# SAFER EALING PARTNERSHIP

# DOMESTIC HOMICIDE REVIEW

## Overview Report into the death of Bilqiis

## In November 2016

**Independent Chair and Author of Report: LAURA CROOM**

**Associate Standing Together Against Domestic Violence**

**Date of Draft: May 2019**



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# 1. Preface

## 1.1 The homicide

1.1.1 Bilqiis and Omar were married and lived in Ealing. In November 2016, Omar was living with his mother in Haringey, having moved in with her after leaving a mental health hospital in the summer of 2016. Omar and his mother were planning to travel to Somalia in the hope that the change of scene would improve his mental health.

1.1.2 That night, Bilqiis brought their four young children to Omar's mother's house to join a small group of family and friends to say goodbye to Omar and his mother. Their tradition is that women dye their hands with henna and men trim and dye their hair and beard with henna when travelling.

1.1.3 Bilqiis went to the bathroom with the henna to dye Omar's hair and Omar locked the door and stabbed her. She was pronounced dead at the scene at 22:06 and Omar was arrested.

1.1.4 On 22 May 2017 Omar pleaded guilty to manslaughter on the grounds of diminished responsibility. His plea was accepted and he was sentenced to a hospital order under Section 37 of the Mental Health Act 1983 and a Restriction Order under Section 41.

## 1.2 Introduction

1.2.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.2.2 This report of a domestic homicide review examines agency responses and support given to Bilqiis and Omar, who were residents of Ealing prior to the point of her homicide in the autumn of 2016, though Omar was temporarily living with his mother in Haringey. Omar and Bilqiis had been married since 2006 and had four children. Bilqiis and Omar had both accessed care for their mental health over a period of several years.

1.2.3 The Review will consider agencies' contacts with Bilqiis and Omar from 15 July 2013, the day that Bilqiis first sought help for her own mental health, to the day of Bilqiis's death. Interactions with the children were also reviewed.

1.2.4 In addition to agency involvement, the Review will also examine the past to identify any relevant background or pattern 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.

1.2.5 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. These reviews allow



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professionals to explore what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2.6 This Review process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

1.2.7 The Review Panel expresses its sympathy to the family and friends of Bilqiis and of Omar for their loss and thanks the family members for their contributions and support for this process.

## 1.3 Timescales

1.3.1 The Safer Ealing Partnership, in accordance with the 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews commissioned this domestic homicide review (DHR) following a decision to proceed with a review in January 2017.

1.3.2 Standing Together Against Domestic Violence (STADV) was commissioned to provide an independent chair for this DHR on 27 February 2017. The completed report was handed to the Safer Ealing Partnership on 10 June 2018.

1.3.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. There was a delay in arranging the first meeting as Ealing sought to identify all the relevant agencies and ensure they had time to review their records so that the first meeting could be as productive as possible. Agencies were contacted as soon as possible after the Review was established to inform them of the Review, their participation and the need to secure their records. The meetings were held on 2 June 2017, 18 September 2017, 17 November 2017 and 22 February 2018, where the draft report was reviewed.

1.3.4 There were delays as Panel members took the draft report through internal steps. The draft report that was revised after the 4th Panel meeting was circulated to the Panel at the end of May 2018. Some of the responses to the second draft were slow to be returned and so the third draft was not completed until October 2018. This was the version that was sent to the family in November 2018.

1.3.5 Following the family's response towards the end of January 2019, the Chair met with West London NHS Trust Panel members and agreed how to reflect the family's concerns in the report. The report was updated and circulated to the Panel again in early May 2019.



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## 1.4 Confidentiality

1.4.1 This Review has been suitably anonymised in accordance to the 2016 guidance. The specific date of death has been removed, the gender of the children and only the independent chair and Review Panel members are named.

1.4.2 To protect the identity of the victim, the perpetrator and family members their names have been anonymised through this Review.

1.4.3 The pseudonyms for the perpetrator and his family were chosen by his family members. The pseudonyms for the victim and her family were chosen by the Panel member from Southall Black Sisters to reflect the background of the family as her family did not respond to the Chair's request for suggestions.

## 1.5 Equality and Diversity

1.5.1 The Chair of the Review and the Review Panel bore in mind all the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the Review process.

1.5.2 Bilqiis was a heterosexual Somali woman who was 41 at the time of her death. Omar was a heterosexual Somali man who was 41 at the time of the homicide. They had been married in a religious ceremony. Both had previous religious marriages, we understand, and had been divorced. These religious marriages were not registered with the civil authorities. Bilqiis had four children with Omar. Both Bilqiis and Omar were Muslim.

1.5.3 Both Bilqiis and Omar suffered from psychosis during the time covered by this review.

1.5.4 Both were also immigrants who had left Somalia in the wake of the civil war there.

1.5.5 To understand the mental health concerns, the author and a member of the mental health review panel joined the DHR Panel. The director of Midaye, a charity that was founded to support the diaspora Somali community (and now works with other immigrant groups as well), attended and talked to the Review Panel about the Somali diaspora experience and about cultural understandings of mental health problems, gender roles and religious marriages. Midaye had not had direct contact with Bilqiis or Omar. The Chair consulted an imam who provides chaplain support to Muslims in mental health facilities in Ealing to talk further about cultural understandings of mental health and religious marriages. We also had Southall Black Sisters on the Panel to provide expert advice on the experience of black and minority ethnic women suffering domestic abuse as well as Hestia who provides a specialist domestic abuse voice. Due to limited resources, Southall Black Sisters could not attend all the meetings.



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## 1.6 Terms of Reference

1.6.1 The full Terms of Reference are included at **Appendix 1**. This Review aims to identify the learning from Bilqiis's and Omar's case, and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.

1.6.2 The Review Panel comprised agencies from Ealing, as the victim was living in that area at the time of the homicide. As the homicide occurred in Haringey, where Omar was living temporarily, agencies there were also contacted by the Strategic Violence Against Women and Girls Lead in Haringey.

1.6.3 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from 15 July 2013, the date that Bilqiis first attended the GP surgery with hallucinations to the date of the homicide. Agencies were asked to summarise any relevant contact they had had with Bilqiis or Omar outside of these dates. Where agencies found such contact, it was reviewed by the Panel and agreement reached as to whether it was pertinent to the purpose of the review.

1.6.4 *Key Lines of Inquiry:* The Review Panel considered both the 'generic issues' as set out in 2016 Guidance and identified and considered the following case-specific issues of cultural understandings of mental health, gender roles, religious marriages, and religion. The steps taken to address these are noted in Section 1.5 above. The Panel also noted the caring roles that Bilqiis and Omar had in relation to each other and to the children. Information about how Bilqiis and Omar coped with their caring responsibilities was gained from their families and IMR writers addressed their agencies' responses to these.

## 1.7 Methodology

1.7.1 Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-government definition of domestic violence and abuse as issued in March 2013 and included here to assist the reader, to understand that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The new definition states that domestic violence and abuse is:

(a) '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; and emotional.

(b) 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



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capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

(c) 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.'

1.7.2 This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

1.7.3 As an 'incident of . . . violence . . . between those aged 16 or over who are or have been intimate partners', Omar's killing of Bilqiis was the most extreme form of domestic abuse. This review looks at what agencies knew in the lead up to this homicide to see if there were patterns of behaviour or evidence of abuse that were seen by the families or professionals around them that might have been identified and addressed.

1.7.4 This Review has followed the 2016 statutory guidance for Domestic Homicide Reviews issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. On notification of the homicide, agencies in Ealing were asked to check for their involvement with any of the parties concerned and secure their records.

1.7.5 As the homicide took place in Haringey, in April 2017 the Community Safety Partnership in Haringey was also asked to determine if Bilqiis or Omar had agency involvement there.

1.7.6 The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Omar or Bilqiis. A total of 28 agencies were contacted to check for involvement with the parties concerned with this Review. Nineteen agencies returned a nil contact, five agencies submitted IMRs and chronologies, and one agency provided a letter only due to the brevity of their involvement and three services provided a summary of engagement only. Two services were interviewed. The chronologies were combined and a narrative chronology is included.

1.7.7 As the provider of the Ealing UCC changed during the timeframe of this review, further information was sought from the new Clinical and Safeguarding Lead who clarified information about a particular visit.

1.7.8 Several Panel members were uncomfortable with the exercise of putting a domestic abuse framework on a situation where there was no evidence of domestic abuse prior to the murder. The finding that there was no evidence of a previous incident or pattern of abuse is reiterated throughout the report.

1.7.9 *Independence and Quality of IMRs:* The IMRs were written by authors independent of case management or delivery of the service concerned. The IMRs enabled the Panel to analyse the contact with Bilqiis and Omar, and to produce the learning for this review. Where necessary further questions were sent to agencies. Four IMRs made



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recommendations of their own, and evidenced that action had already been taken on these. The IMRs have informed the recommendations in this report. The IMRs have helpfully identified changes in practice and policies over time, and highlighted areas for improvement not necessarily linked to the terms of reference for this Review.

1.7.10 *Documents Reviewed:* In addition to the five IMRs, documents reviewed during the Review process have included a court psychiatric report, letter from the Metropolitan Police Service, research on domestic abuse, housing and the health impacts of domestic abuse, and research on domestic homicide reviews, and the Home Office's DHR Case Analysis (December 2016).[1]

1.7.11 *Interviews Undertaken:* The Chair of the Review has undertaken five interviews in the course of this Review. This has included two face-to-face interviews with family members of Bilqiis and of Omar, and with the Director of Midaye Somali Development Network. The Director was then invited and came to the third Panel meeting to have a structured interview with the Panel and answer their questions. The Chair had telephone interviews with an imam who works as a chaplain in mental health hospitals, and with the Standing Together Mental Health Coordinator who has been training mental health staff for the West London NHS Trust. The Chair is very grateful for the time and assistance given by the family and friends and professionals who have contributed to this Review.

1.7.12 The Review Panel met a total of four times, with the first meeting of the Review Panel on the 2 June 2017. There were subsequent meetings on 18 September, 17 November and 22 February 2018.

## 1.8 Contributors to the Review

1.8.1 The following agencies were contacted, but recorded no involvement with the victim or perpetrator:

1.8.2 Haringey agencies:

(a) Whittington Health NHS Trust

(b) Homes for Haringey

(c) Barnet, Enfield and Haringey Mental Health NHS Trust

(d) Hearthstone Domestic Violence Advice and Support Centre

(e) Haringey's Children and Young People Service

(f) NIA – DV service

[1] Home Office ( 2016) *Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews* at www.gov.uk [accessed on 12 January 2018].



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(g) Solace Women's Aid – DV service

(h) Domestic Violence Intervention Project (DVIP) – perpetrator programme

(i) HAGA – Haringey Action Group on Alcohol

(j) The Grove Drug Treatment Service

(k) Victim Support

(l) London Fire Brigade – one route fire safety visit

1.8.3 The following Ealing agencies had no contact with either the victim or the perpetrator:

(a) Ealing Adult Social Care Services

(b) Southall Black Sisters – DV service

(c) Hestia – DV service

(d) National Probation Service

(e) Victim Support

(f) RISE – substance misuse services

(g) Ealing Housing Services

1.8.4 The following agencies and their contributions to this Review are:

| **Agency** | **Contribution- Chronology/IMR/Letter/ Other** |
|---|---|
| GP of Omar, Bilqiis and the children | IMR and chronology |
| Metropolitan Police Service | Letter summarising their involvement |
| West London NHS Trust, formerly West London Mental Health NHS Trust | IMR and chronology<br>Joint visit to Omar's family |
| Ealing Safeguarding Children's Service | IMR and chronology |
| A2 Dominion Housing | IMR and chronology |
| London North West University Healthcare NHS Trust, previously London North West Healthcare NHS Trust | IMR and chronology |
| Ealing Council Education Services, School Attendance Team | Summary of engagement |



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| St. Johns Primary School | Summary of engagement |
|---|---|
| Oakland Primary School | Summary of engagement |

## 1.9 The Review Panel Members

1.9.1 The Panel members for this review were the following.

| Name | Role | Organisation |
|---|---|---|
| Joyce Parker | Community Safety Team Leader | London Borough of Ealing |
| Ann Coles | Designated Nurse Safeguarding Children | Ealing Clinical Commissioning Group |
| Angela Middleton | Patient Safety Lead, Mental Health | National Health Service, England |
| Sariah Eagle<br><br>And then Kogie Perumall | Head of Safeguarding Review and Quality Assurance | Ealing Children's Social Care |
| Pragna Patel | Director | Southall Black Sisters |
| Emelia Bulley | Named Nurse Safeguarding Children | London North West University Healthcare NHS Trust, Community Services |
| Pam Chisholm and then Janice Cawley | Review Officer, Detective Sergeant | Metropolitan Police Service |
| Janet Livesey | Safeguarding Lead<br><br>Ealing Police | Metropolitan Police Service |
| Dr. Oliver Dale | MH Review Chair<br><br>Consultant Psychiatrist | West London NHS Trust |
| Parminder Sahota | Safeguarding Adult Named Professional | West London NHS Trust |



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| | | |
|---|---|---|
| Seem Alsasa, and then Judith Banjoko | Domestic Abuse Services Manager | Hestia |
| Nicole Williams | Area Manager | A2 Dominion Housing Group |

1.9.2 The Chair allowed the Named GP for Safeguarding Children for the Ealing Clinical Commissioning Group to observe the meetings in preparation for any future involvement in DHRs.

1.9.3 *Independence and expertise*: Agency representatives were appropriately independent and had the expertise and seniority to contribute to the review.

1.9.4 The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

## 1.10 Involvement of Family and Friends of Bilqiis and Omar

1.10.1 The Chair of the Review and the Review Panel acknowledged the important role that Bilqiis's and Omar's families could play in the review. From the outset, the Review Panel decided that it was important to take steps to involve the family, friends, work colleagues, and the wider community.

1.10.2 Initially, the Chair of the DHR gained information about the families and who to contact through the Family Liaison Officer and Senior Investigating Officer. As recommended, the Chair notified Bilqiis's sister in writing of the Safer Ealing Partnership's decision to undertake a review on 6 July 2017.

1.10.3 A letter was sent to Omar's family, notifying them of the DHR and the mental health review on 28 July 2017.

1.10.4 The families were provided with Home Office DHR leaflets in English and Somali. They were invited to be involved in this process, have someone with them for support and asked if they had particular needs, such as an interpreter, that we might address.

1.10.5 As both families expressed concern early on in the interview that a DHR might be inappropriate, as they had observed no abuse, the Chair explained the legal obligation on the local authority and the opportunity this offered to learn wider lessons. The terms of reference were provided and discussed with both families.

1.10.6 The notes of the meetings with the families were sent to them for comment and no responses were received.



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1.10.7 **Bilqiis's family**

1.10.8 Bilqiis's sister, Halima, who lived with the family off and on and who now looks after their children, agreed to be interviewed by the Chair for this review and was interviewed at her home. Bilqiis's sister was provided with AAFDA[2] leaflets. The Chair's contact details were provided to Halima to pass on to a friend of Bilqiis's who had shown a willingness to join Halima. The friend did not get in touch and the Chair was unable to obtain contact details from Halima to pursue this input.

1.10.9 Contact was sought with Halima seven times in the course of the review and updates on the process were sent via emails, texts and telephone calls, including when the draft report was completed. The final attempt at contact was made in May 2018, with a letter inviting the sister to read and respond to the draft report and offering a translation, if needed, but also saying that if the sister did not make contact that the Chair would conclude that she did not want to be involved in the DHR process at this time and the report would be finalised and sent to Ealing Council. She was thanked for her previous support and told that the Council would let her know when the report would be published. As the sister did not respond to this, the Chair did not pursue contact further.

1.10.10 **Omar's family**

1.10.11 The Chair sought contact with Omar's mother, with whom Omar lived in the summer of 2016 after leaving the hospital, and with his sister who had been active in his mental health care. Omar's mother chose not to take part.

1.10.12 The DHR Chair and the Chair of the Mental Health Review (MHR) interviewed Omar's family together so that the family did not have to go over the same details twice. The MHR findings were discussed with the family at that meeting.

1.10.13 Omar's sister, Sarah, and brother-in-law, Tom, who supported Omar generally and were closely involved with his care, were interviewed near their home. At this interview, they were asked to review the terms of reference and agreed the timeframe.

1.10.14 An email was sent to the family in April 2018 asking if they would like to read the draft report. A final letter was sent to Omar's sister in May 2018 when the draft report was completed inviting her to read and respond to it. The letter said that if the sister did not make contact that the Chair would conclude that she did not want to be involved in the DHR process at this time and the report would be finalised and sent to the Ealing Council. She was thanked for her previous support and told that the Council would let her know when the report would be published. The sister's husband, Tom, responded and reported

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[2] Advocacy After Fatal Domestic Abuse – a charity that specializes in guiding families of victims of domestic homicides through inquiries



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that they had moved abroad but would be interested in reading the draft, though they were not able to do that immediately. It was several months before the draft was ready to be sent to them.

1.10.15 As Sarah and Tom reported that the postal services in the country where they then lived were unreliable, an electronic version of the report was emailed to them at the end of November 2018. The family responded in mid-January with detailed comments and corrections. Two key points they made were that they did not think that the review reflected the struggle they had getting the mental health care for Omar and it did not address 'the failure of the systems to flex to [Omar's] move from' one area to another.

1.10.16 The Chair of the review met with the authors of the mental health review who were on the Panel to respond to the family's email. Changes and additions were made to this report to better reflect the family's experience and to include changes made to the mental health systems since the draft was written. The family were also advised that they could contact the clinical governance team at West London NHS Trust if they continued to have concerns about either the care that BA received or the subsequent investigation.

1.10.17 The revised report was then taken to the Panel and a final version was sent to the family at the same time as the report was sent to the Community Safety Partnership.

1.10.18 **Contact with the wider community**

1.10.19 Information was gathered from the School Attendance Team and we found that the children had been in a mainstream nursery and then were withdrawn for home schooling. We understand that the children then began to attend an Islamic learning centre.

1.10.20 The Chair sought contact with the learning centre to ascertain if staff there had observed any changes in the children's behaviour and their response. A letter was sent, explaining the process and asking the centre to get in touch. This was followed with a telephone call and several texts to encourage contact. A final letter was sent in the course of writing this review. No response was received.

1.10.21 *Contact with the mosque*. Omar's sister felt that, though Omar was a devout Muslim and attended his mosque regularly, that little case-specific information would be gained from interviewing the imam or management committee at the mosque and anonymity would be difficult to maintain. The Chair therefore did not approach the mosque, feeling that the risks to confidentiality and anonymity outweighed the likelihood of gaining additional insight into the situation, particularly as no evidence of domestic abuse was identified.

1.10.22 However, the Review Panel, on reading the first draft of this report suggested that, as this was the second DHR in Ealing where the victim and perpetrator attended a particular mosque, contact should be made. Standing Together Against Domestic Violence's (STADV) SAFE Communities Project Coordinator undertook to make contact to get the perspective of the mosque, offer support on how to deal with the issue of domestic abuse



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and the opportunity to share any interaction they had with either the victim or the perpetrator. The value of Standing Together contacting the mosque was that they would be able to stay involved after this DHR ends and build a relationship with the mosque to support that organisation over a longer time. By the final draft of this report, the SAFE Communities Project Coordinator had not received a response to her offers of contact and support.

1.10.23 **Involvement of Omar**

1.10.24 Contact was made with Omar through his consultant at the secure mental health unit where he resides. Omar sent back the signed form giving consent for his medical records to be shared but declined to be interviewed or for his employment records to be shared with the Panel.

1.10.25 The Chair had contacted Omar's employer before receiving the signed consent forms from Omar. The Chair explained the DHR process and purpose and asked for their input. The employer declined to be involved. As Omar then informed the Chair that he did not give his consent for the employer to share information, this line of enquiry was not pursued.

## 1.11 Parallel Reviews

1.11.1 *Post mortem.* A post mortem examination was conducted, and the cause of death was recorded as multiple incised wounds.

1.11.2 *Criminal trial:* The criminal trial began on 22 May 2017 and Omar pleaded guilty to manslaughter on the grounds of diminished responsibility. His plea was accepted, and he was sentenced on 24 May 2017 to a hospital order under Section 37 of the Mental Health Act 1983 and a Restriction Order under Section 41. This means that Omar is in a mental health institution where his mental illness is being treated and will not be allowed to leave until the clinician responsible for him determines that he is well enough to leave hospital and asks the Secretary of State for Justice to agree and the Secretary agrees.

1.11.3 As the first Panel meeting took place after the criminal trial had concluded, there were no issues of disclosure.

1.11.4 *Mental Health Review*: A mental health review was undertaken in the spring of 2017 and concluded soon after the DHR was launched. The Chair of the DHR and the author of the MHR visited the family of Omar together. The family had a chance to read the MHR before that meeting and its author talked the family through the review and answered their questions and concerns. The DHR Chair then interviewed them about Omar, Bilqiis and their relationship. The MHR author and another member of the MHR team were DHR Panel members.

1.11.5 *Coroner's report:* Standing Together contacted the coroner in April 2017 to inform them of this DHR and to request the results of the coroner's investigation/inquest. We received



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no response. The Panel member from the Metropolitan Police Service contacted the coroner in January 2018 for the results of their inquest and the coroner replied that they had not known the outcome in this criminal case and that, as a trial had concluded, it was unlikely that they would re-open the inquest.

## 1.12 Chair of the Review and Author of Overview Report

1.12.1 The Chair and Author of the Review is Laura Croom, an Associate DHR Chair with Standing Together Against Domestic Violence (STADV). She is an independent consultant who has worked in the domestic abuse sector for 15 years and received Home Office DHR chairs' training in 2013. She is chairing her tenth DHR.

1.12.2 STADV is a UK charity bringing communities together to end domestic abuse. STADV aims to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides

1.12.3 STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 50 reviews to date.

1.12.4 *Independence:* Laura Croom is independent of all agencies involved and had no prior contact with any family members. She has chaired two previous DHRs in Ealing. The Safer Ealing Partnership was satisfied that STADV's roles in providing coordination of the Ealing MARAC (neither Bilqiis nor Omar were subject to the MARAC) and training for the West London NHS Trust did not compromise its independence in providing the Associate DHR Chair and administration of this DHR.

## 1.13 Dissemination

1.13.1 The following will receive copies of the final report:

- Safer Ealing Partnership
- Directors of Adults and Children's Social Services
- Director of Public Health
- Director of Housing
- Metropolitan Police Service, Ealing Borough commander
- Family members
- The GP practice involved
- Standing Together Against Domestic Violence DHR Team



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- Ealing Safeguarding Adults Board
- Ealing Safeguarding Children Board
- Panel members and their organisations



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# 2. Background Information (The Facts)

| Name used in report | Relationship to Bilqiis | Age at time of Bilqiis's death | Ethnic Origin | Faith |
|---|---|---|---|---|
| Bilqiis | Victim | 41 | Somali | Muslim |
| Omar | Husband through religious ceremony | 41 | Somali | Muslim |
| Halima | Sister of victim | | Somali | Muslim |
| Sarah | Sister of perpetrator | | Somali | Muslim |

## 2.1 The Homicide

2.1.1 *Homicide:* Bilqiis and Omar lived in Ealing. In the autumn of 2016, Omar was living with his mother in Haringey, having moved in with her after leaving a mental health hospital in the summer of 2016. Omar and his mother were planning to travel to Somalia in the hope that the change of scene would improve his mental health.

2.1.2 That night, Bilqiis brought their four young children to Omar's mother's house to join a small group of family and friends to say goodbye to Omar and his mother. Their tradition is that women dye their hands with henna and men trim and dye their hair and beard with henna when travelling.

2.1.3 Bilqiis made the henna and went to the bathroom with it when Omar called her. Shortly after that, Bilqiis screamed 'Mum, Mum, he has a knife and he wants to kill me'. The family ran to help, but the bathroom was locked from the inside and despite their continued efforts, they could not open it. The police were called. There was further shouting and then it went quiet. About 10 minutes later, Omar left the bathroom and went into the bedroom and put a cable around his neck, suggesting he meant to harm himself.

2.1.4 Omar's mother took the cable from Omar and held him. The police arrived and found Bilqiis unconscious. The London Ambulance Service was called and Bilqiis was pronounced dead at the scene at 22:06. Omar was arrested for murder.

2.1.5 *Criminal trial:* At the criminal trial on 22 May 2017, the court accepted Omar's plea of guilty to manslaughter on the grounds of diminished responsibility



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sentenced him to a hospital order under Section 37 of the Mental Health Act 1983 and a Restriction Order under Section 41.

## 2.2 Background Information about Bilqiis and Omar (prior to the timescales under review)

2.2.1 *Background information about Bilqiis:* The following was gathered from the interview with Bilqiis's sister and from the police report. Bilqiis's sister, Halima, came to this country in 2007 and lived with Bilqiis and Omar from time to time when Bilqiis needed additional help, including when Bilqiis and Omar suffered from mental health problems.

2.2.2 Bilqiis was a 41-year-old female Somali immigrant who was a devout Muslim. She was the eldest of 6 children and was born in Mogadishu in Somalia. Her sister said that their life in Somalia was very hard. After the civil war started, people would take their possessions and their money. Though the fighting was not continuous, it was dangerous for women to go out and therefore they would stay home most of the time.

2.2.3 Bilqiis's father wanted a better life for his children, so he arranged to get them out of the country. Bilqiis came to the UK in 2001, when she was 26 years old. She was expected to get a job in the UK and send money back to help the family.

2.2.4 Bilqiis found it difficult when she arrived. She did not know how the systems worked and she wanted to go back to Somalia. Their father encouraged her to stay, saying that she would have a better life here.

2.2.5 Bilqiis's father died in 2003 and Bilqiis decided that she had to be strong for her family in Somalia. Eventually Halima came over to be with Bilqiis. They have extended family here.

2.2.6 Bilqiis was granted indefinite leave to remain in the UK in 2006. She found work as a cleaner and then carer.

2.2.7 *Background information on Omar:* The following information was provided by Omar's sister, Sarah, and brother-in-law and from immigration and police reports.

2.2.8 Omar is a Somali immigrant who came to this country in 1996 when he was 21 and was granted indefinite leave to remain in 2007. Omar got a job as a bus driver in the UK. He was 41 years old at the time of the incident.

2.2.9 Omar has 5 siblings and 2 half-siblings. His parents live in the UK.

2.2.10 Omar's sister reported that the family had a good life in Somalia but their lives became difficult when the civil war started there in 1991. The family then left



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Somalia and went to Ethiopia from where they entered the UK a few at a time as they could not get a family visa. The family paid for someone to get the children to the UK, one by one, and they went to live with distant relatives.

2.2.11 Omar's sister said that Omar did not grow up in an abusive household or one where women were put down. She acknowledged that some Somali women do not have as much freedom as women have in the UK, but says their own mother was able to do a lot of things for herself.

2.2.12 Omar was briefly in an arranged marriage with a woman in Kenya but divorced her in 2005. Omar had no children from that relationship.

2.2.13 *Relationship between Bilqiis and Omar:* Omar and Bilqiis married in a religious ceremony in 2006 and had four children together. The children were all under 12 when Bilqiis was killed.


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# 3. Chronology

## 3.1 Chronology from July 2013 to November 2016

3.1.1 The following is a brief chronology of significant events in the time period under review, that is, from July 2013 to the date of Bilqiis's death. These are the agencies that had significant contact.

| Organisation | Contact with Bilqiis (Y/N) | Contact with Omar (Y/N) |
|---|---|---|
| *Immigration info from Evidence and Enquiry Unit, Home Office* | *Y* | *Y* |
| *West London NHS Trust* | *Y* | *Y* |
| *Ealing Urgent Care Centre* | *N* | *Y* |
| *Ealing Children's Social Care* | *Y* | *N* |
| *GP service* | *Y* | *Y* |
| *London North West University Healthcare Trust – Community Services* | *Y* | *Y* |
| *London North West University Healthcare Trust – Ealing Hospital A&E/Community* | *Y* | *Y* |
| *A2 Dominion* | *Y* | *Y* |

3.1.2 This chronology also includes a few key dates before that time for context. The dates have been generalised.

3.1.3 Omar's family's experience has been added to the chronology following their feedback on the draft report.

3.1.4 Between 2007 and 2012, Bilqiis and Omar had four children.

3.1.5 In the **summer of 2013**, Bilqiis went with Omar and her sister to the GP, reporting a sudden onset of anxiety and visual hallucinations. The GP referred her to Ealing A&E who then referred her to the psychiatry team for further assessment. Bilqiis was referred to the West London NHS Trust Crisis Resolution Home



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Treatment Team (CRHTT). Bilqiis and her sister returned to A&E the next day as Bilqiis was still having hallucinations, but left without being seen.

3.1.6 Bilqiis was under the care of the CRHTT until early December. She engaged with this service, however after being discharged from the CRHTT to the Recovery Team, Bilqiis did not attend any of the follow-up appointments and was discharged from the Recovery Team 5 months later.

3.1.7 In **mid-March 2014**, Omar went to the GP complaining of anxiety. The GP explored his situation. Omar reported that he got angry, that his religion was a help to him, and he did not use drugs or alcohol. They discussed talking therapies.

3.1.8 About the same time Bilqiis went to the GP, complaining of being tired all the time. There was no exploration of MH, despite the events in 2013.

3.1.9 In **June 2014**, the whole family attended the GP for travel assessments in preparation for a trip to Somalia.

3.1.10 Between **June and September 2014**, the family went to Somalia and returned. On their return, Omar went to the GP about malaria he had developed during the trip and about anxiety and depressive symptoms.

3.1.11 Sometime before **September 2015**, Omar married a second wife in a religious ceremony in Somalia. Bilqiis found this out in September and was unhappy about this.

3.1.12 In **October 2015**, Bilqiis went to the GP for worsening psychotic symptoms: confusion, not wanting to eat, crying frequently, and hearing voices. Omar went with her. She reported hallucinations that had worsened over the previous two weeks that included seeing angels and thinking that Omar's face had changed. She also thought she was pregnant with twins. The GP directed Bilqiis to Ealing Hospital A&E where she was seen by a psychiatric liaison nurse who assessed that the symptoms could have a physical cause and prescribed medication. Bilqiis received support from the CRHTT again and was discharged to the GP for follow-up. The CRHTT started daily visits that were regularly reviewed and phased out in the course of the next month.

3.1.13 The GP rang the next day and Bilqiis said that she was feeling better and the hallucinations had stopped.

3.1.14 Following the referral to the CRHTT, the West London NHS Trust referred the children to ECSC because of Bilqiis's psychotic symptoms.

3.1.15 Later that month, the ECSC made an unannounced home visit and saw Bilqiis, her sister and brother. Omar was at work and the children were at the learning



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centre. Bilqiis reported that she was well supported by her family and husband and declined support. The ECSC recorded no further concerns.

3.1.16 In **November 2015,** Omar went to the GP with worsening anxiety and started a 2-week trial of a new drug. He then missed the next two GP appointments scheduled for 4 and 8 days later.

3.1.17 Omar presented to the GP with shoulder and back pain and stress a few times in January 2016.

3.1.18 At the beginning of **February 2016**, Omar asked his GP for a psychiatric review as he was suffering auditory hallucinations and insomnia and an urgent referral was made to West London NHS Trust. Though Omar reported hearing negative voices, he said he did not wish to harm himself or others. He had some insight into his hallucinations not being real and noted that his experience of the civil war in Somalia had given him nightmares for a period of time.

3.1.19 **The same day**, Bilqiis attended the GP and reported tiredness and other symptoms and she said she had reduced her medications for her psychotic symptoms.

3.1.20 The GP referred Bilqiis to the West London NHS Trust Recovery team and to ECSC as Bilqiis had reduced her medications and Omar's mental health was poor. Bilqiis did not attend the first West London NHS Trust appointment arranged.

3.1.21 A few days later, West London NHS Trust contacted Omar who explained that the referral for himself was based on a misunderstanding and declined support. Omar was discharged in the same month as he did not engage. ECSC spoke to Omar who said that Bilqiis had been discharged from the CRHTT and that he had medications that were making him feel better. He also reported a lot of support from their extended family who visit regularly.

3.1.22 **February 2016**. Sometime this month, Omar's second wife in Somalia gave birth to their child.

3.1.23 In **March 2016**, Omar lost his job.

3.1.24 In **April 2016**. Bilqiis seen by West London NHS Trust following GP referral in February. Bilqiis said she felt over-medicated and requested a discharge.

3.1.25 In **mid-May 2016** Bilqiis's sister found Omar by the canal, threatening to jump in. She rang the GP who advised taking him to Ealing Hospital A&E.

3.1.26 The next day, Omar was taken by Bilqiis to the Urgent Care Centre (UCC) where he reported feeling depressed, losing sleep, and weight loss due to poor appetite. He said he was not taking his medication and had felt low for 4 months. Omar



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was referred back to his GP to discuss the side effects of his medication that were causing him problems and to monitor his weight loss. Safety advice was given in case Omar became suicidal again.

3.1.27 In late **May 2016** the GP referred Omar to West London NHS Trust in response to acute deterioration in his mental health. Omar attended Ealing A&E with Bilqiis and a sister (Sarah said she attended) and was assessed and admitted under S. 2 of the Mental Health Act 1983 (as amended by the 2007 Act) to a psychiatric ward in St. Bernard's Hospital. Omar appeared to pose a risk to himself. It was noted that Bilqiis found it difficult to cope with Omar and that he planned to stay with his mother.

3.1.28 The next day the children were referred by St. Bernard's Hospital to ECSC who contacted Bilqiis. Bilqiis reported that she had support from within their family.

3.1.29 Omar responded well to treatment in hospital and the family attended many appointments there with him. Omar's family report that Omar was clear to hospital staff that he was not going back to his family in Ealing when he was discharged but would be staying with his mother in Haringey. The family report discussions with staff of where Omar would live and who would care for him.

3.1.30 On **30 June 2016**, Omar was discharged from hospital and went to stay with his mother in Haringey. At this time, Omar should have been referred to the community mental health services, but that referral was not made. A 7-day follow-up was expected to be carried out by the care coordinator. The 7-day follow-up visit did not take place.

3.1.31 Omar missed his first post-hospital GP appointment on 4 July but attended for a review on **7 July 2016.**

3.1.32 As Omar had not been seen by community mental health services since his discharge from hospital, on **25 July 2016** his sister, Sarah, contacted the ward where he had been. They apologised and completed the referral to community mental health services.

3.1.33 On **28 July 2016**, Omar's sister contacted the GP surgery seeking a new 2-week supply of his medication, as he had still not had contact from the community mental health service. As a result, the GP made an urgent referral back to West London NHS Trust.

3.1.34 The family say that they got a letter from the Recovery Team in early August. Sarah contacted the team to tell them that Omar really was not well and asked for a doctor to see him soon. The family say that an appointment was offered a few days later and the medical records say that this appointment was cancelled, as a family member was unable to accompany him.



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3.1.35 Between **17 and 19 August 2016**, West London NHS Trust sent letters to Omar to set up an appointment on 2 September. They then postponed that appointment to 11 November.

3.1.36 On **2 September 2016**, Omar did not attend an appointment with West London NHS Trust and there was no answer on the landline. This may have been because letters and messages were misdirected to his family. The appointment was re-scheduled for 5 October with a particular doctor and then the case was transferred to a different doctor who already had an appointment arranged for 11 November with Omar. So that 5 October appointment was cancelled – but the letter informing Omar about this was not received.

3.1.37 On **5 & 6 September 2016**, Omar requested additional supplies of his MH medication from his GP.

3.1.38 On **4 October 2016**, Sarah rang to confirm an appointment for Omar on 5 October. However, when Omar attended with his sister on **5 October,** they were told that the doctor did not have clinics on that day. (The letter cancelling this appointment had been sent to the wrong address.) The family were exasperated and insisted on Omar being seen as they felt he was quite unwell, was paranoid, and the family were concerned about the medication. They spoke to a manager who then spoke to the doctor who recommended that Omar take his medications on a different schedule. They also scheduled an appointment with a doctor for 7 October.

3.1.39 On **7 October 2016**, Omar had his first post-hospital review by the community MH team. He was accompanied by his sister. He was seen as posing a low risk of harm to himself or others. Omar reported not taking his medications at the prescribed doses. He was given a crisis plan to follow if he felt his MH was deteriorating.

3.1.40 **1 November 2016**. Bilqiis had her last appointment with West London NHS Trust and was reviewed by a Consultant Psychiatrist. Bilqiis was thought to have good insight into her condition and she reported that she had not taken medication for 6 months. Bilqiis's discharge from MH services was completed on 11 November 2016, following the Safe Discharge protocol with the GP.

3.1.41 **11 November 2016**. Omar was seen by West London NHS Trust who noted that his presentation had improved since the October appointment. Sarah said that she attended this appointment too and asked the doctor if there was a better medication for Omar. She says the doctor said that another medication might work but, as Omar was going abroad, he did not want to change the medication at that time. This was his last contact with MH services.



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3.1.42 Later in November **2016**, Omar requested further medications from the GP pharmacist. A relative of Omar's contacted West London NHS Trust to ask them to fax Omar's medication prescription to the GP surgery as Omar was going abroad and needed enough medication to cover his trip.

3.1.43 The same day, the family had a party to mark Omar's trip to Somalia with his mother. Bilqiis and her sister and the children went to Omar's mother's house for this event. At that event, Omar asked Bilqiis to come to the bathroom with him to henna his beard for the journey and he killed her there.



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# 4. Overview

## 4.1 Summary of Information about Bilqiis from Family

4.1.1 The following information is from the interviews with Bilqiis's sister and Omar's sister and brother-in-law.

4.1.2 Halima, Bilqiis's sister, described Bilqiis as strong and brave and a very happy person. She worked long hours to support her family. She said that Bilqiis loved her family very much and her children loved her.

4.1.3 Bilqiis found work as a cleaner and then as a carer when she moved to the UK. Halima could not recall the names of the employers.

4.1.4 Halima lived with Bilqiis and Omar when she came to this country in 2007. Halima helped Bilqiis with the children.

## 4.2 Summary of Information about Omar from Family:

4.2.1 Omar's family describe Omar as a very religious and mild-mannered person. He is Muslim and his faith is very important to him, as it is to his parents. He attended the local mosque and prayed regularly. Though Omar is very religious, he does not criticise the behaviour of other family members who are less religious.

4.2.2 Bilqiis's sister, Halima, also described Omar as a gentle person. She said that he treated her like a younger sister, and that they got on well, even when he was ill.

4.2.3 Omar and the family went to Somalia in 2014 and Omar went back alone in 2015. He had plans to build a life back in Somalia. While there, he married a woman who was pregnant by him in a religious ceremony. The baby was born in February 2016.

4.2.4 Omar's family say that it is acceptable to have multiple wives in Somalia. Omar's marriages were religious and not legal ones.

4.2.5 Omar's family report that some Somalis do not understand mental health problems in the same way as they are understood in the UK. Sarah said that some are suspicious of medications because they change people's behaviour and can make them 'like zombies'. Some are concerned that if they have mental health problems they will be detained because they will not be thought to have the capacity to make decisions. However, Omar's mother understood the regime for taking medications as she had experience of overseeing mental health



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medications in the wider family. The family felt that Omar could be well-looked after by his mother and Bilqiis agreed with this.

4.2.6 The trip to Somalia that Omar and his mother were planning to take was to give Omar a change, and to have the Quran read over him there. Having the Quran read over him was seen as complementary to medical help. Omar was taking his medication and his sister reported that the plan was that if Omar became worse when he was in Somalia, he would come back.

4.2.7 Though Omar was living with his mother, his sister Sarah undertook a great deal of his care, chased the mental health services for appointments for Omar, ensured he had his medications, and took time off work to accompany him to appointments. The MHR found that Omar's family were key to Omar maintaining his mental health for as long as he did.

4.2.8 Omar's family saw that he got better when he was in hospital and they felt that he received good care there. However, they report that it was a struggle to get Omar sectioned initially and also that they were very frustrated by the lack of coordination of his care when he left hospital and by the administrative errors that delayed his medical oversight in the community. These frustrations were exacerbated by seeing the distress Omar was in. The family had concerns about the medications that were prescribed for Omar. The medical staff discussed this with the family on the occasions that he was seen after his release from hospital and again when they were provided with a copy of the mental health review. The medical decisions taken are outside the scope of this review.

4.2.9 Though Omar's family said when interviewed that they did not think that Omar's attack on Bilqiis was in any way predictable, the lack of coordination of his care has undermined their confidence in the care he received, and this has left them with lasting questions of 'what if'.

## 4.3 Relationship between Bilqiis and Omar

4.3.1 Omar and Bilqiis married in 2006 in a religious ceremony. They were both Muslim and very religious and were bringing up their children in that faith.

4.3.2 Both Bilqiis's and Omar's sisters said that they thought that Bilqiis and Omar had a good relationship, that they worked together very well and were very organised. Omar's sister said that she had never seen them argue or say bad things about each other. Bilqiis's sister said that there was a lot of love between the two of them.



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4.3.3 Omar's sister said that though other Somali women in the UK might think that domestic abuse was a private matter, Bilqiis was a strong woman and so would not have kept any abuse secret.

4.3.4 Halima's understanding of Bilqiis's mental health problems in 2015 was that they stemmed from looking after Omar who was up all night and then looking after the children during the day. Halima said that Bilqiis was exhausted and had hardly any sleep. In response, Halima moved back in to help with the children and make sure that Bilqiis took her medications.

4.3.5 Halima said that Bilqiis and Omar looked after each other very well. When Omar was sick, Bilqiis took care of Omar while Halima looked after the children.

4.3.6 Halima reported that Bilqiis found out about Omar's second marriage through friends.

4.3.7 Omar's sister, Sarah, said that Bilqiis was not happy about the second marriage and that Omar had not told Bilqiis he was going to do this. Though Sarah thought they were the kind of people who would have discussed it, Sarah noted that even if Bilqiis had tried to talk to Omar about it after he came back from Somalia, he just 'wasn't there' because of his mental health problems. Sarah said that Bilqiis and Omar had the kind of relationship that if Bilqiis was very upset about something, it would have affected Omar.

4.3.8 After Omar was admitted under S.2 of the MHA 1983 (as amended by the 2007 Act) and then discharged in June 2016, he went to his mother's house rather than coming home to Bilqiis and his children. Halima said that Bilqiis had talked to Omar's mother and decided that it would be too hard on Bilqiis to look after Omar while he was unwell and to look after the four children as well. They were concerned that Bilqiis's own health would deteriorate again. Omar's family said that there were regular discussions when Omar was on the ward about his living arrangements when he left.

## 4.4 Summary of Information known to the Agencies and Professionals Involved

4.4.1 ***Family GP***

4.4.2 The GP practice provided healthcare to Bilqiis, Omar and their children from 2006 to today. The practice had the most regular contact with the family. Domestic violence is part of the practices' adult safeguarding protocol and the practice noted that the CCG uses the Barnardo's domestic violence risk identification matrix (designed for working with children).

4.4.3 The practice has not had domestic abuse training specifically designed for GP practices. Training on domestic abuse is included within child protection training,



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as detailed within 'The Intercollegiate Document'[3] which identifies several tools for general practice.

4.4.4 *About Bilqiis*

4.4.5 Bilqiis presented with hallucinations on **15 July 2013** and was sent to A&E. The practice knew that the MH team had not been in touch by the next day and that Bilqiis returned to A&E. They then sent two letters to Bilqiis asking her to come for a review as her visits to A&E had not resulted in a plan. Bilqiis did not respond to these overtures.

4.4.6 Bilqiis presented with tiredness in November that year and a number of times thereafter. The response focussed on physical causes.

4.4.7 Bilqiis presented to GP out of hours with Omar on **13 October 2015**. She was hearing voices, had worsening hallucinations, did not want to eat and frequently was crying. She was accompanied by Omar and there is no evidence that she was spoken to alone. Bilqiis was re-directed to A&E where she was assessed by the psychiatric liaison nurse. The GP was later alerted to the psychiatric nurse's assessment that the symptoms could have a physical cause and Bilqiis had been prescribed medication.

4.4.8 Bilqiis was deemed to be at low risk of harm to herself or others. The GP was advised that Bilqiis had a crisis management plan and phone numbers to ring for urgent problems. Bilqiis was discharged to the GP for follow up.

4.4.9 Bilqiis was taken to A&E again the next day by Omar with worsening psychotic symptoms and by the 15th she was admitted to the CRHTT and she was prescribed anti-psychotic medications. It was not clear who was responsible for prescribing after this and the notes show that the GP only prescribed the medication once.

4.4.10 The surgery contacted Bilqiis the next day and Bilqiis reported that she was feeling better and had had no further hallucinations. The GP invited Bilqiis for a further appointment if she felt she needed one. Bilqiis did not attend again about her own mental health.

4.4.11 In February 2016, the GP referred Bilqiis to West London NHS Trust and the children to ECSC in response to Omar's worsening symptoms.

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[3] https://www.rcpch.ac.uk/resources/safeguarding-children-young-people-roles-competences-healthcare-staff



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4.4.12 *About Omar*

4.4.13 Omar presented with back and joint pain on a number of occasions, many of which resulted in sick notes for work. He did not take up the referrals to physiotherapy.

4.4.14 Following Omar's attendance at the GP on **12 March 2014**, the GP's notes were comprehensive. They record his anxiety, his information regarding his wife's mental health problems, that he was a bus driver and that he could get angry, though he did not report any violence. He said that his religion helped. He reported that he did not use alcohol or drugs, had no suicidal intent and a talking therapy was discussed briefly. Omar declined the talking therapy and was prescribed medication.

4.4.15 Omar returned, reporting worsening anxiety symptoms on mid-November and towards the end of January 2016. In November he was prescribed a 2-week trial of medication. He did not attend two follow-up appointments and when he was seen again in early January for the recurring back pain, no questions were asked about the mental health issue.

4.4.16 In early **February 2016**, Omar presented to the GP practice requesting a referral to the mental health team. The GP undertook a comprehensive consultation. The GP recorded information about the voices he was hearing and what they were telling him; he denied wanting to harm himself. Bilqiis's psychiatric history was noted as was Omar's experience of civil war. The GP made an assessment that Omar did not suffer from PTSD, and that Omar did not pose a risk to himself or others. An urgent referral was made to psychiatry. ECSC were contacted and a formal referral made between 1 and 3 February.

4.4.17 When Omar declined the West London NHS Trust referral, his mental health care then reverted to the GP practice. He was restarted on a medication and advised not to drive. As he was a bus driver, this meant that he could not work. There was no investigation into how his wife and children were affected by his mental health problems.

4.4.18 On **16 May**, Omar was reviewed at the practice. His sister-in-law had found him by the canal two days before, threatening to jump in and Bilqiis had taken him to UCC the day before.

4.4.19 Omar went to A&E **on 23 May** and was admitted to the acute psychiatric ward. Omar was not eating, drinking or sleeping very well and had lost weight and felt low. He said the sleeping tablets were not helping.



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4.4.20 Omar was discharged on **30 June 2016** and the GP reviewed Omar on 7 July and noted that he felt unable to leave the house unaccompanied and that he was staying with his wider family.

4.4.21 Omar's discharge letter stated that there would be a follow up in the community, but when the GP saw Omar on **28 July**, he had still not heard from the Recovery Team. The GP issued a 2-week supply of his medications and made an urgent referral back to mental health.

4.4.22 The GP notes record that Omar was then offered appointments with the West London NHS Trust Recovery Team that were then re-scheduled. The GP knew that Omar was seen on 7 October by the Recovery Team and was assessed as at low risk of harming himself and others. As Omar had not been taking the medications as prescribed, he was advised to comply with the treatment and was given a crisis plan if he should feel he was deteriorating.

4.4.23 Omar was last seen by a GP at the surgery on **3 November** and his prescriptions were extended. A further request for medications was made later in November, though it is unclear if this was a verbal or written request. The notes say that Omar was planning to go away.

4.4.24 The family missed 22 appointments over the years, mostly by the parents. The GP responded with its routine letters and texts. There is no evidence that these missed appointments were explored with either Bilqiis or Omar.

4.4.25 *About the children.* The children were brought in regularly for fairly standard childhood complaints. There were several complaints – bed-wetting in two children (during the months that Omar was living with his mother), eczema and constipation that might have been linked to anxiety but are also common childhood ailments.

4.4.26 The GP's notes identify that the children were home-schooled. The IMR writer noted that being home-schooled eliminated the opportunity for observation by educational professionals as another avenue for any problems to be identified.

4.4.27 On 11 and 12 June 2014, family members attended the GP surgery and were seen by the practice nurse for travel assessments for their trip to Somalia.

4.4.28 ***London North West University NHS Healthcare Trust (LNWUHT)***

4.4.29 The LNWUHT IMR covered contact with Ealing Hospital, Northwick Park Hospital, including their A&E departments, and LNWUHT Community Services (health visiting in this case).

4.4.30 This was not a family that the health visiting team had any on-going concerns about. The children were healthy, and their development was on track,



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immunisations were up-to-date. Bilqiis appeared to be coping well with the children and reported a good support network, including her sister and Omar.

4.4.31 *About Bilqiis*

4.4.32 LNWUHT's Community Service had contact with Bilqiis after the birth of each of her four children through the health visitors. There were no concerns raised by the health visitors about the growth or development of the babies and no concerns were raised by the mother.

4.4.33 No domestic abuse was disclosed through the new birth questionnaire which specifically asks about abuse. A number of developmental appointments for the children were missed, though the appointments appeared to conflict with Bilqiis's responsibility to pick the older children up from school/learning centre. The usual procedures of writing to the parent and alerting the GP were not followed.

4.4.34 When Bilqiis attended A&E at Ealing Hospital with Omar on 15 July 2013 following a referral from the GP, she was referred to the psychiatry team. At the time she had symptoms of anxiety and had visual hallucinations.

4.4.35 Bilqiis attended the GP again on 13 October with worsening psychotic symptoms that included hallucinations of angels and that she was pregnant with twins. She was referred to the A&E psychiatric liaison nurse who assessed that these symptoms could have a physical case and medications were prescribed. Bilqiis was given a mental health crisis management plan and phone numbers for urgent help and was discharged for GP follow-up.

4.4.36 *About Omar*

4.4.37 The health visiting records do not record having seen the father during their attendances following the birth of each of the four children. It is good practice to record who was at assessments.

4.4.38 On 15 May 2016, Omar presented at Ealing Urgent Care Centre (UCC) late at night with a history of reduced appetite and sleepless nights. He reported being depressed and was not taking the medication for sleeplessness prescribed by the GP. He reported no desire to self-harm.

4.4.39 Omar was diagnosed with depression and weight loss due to poor appetite. He was advised to see his GP for weight monitoring and maybe blood tests and to discuss changing his medications as he complained of side-effects. He was advised on diet and given safety netting advice in case he had any thoughts of suicide or self-harm.

4.4.40 At his attendance at the Ealing Hospital A&E on 23 May 2016, he was accompanied by his wife and sister-in-law. As he had threatened to harm himself



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by jumping into the canal, he was assessed by the mental health team and admitted to the acute psychiatric ward and referred to the psychiatric team there.

4.4.41 ***West London NHS Trust***

4.4.42 Both Bilqiis and Omar were under the care of West London NHS Trust in the timeframe of this review. Omar was diagnosed with depression with psychotic symptoms. Bilqiis was diagnosed with non-organic psychosis.[4]

4.4.43 *About Bilqiis*

4.4.44 Bilqiis had 3 episodes of care with West London NHS Trust for treatment of psychotic illness. The first was between 15 July 2013 and 10 December 2013 and the second and third were between 13 October 2015 and 11 November 2016. Bilqiis responded to medications and typically discontinued treatment without consulting the mental health team.

4.4.45 The care planned following these episodes was treatment with medication and support from the CRHTT. After the first presentation, Bilqiis was prescribed medications, but did not attend any follow-up appointments and was subsequently discharged.

4.4.46 In July 2013, when Bilqiis attended A&E for hallucinations, she was referred for psychiatric evaluation the next day at her home. The next notice we have of this is a letter to the GP noting that Bilqiis did not attend an appointment on 24 October 2013, showing that West London NHS Trust were aware of her but still had not seen her 3 months later.

4.4.47 The second referral on 13 October 2015 resulted in care from the CRHTT between 13 October and 12 November. This included medications and daily visits.

4.4.48 The third referral on 1 February 2016 was from the GP as a result of Omar's referral. The GP wanted support for Bilqiis and the children. Bilqiis cancelled the 9 February appointment and was seen on 21 April. She said that she felt overmedicated and requested a discharge from the service. There is no record of a conversation about how she is coping with Omar's mental health which was a primary reason for the referral, nor is there a carer's assessment.

4.4.49 She was seen on 1 November 2016 for a final appointment prior to being discharged. She had not taken any medication for 6 months at this time. She

[4] Non-organic disorders are those for which no biological or pathological foundation is identified and which manifest distressing symptoms such as pain or anxiety.



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said she felt well with her only complaint being difficulty in getting up in the morning.

4.4.50 She was discharged in accordance with the Safe Discharge protocol that links secondary and primary care. Her GP agreed to the plan and discharge and Bilqiis was discharged from West London NHS Trust on 11 November 2016.

4.4.51 *About Omar*

4.4.52 Omar was first referred in February 2016 due to low mood, depression, difficulty sleeping and derogatory auditory hallucinations. When he was contacted by the West London NHS Trust Assessment Team, he said that he felt 'okay' and said there had been a mix-up with the GP regarding the referral. He declined an appointment and was given contact details for the mental health team, should he need them and was discharged. It is not clear if the decision to discharge was based on Omar's claim that there was a misunderstanding or on other or additional factors. The MHR found that at this time there were no historical incidents which might indicate risk of future incidents and the assessment made was that the mental health risk was low.

4.4.53 West London NHS Trust did not have records about the 14-15 May attendance at the Ealing UCC.

4.4.54 Omar was re-referred on 23 May as Halima had found him by the canal, threatening to jump in. The psychiatric liaison team met him at Ealing Hospital A&E and referred him to the emergency Duty Team for a Mental Health Act Assessment, after which he was admitted to a mental health ward under S. 2 of the MHA 1983.

4.4.55 West London NHS Trust referred the family to ECSC in line with policy on Omar's admission to hospital. There was no follow-up to this referral. Previous contact with social services was noted and 'staff were led to believe that Omar did not have unsupervised contact with the children during the acute stage of his illness'. This information came from the family as part of a policy that required staff to ask families if there are any reasons why a patient should not have contact with the children.

4.4.56 Omar responded well to treatment and his family and wife reported an improvement on his trial leave on 16 June. No suicidal ideation or self-harm was noted.

4.4.57 Omar's notes show that family members were present during ward reviews and that they all had contact details for the ward, a single point of access, and for the mental health team.



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4.4.58 Omar's family report that they discussed with staff that Omar was going to live with his mother in Haringey and not return to his wife and children in Ealing. Sarah made particular efforts to be clear about these arrangements so that information was sent to the right place. The family recall having conversations about what care he would get at his mother's and who would provide that care. The family think that the missed appointments that show in the mental health records were due to letters being sent to the wrong address.

4.4.59 When discharged from hospital, there is a routine 7-day follow-up in the community as this is a high-risk period. The West London NHS Trust spoke to Bilqiis on the telephone and they left a message at Omar's mother's, but contact was not made directly with Omar as would be expected in line with policy. Bilqiis had no concerns, though Omar was not living with her at the time and how she formed this view is unrecorded.

4.4.60 On discharge, Omar's care was not transferred to the Recovery Team, a community-based team, as should have happened. He was eventually referred there when his sister (on 25 July) and then the GP (on 27 July) highlighted Omar's need for support.

4.4.61 There were scheduling mix-ups as a result of the mental health team not recording that Omar was living with his mother. Letters did not reach him at his mother's. The team knew that Omar did not go home but did not enquire into Omar's relations to Bilqiis and did not record any reason why he was not going home to his family on release.

4.4.62 West London NHS Trust had further unexpected contact with Omar on 5 October as a result of a cancellation letter being sent to the wrong address. Omar and his sister, Sarah, attended for an appointment that had been re-scheduled by the mental health service. The family said they drove across London, cajoled Omar into the car and, despite confirming the appointment the day before, were told when they arrived for an appointment on 5 October, that a doctor was not available as clinics were on Fridays. When Sarah insisted that Omar was seen as he was unwell, they spoke to the practice manager. Omar's sister took the lead in the conversation, as Omar was not very communicative at the time. She said that Omar was paranoid. It was noted that he had no thoughts or plans to harm himself or others. The manager then spoke to a doctor who suggested that the timing of the medication was changed, and crisis planning was discussed. Another appointment was made for Omar with a doctor.

4.4.63 There were subsequent reviews with Omar two days later, on 7 October, and on 11 November. At this second interview, Omar took the lead in the conversation and was able to engage more with the assessment. He had improving insight



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and engaged with the care plan. His sister reported an improvement. No risk indicators for mental health were seen.

4.4.64 The MH Panel reviewed Omar's care and concluded that the care provided had been responsive to his needs and supported his decision making when appropriate.

4.4.65 ***Ealing Children's Social Care***

4.4.66 ECSC received three referrals in relation to the mental health of Bilqiis and Omar. The first was in regard to Bilqiis's mental health, the second in relation to Omar's mental health and Bilqiis self-reducing her mental health medications, and the third related to Omar's admission to hospital. The notes from these referrals were not on all the children's files. All the referrals were risk-assessed as green, that is, that they did not need an immediate MASH[5] check.

4.4.67 _October 2015_. This referral was from the Ealing Hospital A&E Psychiatry Liaison Service Team. ECSC gathered information from the referrer about Bilqiis's auditory and visual hallucinations, that she was not sleeping well and was distressed and that similar symptoms in 2013 had resolved with medication. They noted that Bilqiis had not been taking her medication and had deteriorated. The wide family support was noted. The referrer said that their protocols required a referral to Ealing Children's Integrated Response Service (ECIRS)[6] in such circumstances but that 'no safeguarding concerns regarding the children' are noted.

4.4.68 At an unannounced visit, the social worker (SW) met Bilqiis, her sister and her brother at Bilqiis's home. It is noted that the children were at an Islamic school and not in mainstream education. Bilqiis said that she was well supported by her family and declined further support from ECSC. After Bilqiis's death, her sister described Bilqiis as being depressed and attributed it to the stress of caring for Omar and the children. Halima also said that Bilqiis was on medication for this.

4.4.69 The case was closed on 29 October saying that the CRHTT was visiting daily and the family was well supported by wider family members. Bilqiis was feeling better and there were no concerns around immediate risks to the children.

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[5] Multi-Agency Safeguarding Hub. This is a multi-agency team of professionals who work together to share information within a secure environment to support better decision-making on cases. Cases are assessed as to whether they meet the threshold that needs a multi-agency response.

[6] ECIRS offers a single point of entry for all referrals where there is a need for support or where there are specific concerns about the welfare of a child or young person.

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4.4.70 *February 2016.* This referral from the GP was in regard to Omar's mental health, though it also noted that Bilqiis was reducing her medications. This referral was resolved by contact with the referrer and a telephone conversation with Omar.

4.4.71 Contact was attempted with the GP, the mental health team and with the family initially. Contact was made with Omar who said that Bilqiis had been discharged by CRHTT. Omar said that he had medications, he was feeling better, and they had a lot of support from the family.

4.4.72 A conversation with the GP informed ECSC that Bilqiis was feeling well and appeared stable, though the GP had been concerned that she had reduced her medications. The GP also said that Omar had said he was hearing voices that said he was useless but then retracted this the next day when the GP rang him to tell him that he was referring the family to ECSC. The GP said that he may have misunderstood Omar, but Omar was prescribed medications and referred to mental health services.

4.4.73 The case was closed by ECSC within a week as Omar had advised the SW that things at home were okay and they had a lot of family support. The SW also noted that the family were engaged with the GP. The ECIRS felt that there was no role for them. A note was made that if there was another referral, a consideration should be given to a home visit and an assessment.

4.4.74 *May 2016.* The third referral was from the mental health hospital when Omar was admitted under S. 2 of the MHA 1983. This was resolved by contact with the referrer and a telephone conversation with Bilqiis.

4.4.75 ECSC was told that Omar threatened to jump in a canal, that his wife found his behaviour difficult to cope with and so he had been staying with family elsewhere in London. Bilqiis had been visiting him there on Wednesdays and on Sundays with the children

4.4.76 A conversation with Bilqiis led to the case being closed. Bilqiis said that she had enough support from her sister and brother and did not need a referral to outreach services. She said that Omar was living with his mother while he was unwell. Halima said that the children looked forward to seeing Omar and asked him to come home. He always said that he would come home when he was well.

4.4.77 The ECSC case was closed before Omar came out of hospital and was not re-opened.

4.4.78 *Home schooling*. The Chair reviewed a sample of letters between the parents and the Monitoring Inspector for Children Educated at Home (from Ealing Children's and Adults' Services) regarding annual visits to ensure that pupils are receiving an efficient and suitable education. The letters outlined the provisions



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in place, the children's attainment, made recommendations and included information about the children's social engagement at the learning centre. These letters did not identify any social issues regarding the children and clearly show the parents' efforts to provide the education they desired for their children. The home education the children were receiving was assessed as satisfactory.

4.4.79 ***A2Dominion Housing***

4.4.80 Bilqiis began her sole tenancy of her A2Dominion property on 19 August 2013 and moved in with her husband and children. She had moved there from an Ealing Council property and was a tenant with A2Dominion at the time of her death.

4.4.81 The same housing officer was responsible for Bilqiis's tenancy throughout her time there. The relationship between them appeared to be good as Bilqiis was clear that she preferred to talk to her own housing officer when she contacted the organisation. This would have made it easier for Bilqiis to disclose any abuse.

4.4.82 A2Dominion were not aware of any mental health problems that Bilqiis or Omar had. Officers of A2Dominion are trained in how to respond to domestic abuse incidents however there was never an occasion where this was suspected by or disclosed to the officer in charge of this tenancy.

4.4.83 The majority of the contacts that A2Dominion staff had with Bilqiis and Omar were about rent arrears and repairs. Of the 81 contacts or attempted contacts in the 40 months covered by this review, 24 were about rent arrears. Twice, the rent arrears reached the point where a Notice of Seeking Possession was issued.

4.4.84 A2 Dominion Housing requires safeguarding children and adult training for its staff.

4.4.85 ***Metropolitan Police Service***

4.4.86 The police had some contact with Omar before the timeframe of this DHR. The Panel reviewed this information and agreed that it was not relevant to this report.

4.4.87 The substance of MPS's engagement with Omar and Bilqiis was the identification and prosecution of Omar for the homicide of Bilqiis which is outside the scope of this review.

4.4.88 ***Gaps in information***

4.4.89 There were some gaps in the information and some information conflicted. The Panel agreed that this was due to a change in provider of urgent care and that the information missing was not material to the outcome of this review.



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## 4.5 Other Relevant Facts and Information

4.5.1 **Information about the diaspora Somali community**

4.5.2 *Information from Midaye.* When talking to the director of Midaye, a charity founded to support the diaspora Somali community, she emphasised that she did not know the individuals involved in this DHR and she was speaking from her experience of working within the Somali community. Her information about religious and cultural understandings and attitudes to mental health are included to provide a social context for Bilqiis's and Omar's experience.

4.5.3 *Attitudes to mental health problems*. The director of Midaye reported that there were misunderstandings in the Somali community about mental health problems and types of mental illness. There can be denial that a relative is mentally ill. The first help sought is often spiritual help. When families are frustrated by a lack of improvement, they may then seek medical help. There can also be a suspicion about medications that change a person's behaviour. This can be seen as unnatural and therefore a patient can be encouraged by others in the community to stop taking the medication.

4.5.4 The mental health panel members noted that this concern about with medication is common to patients across all cultures.

4.5.5 *Religious marriages*. Bilqiis and Omar's marriage was an Islamic marriage, according to his sister. The chaplain told the Chair that a Muslim religious marriage requires the attendance of the bride and groom and two witnesses. It is presided over by a religious leader and can take place in a home or in some other private space. To be recognised in British law, a religious marriage would have to be legally registered. Many religious leaders ask or stipulate that the couple get married civilly too and some ask to see the legal paperwork. But the religious leader can be unattached to a mosque and, depending on his background, can be unaware of the legal requirements and the consequences of not being legally married.

4.5.6 The director of Midaye noted that in Somalia under Islamic law, a man is allowed to marry up to four wives. Subsequent marriages are frequently hidden from the first wife who often does not like it when she finds out and may separate from her husband. Some women do not accept the second marriage or subsequent marriages, but some religious women do. Divorce is straightforward and a couple require two witnesses saying religious verses to complete a divorce.

4.5.7 In October 2011, the then junior Minister at the Ministry of Justice, set out information about the consequences of entering into a religious marriage in the



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UK which is unregistered and unrecognised, ‘Any parties to such relationships do not share the same rights as a legally married couple, such as access to financial remedies available on divorce or inheritance rights on the death of one of the spouses, and are treated as cohabitants.’

4.5.8 *The Casey Review*[7] found that ‘the practice of ‘unregistered polygamy’ appears to be more commonplace than might be expected’ and that this had a negative impact on women.

4.5.9 *Attitudes and response to domestic abuse.* The attitude to domestic abuse in the Somali diaspora community is varied, depending on any individual’s background including their community and family attitudes and also on their own experience of violence and/or growing up in a violent environment.

4.5.10 The agencies that Somali women are most likely to talk to are those with whom they have built a relationship of trust – this is likely to be a community or women’s organisation that they are already accessing. Regular concerns about reporting domestic abuse to statutory agencies is that they may not keep the conversation confidential and it is not clear what an agency might do in response to the information.

[7] Casey, Dame Louise. *The Casey Review: A review into opportunity and integration*. December 2016.



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# 5. Analysis

## 5.1 Introduction

5.1.1 There were no signs or patterns of domestic abuse observed by either Omar's or Bilqiis's family, including Bilqiis's sister who lived in the house with Bilqiis and Omar. The agencies involved with the family also had no disclosures or evidence that Omar was abusive to Bilqiis. Bilqiis's death appears to be the result of a single act of domestic violence.

5.1.2 As there was no domestic abuse disclosed or identified, the Panel looked more generally at whether agencies had systems in place that could identify and respond to evidence of abusive relationships. Omar and Bilqiis presented a number of factors that are common in domestic abuse and could have led to more questions being asked to understand their relationship more fully. Though there is no evidence that Omar was abusive, questions about similar indicators in a different family might lead professionals to identify and address abuse. This analysis aims to identify these opportunities. It also makes some recommendations regarding responses to this family where there were four children under twelve and both parents had chronic mental ill health.

## 5.2 Domestic Abuse – what we know

5.2.1 The following is a summary of what we know about domestic abuse, the health impacts of domestic abuse and its links to mental health. The review will then look at the indicators in this case and the response to them.

5.2.2 *Prevalence*. The Office for National Statistics (ONS) estimated that for the year ending March 2017, 6 in 100 adults aged 16 to 59 experienced domestic abuse. Women were more likely to have experienced domestic abuse than men (7.5% compared with 4.3%). [8]

5.2.3 The ONS reports that in the three-year period from April 2013 to March 2016, the majority of domestic homicide victims were female (70%) and 30% were male.

5.2.4 National strategies and guidance. The Government strategy document, *Ending Violence Against Women and Girls (VAWG), 2016 – 2020*, outlines its ambition and commitment to ending all forms of VAWG: "Our ambition is to make awareness of and response to VAWG 'everyone's business' across all agencies, professions

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[8] www.ons.gov.uk. Statistical bulletin.



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and the wider public"[9]. These key aspects of the Government's vision inform the following analysis:

(a) All services make early intervention and prevention a priority, identifying women and girls in need before a crisis occurs, and intervening to make sure they get the help they need for themselves and for their children.

(b) Services in local areas will work across boundaries in strong partnership to assess and meet local need and ensure that services can *spot the signs of abuse in all family members and intervene early* [emphasis added by Review Chair].

(c) Women will be able to disclose experiences of violence and abuse across all public services, including the NHS. Trained staff in these safe spaces will help people access specialist support whether as victims or as perpetrators.[10]

5.2.5 National Institute for Health and Care Excellence (NICE) Guidance on domestic abuse, Recommendation 6 to 'Ensure trained staff ask people about domestic violence and abuse' further details that 'Health and social care service managers should: Ensure frontline staff in all services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose . . .'[11]

5.2.6 <u>*General risk factors for domestic abuse*</u>. NICE guidance on *domestic violence and abuse: multi-agency working* (PH50, Feb 2014)[12] lists the factors that increase the risk of experiencing domestic violence or abuse:

(a) Female

(b) Aged 16-24 (women) or 16-19 (men)

(c) Has a long-term illness or disability – this almost doubles the risk

(d) Has a mental health problem

(e) Is a woman who is separated, with an elevated risk of abuse around the time of separation

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[9] Home Office, VAWG Strategy 2016-2020, p. 12 at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/522166/VAWG_Strategy_FINAL_PUBLICATION_MASTER_vRB.PDF. [Accessed 31 March 2018]

[10] Government's VAWG Strategy 2016 – 2020, p. 14.

[11] National Institute for Health and Care Excellence Guidance (NICE), PH50, p. 12.

[12] NICE Guidance, PH50, p. 27-28 or at https://www.nice.org.uk/guidance/ph50/chapter/3-context#associated-risk-factors. [Accessed 31 March 2018].



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5.2.7 *Health indications of domestic abuse:* The NICE Domestic Abuse Quality Standard (QS116) highlights symptoms or conditions that can be indicators of domestic violence or abuse. Of these, the symptoms that might have been relevant in this case include:

(a) Symptoms of depression, anxiety, post-traumatic stress disorder, sleep disorders.

(b) Unexplained chronic gastrointestinal symptoms and/or pain

(c) Genitourinary symptoms, including frequent bladder or kidney infections

(d) Vaginal bleeding.

(e) Repeated health consultations with no clear diagnosis

(f) Intrusive 'other people' in consultations, including partner spouse, other relatives.

5.2.8 Though Omar and Bilqiis regularly attended GP consultations together, there is no record of intrusive or controlling behaviour during the consultations. In situations where professionals suspect domestic abuse, it is good practice to interview the likely victim alone. Some agencies, such as midwives, do this routinely.

5.2.9 A number of variables affect the impact of domestic abuse on children[13], including the ages of the children, the levels and length of exposure to violence, and how much support they are getting from other people. Symptoms that can be indicative include the following:

(a) Tiredness and sleep disturbance

(b) Stress-related illness

(c) Enuresis (bed-wetting) or encopresis (soiling, often linked to constipation)

5.2.10 *Mental health and domestic abuse*. The link between mental health problems and domestic abuse has been confirmed in a number of studies, showing both that people with mental health problems were more likely to experience domestic violence and that people suffering domestic abuse are more likely to develop mental health problems. One study[14] showed that women with depressive

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[13] Department of Health's Responding to domestic abuse: a handbook for health professionals [2005], p. 19. At http://www.domesticviolencelondon.nhs.uk/uploads/downloads/DH_4126619.pdf. Accessed on 10.1.18.

[14] Trevillion, K. et al. 'Experiences of domestic violence and mental disorders: a systematic review and meta-analysis' *PLOS One, 7, e51740.* http://dx.plos.org/10.1371/journal.pone.0051740. [From https://www.kcl.ac.uk/ioppn/news/records/2012/December/Domestic-violence.aspx. Accessed 17.1.2018]



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disorders were about 2.5 times more likely to have experienced domestic violence over their adult lifetime than women without mental health problems; women with anxiety disorders were over 3.5 times more likely to have experienced domestic violence over their adult lifetime, and women with PTSD were about 7 times more likely.

5.2.11 The link between domestic abuse and mental health is shown in another study that focuses on men with depression and anxiety. This study[15] found that men who have either experienced or perpetrated domestic violence or abuse are more likely to have current symptoms of depression and anxiety. Men who perpetrated 'negative behaviours' in the past year were almost 5 times more likely than non-perpetrators to report symptoms of anxiety. Men who suffered 'negative behaviours', were at least twice as likely to report symptoms of anxiety and depression as men who had not.

5.2.12 *Housing and domestic abuse.* Research in Wales found that there was a link between domestic abuse and rent arrears, with tenants who are victims being four times more likely to have rent arrears related to Notice of Seeking Possession (NoSP) than that of the general population of tenants.[16] Repeat repairs can also be an indication of domestic abuse.[17]

5.2.13 *High risk factors*: The SafeLives DASH Risk Indicator Checklist (DASH RIC) is an evidence-based checklist of twenty-four factors most highly correlated to future serious harm and death as a result of domestic violence. The checklist is used by trained professionals to talk through a client's situation with her or him after they have disclosed abuse to understand the level of risk and to design a bespoke safety plan which can include a MARAC, a multi-agency risk assessment conference.

## 5.3 Domestic abuse services in Ealing

5.3.1 For women and children suffering domestic and sexual abuse in Ealing, there are a number of agencies: Hestia, Women and Girls Network, Housing for Women, West London Rape Crisis, and Victim Support. There are additional services for

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[15] 'Hester, M, Ferrari, G, Jones, SK, Williamson, E, Bacchus, LJ, Peters, TJ, Feder, G. 'Occurrence and impact of negative behavior, including domestic violence and abuse, in men attending UK primary care health clinics: a cross-sectional survey'. British Medical Journal, Vol 5, Issue 5, published May 2015. The study was carried out through 16 GP practices in the south west of England.

[16] Jackson, Rebecca (2013) *The Role of Registered Social Landlords in Tackling Domestic Abuse* in Gwent and the wider implications. From the Domestic Abuse Housing Alliance's website at: www.dahalliance.org.uk/facts.

[17] Sharif, Aisha. 'Housing associations should fight harder to end the abuse of women.' The Guardian, 24 August 2016. Sharif says that Viridian Housing 'found that 95% [of repeat repairs requests] were a direct consequence of violence in the home'.



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black and minority[18] women and children: Southall Black Sisters and an Eastern European refuge.

5.3.2 Men and children suffering abuse can access specialist services through Hestia and Victim Support. Appendix 2 outlines Ealing's VAWG provision.

## 5.4 What we knew about Bilqiis and Omar's situation

5.4.1 We have no evidence of an incident or a pattern of domestic abuse between Omar and Bilqiis.

5.4.2 However, DHRs provide an opportunity to review agencies' practice regarding domestic abuse. Using general indicators of domestic abuse as identified by NICE[19] and specific risk indicators in the DASH RIC show that there were features of Omar's and Bilqiis's lives that might have prompted questions from professionals about domestic abuse. In additional, there are many DHRs of cases where there has been no previous incident or pattern of abuse. More information about these situations might help researchers, practitioners, and professionals to identify further common characteristics and thereby get help to those at risk of experiencing or perpetrating domestic violence sooner.

5.4.3 Bilqiis met 3 of the 5 general indicators for domestic abuse noted by NICE: she was a female with a recurring (if not long-term) mental health problem and was living apart from her husband when she was killed. The identification of general risk factors can signal to a professional that further questions might be asked to understand the situation better.

5.4.4 Where there is domestic abuse, separation between the parties is a time of increased risk. In this case, the reason for the separation was variously described by family members, but not explored by professionals. On a practical level, as services also did not note that Omar and Bilqiis were living separately, there was confusion about appointments.

5.4.5 Some members of the Review Panel were uncomfortable with using the DASH RIC to look at a situation where no domestic abuse had been disclosed or suspected. The value of noting the DASH RIC factors here is that a professional trained in the use of the tool might recognise risk factors in a case and ask more questions to confirm or resolve concerns.

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[18] Black and minority individuals refers to people from ethnic minority backgrounds, including South Asian, African, Caribbean, Middle Eastern and Eastern European.

[19] National Institute for Health and Care Excellence.



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5.4.6 Looking at this case against the DASH RIC, six high risk factors were noted by agencies: the impending separation with Omar going to Somalia, Bilqiis' depression[20], financial issues (rent arrears), Omar's mental ill health, his threatened suicide and a criminal conviction (in this case, fourteen years before Bilqiis's death and considered by the Panel to be unrelated to it). Further questioning can lead to early intervention where abuse is discovered. If no abuse is identified, then that can be recorded too. In another situation with similar factors and where domestic abuse exists, asking questions about abuse could enable early intervention and prevention as envisioned by the Government.

5.4.7 In general, if a person in Ealing disclosed domestic abuse and then revealed these risk factors, that victim would be assessed as medium risk and would be offered the support of a specialist worker to create a safety plan for herself. She could receive on-going support if she desired that. Her recent mental health problems would have been identified as an additional vulnerability.

5.4.8 *Engagement with services*. Though the family attended the GP regularly and engaged with agencies to which they were referred initially, they did not take up other offers of additional help: Omar declined physiotherapy for his shoulder pain, declined psychotherapy for his anxiety, and Bilqiis did not take up appointments with community mental health or for support through the ECSC Early Help service.

5.4.9 Bilqiis, Omar, Halima and Sarah reported that the family were well-supported by the wider family. This was the reason they gave for not accepting some of the additional help offered by agencies. Their declining help reduced the opportunities for agencies to learn more about the family.

5.4.10 Omar was regularly risk assessed by mental health professionals and these assessments showed repeatedly that Omar was a risk to himself but not to others.

5.4.11 It was a notable feature of this case that, as the children were home-schooled and attended a local Islamic learning centre, they did not have the oversight of established schools that most other children have. As a result, the GP was the only professional in regular contact and in a position to identify patterns of symptoms or behaviour that would suggest further questioning.

## 5.5 Analysis of Agency Involvement

5.5.1 The terms of reference for this review were agreed at the 1st Panel meeting. The key lines of inquiry were agreed to be:

[20] This was Bilqiis's sister's description of Bilqiis's experience and not a mental health diagnosis. The DASH RIC does not ask for a medical diagnosis of depression, rather it asks for the victim's assessment of her or his mental state.



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(a) Analyse the opportunity for agencies to identify and assess domestic abuse risk.

(b) Analyse agency responses to any identification of domestic abuse issues.

(c) Analyse organisations' access to specialist domestic abuse agencies.

(d) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.

(e) Analyse the communication, procedures and discussions, which took place within and between agencies.

(f) Analyse the co-operation between different agencies involved with Bilqiis/Omar [and wider family].

5.5.2 The Panel also identified the caring roles Bilqiis and Omar held for each other and looked at cultural understandings of mental health, gender roles religious marriage and religion that might have informed their decisions.

## 5.6 Opportunities for agencies to identify and assess domestic abuse risk; responses to any identification and access to specialist domestic abuse agencies

5.6.1 As there were no indications of domestic abuse identified by professionals or family members, including one who lived in the house with Bilqiis and Omar, the Panel looked at the opportunities to identify and whether agencies had systems in place that could identify abusive relationships or factors that should lead to further inquiry.

5.6.2 A Panel member noted that staff are often worried that digging deeper into a story will almost always uncover something of concern and that there is not enough time to do everything they need to do as it is. However, the Panel member noted that digging deeper into a story can also resolve a concern.

5.6.3 **London North West University NHS Healthcare Trust (LNWUHT)**

5.6.4 This includes the staff of A&E, school nurses as well as health visitors. The Trust would have been in contact with Bilqiis through its health visitors. The Trust has a domestic violence and abuse policy.

5.6.5 None of the children were born in the timeframe of this review, though LNWUHT notes that the standard post-birth questionnaire for new mothers used by health visitors includes questions around domestic abuse.



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5.6.6 There were no developmental problems with any of the children in the family, though many appointments were missed. These missed appointments were not followed up by staff with Bilqiis, Omar or the GP. In this case, it appears that the appointments missed conflicted with Bilqiis's commitment to pick the children up from the learning centre, yet the subsequent appointments were offered at the same time. Where children are not in mainstream schools, follow-ups are important.

5.6.7 **Recommendations from LNWUHT:**

(a) LNWUHT to review the strategies and protocols to ensure that they incorporate the whole family approach and update as appropriate. Train staff in A&E and HVs on the updated strategies and protocols.

(b) LNWUHT to audit a sample of screening tools for domestic violence and mental health to ensure that they incorporate whole family assessment. Ensure the tools are used consistently and effectively.

(c) Levels 2 and 3 safeguarding training to remind staff of the information-sharing procedures and the importance of analysis in a whole family approach.

(d) LNWUHT to ensure staff supervision monitors use of assessment tools, new birth protocols and policies.

5.6.8 As part of this, HV practice is to note who was at the interviews as the other people in an interview might influence the answers given. In this case, the HV notes do not always report this.

5.6.9 **GP surgery**

5.6.10 The information provided by the GP surgery show that the family accessed the service frequently and shared a good deal of information there. This suggests that the family had the sort of professional-to-client relationship that makes it easier for a victim to disclose abuse.

5.6.11 Though there is no evidence of domestic abuse here, there were patterns of Bilqiis's attendance that map to common presentations in cases where there is domestic abuse. For instance, often Omar would accompany Bilqiis to the surgery and vice versa. In October 2015, Omar accompanied Bilqiis to the GP and then A&E when she was having hallucinations. The GP rang the next day and was assured by Bilqiis that she was fine. In situations of domestic abuse, an ever-present partner can indicate coercive control. A pattern of asking for help *in*



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*extremis* and then waving off support when the crisis has passed is also common in situations of domestic abuse as that is often the safer option.[21]

5.6.12 It is important when exploring sensitive issues like domestic abuse that the client is able to respond freely to questions. As such, it is important to create opportunities to speak to the victim/client alone. As Bilqiis and Omar were not separated and spoken to alone, the GP did not have the opportunity to assess any level of fear between them or provide the chance to talk about abuse.

5.6.13 Bilqiis came to the surgery a number of times for tiredness and a physical basis for this was explored, but no exploration of other contributory factors were noted.

5.6.14 **Recommendation from the GP surgery:** GP practice to have targeted training[22] on domestic abuse so that they can identify patterns of presentations and create opportunities to enquire about abuse**.**

5.6.15 *Thinking about the family.* GPs have a limited time to talk to clients so there is a practical limitation in asking questions in addition to the cause of the visit. However, twice in this case, the GPs did this to good effect. In March 2014, the GP explored Omar's situation widely, including noting that he did not use alcohol or drugs. When Omar presented with worsening symptoms in February 2016, there was a thorough consultation that noted Bilqiis's psychiatric history, and Omar's personal history, including a PTSD assessment. The GP assessed Omar's risk to himself and others as low and referred him to psychiatry rather than A&E. On this occasion, the GP explored Omar's wider situation and made referrals for Bilqiis to West London NHS Trust (as she had stopped taking her anti-psychotic medications) and for the children to ECSC.

5.6.16 It would be beneficial to spread this throughout the practice. Particularly when Bilqiis presented with mental health problems in October 2015, it might have been useful to have a wider conversation about her family situation.

5.6.17 **Recommendation from the GP surgery:** GP surgery to review this report together to allow a collaborative approach to learning and developing from this incident.

5.6.18 *Symptoms of stress in the children.* Some of the symptoms that the children displayed might also have been the result of anxiety. There is a recommendation

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[21] Monckton Smith, J. Williams, A. with Mullane, F. (2014) *Domestic Abuse, Homicide and Gender: Strategies for Policy and Practice* (London: Palgrave Macmillan) p. 109.

[22] Royal College of General Practitioners provides advice on commissioning and guidance for general practice at www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/domestic-violence.aspx [Accessed 30 March 2018]

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addressing linking family files to assist GPs to spot patterns. Further questioning could have resolved or informed any diagnosis.

5.6.19 **Recommendation from GP surgery:** The GP surgery to undertake a pro-active approach to routinely ask children about emotional well-being where there are MH problems in the family, recurrent attendances for the same complaint or similar complaints in multiple siblings.

5.6.20 **Recommendation from the GP surgery:** The GP surgery:

(a) Administrative support: Link the medical notes of family members so that practitioners have pertinent information to hand when assessing a patient.

(b) Apply alerts to files where there are significant events related to one of the toxic trio: mental health, substance misuse or domestic abuse, in the patient's life or the lives of family members so that issues can be adequately explored in consultations and a care plan can be devised where required to provide on-going support.

5.6.21 **ECSC**

5.6.22 The ECSC identified that the three referrals did not result in the level of investigation that they expect. More in-depth enquiries should have followed the first referral. It would be expected that there would be MASH checks and a referral for assessment following the second referral. The case notes suggest that a home visit should have been undertaken on the third referral. The third referral should have resulted in more investigation of the family relationships, an understanding of the parents' mental health problems and the impact on the children, and an understanding of the children's contact with their father.

5.6.23 **Recommendation from ECSC:** ECSC to develop consistency in practice through improvements in the following and dip sample case files for improvements in 6 months.

(a) Application of MASH thresholds

(b) Development of lead roles on key areas by particular team members

(c) Workshops on this and other cases where mental health is a feature to build team understanding about thresholds and consistent practice

(d) Development of a format for visits to ensure all key areas are explore

(e) Liaise with the elective Home Education/School Attendance services around how the interface with children's social care may need to improve.



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5.6.24 **West London NHS Trust**

5.6.25 In February 2016, the Trust had information that Omar was paranoid and that the GP wanted support for Bilqiis and for the children as a result of Omar's mental health problems. The Trust noted that Omar was not going back to his wife and children but staying with wider family due to 'issues with Bilqiis', but nothing further was documented.

5.6.26 It does not appear from the notes that these leads about the wider context for Omar and his family situation were followed up. At Bilqiis's 21 April 2016 appointment, there is no record of how she was coping with Omar's mental health problems, though that was largely the reason for the re-referral on this occasion.

5.6.27 As separation is a high-risk time in domestic abuse, it would be valuable to mental health staff making risk assessments to ask questions about a patient's relationships and explore leads from other professionals' concerns.

5.6.28 The West London NHS Trust note that in a mental health setting risk is assessed based on what the patient tells them and on past behaviour. There was no indication from Omar's behaviour or conversation that he posed a risk to anyone beyond himself.

5.6.29 West London NHS Trust outlined their process for assessing the risks that patients pose to family members. These show an approach that incorporates an understanding of domestic violence and a 'Think Family' approach in their work. Though the policies and process are there, it is not clear from this case how these are implemented in practice.

5.6.30 The West London NHS Trust is introducing a new Domestic Abuse policy in October 2018. This policy addresses the issues raised in this review. It lays out West London NHS Trust's Ask-Validate-Assess-Action approach to domestic abuse. It identifies that all staff have a responsibility to identify and respond to domestic abuse. It includes: indicators that staff are likely to see in the course of their work, routine enquiry, risk assessments, and appropriate responses, including safety planning. The policy notes that domestic abuse is part of the existing safeguarding children and adult training and commits to strengthening the domestic abuse element within the safeguarding training as well as sourcing dedicated domestic abuse training to support practice.

5.6.31 **Recommendation for West London NHS Trust:** Within a year of introducing the new domestic abuse policy, West London NHS Trust to assess if staff feel confident of following the policy, especially regarding asking the questions of service users and their families, and responding to disclosures from victims and



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perpetrators, and identifying when to ask questions regarding domestic abuse where the service user, intimate partner or family has caring responsibilities.

5.6.32 There is little information about Omar or Bilqiis as carers for each other. Staff use the six key elements of the Triangle of Care to support collaborative and partnership working with the professional, service user and carer. The use of the Triangle of Care tool promotes safety, wellbeing and recovery. The tool addresses a carer's needs for advocacy, one-to-one support and therapies as required and enables the professional to identify where assessments are required and signpost carers accordingly. The impact of the use of the tool is to be measured by the number of requests made for a carer's assessment and feedback from the carer.

5.6.33 **Recommendation from West London NHS Trust:** West London NHS Trust Clinical Directors to regularly monitor the requests for carers' assessments to ensure that carer's needs and safety are addressed. This is to be managed within the local teams supported through supervision.

5.6.34 **A2Dominion**

5.6.35 Bilqiis and Omar had rent arrears that led to two NoSPs. Bilqiis had many contacts with her housing officer over the arrears. As there is a correlation between rent arrears and domestic abuse, tenants in this situation might be asked about their home situation and if they feel safe there. This will be addressed when the recommendation from a previous Ealing DHR, the DHR for Rose is completed (See Appendix 4, the first recommendation from the Rose DHR.)

5.6.36 The repairs requested did not fall into patterns identifiable as resulting from domestic abuse.

## 5.7 Training, policies and procedures relating to domestic abuse

5.7.1 A2 Dominion, West London NHS Trust and the GP noted that their safeguarding adults and safeguarding children training include domestic abuse.

5.7.2 Safeguarding adult training primarily focuses on 'adults at risk'. Domestic abuse training in this context can result in situations where the training on identifying and responding to abuse is only activated when the victim is an 'adult at risk'. Domestic abuse where the victim has no explicit care needs or where it is the perpetrator who is an adult at risk can be missed.

5.7.3 It can be particularly helpful to have domestic abuse training that is targeted at how domestic abuse most commonly presents to specific professionals. So, for instance, a housing worker attending to repairs may see different signs of abuse



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than a GP in her practice. The Government has funded DAHA[23] to develop standards for housing providers. The Royal College of General Practitioners' guidance for GP practices notes the need to train the whole GP practice team on health markers of domestic abuse[24].

5.7.4 **A2Dominion** report that their staff are trained in domestic abuse as part of safeguarding children and adults at risk training. Specialist domestic violence training especially for those who go into people's houses would enable them to identify and respond to situation where there is abuse.

5.7.5 **GP surgery.** As noted above, training on identifying domestic abuse and creating opportunities for disclosure would be valuable.

5.7.6 The Government's Ending Violence against Women and Girls Strategy for 2016 – 2020 includes FGM. There has been progress in the identification of FGM risk, including recording and referring requirements at a national level. Changes in practice in recent years have included legislative changes introducing mandatory reporting of FGM in children[25], and enhanced data set reporting requirements. In addition to pre-existing requirements to refer children at risk under child protection and safeguarding duties, the awareness of FGM risks has been raised across health and care services.

5.7.7 The GP IMR noted that when the family came in for travel assessments in anticipation of their trip to Somalia in the summer of 2014, this would have been an ideal opportunity to ask about the possible risk of FGM for the daughters.

5.7.8 This is addressed by the following recommendation.

5.7.9 **Recommendation from GP:** The GP surgery to use the safeguarding template on SystmOne.

5.7.10 Panel members noted that not all agencies working with a family will automatically have access to SystmOne. This led to the conversation about consent discussed below.

5.7.11 **West London NHS Trust.** As the CRHTT goes into patients' homes, they, like the housing repair teams, are in an ideal situation to assess the relationships around

[23] Domestic Abuse Housing Alliance at www.dahalliance.org.uk.

[24] Guidance for general practices at www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/domesstic-violence.aspx. [Accessed 30 March 2018].

[25] This duty came into force on 31 October 2015 and was introduced in Section 5B of the Female Genital Mutilation Act 2003, as inserted by Section 74 of the Serious Crime Act 2015. [From www.gov.uk/government/publications/fact-sheet-on-madtory-reporting-of-female -genital-mutilation, accessed 20 July 2018]



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those who are vulnerable through their mental illness. The new policy includes provision of specific training for staff in particular settings.

5.7.12 To support the implementation of the new policy, the following recommendation is made:

5.7.13 **Recommendation for West London NHS Trust:** West London NHS Trust to strengthen Safeguarding Training to ensure staff are confident to apply the requirements of the new West London NHS Trust Domestic Abuse Policy.

5.7.14 **LNWUHT**. The response of HVs to the missed developmental appointments is addressed above at 5.6.7.

5.7.15 **Recommendation from LNWUHT.** All clinical staff in A&E to have an awareness of multi-agency training provided by the Local Safeguarding Children's Board, which is advertised as a multi-disciplinary training, 'Working Together to Safeguard Children'.

5.7.16 **ECSC***.* ECSC identified weaknesses in its application of the MASH thresholds and the need to develop a visit format to ensure all key areas are explored during a home visit. The recommendation at 5.6.23 addresses this.

## 5.8 Communication, procedures and discussion within and between agencies

5.8.1 In the course of this review, the agencies identified a number of ways that information gathering and sharing and communications could have been better.

5.8.2 The Panel spent some time on information-sharing and its challenges. As agencies shared information in the course of the DHR, some identified information that would have been useful to them in working with the family. However, the Panel found that there was no assessment or diagnosis that would have been substantially different with the addition of information known now that was not known then.

5.8.3 Some of the information identified could not have been shared without consent. Panel members agreed that gaining consent to share information early in a professional relationship or consultation would be useful but could, in some circumstances, also threaten to undermine confidence and confidentiality.

5.8.4 **Record-keeping**

5.8.5 **GP.** The GP surgery had information that Bilqiis and Omar had mental health problems but did not link their files to each other or to those of the children. Linking the files would allow pertinent information to be readily to hand when a practitioner is evaluating a situation.



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5.8.6 In the GP notes, it is often not clear who is accompanying children and their relationship to the child. In reviewing the GP notes, the IMR writer noted that the person attending with the children was not always accurately identified. It is important to note who is with the child as decisions regarding a child's healthcare can only be made by someone with parental responsibility.

5.8.7 The **GP recommendation** at 5.6.20 addresses this by linking medical notes of family members and flagging files where there are significant events related to one of the 'toxic trio'[26], that is, mental ill health, domestic abuse and substance misuse.

5.8.8 **GP, A&E, West London NHS Trust**. The notes of all three agencies record interactions with a sister, without noting which sister she was. In situations of domestic abuse, recording the specific relationship of an accompanying person would help the practitioner better interpret the information provided and family dynamic.

5.8.9 **Recommendation from GP:** Response in the GP surgery to accompanying adults

(a) Specifically ask and note the identity and relationship of any adult that accompanies a child into a GP consultation. This is important so that decisions are made with those who have parental responsibility.

(b) Ask and note the identity and relationship of any adult accompanying an adult patient.

5.8.10 The steps in the Triangle of Care include the offer of an early meeting to gather concerns and family history, therefore the recommendation at 5.6.20 addresses this**.**

5.8.11 The recommendation from LNWUHT at 5.6.7 regarding the incorporation of the whole family approach addresses this.

5.8.12 **West London NHS Trust.** In the separate MH review, several care delivery problems were identified and plans put in place by the clinical delivery groups to address these:

(a) 'Omar was not referred to the community team once discharged by the ward.

(i) The [MH] Panel was unable to understand why the referral was not completed and believe this to be a case of human error. The referring team had decided to make the referral and assumed it had been completed. 7-day follow up was attempted on two occasions and

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[26] The term 'toxic trio' can be viewed as pejorative to those suffering this combination of vulnerabilities. However, the Panel members felt that 'toxic trio' was a term widely understood within their agencies.



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within that the assumption had been that follow up was in the process of being arranged. It is possible that a factor in this oversight was that the patient had only just recently been transferred to the ward he was discharged from.

(b) There is no recorded contact made between Omar or his family and the hospital during the leave.

(i) The ward staff did not contact Omar or the family to check how leave was progressing. The [MH] Panel noted that Omar had only been transferred to the ward the day before and this may have disrupted their ability to keep the patient in mind.

5.8.13 A carers assessment should have been considered for Bilqiis as Omar's wife

(i) Although the family appeared fairly well informed, there remained some gaps in the service's understanding of the family situation and what help they might have wished. Given the complexity of both Omar and Bilqiis being referred to the Trust at different states, it seems that this could have been a helpful consideration as there was additional complexity for the Trust, the patients and their family. The Think Family approach might have been better employed.

5.8.14 The recommendation at 5.6.33 for the monitoring of requests for carers' assessment by the West London NHS Trust Clinical Directors would address this.

**Recommendation from West London NHS Trust:** Recommendations from MHR to be disseminated to the relevant hospital wing and an action plan created by their clinical improvement groups to address the care delivery problems noted.

5.8.15 The family raised a concern about the interface between the inpatient and community team and asked for a recommendation to address those failings. The mental health review made recommendations targeted at this and there have been a number of changes to service design since then. These changes arose out of learning across the board, including this particular case, and as part of the Trust's focus on continuing service development. The key changes in the community team that have been made are:

(a) Established a transition team. This team has a lead social worker overseeing all referrals into the team. They also attend the wards for all new patients being referred into the team.

(b) Established care pathways to improve clarity around the responsibility of care by having more clearly identified clinical leads, discrete teams for better defined patient groups, and smaller teams with a smaller overall caseload delivering



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more defined packages of care. This has led to a general improvement in patient flow as well as more coherent team meeting and supervision structures.

5.8.16 Regarding the support for the family, the transition team has a triangle of care lead and there is a carer support worker within the team. Regular evening support groups are now offered for carers.

5.8.17 The safeguarding team at the Trust is also currently developing a training package related to the ten categories of adult abuse identified in the Care Act which includes domestic abuse. The training will be launched in June 2019.

5.8.18 **Communication between agencies**

5.8.19 *GP*. When the GP knew that mental health services had not been in touch with Bilqiis in 2013, they offered extra support themselves but did not chase that specialist response. However, when Sarah requested further medications from the GP at the end of July 2016, the GP reviewed the file and, seeing that Omar had not had any follow-up in the community after his discharge, made an urgent referral to mental health services.

5.8.20 *West London NHS Trust and GP*. The GP surgery was unclear about the prescribed psychiatric medications and who was responsible for overseeing their provision, that is, monitoring uptake, compliance and any side effects. Both Bilqiis and Omar stopped or reduced their medication without professional advice which can have negative consequences. It is important to note here that the homicide is not felt to be the result of this weakness in communication or in the medication regime, but it is raised as a wider practice point.

5.8.21 This lack of clarity was raised as a practice point, for system awareness and learning, with the West London NHS Trust at the Clinical Quality Group (CQG) in March 2018. It was noted that there should be clear, timely communication in writing from the discharging medical team or professional to the patient's GP that documents who is responsible for ongoing prescriptions of medications, monitoring of patient's symptoms, concordance[27] and side effects. The information to the GP should detail whether the specialist service has given the patient a supply of medication (including the number of days supplied). The Trust was asked to clarify and confirm that there are internal trust processes/or Standing Operating procedures (SOPs) in place and to ensure that any gaps in shared prescribing

[27] 'Concordance' refers to a consultation between a health care professional and a patient in a shared-care approach to decision-making that goes beyond mere compliance to a medicine-taking regime. From Weiss, M and Britten, N, "What is concordance" in *The Pharmaceutical Journal,* December 2009. At www.pharmaceutical-journal.com, accessed on 30 March 2018.



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arrangements are identified and reported to the CQG as part of system wide assurance.

5.8.22 This matter has been followed up and discussed with the Trust as a practice quality issue within the CQG and with Medical Leads; to promote shared learning across West London NHS Trust services.

5.8.23 *ECSC and West London NHS Trust*. ECSC perhaps relied too heavily on other agencies' comments in reviewing the situation. There was also some miscommunication between the agencies: that is, when the psychiatric liaison nurse at A&E (1st referral) said that the referral was routine and that they had no safeguarding concerns, that was understood to mean that there *were* no safeguarding concerns rather than that they had not seen or heard anything during their consultation that raised a particular concern about the health and safety of the children. This appears to have reduced the investigation. Similarly, when Omar was admitted to hospital, the referrer said that there were no concerns about his risks to the children but without recording the evidence base for these statements.

5.8.24 **Recommendation from ECSC:** ECSC social workers to question and record the evidence referrers have for 'no safeguarding concerns for the children' when the referral is based on concerns about the adults in the household.

5.8.25 **Overview report recommendation: West London NHS Trust staff to follow-up referrals made to other agencies and record the outcomes to understand the wider context and support for clients and their families.**

5.8.26 *ECSC information-gathering from other agencies.* ECSC say that in practice consent is requested at the point of entry to social care. In this case, there was no consent sought from the parents for agency checks in the course of the three referrals. There was little if any investigation of the background factors affecting Bilqiis's mental problems from other agencies.

5.8.27 **Overview report multi-agency recommendation: Joint training with West London NHS Trust, ECSC and local DA service to understand each other's roles, referrals, assessments of risk, thresholds and assessment processes and what information could/should be shared. Develop new protocols around joint working and referrals, particularly in response to non-engagement**.

5.8.28 *Sharing information with LNWUHT health visitors.* The health visiting service did not know about the mental health problems of the parents and if they had known, particularly about the A&E and UCC attendances, the service considers that it might have investigated the missed appointments to understand the reasons. There may have been a role for health visitors in supporting the family at this time.



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5.8.29 **Overview report recommendation: That the Ealing CCG raise with member GP practices as a practice point: where parents have mental health problems, suffer from domestic abuse or substance misuse, that GPs consider whether there is a role for health visitors in supporting the family and refer them if there is a role.**

5.8.30 *Sharing the learning from DHRs*. In the course of this review, it became apparent that, though Directors of Adults and Children Safeguarding are circulated with the reports, the Safeguarding Boards themselves are not regularly circulated with the DHRs.

5.8.31 **Overview report multi-agency recommendation: That the Ealing Safer Partnership regularly send final copies of DHRs to the Ealing Safeguarding Children Board and the Safeguarding Adults Board.**

## 5.9 Analyse the co-operation between different agencies involved with Bilqiis and Omar and the wider family

5.9.1 *Between West London NHS Trust and GP*. GP had referred Omar to West London NHS Trust for hallucinations in February 2016. The GP had also noted that Bilqiis had MH problems and that the two had four children. Seeing the complexity of the situation, the GP had referred Bilqiis to West London NHS Trust and the family to ECSC for support. The MH team discharged Omar after talking to Omar and the GP on the phone. This was the occasion where Omar and the GP both said that there might have been a misunderstanding.

5.9.2 To assist such conversations between agencies, the GP surgery made the following recommendation.

5.9.3 **Recommendation for the GP:** The GP surgery will explore the detail of hallucinations – the content, frequency, impact on the patient – to help assess the urgency of action.

5.9.4 *GP to ECSC*. The GP referred the family to ECIRS at the beginning of February 2016. The SW was in touch to gather more information.

5.9.5 *West London NHS Trust to ECSC*. West London NHS Trust referred to ECSC twice. They did not record any specific concerns about the children and noted to ECSC that this was a routine referral. West London NHS Trust did not follow up their referrals by talking to ECSC about their assessments and conclusions. Gathering this information could have informed their approach and would have helped to develop an understanding of the family arrangements, in keeping with a Think Family approach required by the Care Programme Approach. The West London NHS Trust reflected that it would not have changed their clinical decisions about Omar or Bilqiis.



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5.9.6 The multi-agency training recommendation at 5.8.27 and the recommendation about following up referrals at 5.8.25 would address this.

5.9.7 *ECSC*. ECSC had three referrals for this family and concluded each referral without evidence that the family's situation was fully understood. Talking to agencies in addition to the referrer would have provided a fuller understanding of the family's situation, capabilities, and support. There is no evidence of conversations with health visitors or the schools or conversations with Bilqiis or Omar about such contacts. An assessment of the relationship between Bilqiis and Omar would have been useful as well.

5.9.8 Similarly, when the family was referred for the third time, there is no evidence of the worker seeking consent to talk to other agencies or having contact with the school. It may be that the social worker took a positive inference from the wider family involvement and the knowledge that Omar had moved out of the family home prior to the incident and that there were no specific concerns raised by other agencies about the children. The focus seems to be on Omar's mental health problems, but Bilqiis was still under the care of the community mental health team. It would have been reasonable to make further agency enquiries to understand the impact on the children of their parents' mental health issues.

5.9.9 The recommendation at 5.8.24 addresses this.

5.9.10 *ECSC to West London NHS Trust*. The second referral in February 2016, though received as a result of both parents having mental health problems and therefore reaching a higher threshold of concerns, did not receive commensurate attention. On reflection, it was felt that ECSC decisions were based on limited information and that a referral to MASH would have been appropriate. This would have provided further information that might have resulted in the threshold being met for Children and Family Assessment.

5.9.11 See the recommendation for ECSC at 5.6.23 about consistency and oversight.

5.9.12 When Omar was discharged from hospital, West London NHS Trust understood from the family that Omar would not have unsupervised contact with the children. For ECSC, a statement from West London NHS Trust to this effect would have influenced their decisions about how to take the referral forward. Clarity in referrals about the evidence supporting statements would enable better decision-making. For instance, a statement that 'there are no concerns about the children'

might suggest that an assessment has been made and discovered nothing. The recommendation at 5.8.24 addresses recording of evidence that referrers have for their concerns or for no concerns.

## 5.10 The Voice of the Child



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5.10.1 This was a family under pressure: both parents suffered mental ill-health, the father had lost his job, their housing was not secure, and they had four children under 12 whom they home-schooled. Though the voice of the child is a central tenet of a Think Family approach and level 3 safeguarding children training, no agency spoke directly to the children in this family about their home life.

5.10.2 *ECSC*. Following the first referral, a social worker attended the family home unannounced. In this situation, a SW would be expected to observe the family and, having gained consent from the parents, would be expected to speak to the children alone to get a sense of their routine, their lives, and the impact of Bilqiis's mental health problems. The SW would be expected to develop an understanding of the mental health condition. This did not happen though the social worker attended the house at a time when the children might be expected to be home from school and they were not.

5.10.3 *Home-schooling*. The children were registered as being home schooled and ECSC noted that they attended a private Islamic learning centre. Where children are in formal education, schools and the health professionals there usefully provide valuable information about the support that a family might need. In this case, on the second referral, the family gave consent to contact the learning centre, but this was not followed up by ECSC.

5.10.4 The learning centre did not respond to the Chair's attempts to interview the director or head teacher about the centre's interactions with the family. As we were not able to have those discussions with the learning centre, the Panel's discussion moved to a more generic level about oversight of home-schooled children.

5.10.5 The Panel identified that when children are home-schooled, they have limited visibility to those outside their family circle. The yearly visits by Ealing's Children's and Adults' Services' Education Consultant to assess the educational arrangements made for the children focus on the children's education and provide only a snapshot of a family's wider social context. In similar situations, only the GP and the HV are in a position to ascertain if a child's behaviour suggested there was abuse at home.

5.10.6 While this DHR has been underway, the Government has raised concerns about the growing number of children being home-schooled and proposed a register for home-schooled children so that they do not disappear 'off the radar'.[28] This would require the registration of children who have never been to school, whereas currently children are registered only when they are removed from school for

[28] Weale, Sally (2019) 'Council register of home-schooled children proposed', *The Guardian*, 2 April.



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home-schooling. The Government said that it wanted to protect vulnerable children who may remain hidden from the authorities as well as those going to illegal schools.

5.10.7 The Panel considered if it was desirable and possible for agencies involved with children to flag the files of those who are home-schooled. It was thought that this could be part of the initial information-gathering and regular updating when a new client enters a service. Noting and flagging home-schooling would highlight the reduced opportunities for oversight and would alert professionals to ask additional questions and explore situations more fully where there are indications of abuse or neglect.

5.10.8 **Overview report multi-agency recommendation: Information gathering and sharing. That West London NHS Trust, ECSC and primary care services review their intake, information sharing and referral processes to**

(a) **include gathering and regularly updating information on the schools that children in the family attend or whether they are home schooled. This would speed up information-sharing when there are risks identified and would remind agencies working with home-schooled children there is no agency or organisation, such as a school, that has regular oversight of the children**

(b) **gain early consent to share information with other agencies in response to identified concerns.**

5.10.9 *Non-engagement*. Bilqiis and Omar were offered extra support several times in the timeframe of this review. Both noted the family support they had when declining a service. When researching a repeat referral in a short period of time (Feb to May 2016 here), SWs might see a repeated refusal of support services as a prompt to explore the situation more fully and corroborate information provided by the family. This would inform the conversation with the parents, the assessment and the decision-making about next steps. The recommendation about joint training with West London NHS Trust, ECSC and DA services at 5.8.24 addresses this.

5.10.10 **Overview report multi-agency recommendation: Ealing VAWG Strategic group to ask agencies to audit their practices for a Think Family approach, specifically regarding practices around domestic abuse, mental health and sharing information.** Practice should reflect the Think Family approach shown in agencies' policies.

## 5.11 Good practice identified



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5.11.1 *GP*. In March 2014 and in February 2016, when Omar presented with mental health problems, a doctor at the GP surgery asked questions about his family and the broader social context of Bilqiis and Omar and made family-focused referrals as a result. This acknowledged the wider impact of Omar's mental ill health, Bilqiis's history of mental ill health and the family's likely need for wider support. This was particularly good practice.

5.11.2 The GP has a protocol for following up missed appointments, particularly those for children. Linking family files would make this easier for practitioners to see family patterns.

5.11.3 In discussion with Omar, the GP learned something of his time in Somalia and the surgery have determined that they could develop their skills in eliciting information about patients' experiences of violence.

5.11.4 **Recommendation from the GP**: Develop techniques for asking about experiences of violence, particularly for those who have come from outside the UK.

5.11.5 Professionals were told and observed that the family had good support from extended family. The files also suggest, from the regularity of the contact, that the family had confidence in their GP and Bilqiis had a good working relationship with her housing officer. These relationships with the GPs at their surgery and the housing officer would have provided the supportive environment that helps women disclose abuse. Notably on two occasions the GP had a fuller discussion with Omar where additional support needs were identified and referrals were made.

5.11.6 *West London NHS Trust*. After Bilqiis was re-referred to in October 2015, the Trust demonstrated its Think Family approach by referring the children to ECSC for support.

## 5.12 Equality and Diversity

5.12.1 The Panel identified that sex, disability (mental health issues), race/national origin (Somali immigrants), and religion were protected characteristics pertinent in this case and were considered by the Panel to determine if responses of agencies were motivated or aggravated by these characteristics.

5.12.2 The Panel did not find evidence that responses of agencies to Omar, Bilqiis or the family were less favourable as a result of these characteristics. However, there were several times where professionals might have identified that Omar and Bilqiis faced barriers as a result of their mental health problems and national origin and might have addressed these more directly.



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5.12.3 *Sex.* Sex is always a protected characteristic to be explored in a DHR as being a woman is a significant risk factor for domestic abuse[29]. In this case, there is no evidence that Bilqiis suffered abuse or that her sex created particular barriers for her or affected how agencies engaged with her.

5.12.4 The Government's guidance[30] on FGM shows that 98% of girls and women aged 15 to 49 in Somalia have undergone FGM. Before the family went to Somalia in 2014, they came to the GP surgery for travel inoculations. The family has 2 young daughters, yet the risk of FGM was not explored with the mother before trip. **This is addressed in a GP recommendation at 5.7.9 to use the safeguarding template on SystmOne.**

5.12.5 *Disability.* S. 6 of the Equality Act defines disability as a 'substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities.' It is difficult to assess if the mental health problems that Bilqiis and Omar suffered had long-term adverse effects as they dipped in and out of services and Omar's employers declined to be involved with this review. The information the Panel reviewed did not show any less favourable treatment based on their mental ill-health or perception of mental ill-health.

5.12.6 *Religion, national origin/culture*. Omar and Bilqiis were married in a religious ceremony. We understand that when Bilqiis found out that Omar had married a second wife, she was not happy about this. Because they had a religious marriage without a civil ceremony, Bilqiis would not have had the same rights as a legally married person would, such as access to financial remedies available on divorce or inheritance rights on the death of a spouse. The issue was unresolved when Omar's mental health deteriorated. It may be that Bilqiis and Omar were aware of the differences in the legal protection offered by a religious marriage and one without a civil law component and preferred the religious marriage alone.

5.12.7 The stress of this new situation may have undermined Bilqiis's mental health, as well as his. Bilqiis's second engagement with the psychiatric team was soon after Omar returned from Somalia and after she learned of his second religious marriage. Omar's mental health deteriorated in the aftermath of this second marriage and particularly around the time of the birth of his child in Somalia.

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[29] In 2014/2015 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides). The Office for National statistics showed that the majority of domestic homicides recorded between April 2013 and March 2016 were female.

[30] Department for Education and the Department of Health and Social Care, (2016) *Multi-agency statutory guidance on female genital mutilation*, p. 10.



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5.12.8 Community organisations devoted to particular immigrant groups might be more accessible for some people as they would not expect any cultural barrier. For these people, the Panel felt that stronger connections between community groups and domestic abuse service providers might be made.

5.12.9 With the understanding that knowledge increases choice, this review makes the following recommendation.

5.12.10 **Overview report recommendation: Ealing VAWG Strategic Group to incorporate findings from this report in its plans for delivering the Ealing VAWG strategy, in particular,**

(a) **to engage the faith-based communities in this agenda and**

(b) **to link DV service providers to immigrant and other community groups and**

(c) **to provide information on the legal differences between religious marriages and religious marriages with civil registration to local community groups**

5.12.11 The family missed 22 appointments at the GP over the timeframe of this review. As Bilqiis and Omar had not been raised in this country and English was not their first language, it might have been useful to have a conversation to ensure that there was no misunderstanding about the need for the appointments and the procedure for alerting the surgery to times when they could not attend a booked appointment.

5.12.12 *Language*. The agencies involved with the family did not note any language problems in working with the family. Omar's sister said that language could be a barrier for someone like Bilqiis if she had been suffering from domestic abuse and had mental health problems. But she did not think that language had been a barrier for Bilqiis herself. Bilqiis's sister said that Bilqiis did not have difficulties with English.

5.12.13 ECSC uses interpreters regularly where families have little English. There was no evidence that this was needed for this family. The team have a good knowledge of the local Somali community and there are consultations about cultural norms. Similarly, the West London NHS Trust never noted needing an interpreter when working with this family.

5.12.14 The only occasion when a communication difficulty was noted was between the GP and Omar in February 2016 and this followed a pattern of raising a concern and then declining services.



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5.12.15 Nevertheless, it is good practice to ask and record whether someone needs communication support where English is his or her second language.

5.12.16 **Recommendation from the GP**: GP reception staff to confirm addresses and/or phone numbers whenever clients attend to avoid missed correspondence. Review with patients the surgeries' modes of communication to identify any barriers such as literacy problems that would limit their engagement with the surgery.

5.12.17 *Mental illness*. The director of Midaye outlined for the Panel traditional Somali attitudes to mental illness. As Omar and Bilqiis were immersed in the local Somali community, these views may have influenced them.

5.12.18 The families of Omar and Bilqiis reported concerns about the effects of the medications. These concerns were familiar to the mental health professionals and they are experienced in addressing these. In addition, Omar's family had experience of following mental health medication regimes so were knowledgeable about the need for adherence to the routine prescribed.

5.12.19 The Panel recognises that mental illness is stigmatised in most cultures. It is useful to recognise the culturally-specific ways that the stigma plays out in order to provide a person-centred response. This appears to have been recognised by both the professionals and the families.

5.12.20 *Caring responsibilities.* Though Bilqiis and Omar were well-supported by their families, Bilqiis's sister said afterward that she thought Bilqiis's mental health problems had been exacerbated by looking after Omar when he was ill and also looking after the children. It may have been difficult for Omar and Bilqiis to accept additional support from outside their social networks, but the GP and West London NHS Trust, knowing that both had poor mental health, were in a position to identify the need for a carer's assessment that could have created the basis of a conversation around support needs and provided targeted and specialist help.

5.12.21 Recommendations above for the Ealing VAWG strategic group to ask organisations to audit their practices for a Think Family approach (5.10.9) and the specific recommendations for the GP surgery (5.6.20b) and West London NHS Trust around carer's assessments (5.6.33) address this concern.



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# 6. Conclusions and Lessons to be Learnt

## 6.1 Conclusions

6.1.1 The domestic homicide reviews are undertaken to identify ways to improve the identification and response to domestic abuse in a multi-agency setting. Omar and Bilqiis had close family members who knew them very well and Bilqiis's sister lived with the couple. This wider family and the professionals involved with this family identified no incidents, episodes, or patterns of behaviour that led them to think that Bilqiis was being abused by Omar. Neither Bilqiis nor Omar spoke of their relationship as problematic or abusive. They appeared to be supportive of each other and very close to their children.

6.1.2 The evidence strongly supports the conclusion that this was a family under some stress due to the mental health problems of both parents, but there is no evidence of previous domestic abuse.

6.1.3 In an effort to learn from this case, however, the Panel noted areas for improvement in practice.

6.1.4 The presenting problem of mental health issues might have led agencies to ask about other vulnerabilities such as domestic abuse and substance misuse. The link needs to be identified by professionals so that further questions are asked when one of the 'toxic trio' is present.

6.1.5 Staff need to be aware of the indicators of domestic abuse that they are likely to observe in the course of their work. For instance, GPs need to be aware of health indicators, housing officers of links between rent arrears, repeat repairs and domestic abuse. All need to ask questions to either gather information or close down concerns. In this case, further questioning would likely have closed down the concerns.

6.1.6 GPs and mental health services need to be more 'carer aware', develop joint strategies to carers in line with the Care Act.

6.1.7 Agencies might have responded to the family as a whole, noting that there were four young children being mostly home-schooled in a household where there were two parents with mental health problems. Across agencies, there appeared to be a weakness in the Think Family approach which might have led to a wider understanding of the family's situation: opportunities were missed to observe and talk to the children about their home life to factor in to assessments; the multiplicity of issues including both parents having mental health issues and the refusal of



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extra support might have fed a more coordinated response; and an assessment of the impact on Omar and Bilqiis of the other parent's mental health problems through a carer's assessment might have provided specialist support in addition to the care and help supplied by the family.

6.1.8 Agencies noted and observed that the family had wider family support and completed their evaluations by relying on the comments and observations of other agencies. Conclusions were drawn without the evidence for them being thoroughly documented.

6.1.9 The Panel discussed that where parents are home-schooling their children, the opportunities to identify concerns are reduced. The agencies that do see those children can enhance their observations if their systems capture the fact of home-schooling and alert professionals during consultations. The Panel hopes that the recommendations here will help the surgery and the other agencies enhance their response.

6.1.10 A number of episodes suggested the following about the response of agencies:

(a) Agencies relied too heavily on other agencies' views in completing their assessments. In particular this was a concern regarding assessments of the needs and risks to the children.

(b) Agencies assumed that a client was getting all the help they needed because they had been referred, were accessing a particular service or said that family was helping.

6.1.11 Professionals need to talk to each other to understand the full situation: what assessments have or have not been made, what agencies are actively involved, and ask questions about the nature of family support. Only when all the information is gathered, can agencies work together to address a problem or support a client or patient.

6.1.12 As a result, improvements in how agencies communicate, and work together recommended here will also improve the response to domestic abuse.



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## 6.2 Lessons Learned

6.2.1 *Lesson 1:* There are connections between particular mental health problems (depression, self-harm, anxiety and trauma[31]) and domestic abuse with some common risks factors. Asking questions to understand the relationships between a mental health patient and his or her wider network of family or friends will help to inform risk assessments for both domestic abuse and mental health.

6.2.2 *Lesson 2:* Think Family across all agencies. This includes understanding the impact on the other family members of one or more members' vulnerabilities, recommending and providing carer assessments, and seeking and sharing information with other relevant agencies.

6.2.3 *Lesson 3:* When gathering information from other agencies and service users about a case, professionals should record the evidence they have used to support the conclusions they have drawn, particularly where there are cultural taboos around the subject matter.

6.2.4 *Lesson 4*: Professionals engaging with families where the children are home-schooled have a valuable opportunity to identify safeguarding and health concerns that might benefit from wider support and to offer that support or referrals.

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[31] Trevillion, K. et al. 'Experiences of domestic violence and mental disorders: a systematic review and meta-analysis' PLOS One, 7, e51740. http://dx.plos.org/10.1371/journal.pone.0051740. [From https://www.kcl.ac.uk/ioppn/news/records/2012/December/Domestic-violence.aspx. Accessed 17.1.2018]



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# 7. Recommendations:

## 7.1 IMR Recommendations (Single Agency):

## 7.2 London North West University Healthcare NHS Trust

7.2.1 **Recommendation 1.**

(a) LNWUHT to review the strategies and protocols to ensure that they incorporate the whole family approach and update as appropriate. Train staff in A&E and HVs on the updated strategies and protocols.

(b) LNWUHT to audit a sample of screening tools for domestic violence and mental health to ensure that they incorporate whole family assessment. Ensure the tools are used consistently and effectively.

(c) Levels 2 and 3 safeguarding training to remind staff of the information-sharing procedures and the importance of analysis in a whole family approach.

(d) LNWUHT to ensure staff supervision monitors use of assessment tools, new birth protocols and policies.

7.2.2 **Recommendation 2.** All clinical staff in A&E to have an awareness of multi-agency training provided by the Local Safeguarding Children's Board, which is advertised as a multi-disciplinary training, 'Working Together to Safeguard Children'.

## 7.3 GP Surgery

7.3.1 **Recommendation 1.** Administrative support

(a) Link the medical notes of family members so that practitioners have pertinent information to hand when assessing a patient.

(b) Reception staff to confirm addresses and/or phone numbers whenever clients attend to avoid missed correspondence. Review with patients the surgeries' modes of communication to identify any barriers such as literacy problems that would limit their engagement with the surgery.

7.3.2 **Recommendation 2.** Response to mental health problems:

(a) Apply alerts to files where there are significant events related to one of the toxic trio: mental health, substance misuse or domestic abuse, in the patient's life or the lives of family members so that issues can be adequately explored in consultations and a care plan can be devised where required to provide on-going support.



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(b) Explore the detail of hallucinations – the content, frequency, impact on the patient – to help assess the urgency of action.

7.3.3 **Recommendation 3.** Response to those accompanying adults

(a) Specifically ask and note the identity and relationship of any adult that accompanies a child into a GP consultation. This is important so that decisions are made with those who have parental responsibility.

(b) Ask and note the identity and relationship of any adult accompanying an adult patient.

7.3.4 **Recommendation 4**. GPs to have targeted training on domestic abuse so that they can identify patterns of presentations and create opportunities to enquire about abuse.

7.3.5 **Recommendation 5.** Develop techniques for asking about experiences of violence, particularly for those who have come from outside the UK.

7.3.6 **Recommendation 6.** GPs to use the safeguarding template on SystmOne.

7.3.7 **Recommendation 7.** GP surgery to review this report together to allow a collaborative approach to learning and developing from this incident

7.3.8 **Recommendation 8.** GP surgery to undertake a pro-active approach to routinely ask children about their emotional well-being where there are mental health problems in the family, recurrent attendances for the same complaint or similar complaints from multiple siblings.

## 7.4 West London NHS Trust

7.4.1 **Recommendation 1**. Recommendations from MH Review disseminated to the relevant hospital service line and an action plan created by their clinical improvement groups to address the care delivery problems noted.

7.4.2 **Recommendation 2**. West London NHS Trust Clinical Directors to regularly monitor the requests for carers' assessments to ensure that carer's needs and safety are addressed. This is to be managed within the local teams supported through supervision.

7.4.3 **Recommendation 3.** West London NHS Trust to strengthen Safeguarding Training to ensure staff are confident to apply the requirements of the new West London NHS Trust Domestic Abuse Policy.

7.4.4 **Recommendation 4.** Within a year of introducing the new domestic abuse policy West London NHS Trust to assess if staff feel confident to implement the policy, especially regarding asking the questions of service users and their families, and responding to disclosures from victims and perpetrators, and identifying when to



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ask questions regarding domestic abuse where the service user, intimate partner or family has caring responsibilities.

## 7.5 Ealing Children's Social Care

7.5.1 **Recommendation 1**. Social workers to question and record the evidence referrers have for 'no safeguarding concerns for the children' when the referral is based on concerns about the adults in the household.

7.5.2 **Recommendation 2.** Develop consistency in practice through improvements in the following and dip sample case files for improvements in 6 months:

(a) Application of MASH thresholds

(b) Development of lead roles on key areas by particular team members

(c) Workshops on this and other cases where mental health is a feature to build team understanding about thresholds and consistent practice

(d) Development of a format for visits to ensure all key areas are explore

(e) Liaise with the elective Home Education/School Attendance services around how the interface with children's social care may need to improve.

## 7.6 A2 Dominion Housing

Following a review of previous DHR recommendations in Ealing, the implementation of a previous recommendation (from the Ealing DHR for Rose) would also address issues raised in this DHR about the development of the housing response to domestic abuse. That recommendation is in Appendix X.

## 7.7 Overview Report Recommendations

7.7.1 The recommendations below should be acted on through the development of an action plan, with progress reported on to the Safer Ealing Partnership within six months of the review being approved by the partnership.

7.7.2 **Recommendation 1. Information gathering and sharing**. That West London NHS Trust, ECSC and primary care services review their intake, information sharing and referral processes and procedures to:

(a) include gathering and regularly updating information on the schools that children in the family attend or whether they are home schooled. This would speed up information-sharing when there are risks identified and would remind agencies working with home-schooled children that there is not another agency with regular oversight of the children.

(b) gain early consent to share information with other agencies in response to identified concerns.



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7.7.3 **Recommendation 2. West London NHS Trust staff** to follow-up referrals of service users and their families for safeguarding children and safety planning to record if the referral has resulted in the service user and/or their family being supported.

7.7.4 **Recommendation 3. Joint training with West London NHS Trust, ECSC and local DA service** to understand each other's roles, referrals, assessments of risk, thresholds and assessment processes and what information could/should be shared. Develop new protocols around joint working and referrals, particularly in response to non-engagement.

7.7.5 **Recommendation 4. Ealing VAWG Strategic Group** to incorporate findings from this report in its plans for delivering the Ealing VAWG strategy, in particular,

(a) to engage the faith-based communities in this agenda and

(b) to link DV service providers to immigrant and other community groups and

(c) to provide information on the legal differences between religious marriages and religious marriages with civil registration.

7.7.6 **Recommendation 5. Ealing VAWG Strategic Group** ask agencies to audit their practices for a Think Family approach, specifically regarding practices around domestic abuse, mental health and sharing information. Practice should reflect the Think Family approach shown in their policies.

7.7.7 **Recommendation 6: That the Ealing CCG** raise with member GP practices as a practice point: where parents have mental health problems, suffer from domestic abuse or substance misuse, that GPs consider whether there is a role for health visitors in supporting the family and refer them if there is a role.

7.7.8 **Recommendation 7: That the Ealing Safer Partnership** regularly send final copies of DHRs to the Ealing Safeguarding Children Board and the Safeguarding Adults Board.



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# Appendix 1: Domestic Homicide Review Terms of Reference

## Case of Bilqiis

This Domestic Homicide Review is being completed to consider agency involvement with Bilqiis and Omar following the death of Bilqiis in the autumn of 2016. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

**Purpose of DHR**

1. To review the involvement of each individual agency, statutory and non-statutory, with Bilqiis and Omar and their children during the relevant period of time 15 July 2013 up to the time of Bilqiis's death in the autumn of 2016. To summarise agency involvement prior to 15 July 2013.

2. To establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to identify and safeguard victims.

3. To identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

4. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate to prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

5. To contribute to a better understanding of the nature of domestic violence and abuse.



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6. To highlight good practice.

**Role of the DHR Panel, Independent chair and the CSP**

7. *The Independent chair of the DHR will:*
   a) Chair the Domestic Homicide Review Panel.
   b) Co-ordinate the review process.
   c) Quality assure the approach and challenge agencies where necessary.
   d) Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

8. *The Review Panel:*
   a) Agree robust terms of reference.
   b) Ensure appropriate representation of your agency at the Panel: Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a Panel meeting.
   c) Prepare Individual Management Reviews (IMRs) and chronologies through delegation to an appropriate person in the agency.
   d) Discuss key findings from the IMRs and invite the author of the IMR (if different) to the IMR meeting.
   e) Agree and promptly act on recommendations in the IMR Action Plan.
   f) Ensure that the information contributed by your organisation is fully and fairly represented in the Overview Report.
   g) Ensure that the Overview Report is of a sufficiently high standard for it to be submitted to the Home Office, for example:
      - The purpose of the review has been met as set out in the ToR;
      - The report provides an accurate description of the circumstances surrounding the case; and
      - The analysis builds on the work of the IMRs and the findings can be substantiated.
   h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, Panel deadlines and timely responses to queries.



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i) On completion present the full report to the Safer Ealing Partnership.
j) Implement your agency's actions from the Overview Report Action Plan.

9. *Ealing Safer Partnership:*
   a) Translate recommendations from Overview Report into a SMART Action Plan.
   b) Submit the Executive Summary, Overview Report and Action Plan to the Home Office Quality Assurance Panel.
   c) Forward Home Office feedback to the family, Review Panel and STADV.
   d) Agree publication date and method of the Executive Summary and Overview Report.
   e) Notify the family, Review Panel and STADV of publication.

**Definitions: Domestic Violence and Coercive Control**

10. The Overview Report will make reference to the terms domestic violence and coercive control. The Review Panel understands and agrees to the use of the cross-government definition (amended March 2013) as a framework for understanding the domestic violence experienced by the victim in this DHR. The cross-government definition states that domestic violence and abuse is:

    "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; and 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."

    This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."



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### Equality and Diversity

11. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both Bilqiis and the Omar (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation). It will also seek to identify any additional vulnerabilities and those of particular interest to Ealing Council as it formulates policy.
12. The Review Panel identified the following protected characteristics of Bilqiis and of Omar as requiring specific consideration for this case: sex, race/ethnicity, religion and disability (mental health).
13. The Panel identified the possibility of needing an interpreter when talking to some family members and interpretation services were sought from Ealing.
14. *Expertise:* The Review Panel identified the need for input about the experience of Somalian immigrants in this country and the cultural background of the victim and perpetrator and cultural attitudes to mental health.
15. If Bilqiis and Omar did not come into contact with agencies that they might have been expected to, then consideration will be given by the Review Panel on how lessons arising from the DHR can improve the engagement with local communities.
16. The Review Panel will review the impact on Bilqiis or Omar’s immigration status and how agencies responded to their needs. They will also identify if there were issues around both Omar’s and Bilqiis’s caring roles as Omar took time off work to care for Bilqiis and was subsequently unwell.
17. The Review Panel agrees it is important to have an intersectional framework to review Bilqiis and Omar life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one’s experience with local services/agencies and within their community.

### Parallel Reviews

18. Both the victim and the perpetrator had received services for mental health concerns. The perpetrator had been admitted to a mental health unit and therefore a mental health review was in progress when this DHR began.
    a) The Chair of the mental health review joined the Review Panel.
    b) The Chair of this review and the Chair of the mental health review agreed to work as closely as possible, given the different timeframes.



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19. If there are other investigations or inquests into the death, the Panel will agree to either:
    a. Run the review in parallel to the other investigations, or
    b. Conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.
    c. It will be the responsibility of the review Panel Chair to ensure contact is made with the Chair of any parallel process.

**Membership**

20. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the Panel meetings. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a Panel meeting.

21. The following agencies are to be on the Review Panel:
    a) Clinical Commissioning Group
    b) NHS England
    c) Ealing Community Services, London North West University Healthcare NHS Trust
    d) West London NHS Trust, previously West London Mental Health Trust
    e) Ealing Children's Social Care Services
    f) Ealing Safer Communities
    g) A2 Dominion Housing services
    h) Hestia
    i) Southall Black Sisters
    j) Metropolitan Police Service (Borough Commander or representative, Senior Investigating Officer (for first meeting only) and IMR author)
    k) The Chair of the mental health review

22. The Chair will invite a Somali organisation or specialist to contribute to the review.

23. Other agencies may be invited to join the Panel or contribute to the review as more information comes to light.



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24. Omar lived in Haringey with family members at the time of Bilqiis's death. The Review Panel considered this and the Haringey Community Safety Partnership alerted their local agencies to the review and asked if they had had contact. This was reviewed and further information sought at the first review.

25. The children of Bilqiis and Omar were home-schooled, and the Review Panel will seek information from the Learning Centre that the children attend to ascertain the children's awareness of their parents' mental health problems and any abuse

**Role of Standing Together Against Domestic Violence (STADV) and the Panel**

26. STADV have been commissioned by the Ealing CSP to independently chair this DHR. STADV have in turn appointed their DHR Associate (Laura Croom) to chair the DHR. The DHR team consists of two Administrators and a DHR Manager. The DHR Administrator (Amy Hewitt) will provide administrative support to the DHR and the DHR Team Manager (Gillian Dennehy) will have administrative oversight of the DHR. The manager will quality assure the DHR process and Overview Report. This may involve their attendance at some Panel meetings.

**Collating evidence**

27. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted and secure all relevant records.

28. Chronologies and Individual Management Review (IMRs) will be completed by the following organisations known to have had contact with Bilqiis and Omar during the relevant time period:
    a. West London NHS Trust
    b. Ealing Children's Social Care
    c. A2 Dominion Housing
    d. GP for Bilqiis, Omar and their children – Argyle Surgery
    e. London North West Hospital Trust
    f. Metropolitan Police Service

29. Further agencies may be asked to completed chronologies and IMRs if their involvement with Bilqiis and Omar becomes apparent through the information received as part of the review.



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30. Each IMR will:
    - Set out the facts of their involvement with Bilqiis and/or Omar, and/or their children
    - Critically analyse the service they provided in line with the specific terms of reference;
    - Identify any recommendations for practice or policy in relation to their agency;
    - Consider issues of agency activity in other areas and review the impact in this specific case.

31. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Bilqiis and Omar in contact with their agency.

### Key Lines of Inquiry

32. In order to critically analyse the incident and the agencies' responses to Bilqiis and/or Omar, this review should specifically consider the following points:
    a) Analyse the communication, procedures and discussions, which took place within and between agencies.
    b) Analyse the co-operation between different agencies involved with Bilqiis/Omar [and wider family].
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d) Analyse agency responses to any identification of domestic abuse issues.
    e) Analyse organisations' access to specialist domestic abuse agencies.
    f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.

*As a result of this analysis, agencies should identify good practice and lessons to be learned. The Review Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.*

### Development of an action plan

33. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to Ealing Safer Communities on their action plans within six months of the Review being completed.



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34. Ealing Safer Communities to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

**Liaison with the victim's family and perpetrator and other informal networks**

35. The review will sensitively attempt to involve the family of Bilqiis in the review. The Chair will lead on family engagement with the support of the police Family Liaison Officer and the mental health review Chair.

36. The Review Panel discussed the involvement of children in the DHR at the 1st Panel Meeting. As there is very little information about the children, and they were home-schooled, the Review Panel have asked for more information from Ealing Children's Social Care who have an on-going relationship with the children. In particular the Review Panel would like to know if the children were aware of or exposed to any abuse and what their home experience was like as both of their parents had been diagnosed with psychosis within the last 4 years. Any contact with the children will be facilitated by Ealing Children's Social Care.

37. Omar will be invited to participate in the review through his mental health professionals as he has been sentenced to a hospital order due to his mental health.

38. Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

39. The Review Panel discussed involvement of other informal networks of the Bilqiis/Omar and agreed it was proportionate to the DHR to invite the following organisations to be involved in the DHR: representatives of Omar's mosque, the learning centre that the children attended.

**Media handling**

40. Any enquiries from the media and family should be forwarded to the Ealing Safer Communities who will liaise with the Chair. Panel members are asked not to comment if requested. Ealing Safer Communities will make no comment apart from stating that a review is underway and will report in due course.



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41. Ealing Safer Communities is responsible for the final publication of the report and for all feedback to staff, family members and the media.

**Confidentiality**

42. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

43. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

44. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Documents will be password protected.

**Disclosure**

45. Disclosure of facts or sensitive information will be managed and appropriately so that problems do not arise. The review process will seek to complete its work in a timely fashion in order to safeguard others.

46. The sharing of information by agencies in relation to their contact with the victim and/or the perpetrator is guided by the following:
    a) The Data Protection Act 1998 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles': The 2016 Home Office Multi-Agency Guidance for the Conduct of DHRs (Guidance) outlines data protection issues in relation to DHRs(Par 98). It recognises they tend to emerge in relation to access to records, for example medical records. It states 'data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims of domestic abuse for the purposes of a DHR should not normally pose



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difficulty – this applies to all records relating to the deceased, including those held by solicitors and counsellors'.

b) Data Protection Act and Living Persons: The Guidance notes that in the case of a living person, for example the perpetrator, the obligations do apply. However, it further advises in Par 99 that the Department of Health encourages clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:
   - The review team should be informed about the existence of information relevant to an inquiry in all cases; and
   - The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or
   - partial redaction of record content.

c) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).

d) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:
   i) It is needed to prevent serious crime
   ii) there is a public interest (e.g. prevention of crime, protection of vulnerable persons)



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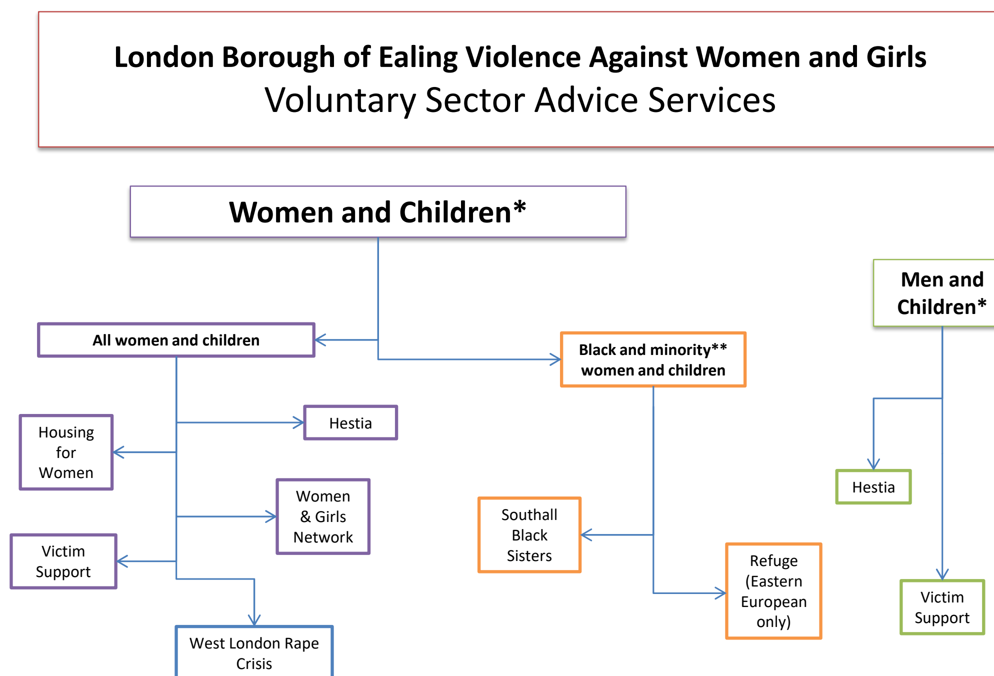
# Appendix 2: VAWG services in Ealing




If you are unsure which agency to refer to, contact any of above agencies for advice and support

**All high risk cases (experiencing or threatened with serious harm or death) can also be referred to Ealing MARACs via the above and other agencies**

In an emergency, call the police on 999 and Ealing Council for children and adult safeguarding on 020 8825 8000

* Each agency provides different services to children dependant on age and gender criteria (see below for details)

**Black and minority Individuals refers to people from ethnic minority backgrounds, including South Asian, African, Caribbean, Middle Eastern and Eastern European

In addition to the services listed, there is also the Women's Wellness Zone for complex needs covering mental health, domestic abuse, substance misuse and sex working.



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# Appendix 3: Action Plan

| Recommendation | Scope of recommendation i.e. local or regional | Action to take | Lead Agency | Key milestones in enacting the recommendation | Target Date | Date of Completion and Outcome |
|---|---|---|---|---|---|---|
| *What is the over-arching recommendation?* | *Should this recommendation be enacted at a local or regional level (N.B national learning will be identified by the Home Office Quality Assurance Group, however the Review Panel can suggest recommendations for the national level)* | *How exactly is the relevant agency going to make this recommendation happen?*<br><br>*What actions need to occur?* | *Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?* | *Have there been key steps that have allowed the recommendation to be enacted?* | *When should this recommendation be completed by?* | *When is the recommendation and actually completed?*<br><br>*What does the outcome look like?* |
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# Appendix 4: Related actions from previous DHRs

The Chair requested the action plans for previous DHRs for Ealing. From the recommendations supplied, the following link to recommendations from this DHR. These are provided to assist with linking new actions to on-going action planning.

**Recommendation from Rose:** VAWG Housing-Sub group to produce a specific housing and domestic violence policy and procedures, to especially detail the relation between rent arrears and domestic abuse responding to repairs, noise nuisance reports and making referrals to specialist services. And ensure that all relevant staff are trained on this policy and procedure.

**Recommendation from Rose**: Ealing CCG to consider how mental health diagnoses and domestic violence issues are coded or flagged within GP records.

**Recommendation from Rukhsana**: NHS England to review the use and effectiveness of the IRIS programme across London GP practices to consider potential for wider commissioning of the project.

**Recommendation from Barbara**: The Ealing CCG and Ealing Borough Council review provision for carers against the Triangle of Care and develop services to help identify and respond to carers of those with mental health problems, including carer's assessments.

**Recommendation from Rukhsana:** Ealing VAWG Strategic Group to incorporate findings from this report in its plans for delivering the Ealing VAWG strategy, in particular:

(a) To engage the faith-based communities in this agenda.



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# Appendix 5: Abbreviations

| | |
|---|---|
| CQG | Clinical Quality Group |
| DA | Domestic abuse |
| DAHA | Domestic Abuse Housing Alliance |
| DASH RIC | Domestic Abuse Stalking and Harassment Risk Indicator Checklist |
| ECIRS | Ealing Children's Integrated Response Service |
| ECSC | Ealing Children's Social Care |
| CRHTT | West London NHS Trust's Crisis Resolution Home Treatment Team |
| IRIS | Identification and Referral to Improve Safety |
| LNWUHT | London North West University NHS Trust |
| MASH | Multi-Agency Safeguarding Hub |
| MH | Mental Health |
| MHA | Mental Health Act 1983 |
| MHR | Mental Health Review |
| NICE | National Institute for Clinical Excellence |
| NoSP | Notice of Seeking Possession |
| SW | Social worker |
| UCC | Urgent Care Centre |



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