. He was being treated by his GP for depression and was prescribed the antidepressant drug, sertraline. At a medical assessment when he self-presented to the Royal London Hospital (RLH) Emergency Department in March 2015, he described a difficult childhood, including in his relationships with siblings. He reported that he had completed a degree in genetics and microbiology but had dropped out of a Master's degree course because he was using too much cannabis.

30. He had held various short-term employments, mainly in work to do with IT, sometimes within the NHS locally. He stopped working in December 2014 because he felt too much stress. His mother had recently been discharged from hospital after a short admission due to hyper-glycaemia and he has a close relationship with her. But his siblings did not do what he perceived to be their share of looking after her and then blamed him when things went wrong.

31. He had told the Admission Ward nurse that he did not feel safe at home and thinks he wants to beat his brother with whom he lives "to a pulp". In the course of the psychiatric assessment, in which he was diagnosed with paranoid personality disorder, he went on to disclose increasingly smoking cannabis (£75 worth every two weeks) and to drinking two cans of beer a day. He described the family dynamics as being "very difficult" and related those and other scenarios that had a strong persecutory theme, as follows:
    - He has no food at home and no money and his sister controls their mother's finances and does not give him money for food when she thinks he is not looking after the mother properly
    - When he has food, such as pot noodles, he hides it and his brother then steals it
    - He often thinks there is foul play going on
    - When praying at the Mosque, he felt someone's foot touch his and he could not move his leg properly for two weeks as he suspected a jellyfish sting

- He had been 'drugged' or 'poisoned', including by his sister who put something in a curry she had made which made him bleed from all his orifices
- People do not look directly into his eyes as he believes his 'glasses are bugged' and people know that if they look at him everything is being recorded
- His family has told the police that he is a terrorist and on one occasion he saw police outside his house and noticed that their radio was interfering with his laptop. He approached them and they denied they were watching him but he took their shoulder numbers and called the local police to check their identities

32. He also disclosed that he was on the sex offender register. Police records have confirmed this fact. In February 2008, Abdul was observed by police to be standing close to women on buses and a sexual motive was suspected. He was stopped and searched and a pornographic DVD and empty cannabis bags found but no further action taken. In November 2009, members of the public detained him for an offence of sexual assault by touching and he subsequently accepted an adult caution. In November 2011, a female bus driver was indecently assaulted by touching and, as a result of CCTV examination, Abdul was arrested and convicted of the offence in July 2010. He received a 24-month Community Order and became a Registered Sexual Offender (RSO). Under the Multi Agency Public Protection Arrangements (MAPPA)[2] by Tower Hamlets police 'Jigsaw Team'; this was managed at Level 1.

33. Consequently, Abdul was visited a total of 18 times from initial registration until his death. Once registered, he was compliant with the notification requirements and his behaviour did not raise any concerns to his offender manager that he would commit further sexual offences. The last occasion he was visited was in April 2015 when he told the visiting officers that there were no issues but mentioned he didn't get on with his brother and that they barely spoke. This was consistent with earlier notes about their troubled relationship but there was no hint of an escalation in the level of violence between them.

34. Abdul also has an adult caution recorded by the police for assaulting his brother in September 2007 in the circumstances described below in DAI (Domestic Abuse Incident) 1.

35. Abdul's pastime and passion was horticulture and he was a local volunteer for the 'Trees for Cities' charity. He had pursued a NVQ level 2 in horticulture in the academic year 2011/12 and made a number of Bengali friends there. They describe him as a kind and gentle soul who was also very engaging and could lift everyone's spirits in the team.

36. He had shared with his friends some of the fears disclosed and recorded in the psychiatric assessment in March 2015 above. He also repeatedly asked one of the female friends to marry him because he felt pressure as the first-born son to be married. She has been spoken to and says that he was always courteous but he just was not for her so his requests were kindly declined.

37. One manifestation of his passion for horticulture was the entrance to the flat being festooned with growing plants and many more were inside being cultivated from seeds and he would gift these to his friends. Those from 'Trees for Cities' that knew him set up a

[2] See notes on MPS forms and processes on pp22/24

memorial messaging site on WhatsApp social media and have planted a tree near to his home with a plaque: "In fond memory of Abdul".

38. Unfortunately, this absorbing and therapeutic hobby became a source of friction between the two brothers.

Yunus

39. Yunus was aged 29 when he killed his older brother. From a medical assessment in March 2014 when he had been referred by his GP for help with ceasing alcohol and cannabis consumption, it has been gathered that he had a happy childhood and completed secondary education with a BTEC in media studies. He attended one semester at university but was involved in a car accident and left, aged 20. He last worked as shelf filler at a Co-Operative store in December 2013 but was asked to leave because of his drinking.

40. He disclosed that he started drinking vodka when aged 16 and became more dependent on it over time. More recently, he had switched to cider and was consuming 22 units of alcohol per day. At around the same time he started to smoke cannabis and was now on four joints a day

41. He was feeling anxiety most of the time, possibly related to alcohol withdrawal, and is upset with his drinking habit. He displayed an excellent insight into his problem and planned to stop cannabis and alcohol. The impression was gained of both alcohol and cannabis dependency and he was referred to the Tower Hamlets Specialist Addiction Unit (THSAU) and the Tower Hamlet Community Alcohol Team (THCAT) nurse at the GP surgery for an appointment in April 2014 that resulted in his attendance at Alcoholics Anonymous for a short period but did not keep up attendance.

42. Yunus has two adult cautions for common assault; on Abdul in November 2011 (DAI 3), and on his sister in August 2012 (DAI 8) in the circumstances described below.

43. After initial reluctance at the time of the verdict, Yunus has reflected and agreed to be interviewed by the Chair in the presence of his offender manager. To his credit he regrets that he is responsible for killing his brother and admits that the tension between them had become unbearable and he just "snapped" whilst intoxicated, as he could "take no more". He describes his older brother as highly intelligent but at the same time "manipulative". He went on to provide an example of a major rubbing point between them of who should take responsibility for cleanliness in the home. According to him, Abdul would appear to wash dirty cutlery and then leave it to dry when he had, in fact, smeared it in grease.

The care of Minu

44. The care provided to Minu, mother of both Abdul and Yunus is highly relevant to this review and is the backcloth to the events that led to the death of Abdul because much of the discord between the brothers arose from the care responsibilities they shared for their mother as an adult at risk that seemed never to be reconciled between them.

45. Minu had a medical history of stroke, schizoaffective disorder and diabetes. She was admitted to the care of Barts district nursing service in Tower Hamlets in December 2008

following a stroke. She initially underwent a period of rehabilitation at Mile End Hospital and was subsequently cared for her two daughters and two sons at home with community support. One daughter was identified as her main carer.

46. In parallel, Tower Hamlets Adult Social Care Department provided a care management/social work service and provided a home care service via London Community Home Care (LCHC) during the week and St Hilda's East Community Centre (SECC) at weekends and they maintained a log of visits. By June 2010, her mobility had deteriorated and she was bedbound requiring an increased package of care which constituted of two-carer visits four times a day together with Barts district nurse visits three times a day to administer her medicines, monitor her pressure care area and set up her feeding via a PEG tube, (a long-term solution for maintaining nutrition for someone who has a poor swallow reflex).

47. From February 2010, there were numerous contacts with Minu and her daughter but there is limited mention or reference to the sons living at the property until February 2013 when concerns were raised about the condition of the home. The problem persisted and in July 2013 a social work visit was arranged to discuss the concern.

48. The flat was generally unkempt and unsanitary as the brothers argued about whom should be responsible for cleanliness. The bedroom occupied by Minu was maintained to a satisfactory standard by the care worker regime. As the result of the incident in September 2013 (DAI 11), the sisters became involved and commissioned a deep clean with regular contracted cleaning to follow.

49. Yunus is first referred to in the context of him providing care for his mother in September 2013 when he agreed to give her medicine and feed as the nurses were delayed. He was also the person who contacted the nurses when the machine used to deliver the feed was not working. There is a note in in the care record March 2014 recording the contact details for the two daughters. This may have been prompted, as they were no longer living at the property.

50. The first indication that all was not well with Abdul is recorded in April 2014. The nurse was alarmed by his behaviour and left the property without completing her notes. There is no incident report for this and it is not clear if the incident was escalated to a line manager. However, throughout May 2014 the district nurses noted that both sons ignored their advice about safe positioning for Minu. A case conference held in May 2014 to discuss the concerns included a report of the police seen escorting one of the sons off the premises. There is no police record of this incident, including by cross-reference to the RSO visit log. No safeguarding alert was raised on this occasion but there was a plan to contact the Community Mental Health Team (CMHT) regarding Abdul.

51. During a visit in May 2014, it was noted that Minu was agitated and trying to tell the nurses something but they could not understand her owing to a language barrier. Two weeks later the nurses noted the smell of marijuana, unsanitary conditions in the home and an infestation of flies. The nurses also recorded that Minu is again lying flat. Adult Social Care was contacted and these concerns raised along with a reference to the aggressiveness of

the family. They were advised to report this to the police but it is not recorded whether this was done [Note: there is no report recorded by the police].

52. In October 2014, it was reported by a care worker that Yunus was feeding Minu by mouth whilst her PEG feed was connected. He was also dancing while feeding her. This was reported to the GP who sent a community nurse to check on welfare.

53. There developed a growing concern about the safety of the nurses visiting and the suitability of the sons to be helping to care for their mother. One son declined to help lift her as he was intoxicated and it was reported that they were attempting to give Minu a drink by mouth that would have been unsafe. The son [not recorded which one] blamed the carers for doing this.

54. In December 2014 there was a disagreement between the visiting district nurse and a son [again, identity not noted] over the safe position for Minu to be administered medication. The son's opinion was that his mother was uncomfortable and he manipulated the bed to an unsafe position. When she pointed this out, the son asked her to leave. The nurse did so and reported the incident to her manager who then attended with her and spoke to the son. Despite the explanation from the manager that confirmed the medical safety advice, the son insisted that he was right and persisted with his view that the nurse should not again attend the home. The manager then contacted sister 4, who undertook to speak to her brother.

55. Later in December, the manager spoke to a colleague in Adult Social Care whom he assumed was a social worker but was a First Response Officer who is not a social worker. On his written account at the time, he understood that the matter had been recorded as a safeguarding issue that needs urgent attention. The ASC record notes that: "Referrer is requesting an urgent review to discuss these issues and advise son how the meds should be administered" but it is not logged as either a safeguarding issue or urgent in the tick boxes available and 'neither' is the chosen option.

56. Six days later, respective managers discussed the matter by telephone and there appears to have been a difference of opinion. The DN manager has said she maintained that this was a safeguarding issue and that Minu was a vulnerable adult, there being a history of aggression from the sons, hence the nurses were now attending in pairs. She records that the First Response manager acknowledged the vulnerable adult point but was insistent that the issue was one of the quality of district nursing care. It was left that further clarification would be sought through a family meeting.

57. The written accounts of these conversations have been compared and the differences noted and it appears that this is a missed opportunity for an adult safeguarding meeting around the care of Minu, an adult at risk. It may have been possible to also check the audiotapes kept by the Council to ascertain which written record is more accurate but, after this passage of time, they have been re-recorded.

58. Although the district nurses were by now visiting in pairs, in early January 2015, a nurse visited alone and found stickers on the front door saying, 'LET MY PEOPLE GO'. Fearful

to enter she contacted the office and two other nurses agreed to do the visit. A referral to the CMHT duty desk asking for a review of Abdul was made but not accepted as he had not attended previous appointments and his GP was contacted to make the referral.

59. Yunus recalls this incident and how his brother had posted the same message all around the home that day and he had to calm his mother who had become visibly alarmed by Abdul's behaviour.

60. By the end of January 2015, the visiting district nurse was concerned for Minu's health and she was admitted to hospital for observation overnight and found to have high blood sugar and high blood pressure. In early February, Yunus disclosed domestic abuse perpetrated by Abdul. He told the nurses that he had reported this to social services but that nothing had happened. The nurses also reported a phone conversation with Yunus' sister who called him an idiot and told the nurses to ignore him.

61. A Safeguarding Case Conference was then held in which it was established that the 'son with mental health issues' [presumably, Abdul] had given his mother medication that should have been administered by the nurse. He had been abusive to nurses and video recorded their work; they felt unsafe in his presence. A referral was made to the CMHT (see the clinical assessment at the RLH in March 2015 in paragraphs 29-31 above for the outcome).

62. Prior to discharge two weeks later, Minu underwent a mental capacity assessment, demonstrated capacity and wanted to be discharged to her home. The district nurses restarted visits with a plan in place to maintain their safety.

63. In the week prior to the discovery of Abdul deceased in early September 2015, it is known that he had been left for about six days to decompose and the odour of decay was very noticeable to the medics and officers who entered his bedroom to recover his body. It seems that a prevailing pungent odour was not remarkable for the care workers and district nurses as only routine reports were filed in this period.

64. The Panel did find this astonishing and caused further enquiries to be made with the staff who attended Minu in that period. Strong odours in the flat were commonplace, had been the cause of earlier complaints and deep cleansing had been undertaken as a result. The deceased had been wrapped in several layers of clothing and bedding. His bedroom door was closed. The sanitary condition of Minu's bedroom was satisfactory. It was not possible to take this further other than as learning within Adult Social Care.

65. Minu was present in the flat and may well have heard the argument and fight in which her youngest son murdered her eldest, which must have been profoundly distressing. Due to her medical condition, she was not competent to be a witness and was not interviewed. By the end of September, she had become more unwell, was admitted to hospital and died within a few days.

Reported and possible domestic incidents between the brothers and other siblings

Domestic Abuse Incident (DAI) 1 – mid-September 2007

66. Police were called because a verbal argument between the brothers had occurred after Yunus resigned from his job. This escalated and Abdul assaulted Yunus by grabbing him around the neck. Yunus recalls that this was an arm lock around his neck and that his sister helped to pull Abdul away. Abdul was arrested for common assault, admitted the facts and accepted a police caution for the offence.

67. A domestic incident report (Book 124D[3]) was completed and the DASH risk assessment conducted that placed Yunus as a standard risk[4]. It is not possible to investigate this report further as papers were filed locally and then destroyed after the seven-year retention period.

DAI 2 – early July 2008

68. Police attended the report of a verbal argument between Abdul and three of his sisters over the care of their mother. There were no criminal offences apparent and the incident was recorded as a non-crime domestic incident and the matter closed. Again, paper records have been disposed of.

DAI 3 – mid November 2008

69. Andul called police to the family home claiming that his mother and brother were being aggressive and abusive to him. Officers identified that the matter was a non-crime domestic incident and it was recorded on the Computer Aided Despatch (CAD) system. Extant policy was that a CRIS (Crime Report Information System) report should also have been completed but it was not.

70. The IMR author contacted both officers who attended the call and neither has any recollection, so are unable to assist the review. Current policy would not allow that a CAD record be closed without a CRIS number recorded in the result field.

DAI 4 - early October 2010

71. Police were called to a verbal argument between Yunus and sister 6. Yunus came home drunk and accused sister 6 of stealing money from him. Investigation established that he was mistaken so no offence was disclosed. Yunus was asked to leave the property and return when he had sobered up. A 124D was completed and the DASH risk assessed as standard. This incident is also recorded in the Adult Social Care (ASC) IMR because sister 3 had contacted the social worker when the police had been called.

DAI 5 - mid May 2011

72. Abdul shouted at his elderly mother and threw a cassette player across the room, causing damage to it. Yunus was in the premises and heard Abdul shouting and something breaking so called the police. Police attended and a 124D was completed and the risk assessed as standard.

[3] See notes on pp22/24
[4] Ibid

73. For medical reasons their mother was unable to provide a witness statement. Yunus did provide a statement but he could only describe what he had heard. The evidence was presented to an Evidential Review Officer (ERO)[5] and the case was closed, as there was insufficient evidence to refer to the CPS for a charging decision.

74. The IMR author has noted that Minu was clearly an adult at risk but the policy and training was not yet in place to ensure that a MERLIN[6] (Missing Persons and Related Linked Indices) PAC (Pre Assessment Checklist) 'Adult Come to Notice' (ACN) would be created and shared with LBTH Adult Social Care. Training for this procedure commenced in January 2013 and the policy was implemented in April 2013.

DAI 6 - early November 2011

75. Yunus accused Abdul of going into his room without permission. A verbal argument ensued and Yunus pulled Abdul to the ground. When Abdul broke free he started to call the police and Yunus punched him in the face, causing minor injuries. Police attended and Yunus was arrested.

76. A 124D was completed and the DASH assessment was medium risk. Yunus was interviewed and admitted punching his brother. The case was referred to an ERO who authorised that a police caution for common assault be the judicial disposal.

77. Abdul was informed of his brother's caution the following day. He told the investigating officer that he would have preferred that Yunus be given a verbal warning instead, saying that he believed this incident was a 'one off', aggravated by his brother's drinking habit and that they were back on speaking terms. In the light of this development, the investigating officer revised the risk assessment to standard. There is no record of any referrals being made or offered and the case was closed.

DAI 7 - late July 2012

78. Abdul and Yunus had a verbal argument after Yunus moved a small indoor plastic greenhouse belonging to Abdul. Officers attended the address and, although no offences were identified, a 124D was completed and the DASH risk assessment was standard. The Community Safety Unit (CSU) undertook a secondary investigation and recorded that both Abdul and Yunus were given details of Tower Hamlets 'One Stop Shop' (the Jagonari Centre). The investigation was then closed with no further action taken.

79. The IMR author has noted that the primary investigator commented in the CRIS report that Abdul was apparently suffering from mental health issues but did not expand on what had been observed; moreover, that the secondary investigator did not explore the mental health issue further.

DAI 8 - mid August 2012

80. Ynus had a verbal argument with his younger sister (6) that culminated in Yunus holding her down on a bed. Yunus had demanded money from his sister so he could buy

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[5] Ibid
[6] Ibid

cannabis. When she declined Yunus became aggressive and shouted at her. When she tried to call the police, Yunus pinned her down and took the battery from her phone. Upon release, she called police from the house phone.

81. Police attended and Yunus was arrested for common assault on sister 6. A 124D was completed and the DASH risk assessment was standard. Yunus was interviewed and admitted assaulting his sister by pinning her down. The matter was referred to an ERO who authorised a caution for common assault. Sister 6 moved out of the property whilst Yunus was in custody.

Possible DAI 9 – late July 2013

82. Almost 12 months later, the emergency ASC duty team received a call from Abdul who described an argument between siblings that evening. There had been 'family dynamics' for some time and he did not feel safe in administering medication to Minu. Abdul sounded intoxicated and confessed to using alcohol and cannabis. He was advised to address difficulties between siblings by talking between them. Yunus' recollection of this incident is that it was he that was mainly taking responsibility for the administration of his mother's medication.

83. At a follow up visit by a social worker, sisters 3 and 6 were interviewed and it was established that Yunus is supportive and does administer evening medication. Concerns regarding kitchen hygiene were noted. Although Abdul was described as supportive, both sisters were unaware that he had mental health problems but did suggest that he is 'short tempered'. Sister 6 disclosed that her relationship with Abdul had broken down and she did not speak to him. The sisters also complained about the quality of care during the week.

Possible DAI 10 - mid September 2013

84. Abdul contacted the social worker and complained that he had been "lumbered" with the responsibility of his mother's care. This was contributing to his relapse as he has mental health problems. He reported that he had an altercation with his brother the previous evening, accusing him of not pulling his weight and being unsupportive to their mother. He wanted nurses to care for his mother's medical needs.

85. The social worker pointed out that this had already discussed with sister 3 and he responded that she walks away when she sees him and does not talk to him. He disclosed that his sister 4 is also adding pressure on him with extra tasks that he feels this will cause his breakdown. It was agreed that liaison would be with the sisters and a community nurse did attend that weekend.

DAI 11 - late September 2013

86. Abdul and Yunus had a verbal argument after Yunus moved some of Abdul's plants without his permission. On police arrival, no offences were identified and the matter was dealt with as a non-crime domestic incident. A 124D was completed and the DASH risk assessment was standard. The primary investigators were concerned about Abdul's mental health and that he and his brother lived with their elderly bed ridden mother. A Vulnerable Adult MERLIN/PAC was completed and shared with Adult Social Care in early October.

87. Both the Primary and Secondary Investigators recorded in the CRIS report that background checks had been completed with the result that there was: 'No history of DV'. There is no record of Abdul being contacted by the secondary investigator or informed of appropriate support referral agencies. The case was closed without further action.

88. Properly conducted five-year background checks would have revealed to the primary and secondary investigators that there was a history of domestic abuse incidents between Abdul and Yunus and some involving other members of the family. Had this information been taken into account, it may have influenced the risk assessment judgement.

89. Nonetheless, the Public Protection Department (PPD) in their quality assurance role did conduct follow up research and note the history between Abdul and Yunus and also list the family members living at the flat for future reference.

90. The MERLIN/PAC report was received by the social worker who recorded that the siblings all have a volatile relationship with Abdul and there is a lack of communication between them. Minu's daughter, sister 4, is the main carer and oversees her mother's care. There have been problems around maintaining hygiene in the property that all siblings agreed to manage. Sister 3 organised a deep clean and regular contracted cleaning was to follow.

91. In a follow up visit with Minu (mid October), the social worker made Minu aware of the incident and ascertained that she felt safe. The offer of a 24-hour placement was declined with the expressed wish to stay at home. Yunus was also present and intoxicated. He reported that he drank in order to deal with his problems, the main one being his brother. Yunus' recollection of this visit is its significance in tension building between the brothers and the beginning of the irrevocable breakdown in their relationship.

92. At a subsequent review meeting in early November, Abdul was present and very angry, shouting and arguing with sister 4 about the cleaning issue. Yunus then emerged from his room and accused Abdul of being the one failing to clean up but refused to engage with the social worker and retired to his room. Abdul then mentioned that the plants in the flat were his 'therapy tool' for his mental health problems. Minu was again spoken to and confirmed that the sons regularly argued but she was not frightened by the fighting. Alternative housing options for the brothers to resolve the tensions were considered but assessed as impractical.

93. In early December 2013, Abdul called ASC in a distressed state and asked to speak to a manager about the boiler having broken down. He disclosed that his mental state is fluctuating, he was very depressed and anxious and domestic responsibilities were overwhelming him. At a subsequent visit, he disclosed that his mother is angry with him and avoiding eye contact.

<u>DAI 12 - mid July 2014</u>

94. Abdul, Yunus and one of their sisters had a verbal argument. Sister 5 came to visit their mother and had an argument with Yunus over the general state of the property and police were called. On hearing the argument, Abdul came out of his room and took the side of his sister but she then left prior to the attendance of the officers. A non-crime domestic incident was recorded, a 124D completed and the DASH risk assessment was standard.

95. A supervisor in the CSU set out an investigation plan for the secondary investigation. However, by this time it was noted that there was a subsequent criminal allegation (DAI 13 below) involving the two brothers. It was decided and recorded that the risk would be managed for the substantive offence and the CRIS report for this incident closed.

96. The IMR author has noted that there was a missed opportunity to generate and share a MERLIN PAC with Adult Social Care concerning the issues within the home.

DAI 13 - late July 2014

97. Abdul called police because Yunus had been in an argument with a plumber who had visited the home [Note: not known if connected to the boiler breakdown reported in December 2013 above]. Abdul considered this was rude of Yunus and he left to apologise to the plumber. On his return he discovered that Yunus had deliberately unearthed one of his plants. Yunus left before police arrived.

98. A 124D report and DASH risk assessment was completed in which the following concerns were noted:
    - Abdul's perception of risk is that he is concerned for the safety of his mother and that he and his brother do not get on in a feud that is on-going
    - Under the question about escalation, he reported that Yunus has a drug and alcohol problem and that this may be affecting him. He fears that the abuse may escalate
    - The reference to strangulation was answered with the fact that Yunus had previously [date not recorded] grabbed him by the throat and shouted, "Why don't you die!"
    - For the question about controlling and/or jealous behaviour, it is noted that Abdul believes Yunus is jealous of him
    - Under the abuse question, Abdul claimed that Yunus drinks alcohol and smokes cannabis and this may be affecting his mental health

99. The remaining 12 questions in DASH either were not applicable or answered in the negative. The risk was assessed as 'medium'. A CRIS record was opened for criminal damage to the plant.

100. The CRIS report was passed to the CSU for secondary investigation. The CSU Supervisor noted the concerns identified by the primary investigation and drafted a bespoke investigation plan for the secondary investigator. The supervisor also circulated Yunus as 'wanted' for interview on the Police National Computer (PNC) and brought the case to the attention of a Detective Inspector.

101. In mid-September 2014, Yunus was arrested at his home. He was interviewed and provided police with a prepared statement, in which he denied causing damage to the plant. He went on to suggest that the damage could have been caused by any number of people including, carers, district nurses or other family members. The CRIS record has been examined and no further information about the throat-grabbing incident is noted. For Yunus' part, he has no recollection that he grabbed Abdul by the throat and the police put no such allegation to him.

102. Despite numerous attempts by the investigator to contact Abdul while his brother was in detention, including by personal visit, telephone and email, he did not respond. The officer then reviewed the risk to Abdul using the RARA[7] model and re-assessed the risk to him as 'standard'. A Detective Inspector reviewed the circumstances and authorised that the investigation be closed with no further action against Yunus.

103. The IMR author has noted that this was the third incident involving Abdul and Yunus and family to come to police notice within a twelve-month period and the second with omission of sharing of concern with partner agencies, specifically Adult Social Care. Notwithstanding the comprehensive risk assessment on closing this investigation, consideration could and should have been given to a wider systemic review and the potential for referral of the bigger picture to the local MARAC.

DAI 14 - early September 2015

104. Some 13 months later at about 1915 in early September 2015, Sister 5 called police to the family home where she had discovered the decomposing body of her brother Abdul lying in his bed covered by bedclothes. Minu was in bed as usual. The circumstances are that her younger brother, Yunus, had contacted Sister 5 from the Royal London Hospital where he was being treated for bites to fingers on both hands, one of which was subsequently amputated due to risk of gangrene. In the course of this conversation he told her that Abdul was dead in the flat.

105. Yunus was arrested at the hospital and claimed both his injuries and the killing of his brother were caused in the course of a domestic argument and fierce fight between them on the previous Friday in August. In interview, he claimed that he was acting in self-defence and persisted with this account to the point of his trial at the Central Criminal Court. The Jury who unanimously found him guilty of murder clearly rejected his version of events. In February 2016, he was sentenced to life imprisonment with a minimum term of 12 years.

106. The cause of death was manual compression of the neck and the Jury was shown X-Ray images of fractures to the hyoid bone and thyroid cartilage. In addition, it was established that the sternum was fractured through the centre along with several ribs, an injury consistent with extreme force being applied to the chest such as by kneeling with the whole body weight applied.

[7] See notes on pp22/24

Notes on MPS forms and processes

107. The 124D (Domestic Abuse Booklet) will be completed at all incidents falling within the definition of domestic abuse, whether identified as a crime or non-crime incident. The investigation booklet has been designed to assist response officers in the initial investigation of domestic incidents / abuse as it is imperative that corroborative evidence is gathered during the early stages. The booklet provides details of questions to be asked to identify risk and to enable officers to intervene effectively and contains a tear-off slip to be handed to victims, giving them contact numbers for support agencies and information on how police will continue with the investigation.

The DASH ((Domestic Abuse, Stalking and Honour Based Violence) risk assessment model was adopted by the MPS in August 2010 and it was rolled out during 2011. On the basis of responses to the questionnaire, officers use professional judgment to evaluate and supervisors to confirm or adjust the risk level as standard, medium or high, as follows:

- *Standard* – the current evidence does not indicate risk of causing serious harm
- *Medium* – there are identifiable indicators of harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown and drug or alcohol abuse
- *High* – there are identifiable indicators of serious harm. The potential event could happen at any time and the impact would be serious

The RARA Risk Review model invites officers to review the case against the following headings:
R - Remove the risk
A - Avoid the risk
R - Reduce the risk
A - Accept the risk.

Domestic Abuse Toolkit
Since July 2013 the MPS has replaced its SOP (Standard Operating Procedure) approach with operational 'toolkits' as a checklist containing mandatory and discretionary options for which, in relation to domestic abuse, there are four phases: primary investigation, primary supervision, secondary investigation and secondary supervision. The purpose is to continually seek to identify, assess, reduce, mitigate and manage risk and for a specialist investigator to conduct a DASH 2 (supplementary) risk assessment on the MPS CRIS (Crime Report Information System) in all medium and high risk cases, if not already completed

MERLIN PAC
MERLIN is the system that is used to record information on Missing Persons, Children and Vulnerable Adults. The Pre Assessment Checklist (PAC) is the method for recording incidents where a child, young person or adult comes to the notice of police and there are concerns about their wellbeing or safety. This allows the raising of concern within the MPS or with partner agencies. The completed PAC will be automatically routed to the Borough Public Protection desk, or Multi Agency Safeguarding Hub (MASH) for the area where the child, young person or adult lives.

MARAC (Multi Agency Risk Assessment Conference) is a Borough based multi-agency victim focused meeting where information is shared on the highest risk cases of domestic abuse between different statutory and voluntary sector agencies.

MAPPA (Multi Agency Public Protection Arrangements)
These arrangements are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders (Criminal Justice Act 2003). The Police are responsible for managing MAPPA offenders in Category 1 (Registered Sex Offenders), however in practice will share the management with probation. The Police are responsible for ensuring that Category 1 offenders are entered on ViSOR, a central, web-enabled, national system, accessible over the Criminal Justice extranet and holds details of subjects that fall into a range of categories.

The Gravity Factor Matrix was developed by the Association of Chief Police Officers (ACPO) to assist in making cautioning / charging decisions for adults. The key factors which will be relevant in deciding whether to charge, caution or conditionally caution an offender for an offence are:

a) Do they admit the offence?
b) The seriousness of the offence
c) The previous offending history of the offender and
d) Does the disposal adequately address, support and reduce the risk of reoffending?
e) Where the Full Code Test is met, would the public interest be properly served by issuing a simple or Conditional Caution
f) Views of the victim

ANALYSIS

108. Abdul and Yunus shared the family home with their mother Minu who was bedridden in her own room following a stroke in 2008. Their six sisters were either married or lived elsewhere, the last departing the family home in August 2013. Minu's care requirements were met by a combination of adult social care and community nursing.

109. The brothers assisted with medication and feeding in an *ad hoc* way but this was a source of tension and frustration between them as to who was responsible for what, in particular, for maintaining the cleanliness of the home. Their competence as carers for Minu was also a concern for the district nursing team.

110. Abdul's passion for horticulture in the home and on the balcony to the front door was a frequent cause of the continuous arguments between them. They were each heavy drinkers and cannabis users and, in Abdul, this manifest in a diagnosis of possible paranoid personality disorder while Yunus was being treated for anxiety associated with his alcohol and cannabis dependency.

111. The constant and unresolved discord between the brothers culminated in Yunus murdering his elder sibling by manual strangulation in the course of one of the frequent arguments and fights between them. The family were known to a number of agencies.

112. **The Metropolitan Police** knew Abdul as a registered sex offender and he was visited 18 times in the routine of supervision at level 1 and, other than the observation that the brothers did not get on with each other, the specialist officers noted nothing of relevance to this review. The brothers came to notice on seven other occasions for domestic abuse incidents between each other and on three others when a sister was also involved.

113. Abdul accepted an adult caution in 2007 for assaulting Yunus by grabbing around the neck. Yunus accepted an adult caution for punching Abdul in 2011 and again for a common assault on sister 6 in 2012 whereby he held her down whilst demanding cash for his cannabis habit. There is a further reference to throat grabbing in the context of the damage to the plants, this time by Yunus on Abdul, but it was not pursued or corroborated.

114. Following the policy change in April 2013 to share a MERLIN/PAC with adult social care there were three opportunities (in DAI 11-13) to do so and only one (DAI 11) was taken. Notwithstanding that the 5-year background checks were not initially done, this was corrected by the PPD and the referral resulted in social worker involvement and problem solving activity by engaging with the sisters to highlight the running battle between the brothers over who was responsible for cleanliness in the home between September and November 2013.

115. The other two incidents were some seven months later and close together in July 2014. The supervisor linked them for the purpose of risk management but did not ensure this was backed up with a MERLIN/PAC to adult social care that may then have resulted in

further problem solving actions. A step back from what is the current operation or investigation to look at the connections between that and prior incidents may also have triggered a second partner agency referral.

116. **LBTH Adult Social Care** was involved with the family through the care arrangements for Minu following her stroke and confinement to bed in 2008. This was contracted to one provider during the week and another at weekends and, when she was discharged from hospital following her stroke, the doubling up of care workers attending Minu was approved to allow care to be provided for her safety.

117. The social workers responsible for Minu had very limited contact with either of the brothers and they were not considered as carers. Carers' assessments were offered to one daughter who identified herself as the next of kin and carer but it appears she did not feel there was a need for an assessment. The wider family were not considered and the care arrangements changed over the years.

118. There was an awareness that the there was a volatile situation within the household with members of the family not talking to each other, and, on occasions, the brothers shouting at each other. It was clear that they did not get on and they were unable to negotiate a relationship to be at home without conflict.

119. The main experience of the social worker who had most contact with the family was that Abdul was either out at 'work' or tended to stay in his room. He had reported he did not feel safe administering medications or feeding his mother and had been observed 'force feeding' her while under the influence of alcohol and/or drugs.

120. It would be usual to understand Minu as an individual and gather some contextual history in an assessment. Also, it would be usual to apply a degree of analysis on observations and assessments undertaken with Minu, particularly with concerns about the relationships in the home being openly expressed and a perceived level of conflict between the brothers. This does not appear to have happened so knowledge of the relationships at home was not complete. Had it been, it would be usual to convene a conference or professionals meeting.

121. **Barts Health NHS Trust** provided district nurses to Minu, classified as an adult at risk who was unable to protect herself from neglect or abuse.

122. There were a number of missed opportunities to report safeguarding concerns for Minu in respect of her two sons. Throughout May and June 2014 incidents are recorded in the care record that include refusal of the sons to adhere to advice about safe positioning when feeding which could have led to aspiration, reports of aggressive behaviour by the sons and drug use. There was also an occasion where Minu was distressed and unable to make her understood by the nurses. The nurses did not record any attempt to follow this up by securing an interpreter.

123. The nurses did raise a safeguarding concern with Adult Social Care following an incident in early December 2014, however there are differing accounts on what was agreed and a difference of opinion as to whether this was a safeguarding issue or a complaint

about the work of district nurses so the referral not progressed. This was a missed opportunity.

124. At the end of January 2015 a district nurse attempted to contact the safeguarding team at Barts but this was a Saturday and no incident report was completed or safeguarding referral was made.

125. A safeguarding referral and case conference was undertaken during Minu's admission to hospital in February 2015, however a planned family meeting did not take place. She had the mental capacity to decide her discharge destination and was discharged home. Even though this was Minu's preference, it is not clear what protection plan was in place for her. The community nurses did review and enhance their care plan but a planned mental health review for Abdul did not take place prior to Minu's discharge home.

126. There is one disclosure of domestic abuse in the home recorded in early February 2015 but it is not clear if this was recognised as such or reported other than to record it in the care record. The definition of domestic abuse has broadened to include not only intimate partners but also family members irrespective of gender and there have been a number of developments to improve Barts Health staff's ability to respond effectively to safeguarding concerns and domestic abuse since this time.

127. The nurses raised concerns about the cleanliness of the home environment early in their contact with the family. A social worker agreed to discuss this with the family however it is evident that this issue persisted. There is also a reference to a fly infestation in May 2014. Yunus had wrapped several layers of clothing and bedding around his dead brother and the bedroom door was firmly shut. It is likely that, as this was the common condition of the home, the nurses were not alerted that anything was wrong when they were visiting the home during the six days that Abdul's body lay decomposing in his room.

128. It is usual for family members to receive support and training from health professionals if they are participating in care provision. Initially it was the daughters who were the primary carers, however over time this changed. It is unlikely that the sons were ever acknowledged as carers for their mother and therefore unlikely that an assessment was made of their ability and suitability to undertake the role and specific support offered.

129. **East London Foundation Trust,** who provide mental health services in Tower Hamlets and neighbouring Boroughs, undertook a level 1B Serious Incident Review (SIR) of all the known episodes of care provided to Abdul and Yunus, using the Root Cause Analysis methodology.

130. <u>Care delivery problems relating to Abdul</u>

It is the opinion of the SIR panel that Abdul was discharged from the ward prematurely in March 2015 having been on the ward for fewer than 24 hours. Care planning and risk assessment around discharge planning were insufficiently robust for the following reasons:

- Abdul had been admitted with a suspected presentation of psychosis the previous evening. It was not reasonable to assume that all his psychotic symptoms had resolved

overnight, indeed there was on-going evidence of paranoid ideation in the nursing reports and in the ward round interview which may or may not have reached delusional intensity

- No collateral history had been obtained
- No independent forensic history had been obtained including a police national computer check
- Abdul was not agreeing to a trial of anti-psychotic medication but there was no consideration of whether or not a mental health act assessment should be arranged
- Abdul was reporting family conflict and ideas of aggression towards his brother in the context of paranoia. There was no evidence of a proper risk assessment in relation to risks to this brother or to his very frail mother who had recently returned from hospital following treatment for a stroke. Safeguarding risks were not considered at the ward round in this context
- It was unrealistic to consider that telling Abdul to stop smoking cannabis would be likely to modify his behaviour. Given that the staff involved considered cannabis to be causative in the aetiology of the paranoid symptoms of Abdul, a more likely scenario would be that Abdul would continue to smoke cannabis and therefore continue to be symptomatic, thus increasing his risks to self and others
- Follow up had been arranged for six to eight weeks' time. It was predictable that Abdul would not attend this follow up appointment given that he had failed to attend three previously arranged appointments

131. Care delivery problems relating to Yunus

The original referral from the GP is dated early January 2014 but is noted on THSAU (Tower Hamlets Special Addiction Unit) documentation as being received in mid-February 2014. It is not possible to identify where in the transmission of the referral, the delay occurred.

132. The review panel were initially unable trace the letter written to the GP by the Speciality Doctor as mentioned in the case notes. It is not filed in the case notes, nor has it been found in the THCAT notes. The speciality doctor was able to trace an email copy of the letter and the GP at interview confirmed that the practice had received their copy of the letter.

133. Service delivery problems relating to Abdul

None identified

134. Service delivery problems relating to Yunus

There have been delays and difficulties in obtaining data from the Tower Hamlets Specialist Addictions Service, which are suggestive of wider systemic problems. Examples include the inability to find in the case notes the letter written by the Speciality Doctor to the GP and the fact that the case notes of Yunus had not been uploaded onto the Nebula electronic patient record and had to be retrieved following a dedicated search on the EDM (ELFT Date Management) electronic file storage system

135. Contributory Factors related to Abdul

- It became clear at interview that by the time of the ward round, Abdul's difficulties were being viewed as solely related to his self-reported cannabis intake. His urine sample was positive for cannabis and benzodiazepines but there was insufficient available information for the treating team to be clear about whether his symptoms had been caused by cannabis or were being self-medicated by cannabis (as is not infrequent in patients with emerging psychosis). Interviewees reported that care planning would have proceeded differently for Abdul had cannabis not been seen to be involved in the presentation
- The panel considered whether there were other factors influencing such early discharge such as pressure on beds, which was cited by one interviewee. However, it is not clear that such potential pressures influenced decision making in this case as the contemporaneous bed management statistics and duty senior nurse report did not identify any pressure on beds at this time

136. Contributory Factors related to Yunus

- The current THSAS (Tower Hamlets Specialist Addiction Services) database (Nebula) identified Yunus as a previous service user. However, his case-note paper files had been stored on a separate file storage system EDM and not transferred to Nebula. This portal is only available for viewing. The panel were told that when Nebula was implemented, a decision had been made to migrate only the notes of currently open cases from EDM to Nebula. However, staff were unsure what if any further migration could occur (without uploading through printing and scanning) should old cases require re-opening
- Nebula is the third electronic patient record used by substance misuse services within the last few years superseding first Orion and then Theseus
- At the time of Yunus' referral to THSAS in 2014, there was no facility for cross referral checking against RiO (to which the Specialist Addiction Services did not have access)
- The panel were told that the previous administrator responsible for typing medical letters was storing her work on her H drive rather than the serviced shared K drive

CONCLUSIONS, LESSONS LEARNED AND GOOD PRACTICE IDENTIFIED

137. For a family that has endured such a terrible sequence of events, there must be an acutely painful tension between the death of one brother and the likely incarceration of the other and they remain firm in their view that Yunus is innocent of murder and should not have been convicted. If not challenging enough, this dilemma was closely followed by the loss of their mother. The Panel would like to offer heartfelt condolences to the family for their compound loss.

138. The fundamental purpose of reviews carried out under this legislation is to establish what lessons are to be learned regarding the way in which local professionals work individually and together to safeguard victims, in this case, Abdul, and, to some extent, Minu. Findings from reviews of this nature also can work to eradicate a conducive culture for domestic abuse and violence between siblings as well as partners.

139. The inherent risks to be avoided in formulating conclusions and identifying lessons are 'hindsight biases' and 'outcome biases'. The Panel has sought throughout to understand the agency operating contexts in which this tragedy occurred so that the report does not become 'should've-ist' or 'second-guessing' in character. Nonetheless, the review has identified a number of missed opportunities and learning from them that could improve the system for safeguarding in the London Borough of Tower Hamlets and elsewhere for the future.

140. From the MPS perspective, there were some missed opportunities during 2014 to alert and engage with other safeguarding agencies and to develop greater understanding of the connections between incidents over time. However, the last contact in September 2014 was some twelve months before the extreme of violence that was in the end inflicted by Yunus on Abdul in late August 2015. This passage of time and the relatively low level of violence between the siblings hitherto known to the police would not have presaged that it could result in the homicide of Abdul.

141. For Adult Social Care, there is nothing to suggest that action could have been taken that would have directly prevented the death of Abdul, however, more could have been done to understand the impact of the hostility between the brothers on Minu and the family and to reduce risks in the home.

142. The Barts Health Trust conclusion is that, although it was predictable that there would continue to be concerns regarding Minu's sons' behaviour in the home, it is unlikely that the level of violence could have been anticipated by the district nursing team. There does seem to be some confusion within the health and social care teams about who was undertaking the role of carer for Minu and this, together with concerns for personal safety, may have over-shadowed the risks that the brothers posed to each other.

143. The East London Health Trust root cause analysis has concluded that the homicide occurred almost six months after ELFT staff had any contact with Abdul. There was an even longer interval in service provision for his brother, Yunus. Therefore, the ELFT review

panel could not reasonably speculate about the root causes of the incident or whether it was predictable or preventable.

144. In the case of Abdul, the salient finding is the premature discharge following his admission to Tower Hamlets Centre for Mental Health and the lack of consideration of the implications of cannabis use and safeguarding concerns in formulating risk management and care planning. The SIR Panel had no concerns about the care provided to Yunus by ELFT services and the findings and recommendations in his case refer to electronic patient data storage and retrieval

145. In considering all the evidence from agencies involved with this family, overall there is no identifiable root cause, no omission or dereliction of duty by any individual or single safeguarding agency that failed to limit the opportunity for Yunus to inflict the fatal injuries on his brother Abdul. The level of detail about the buildup in tension between the brothers available through hindsight was not available to agencies at the time of the fatal incident and we conclude that what was available would not have enabled services to predict that the level of violence would escalate to the point of homicide. There is no evidence in this review of a collective failure.

Lessons learned

146. In the course of the MPS IMR the requirement to share a MERLIN/PAC with (in this case) adult social care has been highlighted, together with the need for a learning debrief, as reflected in the recommendation that follows.

147. From the perspective of LBTH ASC, there are issues around communication and consideration relating to working in a household where there was a level of what can be seen as violence or aggression as it does not appear that agencies really discussed concerns they had around the behaviour of the brothers. To some degree it comes over that they mainly kept to themselves and thus were not engaged as staff were focussed on Minu. Staff could have explored the family dynamics further and considered convening a strategy meeting or conference.

148. This does give the perspective, and possible lessons to be learned around wider family working and the interaction with informal carers. There is nothing to suggest by doing things differently the outcome would be different but wider family work including the brothers (and there were some attempts to speak to them) might have identified the level of the family dynamics at play.

149. Barts Health have identified that:

- It is everyone's responsibility to raise safeguarding concerns if they have them. The nurses were over reliant on escalating to seniors instead of raising the concerns themselves via DATIX[8] and safeguarding referrals
- Domestic abuse should always be reported and followed up by a risk assessment. Had this information been shared, links could have been made to other reports of violence between the brothers

[8] The electronic incident recording system

- More could have been done to develop a protection plan for Minu before her discharge from hospital
- There is little evidence of wider information sharing between other agencies and the health services going into the home. This is likely to be complicated because the district nurses were concerned primarily with Minu's care. A 'think family' approach may have strengthened the support provided

150. From the ELFT SIR, regarding Abdul, the panel were concerned about the possibility that the factor of cannabis consumption may have altered the way in which the presentation of Abdul was viewed, adversely affecting treatment planning and risk management and leading to premature discharge. Many service users with diagnoses of severe and enduring metal illness are also cannabis users and this should be seen as an extra risk factor rather than a reason to under assess and treat.

151. Dual diagnosis is unexceptional in this patient population and should not be seen as a barrier to care. Additionally, the SIR panel are particularly concerned that safeguarding considerations relating to both his brother and mother do not seem to have been fully evaluated before taking the decision to discharge

152. In the case of Yunus, the ability of Specialist Addictions Services staff to easily access and store their own patient records and to cross check against other ELFT records has been compromised by the way in which electronic databases have been configured and used.

153. From Yunus' perspective, the police could have paid more interest in listening to both sides of the story when they are called. Having benefited greatly from counselling since being sentenced, he believes that the offer of counselling when the relationship with his brother was breaking down would have assisted him to see issues in perspective and walk away from tension rather than respond aggressively.

154. He harboured a suspicion that his brother was bullying their mother and he readily admits that he also behaved disrespectfully to her, particularly when intoxicated. He suggests that the installation of CCTV would have been a deterrent to negative behaviour by them both, as well as providing an evidence record available for scrutiny. The obvious question arising is the matter of Minu's right to privacy and this would need to be carefully balanced against her right not to be abused in the manner that has been described. There is precedent in the Adult Care Home environment where CCTV has proved invaluable in rooting out bad practice and the protocols developed there could be a useful starting point for research.

Good practice identified

155. The MPS IMR did not highlight good practice to be shared. The ASC IMR found there was evidence of joint working and planning focussed on Minu between health and social care staff.

156. The Barts IMR identified that the nurses were diligent and caring despite being alarmed and on occasion distressed by the sons' behaviour. Risks were identified and

escalated through the line management structure. There have also been a number of improvements in practice since this domestic homicide was discovered:

- A number of bespoke face-to-face training sessions have taken place for district nurses working in Tower Hamlets.
- The members of the safeguarding team attend the daily safety huddles on site and ask directly about known or potential domestic abuse cases and remind staff of their responsibilities.
- An external review of safeguarding practice throughout the Trust was undertaken throughout August 2015. The recommendations from the review were used to inform a multiagency summit to develop a Trust wide strategy for safeguarding adults which will include an enhanced training plan and strengthened leadership, governance and assurance frameworks.
- The model in place to support good safeguarding practice is to be reviewed in line with the new leadership operational model that will include a safeguarding lead for each hospital site and greater clarity of roles and responsibilities for all grades of staff.
- A domestic abuse training strategy has been developed at Barts, in line with the NICE guidance. It includes an implementation plan that is in the early stages of progression. The strategy will include 3 levels of training to meet the training needs of staff in different roles.
- Barts Health has approved a domestic abuse policy and procedural guidelines that include best practice flowcharts for staff responding to concerns about domestic abuse. There are sections on possible signs of abuse and what action to take including details of local support service, responsibilities in relation to risk assessment and information sharing.
- Pages dedicated to domestic abuse are accessible on the Trust intranet. Staff has access a range of information about national and local support services, risk assessment, referral processes and forms and relevant local and national documents. There is a quick means of accessing this via the home page as well as links on the safeguarding children and the safeguarding adults' pages.

157. The ELFT SIR identified the following good practice:

- The duty psychiatrist who assessed Abdul at the Royal London Hospital made a comprehensive and thorough assessment including a very detailed risk assessment that was well documented on RiO (see paragraphs 29-31). She also liaised effectively with the senior psychiatric trainee on call regarding the plan for admission.

- The initial assessments of Yunus by both the nurse and specialist doctor from Tower Hamlets Specialist Addictions Service were comprehensive and relevant including good care planning and risk assessment and an appropriate onward referral.

RECOMMENDATIONS

158. The respective agency IMRs have been studied for recommendations and the expectation of the Panel is that these will be advanced internally and progress reported to Tower Hamlets Community Safety Partnership. They are also set out in a combined Action Plan in appendix 5.

Single agency recommendations from Independent Management Reviews

159. Metropolitan Police

It is recommended that Tower Hamlets Senior Leadership Team (SLT) carry out a dip sample of reports to ensure that ACN reports are being created where required.
All officers involved in the investigation of the domestic abused incidents on 19/07/2014 [DAI 11] and 23/07/2014 [DAI 12] should be de-briefed by the SLT in order to assess the officers' knowledge of the Vulnerable Adult Framework (VAF).

160. LBTH Adult Social Care

- In complex cases, or where concerns are raised, practitioners convene professionals' meetings to share information
- Where, as a result of concern around safeguarding or risk behaviour, referrals are made to other agencies, practitioners do not close casework and they monitor responses so that their support planning can respond to advice and provision of the other agency. Where responses are delayed or insufficient to manage risk, practitioners remain involved to secure a response or escalate according to the risks or concerns that trigger the original request

161. Barts Health NHS Trust

No recommendations were made in the Barts Health IMR, however, it is noted that six separate improvements to practice have already been implemented as a result of this and other IMRs, as set out in paragraph 148 above

162. East London Foundation Trust

Related to the Serious Incident Review for Abdul

- No patient should be considered for discharge from THCfMH within 24 hours of admission without the agreement of a senior member of staff. Senior members of staff include the following: the borough lead nurse and deputy borough lead nurse, the responsible clinician or duty consultant and the modern matron or ward manager
- This case (including both SIR reports) should be discussed at the next Tower Hamlets Quarterly Learning Lessons Seminar scheduled for 17th May 2016 (completed)

163. Related to the Serious Incident Review for Yunus

- That attempts are made to retrieve patient data from the H drive of the former administrator who has now left the Trust (enquiries completed without success)
- That the senior management team of Tower Hamlets Specialist Addictions Services should review the migration strategy between EDM and Nebula and analyse the risks and benefits of further migration of all EDM patient data

Panel recommendations for multi-agency implementation

164. There was a general avoidance by both Barts Health and LBTH Adult Social Care of the ongoing feud between Minu's sons and, in December 2014 a marked difference of understanding between the agencies about the safeguarding of Minu who was an adult at risk. This, and the omission by police to notify other agencies of the incident notified to them in July 2014, meant that there were no multi agency conferences or referrals to MARAC about the building aggravation between her sons and risk of harm to Minu as well as them.

165. As mentioned in paragraph 141 above, the Barts Health review identified that a 'think family' approach is a valuable lesson and could be developed into a case study and narrative to inform a Tower Hamlets learning event such as has been implemented following the ELFT SIR (paragraph 154 above)

166. LBTH Adult Safeguarding Board

To commission a task and finish group to review the specific learning from this review about effective communication between safeguarding agencies, adopting a 'think family' approach to develop a narrative case study to be shared at relevant Tower Hamlets Partnership learning events

167. The proposal in paragraph 146 from the perpetrator, Yunus, that CCTV installation in the bedroom of Minu would have acted as both deterrent for inappropriate behaviour and a source of evidence in the event of a dispute or, indeed, a safeguarding conference or a prosecution if required. It is felt that access to such irrefutable evidence in this case would have saved a great deal of time in handling disputes and ensuring proper safeguarding measures. It would also have acted to protect care workers from spurious allegations. Obviously, there are issues such as cost, consent (eg compliance with the Regulation of Investigatory Powers Act) and process management to be resolved but it is felt that, with advances in portable and less costly technology, these issues are not insurmountable, there is precedent and the business case could be made out for fuller consideration.

168. LBTH Adult Safeguarding Board

To commission a project working group to explore the greater use of CCTV in the context of adult safeguarding within a suspected domestic abuse environment and present findings and recommendations for consideration

Author

Bill Griffiths CBE BEM QPM

8 February 2018

Glossary

ACN	Adult Coming to Notice (MERLIN)
ACPO	Association of Chief Police Officers
A&E	Accident and Emergency
CAADA	Safe Lives - Coordinated Action Against Domestic Abuse
CCG	Clinical Commissioning Group
CCTV	Closed Circuit Television
cjsm	Criminal Justice Secure eMail
CSU	Community Safety Unit
DAI	Domestic Abuse Incident
DASH	Domestic Abuse, Stalking and 'Honour'-based violence
DHR	Domestic Homicide Review
DVHR	Domestic Violence Homicide Review
EDM	ELFT Data Management system
ELFT	East London Foundation NHS Trust
GP	General Medical Practitioner
gsi	Government Secure Internet
HMIC	Her Majesty's Inspector of Constabulary
IDVA	Independent Domestic Violence Advocate
IMR	Independent 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
NVQ	National Vocational Qualification
PNC	Police National Computer
PPD	Public Protection Desk
pnn	Police National Network
RLH	Royal London Hospital
SLT	Senior Leadership Team
SOP	Standard Operating Procedure
THCAT	Tower Hamlets Community Alcohol Team
THCfMH	Tower Hamlets Centre for Mental Heath
THSAU	Tower Hamlets Specialist Addiction Unit
THSAS	Tower Hamlets Specialist Addiction Services
ToR	Terms of Reference

Name abbreviations used

Abdul	Victim
Yunus	Perpetrator and younger brother of victim
Mina	Mother of both; also of six daughters
Sister 3	[Sisters in age order – sisters 1 and 2 did not feature in review]
Sister 4	
Sister 5	
Sister 6	

Tower Hamlets Community Safety Partnership – DVHR Panel for Abdul

Distribution List

Name	Agency	Position/ Title
Will Tuckley	LB Tower Hamlets	Chief Executive
Shiria Khatun	LB Tower Hamlets	Councillor for Community Safety and 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
Alan Tyrer	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
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
Jane Callaghan	Barts Health	[Awaits]
Karen Sobey Hudson	NHS England	Patient Safety Projects Manager (London Region)
Clare Williamson	Victim Support	East Area Manager
Bill Griffiths	Independent Chair	Independent Chair and author of 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

Appendix 1

Home Office

Public Protection Unit
2 Marsham Street
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T: 020 7035 4848
www.gov.uk/homeoffice

Menara Ahmed
Domestic Violence and Hate Crime
Team Safer Communities
London Borough of Tower
Hamlets Mulberry Place
5 Clove
Crescent
London
E14 1SA

26 September 2017

Dear Ms Ahmed,

Thank you for submitting the Domestic Homicide Review report for Tower Hamlets to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 25 July 2017. I very much regret 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 this was a good review, however, they felt that the central issue at the heart of the review is the fact that the two brothers were carers to their mother and you may, therefore, wish to consider re-shaping the report to more clearly draw out this dynamic.

The Panel also felt that there was insufficient analysis on the role of adult social care and health agencies. In addition, the Panel considered safeguarding issues, particularly the described confusion over referral, warranted more detail and scrutiny as to whether policy and procedures were followed.

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

- The Panel noted several examples in the report where additional probing may have

been useful. For example, paragraph 56 describes that the victim had been dead for 6 days and that care workers and district nurses were attending the address during this period, but there is no examination of why they did not explore the source of the odour. A further example is references in the report to a growing concern for the safety of nurses and care workers visiting the address; however there is no explanation of what may have triggered the increasing concern;

- There could be more analysis of the family's GP practice responses to family members' health problems. For example, did district nurses and social workers liaise with the GP practice? Was the GP aware of safeguarding issues?

- The Panel noted that paragraph 149 records a psychiatrist undertaking a thorough risk assessment, but this is missing from the chronology and no detail of its contents are given;

- There is a key fact in the table on page 8 of the overview report regarding the victim's contact with the Metropolitan Police Service which the Panel felt was sufficiently important that it should also be included in the executive summary;

- From a layout point of view, the Panel concluded it would have been helpful if the domestic abuse incidents had been placed in chronological order within the chronology to give overall context of events taking place at the time;

- It would help inform the reader if the services provided by the organisation mentioned in paragraph 121 could be clarified, for example that it is Mental Health Services;

- You may wish to review recommendations 7 and 8 as the Panel's view was that these may be the responsibility of the Adult Safeguarding Board;

- You may wish to consider enhancing anonymity by removing specific named local areas and instead using broader terms such as "Tower Hamlets area;

- Acronyms should be spelled out in full the first time they are used, e.g. THSAU and THCAT;

- The executive summary does not follow the statutory guidance which recommends a separate document that can be read in isolation.

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

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel

Tower Hamlets Community Safety Partnership – DVHR Panel for Abdul

Response to points in Home Office letter dated 26 September 2017
Agreed in DHR Panel meeting on 4 December 2017

Point	Letter extract	DHR Panel response
1	This was a good review, however, [the Panel] felt that the central issue at the heart of the review is the fact that the two brothers were carers to their mother and you may, therefore, wish to consider re-shaping the report to more clearly draw out this dynamic	Dealt with in paragraphs 44-64
2	The Panel also felt that there was insufficient analysis on the role of adult social care and health agencies. In addition, the Panel considered safeguarding issues, particularly the described confusion over referral, warranted more detail and scrutiny as to whether policy and procedures were followed	As set out in paragraphs 54 to 57 (formerly 47-50), the Panel investigation established that this was not a breach of policy and procedures, but a disagreement between professionals that was a missed opportunity and lessons have been learned – paragraphs 147 to 148 (formerly 139-140)
3 (Bullet point list 1)	The Panel noted several examples in the report where additional probing may have been useful. For example, paragraph 56 describes that the victim had been dead for 6 days and that care workers and district nurses were attending the address during this period, but there is no examination of why they did not explore the source of the odour. A further example is references in the report to a growing concern for the safety of nurses and care workers visiting the address; however there is no explanation of what may have triggered the increasing concern;	Regarding the odour, paragraph 56 is unchanged (now 63) An additional paragraph 64 sets out our findings Our view of the safety issues is set out fully in paragraphs 53 to 59 (formerly 45-51)
4 (2)	There could be more analysis of the family's GP practice responses to family members' health problems. For example, did district nurses and social workers liaise with the GP practice? Was the GP aware of safeguarding issues?	Dealt with in paragraph 52 (formerly 45)
5 (3)	The Panel noted that paragraph 149 records a psychiatrist undertaking a thorough risk assessment, but this is	This was dealt with fully in paragraphs 29-31 (formerly 22-24} and a cross-reference has been inserted in paragraph 156 (was

	missing from the chronology and no detail of its contents are given	149)
6 (4)	There is a key fact in the table on page 8 of the overview report regarding the victim's contact with the Metropolitan Police Service which the Panel felt was sufficiently important that it should also be included in the executive summary	'Key fact' of Adbul's offending history now included in the executive summary
7 (5)	From a layout point of view, the Panel concluded it would have been helpful if the domestic abuse incidents had been placed in chronological order within the chronology to give overall context of events taking place at the time	Not accepted by DHR Panel. We wished to provide focus on the care provided to Mina. Her care and the domestic abuse incidents were, and are, provided for the reader to follow in the integrated chronology at appendix 4
8 (6)	It would help inform the reader if the services provided by the organisation mentioned in paragraph 121 could be clarified, for example that it is Mental Health Services	Corrected – now paragraph 128
9 (7)	You may wish to review recommendations 7 and 8 as the Panel's view was that these may be the responsibility of the Adult Safeguarding Board	Corrected
10 (8)	You may wish to consider enhancing anonymity by removing specific named local areas and instead using broader terms such as "Tower Hamlets area"	Corrected
11 (9)	Acronyms should be spelled out in full the first time they are used, e.g. THSAU and THCAT	Corrected
12 (10)	The executive summary does not follow the statutory guidance which recommends a separate document that can be read in isolation	Original submitted in November 2016 and new guidance issued in December. Executive Summary has now been excised for publication with this overview

Appendix 2

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 January 1 2007 to date of homicide discovery], 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 a 'vulnerable adult' and, if so, what specialist advice or assistance may be required. An initial discussion by the Panel has identified that all the above-named are Bengali Muslim.

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: An initial discussion by the Panel has identified that Abdul was a subject of MAPPA level 1 management]

6. To determine whether this case meets the criteria for a Safeguarding Adult Review, as defined in the Care Act 2014, if so, how it could be best managed within this review [Note: An initial discussion by the Panel has identified that there are no child care issues for this review]

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 review[9].

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

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

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

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 Abuse[10]

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.

[10] Updated and published in August 2013 by the Home Office

Appendix 3

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, or direct management of any MPS employee. In the early 1990's he had contact with the Investigating officer dealing with the criminal investigation who was at that time a patrolling constable.

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 review, Tony has no personal or business relationship or direct management of anyone else involved.

Appendix 4

Timeline of events[11]

Date & ref	Event and who involved	Outcome if any	Comments
Sep 2007 DAI 1	Police called when Abdul assaulted Yunus by grabbing him around the throat after a verbal argument about work	Abdul accepted police caution for common assault DASH assessment standard	
Jul 2008 DAI 2	Police called to argument between Abdul and three sisters over care for Minu	No criminal offences disclosed and recorded as domestic incident DASH standard	
Nov 2008 DAI 3	Police called by Abdul claiming that Yunus and Minu were being aggressive to him	As above	

[11] For acronyms see glossary

Dec 2008	Minu suffered stroke	Placed under care of Barts following discharge from RLH	
Sep 2009	Abdul detained by members of the public for sexual assault (by touching) on a female	Arrested by police and accepted adult caution	
Nov 2009	Abdul arrested for sexual assault by touching of a female bus driver having been identified from CCTV	Pleaded guilty to offence, sentenced to a 24-month Community Order and placed sex offenders register	Managed by local police at level 1 18 home visits between registration and time of death
Jun 2010	Minu's health deteriorates	Minu confined to bed with a PEG feed Deemed a 'vulnerable adult' (now adult at risk) Regime of daily carer and district nurse visits	
Oct 2010 DAI 4	Police called to argument between Yunus (who was intoxicated) and sister 6 whom he had accused of stealing	Ascertained that he was mistaken and invited to leave premises to sober up DASH standard	
May 2011 DAI 5	Police called by Yunus when Abdul shouted at Minu and damaged a cassette player	Abdul arrested but case closed as insufficient evidence DASH standard	Minu identified as an adult at risk but policy and training to submit MERLIN PAC not yet in place

Nov 2011 DAI 6	Abdul called police following argument and punch in face by Yunus	Yunus arrested and accepted police caution for assault Abdul then had change of mind and would have preferred a verbal warning DASH medium revised to standard	
Jul 2012 DAI 7	Police called by Abdul following verbal argument with Yunus because he had moved a small greenhouse	No offences disclosed Both referred to Jagonari Centre DASH standard	Primary investigator noted that Abdul apparently suffering from mental health issues
Aug 2012 DAI 8	Police called when Yunus demanded money from sister 6 to buy cannabis and assaulted her by pinning her down by the arms	Yunus arrested and accepted police caution for common assault DASH standard	
Jul 2013 Possible DAI 9	Abdul called emergency ASC team regarding argument between siblings over medication for Minu	Abdul sounded intoxicated and admitted using alcohol and drugs Follow up visit by social workers with sisters 3 and 6 established Yunus supportive and supplies evening medication to Minu Abdul described as supportive but sisters unaware of mental health problems for him although accepted 'short tempered'	Poor hygiene conditions noted Sister 6 disclosed that relationship with Abdul had broken down
Aug 2013	Sister 6 became married	Last of the sister siblings to leave the family home	

Sep 2013 Possible DAI 10	Abdul contacted social worker to complain that 'lumbered' with responsibility for care of Minu Had previously altercation with Yunus as he was not pulling his weight	Social worker said that this had been discussed with sister 6 and Abdul responded that she ignores him Abdul added that sister 4 is adding pressure by giving him extra tasks and this will cause his breakdown	Agreed that liaison would be with sisters and district nurse attended that weekend
Sep 2013 DAI 11	Police called by Abdul as Yunus had moved some of his plants	No offences disclosed and recorded as domestic incident DASH standard MERLIN PAC forwarded to ASC re Minu	
Oct 2013	Follow up visit by ASC social worker to police MERLIN PAC	SW recorded sister 4 as main carer and established with Minu that she felt safe Minu declined offer of 24-hour care Yunus present and intoxicated saying he drank to deal with problem of brother	
Nov 2013	Review meeting with family – Abdul, Yunus and sister 4	Abdul angry and shouting at sister 4 re cleaning issue and that plants are his 'therapy tool' Yunus emerged from room and accused Abdul of failing to clean up but would not engage with SW SW confirmed with Minu that not afraid	Deep clean organised by sister 4 Alternative housing options for brothers discussed but assessed as impractical
Dec 2013	Abdul called ASC in distressed state regarding broken down boiler	Disclosed that his mental state is fluctuating At subsequent visit said that Minu is angry with him and avoiding eye contact	
Apr 2014	Abdul challenged district nurse over the need for antibiotics for his mother	Nurse became fearful and left without completing her notes	

May 2014	District nurses were challenged by both sons about the safe positioning for Minu to receive her feed	Meeting held with GP practice in May 2014 In visit in late May, Minu seemed agitated and trying to say something but nurses could not understand due to language	Unclear if either matter was followed up
Jul 2014 DAI 12	Police called when sister 5 visited and argued with Yunus about the state of cleanliness Abdul emerged and took the side of their sister	No offences disclosed and recorded as domestic incident DASH standard Linked by supervisor to DAI 13	Missed opportunity to generate and share a MERLIN PAC with ASC
Jul 2014 DAI 13	Abdul called police because Yunus had been rude to a plumber who had visited and he left the flat to apologise to him. On his return Yunus had deliberately unearthed one of his plants and then decamped	CRIS record opened for criminal damage to the plant Yunus circulated as 'wanted' and interviewed in mid Sep 2014 when denied offence and case closed DASH medium later revised to standard Reference therein to being grabbed by the throat with threat: "Why don't you die!"	Third DA incident within 12 months should have prompted consideration a strategic review and possible referral to MARAC
Oct 2014	Care worker reported that Yunus was feeding Minu by mouth while the PEG feed was attached and was also dancing while feeding her	Reported to the GP who sent a district nurse to check on welfare	Unable to verify as not given access to Minu GP record
Early to mid Dec 2014	Disagreement between 'son' (not known which one) and district nurse about correct position for Minu	Son asked nurse to leave, which she did and returned with manager. Son persisted with view, including that the nurse should again attend to Minu Sister 4 contacted and agreed for family to administer medication that day In early Dec 2012, nurse manager referred matter to ASC as "a safeguarding issue that needs urgent	Clarification was supposed to be sought through a family meeting but no record of one taking place District nurses started visiting in pairs

		attention" but recorded by ASC as "Referrer requesting an urgent review" and neither 'safeguarding' or 'urgent' selected from options on form 8 days later, ASC and Barts managers discussed events and disagreed on whether this was a safeguarding issue or a nursing competence complaint	
Jan 2015	District nurse attending alone noticed a sticker on the door: "LET MY PEOPLE GO" and she did not enter	A referral was made to the CMHT duty desk for a review of Abdul This was not accepted due to previous DNA	
Mar 2015	Abdul self-presented at RLH emergency department and admitted for assessment	Disclosed multiple mental health issues leading to a possible diagnosis of paranoid personality disorder, as well has alcohol and cannabis use Discharged to outpatients after 24 hours	Did not attend outpatients appointment
Mar 2015	Last visit by Abdul to GP	Recorded as a 'meandering consultation – just wanted to touch base' Described fears over having mother in hospital; - she is back now Same issues with brother	No indication of escalation in home situation
Apr 2015	Last visit by local police for RSO check	Abdul reported that he did not get on with Yunus and they barely spoke	This was consistent with earlier reports of a troubled relationship No indication of escalation in tension or violence

Sep 2015 DAI 14	Sister 5 called police having spoken to Yunus who was being treated for hand injuries at RLH and then discovered the decomposing (for 6 days) body of Abdul	Yunus arrested and charged with murder, claiming to Abdul caused in self defence Convicted of murder at Central Criminal Court and sentenced to 12 years imprisonment in 02/16	

Appendix 5

ACTION PLAN

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key Milestones Achieved in enacting recommendations	Target Date	Date of completion and outcome
1 Tower Hamlets Senior Leadership Team (SLT) carry out a dip sample of reports to ensure that ACN reports are being created where required	Tower Hamlets Police	Ongoing dip sampling of reports to ensure compliance with MPS Vulnerability and Protection of Adults at Risk Toolkit	MPS	Dip sample search created to assess compliance	31 October 2016	31 October 2016 **Ongoing**
2 All officers involved in the investigation of the domestic abused incidents reported to police should be de-briefed by the SLT in order to assess the officers' knowledge of the Vulnerable Adult Framework (VAF)	Tower Hamlets Police	All serving officers involved in Domestic Homicide Review advised of recommendation and reminded of requirements of MPS Vulnerability and Protection of Adults at Risk Toolkit	MPS	SLT arranged personal debriefs for all officers involved.	31 October 2016	26/10/2016 **Complete**
3 In complex cases, or where concerns are raised, practitioners convene	LBTH Adult Social	Instruction to staff and managers to be advised of recommendation	LBTH Adult Social	Practitioner checklist audit process	31 October 2016	31 October 2016

professionals meetings to share information	Care	A Practitioner checklist audit process will be introduced.	Care			**Ongoing**
4 Where, as a result of concern around safeguarding or risk behaviour, referrals are made to other agencies, practitioners do not close casework and they monitor responses so that their support planning can respond to advice and provision of the other agency. Where responses are delayed or insufficient to manage risk, practitioners remain involved to secure a response or escalate according to the risks or concerns that trigger the original request	LBTH Adult Social Care	Instruction to staff and managers to be advised of recommendation Supervision and practitioner checklist will identify unusual delays in casework progress and closure on a monthly basis.	LBTH Adult Social Care	Supervision and practitioner checklist to be introduced and auditing to start	31 October 2016	31 October 2016 **Ongoing**
5 No patient should be considered for discharge from THCfMH within 24 hours of admission without the agreement of a senior member of staff. Senior members of staff include the	ELFT	Instruction to be issued for dissemination to senior nurses and medical staff setting out learning from the Serious Incident review: ‘During weekends no patient reviewed within 24	ELFT	Issue of internal memo Director of Nursing to all senior nurses and medical staff	31 July 2016	22 July 2016 **Complete**

following: the borough lead nurse and deputy borough lead nurse, the responsible clinician or duty consultant and the modern matron or ward manager		hours of admission should be discharged without discussion with the following staff: the Responsible Clinician or the Duty Consultant, the Borough Lead Nurse or Matron'				
6 The senior management team of Tower Hamlets Specialist Addictions Services to review the migration strategy between EDM and Nebula and analyse the risks and benefits of further migration of all EDM patient data	ELFT	The strategy for on-going migration of patients between EDM and Nebula is that ALL new referrals should be checked against EDM, when a new referral is identified as previously being treated and having a record on EDM this record should be uploaded to the client record on Nebula.	ELFT	Policies and procedures for paperless offices were issued in November 2014 Recommendations as a result of review: 1. Formalise in-service operational policy 2. Re-affirm policy with support system staff 3. Extend policy to include ex-service users who are subject to either a subject access request or request for information from complaints/incidents 4. Carry out audit of caseload to ascertain current compliance	31 October 2016	Latest update 18 July 2016 **Ongoing**

7 LBTH Adult Safeguarding Board to commission a task and finish group to review the specific learning from this review about effective communication between safeguarding agencies, adopting a 'think family' approach to develop a narrative case study to be shared at relevant Tower Hamlets Partnership learning events	LBTH	Identify membership and form task and finish group to undertake review of learning from this review and prepare a narrative case study for use in learning events in LBTH	LBTH	1. Form task and finish group within LBTH 2. Adopt 'think family' approach to develop a narrative case study from this review 3. Prepare plan for presentation of case study at relevant learning events in LBTH 4. Complete plan for presentations	31 December 2016	31 December 2016 **Ongoing**
8 LBTH Adult Safeguarding Board to commission a project working group to explore the greater use of CCTV in the context of adult safeguarding within a suspected domestic abuse environment and present findings and recommendations for consideration	LBTH	Identify membership and form project working group to undertake review of potential use of CCTV in the context of an adult safeguarding environment and present findings and recommendations for consideration by LBTH Adult Safeguarding Board	LBTH	1. Form project working group 2. Identify potential use of CCTV in the context of adult safeguarding 3. Identify risks, benefits and control measures (eg RIPA consent issues) 4. Present findings and recommendations to CSP	31 December 2016	31 December 2016 **Ongoing**