DOMESTIC HOMICIDE REVIEW

Hammersmith & Fulham Community Safety Partnership

Report into the death of Senai
May 2020

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February 2022

Glossary

CATT: Crisis Assessment & Treatment Team
CCG: Clinical Commissioning Group
CMHT: Community Mental Health Team
CPA: Care Programme Approach
CSP: Community Safety Partnership
CYPS: Children's and Young People's Service
DHR: Domestic Homicide Review
IDVA: Independent Domestic Violence Adviser
IMR: Individual Management Review
LB: London Borough
MARAC: Multi-Agency Risk Assessment Conference

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Preface

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

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

1. Introduction

1.1 Domestic Homicide Reviews (DHRs) came into force in April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by-

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship or

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

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

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

1.2 The purpose of a DHR is to:

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

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

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) 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

[1] Not his real name

effectively at the earliest opportunity.

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice[2].

1.3. In May 2020, Hammersmith & Fulham Community Safety Partnership were notified of the death of a male resident (Senai) allegedly killed by his brother (Amaris[3]).

1.4. The decision to undertake a DHR was made by Hammersmith & Fulham Community Safety Partnership in May 2020 in consultation with local partners and specialists. The Home Office was duly informed a few days later (within a week of the death). An independent Chair was appointed in August 2020 and the Panel met for the first time in August 2020 where IMRs were commissioned, and agencies advised to implement any early learning without delay. These actions ran alongside the ongoing criminal investigation and proceedings. Three further meetings of the Panel were subsequently held in September, October, and December 2020 at which point the process was suspended until criminal proceedings had concluded.

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

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

1.7. The process concluded in February 2022.

1.8. Domestic abuse is a key priority for Hammersmith and Fulham Community Safety Partnership and is part of their Strategic Plan. Their goals in 2020-21 included providing specialist advocacy and support services for survivors and coordination of specialist domestic abuses courts to improve domestic abuse conviction rates. Previous reviews undertaken in the area were considered (DHRs and Safeguarding Reviews). One of these - a DHR - was found to be relevant as it also concerned a family homicide, involved mental health issues, and learned similar lessons. This DHR concluded in March 2018 which suggests that the learning may not yet have been fully embedded. Recommendations in this DHR have been duly reviewed to take account of this.

1.9. Domestic abuse is also a priority for London Borough of Hammersmith & Fulham, and they commission a number of specialist domestic abuse services. These include:

- The Angelou VAWG service for victim and survivors[4]
- Coordination services for MARAC
- Coordination services for Specialist Domestic Abuse Courts
- Co-located IDVA in Housing
- Co-located IDVAs in Children's and Young People's Services
- Impact Project – co-located IDVAs in criminal justice settings and a

[2] Home Office, (2016) "Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews", https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf
[3] Not his real name
[4] https://www.angelou.org/

Performance and Review Coordinator
- Coordination services for Housing Operation Group and Sanctuary Scheme
- Coordination services for Children and Health Group

2. Overview

2.1. Persons involved in this DHR

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

2.2. Amaris also had child from a former partner. None of the brothers' children were present during the fatal event not had they ever lived at this address.

2.3. Background context

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

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

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

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

2.4. Summary of the incident

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

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

2.4.3. Adult 1 thought that the brothers were arguing about a girl but couldn't be sure. He said he thought Senai appeared to be the more aggressive of the two.

2.4.4. Adult 1 was unclear how Amaris came to have the knife but was able to identify it as a kitchen knife that was in regular use in the flat. He described how Amaris was saying to Senai, '*get out of my house'* to which his brother repeatedly replied*, 'come and make me'*.

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

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

2.4.7. Amaris went downstairs to let them in where he was met by police officers. Police had been called by the Ambulance Service. On arrival, the police were met by Amaris on the ground floor, coming out of the lift. As he approached the police, Amaris held out his hands in a stacked cuff position and said, '*I just stabbed my brother, I did it out of anger'*. This interaction was captured on the police officer's body worn camera.

2.4.8. Other police officers who arrived at the scene made their way to the 5th floor of the building, where they found Senai unconscious on the ground outside address 1.

2.4.9. The Ambulance Service arrived shortly afterwards but despite their best efforts, they were unable to save Senai.

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

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

3. Parallel reviews

3.1. An inquest was opened by Her Majesty's Coroner and was adjourned pending the outcome of the criminal trial. Communication channels were established with the Coroner who decided not to reopen the inquest after the trial had concluded.

3.2. Senai and Amaris had both been in receipt of mental health services: Senai since 2015 and Amaris since 2011. As a consequence, West London NHS Trust undertook a level 2 Serious Incident Investigation[5] which was completed in March 2021. Liaison was established to avoid unnecessary duplication and terms of reference were set which reflected the concerns of both Reviews. The findings from this report are discussed later in the report.

3.3. Liaison was established between the DHR and Hammersmith & Fulham Adult Safeguarding Board with the latter receiving regular updates on progress and emerging findings.

4. Domestic Homicide Review Panel

The DHR Panel was comprised of the following:

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

[5] A Level 2 investigation means that the review was undertaken by an independent Chair

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

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

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

5. Independence

5.1. The author of this report, Davina James-Hanman, is independent of all agencies involved and had no prior contact with any family members. She is an experienced DHR Chair and is also nationally recognised as an expert in domestic violence having been active in this area of work for over three decades. Further details are provided in appendix C.

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

5.3. One of the agencies who attended was Standing Together Against Domestic Abuse. The Panel Member did not have any direct contact with any of the subjects of this Review but did prepare the papers for the MARAC meeting where the case involving the victim and his former partner case was discussed as the usual co-ordinator was on annual leave. This MARAC meeting was not an event which directly related to the death and MARAC minutes were not requested by the panel.

6. Terms of Reference and Scope

6.1. The full terms of reference can be found at appendix A. The key lines of inquiry were as follows:

For anyone with relevant information:

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

For specific agencies:

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

For all agencies:

- Establish the sequence of events for both Senai and Amaris, leading up to the death in May 2020 from January 2005 (with any relevant previous events summarised).
- Establish whether there was effective and appropriate communication and liaison within and between agencies
- Consider whether policies and protocols were in place, whether they were followed and if these were fit for purpose – in particular whether staff readily consider family abuse and not just partner abuse.
- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- Were responses sensitive to the ethnic, cultural, linguistic, and religious identity of the brothers and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?
- Were senior managers or other agencies and professionals involved at the appropriate points?
- Are there any implications for ways of working, training, management, and supervision, working in partnership with other agencies and resources?
- Did any restructuring during the period under review and / or the pandemic have an impact on the quality of the service delivered?
- How accessible were the services for the brothers?
- Consider whether any actions taken in this case give rise to serious concerns about the way in which local professionals and/or services worked together to safeguard adults at risk.
- To highlight and learn from any positive practice.

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

7. Confidentiality and dissemination

7.1. The findings of this Overview Report are restricted. Information is available only to participating officers/professionals and their line managers, until after the Review has been approved for publication by the Home Office Quality Assurance Panel. Members of the victim's family have also been offered sight of a copy of the report (see section 9 for more detail).

7.2 As recommended within the '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* to protect the identities of those involved, pseudonyms have been used and precise dates obscured.

7.3 The Executive Summary of this report has also been anonymised.

7.4 This has not prevented agencies taking action on the findings of this Review in advance of publication.

7.5 Subsequent to permission being granted by the Home Office to publish, this report and the executive summary will be widely disseminated to key local statutory and partnership boards including, but not limited to:

- Community Safety Partnership Board
- DHR Panel members
- Safeguarding Adults Board
- The Coroner
- Health & Wellbeing Board
- VAWG Strategic Board and the Risk and Review and DHR subgroups
- Domestic Abuse Commissioner

They will also be shared with the Commissioner of the MPS and the Mayor's Office for Policing and Crime (MOPAC).

7.6. Once permission is granted by the Home Office to publish, the recommendations will be owned by the CSP. The Community Safety Unit at the London Borough of Hammersmith & Fulham will be responsible for monitoring progress on implementing the action plan, as well as hosting a learning event to bring together local partners to consider the DHR.

7.7. Actions and learning events will be taken forward in the context of the wider partnership. This process will be coordinated through the Risk and Review Group and the DHR Subgroup.

7.8. One-page learning summaries will be created for professionals and used to aid learning across the partnership.

7.9. All DHRs are published on the following permanent hyperlink: https://www.lbhf.gov.uk/crime/domestic-violence/fatal-domestic-violence .

8. Methodology

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

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

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

	Had involvement with Senai	Had involvement with Amaris	Completed a report for the DHR Panel[6]
West London NHS Trust	Yes	Yes	Yes
London Borough of Hammersmith & Fulham Children's and Young People's Service)	Yes	No	Yes
Victim Support	Yes	No	Yes
Metropolitan Police	Yes	Yes	Yes
London Borough of Hammersmith & Fulham	Yes	No	No

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

Housing Management			
The Guinness Partnership	No	Yes	Yes
Imperial College Healthcare NHS Trust	Yes	No	Yes
Mind	Yes	No	No
Mapesbury Medical Group	No	Yes	No
H&F Adult Social Care	Yes	Yes	No
London Ambulance Service	No	Yes	No
Cassidy Medical Centre	Yes	No	No

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

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

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

9. Involvement of family and friends

9.1. The family of the victim were informed about the commencement of the DHR and invited to participate with a variety of options suggested. Contact was made with two half-brothers who had been designated as the family spokespeople and the victim's former partner and mother of his children (referred to as Janet in this report). As the criminal investigation was still on-going at this point, initial contact was made through the Family Liaison Officer (FLO). The family were sent a copy of the draft terms of reference and invited to comment on them. They were also provided with the relevant Home Office leaflet and information about AAFDA[7]. No response was received.

9.2. Once criminal proceedings had concluded, the Chair recontacted the victim's family and invited their participation a second time. No response was received.

9.3. The Chair was able to contact Amaris who was interested in being kept informed but who did not wish to actively contribute.

9.4. The chair contacted members of the victim's family (as described above) to give

[7] AADAFA provide expert peer support to family members in the aftermath of a domestic homicide. www.aafda.org.uk

them the opportunity to comment on the overview report before it was reviewed by the CSP but no response was received. Family members will be contacted again prior to publication and offered a final opportunity to contribute.

10. Key events

Senai

10.1 Senai was 32 at the time of the incident. His parents separated when he was a small child, and his father married his stepmother. He and his family left Eritrea and sought political asylum in the UK due to the civil war. He had four brothers and one sister, but only one brother, Amaris, shared the same biological parents. His biological mother moved to the USA and he met her once at aged 18 years. Senai and Amaris did not find out that their stepmother was not their biological mother until Senai was 17 and Amaris was15.

10.2 In July 2011, he was reported for domestic abuse and was later arrested and charged with common assault.

10.3 The following month, Police were called to reports of a large-scale disturbance involving a large group of youths carrying poles and sticks. Senai was one of a group of ten who were arrested. He was charged with the offence of violent disorder.

10.4 The following summer (2012), Senai was found to be in possession of four bags of herbal cannabis. He was arrested and given a Fixed Penalty Notice. A couple of months later, he was arrested for smoking a cannabis cigarette and given a caution.

10.5 In March 2014, Senai had a Carers Assessment completed by the Carers Network as he was providing care for his brother, Amaris (see below for details). He was awarded a £300 grant for a laptop and driving lessons.

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

10.7 A week later, Senai reported feeling depressed to his GP. He stated that the reason for his low mood was his girlfriend's pregnancy. He was prescribed anti-depressants. There is no record of any enquiry about domestic abuse.

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

10.9 In April 2015, Senai was reported missing by his girlfriend Janet, who was heavily pregnant. He had been at her address, and she became worried about his mental

health. He had burnt his hands with a lighter and left the address. She reported that his mental health had deteriorated over the last two weeks with him constantly talking about God and the angel of death. He hadn't slept for 2 weeks and had stopped looking after himself. Later that day, police received calls about a man behaving erratically in a children's playground. On arrival, this proved to be Senai, and he was conveyed directly to hospital where he was sectioned under the Mental Health Act. He was later diagnosed as having drug induced psychosis. He was discharged two weeks later into the care of the Crisis Resolution Team who were supervising his medication in the community. A referral was also made to the FIRST team (First Incidence of Psychosis Team), to manage Senai's longer term care needs in the community.

10.10 Three days later, Senai and Janet's child was born. Given the history of mental ill health, and the potential risk to a very young and vulnerable baby, Children's, and Young People's Service (CYPS) decided to complete a Child and Family assessment because the risk and the protective factors in the family were unknown at that point. The outcome of the assessment was that no further involvement was needed from CYPS. Senai did not live with Janet and the baby; he was never left alone with the baby and was co-operating with mental health services.

10.11 By July 2015, however, Senai was declining support from the Early Intervention Team, and he was duly discharged.

10.12 In early December 2015, Senai was arrested during a drugs raid, but no further action was taken.

10.13 In September 2016, the Police received a call from Janet's friend. She told police that during a telephone conversation with her friend she could hear the sound of an argument between the couple and was now unable to contact her. Police attended and spoke to Janet who denied any violence had taken place and that it was only a verbal argument. Janet was six months pregnant with her second child. Senai was staying over at her flat when the incident occurred. The police officer completed a DASH risk assessment and assigned a rating of standard. As this did not meet the threshold for referral to MARAC, a referral instead was made to the local MASH (Multi-Agency Safeguarding Hub) and thorough checks carried out. The outcome was for no further action to be taken.

10.14 In December 2016, Janet and Senai's second child was born.

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

10.16 In early March 2017, Janet's mother called the police. She told them that Janet had called her stating that she had been assaulted by Senai.

10.17 Police attended Janet's flat where she told them that she and Senai had been in a relationship for seven years. They didn't live together but Senai would stay over occasionally. Earlier that day Senai had accused her of ignoring him and when she asked him to leave, he head-butted her, causing a cut to her head. He left the scene immediately after. A DASH risk assessment was completed, and an offer made to refer Janet to Advance (a local domestic abuse charity) but this was declined. Senai was arrested and interviewed during which he answered 'no comment' to all questions. He was charged with assault by beating and bailed to appear at West London Magistrates Court at the end of March. The matter was discontinued at court by the Crown Prosecution Service.

10.18 These events triggered a further assessment by CYPS. As part of this, Senai was contacted twice but did not respond. It should be noted that practice has since changed, and more assertive steps are taken to engage with perpetrators. The assessment eventually concluded that no further action was required at this time. This was based on Janet having co-operated with the police, taking advice not to allow further contact and being willing to engage in services to support a better understanding of domestic abuse. There were no other concerns about the children's health and development; they were seen in the course of the assessment and were healthy and happy.

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

10.20 In April 2019, Senai was stopped by police and searched. He was found in possession of a bag of cannabis, so he was arrested. He was given an Adult Community Resolution.

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

10.22 In September 2019, Janet contacted the police again to report that Senai had assaulted her. She reported that he was controlling towards her and had previously threatened to stab her if she ended their relationship. She also reported that three weeks earlier, Senai had assaulted her by hitting her across the back of her head. A DASH risk assessment was completed with 'medium' rating assigned. Children and Young People's Service were informed.

10.23 Senai was arrested and interviewed during which he denied any wrongdoing. He was bailed with conditions not to contact Janet, attend the family home or the children's school or nursery.

10.24 In the meantime, Janet decided that she would rather seek an injunction than support a prosecution. She was referred to Advance and with their support, obtained a non-molestation order. When Senai returned to the police station, he was served with the order and no further action was subsequently taken.

10.25 The police notified CYPS who undertook a further assessment. This one was much more robust than the previous ones and pleasingly showed that changes in policy had been embedded in practice. For example, the social workers were in contact with the police to understand the immediate risks and the bail conditions. Janet was referred to a domestic abuse service that supported her to obtain a non-molestation order which placed some ongoing constraints on Senai's contact with her and the children. Practical safety planning strengthened the security of the family home. There was ongoing support around domestic abuse with the allocation of an IDVA. The wider maternal family were engaged in the assessment and safety planning as a protective measure. Most importantly, the case was referred to MARAC which allowed for a multi-agency response to the risk of domestic abuse in this family and this included involving the mental health service who were working with Senai. There was very strong management oversight of the assessment, and the conclusions were reviewed and agreed by the manager when the case was closed. Senai once again did not respond to attempts to engage him despite being contacted several times. It is possible that Senai was in hospital when these attempts were made but CYPS records are unclear

on this point. As demonstrable improvements have been made in practice since this time, a recommendation has not been made.

10.26 Towards the end of September 2019, Senai presented to the Emergency Department with acute mental health symptoms. He reported that he was hearing voices telling him to jump from his flat, which was situated on the 17th floor. He also reported that he was fearful of being there, had no bed and no cooker. He also mentioned that he had not seen his children for three weeks. He stated that he was being abused and controlled financially by others but declined to give any further information on this despite being asked. He denied using cannabis.

10.27 Senai was seen by Psychiatric Liaison (part of West London NHS Trust). The outcome was that he was informally admitted to hospital.

10.28 In mid-October 2019, he was discharged from the ward to Amaris's accommodation. The previous day, the Occupational Therapist and Senai had completed a visit to Senai's flat and verified that there was no cooker, no bed, and no furniture to speak of. The electricity was not working either.

10.29 Arrangements were made for Senai to be given information about a charity for support with acquiring home appliances and for advice about his accommodation.

10.30 He was referred into the Treatment Recovery Team. He was advised that he would be followed up but that he did not meet the criteria for care coordination. At the follow-up meeting a week later, Senai informed staff that the fixtures and fittings for his flat had been delivered.

10.31 At the end of the month, Janet and Senai were discussed at MARAC. The meeting identified Senai's pattern of domestic abuse as a risk factor that needed to be addressed. There were actions for West London NHS Trust to explore relationships with him and if any abuse or concerns were disclosed by Senai, to offer a referral to the local perpetrator programme and the Respect phone line for perpetrators. This did not happen until mid-March 2020. Janet's address was flagged as high risk for all agencies.

10.32 Senai's mental health continued to decline. In early November 2019 he was assessed by the Transitions Team after he presented with hearing voices 'telling him to do things'. He also claimed to be the victim of financial abuse again but was again unwilling to provide any further details. Senai had also moved in with Amaris out of fears for his safety in his own flat on the 17th floor but reported that this had become a problem, because of the impact it had on both their mental states. Senai reported that he was worried his presence would cause his brother to relapse, and that this was causing him anxiety. There are no records of his concerns being explored.

10.33 He continued to receive input from West London NHS Trust mental health services and by December 2019, they made the decision to allocate him a care co-ordinator. This never happened before Senai's death.

10.34 Senai was due to have an appointment in March 2020, but this was re-scheduled by West London NHS Trust. Two voice mail messages to Senai did not result in any response and he died before any further appointments took place.

Amaris

10.35 Amaris was 30 at the time of the incident.

10.36 He first appeared in agency records in 2009 when he completed a homeless application. He advised London Borough of Hammersmith & Fulham that he was currently homeless as his brother – with whom he was residing – had given him a Notice to Quit. Prior to this, he had been living with a girlfriend in Edinburgh, but this relationship had broken down. Before this, he had been in prison for one year, for drug dealing.

10.37 Amaris was referred to supported accommodation at Edith Road.

10.38 In May 2010, Amaris was stopped by police and searched under the Misuse of Drugs Act. The search was negative, so no further action was taken.

10.39 In June 2010, Amaris was stopped by Police after throwing the contents of a bottle over a police car. When spoken to, he became verbally aggressive and violent and attempted to bite an Officer. He was arrested in relation to Public Order offences and was issued with a Fixed Penalty Notice.

10.40 In July (twice) and August 2010, Amaris was stopped and searched. On each occasion, nothing was found and there was no further action taken.

10.41 In August 2011, Amaris was admitted into hospital due to mental illness and released in October. The (low level) supported accommodation was no longer suitable due to his new diagnosis and he was referred to a different (medium) supported accommodation hostel which could better meet his needs, only to be transferred again to a third supported housing accomodation hostel which accommodated those with very high support needs.

10.42 In August 2012, Amaris was arrested for drug offences in Portsmouth. It was later confirmed that he had been supplying drugs.

10.43 In March 2013, Amaris was placed on Section 48/49 and admitted to hospital. He was diagnosed with paranoid schizophrenia and mental and behavioural disorders due to multiple drug use. He was discharged in January 2014 to the London Borough of Hammersmith & Fulham Early Intervention Service. The previous month he was on overnight leave from the hospital and was once again stopped and searched under the Misuse of Drugs Act. Nothing was found so there was no further action taken.

10.44 In May 2014, Amaris was detained under Section 2 of the Mental Health Act 1983, and subsequently under Section 3. This was for non-compliance with medication and reduced engagement. He was subsequently allocated a care co-ordinator and discharged in September 2014.

10.45 While at hospital, housing and his care coordinator worked jointly to find alternative suitable accommodation for Amaris and he moved into (medium) supported accommodation upon discharge.

10.46 In January 2015, Amaris left the hostel to travel to Ethiopia for religious purposes[8]. Upon return, he was living with his step-mother who evicted him in June

[8] Further detail was not available. However, the Panel were advised that sometimes if people have a mental or physical health issues or if they feel like their life is not going well, they sometimes go to Ethiopia

2015 stating her property was overcrowded and she could not cope with his mental illness.

10.47 Amaris then went through a period of living in various temporary accommodation hostels. Permanent re-housing was proving difficult due to past problems with running up rent arrears.

10.48 In December 2015, Amaris reported his former partner to the police for failure to return a mobile phone he had loaned her. This was recorded as a domestic abuse incident and a DASH completed. Investigators established that Amaris had, in fact, given his former partner the phone and the case was closed.

10.49 In July 2016, Amaris was once again stopped and searched under the Misuse of Drugs Act. Nothing was found so no further action was taken.

10.50 In December 2016, Amaris informed the Recovery Team at West London NHS Trust that he was contacted by the police regarding an investigation. The victim was a mutual friend, and he was, therefore, living outside of the borough, at an undisclosed address to stay safe.

10.51 A meeting took place between the Metropolitan Police and the Recovery Team. The police agreed to fund the accommodation out of borough until the following week. It was agreed that he required re-location, and on-going engagement for at least six months with mental health services.

10.52 In February 2017, it was noted that although Amaris had been stable, and discharge plans from the Recovery Team had been discussed, following witness testimony, he should continue to be supported through the trial process.

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

10.54 By January 2018, the court case had concluded, and Amaris was offered temporary accommodation back in the London Borough of Hammersmith & Fulham.

10.55 In March 2019, he was offered permanent accommodation at address 2 which he accepted. He was also offered support by his then care co-ordinator if he needed it. Amaris gave Senai as his emergency contact and next of kin. Thereafter, the Guinness partnership had intermittent contact with Amaris over unrelated matters (tenancy check-up, occasional repairs, sorting out rent payments etc). None of these contacts gave rise to any concerns and on no occasions that staff were inside the property, was there any indication of other people living there other than a mattress in the lounge which was explained as being a substitute for a sofa.

10.56 In the one-year period leading up to the incident there appears to be only routine agency contact relating to Amaris but no significant changes in circumstances. His attendance for his monthly depot injection was slightly erratic in the latter part of 2019, but then stabilised in 2020.

10.57 In September 2019, Amaris attended his last Care Programme Approach (CPA) meeting, at the Claybrook Centre, with his allocated Consultant Psychiatrist and care co-ordinator. He reported he had been working evening shifts at a pizza kitchen. He

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to go to specific monasteries to speak to religious leaders and to complete certain religious rituals to help them get better.

said he had mended relationships with his family. He had a history of substance misuse but at this time he stated he wasn't using any substances. He expressed that he would like his medication reduced. However, he did state that he can be quite forgetful (with regards to medication for example). He reported an erratic sleep pattern, but advised he was not experiencing suicidal ideation, or psychotic symptoms. He provided Senai's contact number as next of kin. The plan was to offer a treatment review in 3 months' time, and an Outpatient's Appointment in 6 months' time. There was a consideration for referral to GP because of his stability. The impression was that he was in remission from psychosis with medication, but that he needed to improve medication management.

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

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

11. Equality and Diversity

11.1 The nine protected characteristics[9] under the Equality Act 2010 were reviewed and due consideration given as to whether or not these were applicable.

11.2. Disability and race were found to be relevant.

11.3. Age, gender reassignment, marriage and civil partnership, pregnancy and maternity, and sexual orientation were not relevant to the circumstances of this case.

11.4. Sex was relevant insofar as the vast majority of domestic abuse victims are female, unlike in this case. Even when restricting domestic homicides only to those committed by family members, this still holds true with most consisting of an adult son killing their mother. Sibling homicides are relatively rare (approximately 3% of domestic homicides[10]) and there is very limited research available.

11.5. Religion was an issue insofar as Senai converted to Islam and issued threats to members of his family if they did not follow suit. This resulted in him being charged with threats to kill (see paragraph 10.8). This would suggest that the brothers' family were Christian Eritreans.

[9] These are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation

[10] '*Spotlight briefing #1: Adult family Homicides'* Thien Trang Nguyen Phan, Lis Bates, Katie Hoeger, Phoebe Perry, Angie Whitaker, Vulnerability Knowledge & Practice Programme January 2022

11.6. Both Senai and Aramis were of Eritrean origin, located in East Africa. To ensure that the Panel had a shared cultural understanding of the Eritrean community, at the second panel meeting, they received a presentation which addressed: Eritrean modern history including the civil war, the concept of domestic abuse within the Eritrean community, UK demographics, and the potential influence of culture and religion.

11.6.1. The Review Panel has not identified any concrete information that either Senai or Amaris' experience of services were directly or indirectly affected by race. However, this does not mean it may not have been relevant. For example, Senai had been stopped and searched by the Metropolitan Police 17 times and Aramis on four occasions. Although the Panel does not have detailed information on their experiences of stop and search, there are well documented concerns on the disproportionate use of stop and search on Black men. A report released by the Equality and Human Rights Commission included information that some police forces had conducted stops on the basis of stereotypical assumptions, with Black people being at least six times as likely to be stopped as white people.[11] It is also well documented that Black men are disproportionately represented within the mental health system as are refugees[12] with many arguing that experiences of racism are a contributory factor to this outcome.

11.6.2. Additionally, the brothers arrived in the UK as children escaping the civil war in Eritrea. Senai was seven years old, and Amaris was nine years old at the time. Unfortunately, the Panel has no information on their experiences as refugees and how it may have impacted them. This is commented upon further in the analysis section (paragraph 12.1).

11.7 If mental illness is enduring in nature (ie for longer than 12 months) it is categorised as a disability under the Equality Act. Both brothers had a diagnosis of paranoid schizophrenia, and this undoubtedly impacted on their lives. At the time of the incident, Amaris' symptoms were being managed with monthly depot injections; a regime with which he was complying. Senai was awaiting the allocation of a care co-ordinator at the time of his death. Failings were found in the care provided to both brothers and as such it could be argued that their disability was not effectively addressed.

11.8. The Panel noted that despite the lack of specific research into sibling homicides, many of the themes emerging from research[13] into family homicides also had applicability here. These included: the assailant being male; having mental health issues; having experienced childhood trauma and being financially unstable. It should be noted that sibling homicide is relatively rare when compared with other adult family homicides which are mostly adult sons killing their mothers.

12. Analysis

[11] Equality and Human Rights Commission (2010) '*Stop and Think: A critical review of the use of stop and search powers in England and Wales*', Available at: https://www.equalityhumanrights.com/sites/default/files/ehrc_stop_and_search_report.pdf.

[12] See for example: https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities

[13] See, for example: https://domestichomicide-halt.co.uk/wp-content/uploads/2021/11/MMU2621-Briefing-paper-Adult-Family-Domestic-Homicide_V5.pdf and https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5f633ee1e0e0be6ec5b858a1/1600339696014/Standing+Together+London+DHR+Review+Report.pdf and https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5efcb376866b33242d04c3cb/1593619318736/AFV+Briefing+Sheet.pdf

Information provided to the Panel was analysed against each of the key lines of enquiry set out in the terms of reference.

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

12.1.1. The brothers arrived in the UK as children escaping the civil war in Eritrea. Senai was 7 years old, and Amaris was 9 years old.

12.1.2. No agency had any recorded history of what this journey was like and what they may have witnessed prior to their arrival in the UK. It would have been helpful for this to have been covered in the various health assessments the brothers underwent.

12.1.3. Senai was first admitted to a psychiatric ward in April 2015, Amaris a year earlier.

12.1.4. It is complicated to unpick the impacts of several possible intersections. It has been established that both brothers had a diagnosis of paranoid schizophrenia; both may also have experienced issues related to being refugees, both appeared to use cannabis although the exact extent of this is unknown, and allegations were made by Senai about both brothers experiencing a violent childhood although Amaris denied this. Whatever the exact nature of the intersections, there can be no doubt that arriving in an unknown country as a refugee is a stressful experience and that extended wraparound support is needed to ensure a smooth transition and resettlement. Such support needs to inform holistic assessments and be trauma informed.

12.1.5. Information on accessing public services should also be more widely available, especially those which cater specially for young Black men, and which may be perceived to carry less social stigma than statutory mental health services. A recommendation regarding social prescribing has been made.

12.2. What do we know of the brother's substance use?

12.2.1. Both Amaris and Senai consumed cannabis; information about the duration and extent of this remains patchy but see 12.5 below.

12.3. Establish a clear picture of the offending history of both brothers

12.3.1. This was done and is included in the narrative above.

12.4. Were the Guinness Partnership aware of the sub-letting and was this with their approval? If not, what mechanisms might need to be put in place to identify (what appears to be) statutory over-crowding?

12.4.1. The Guinness Partnership were not aware of the subletting arrangements Amaris had made. Visits in line with existing policy did not highlight any concerns regarding sub-letting and / or overcrowding. Additionally, a number of home visits for repair were undertaken and again, no concerns were raised or documented. It was felt that detecting illegal sub-letting when tenants are engaged in deliberate concealment would require more resources than are available.

12.5. What were the results of the toxicology tests?

12.5.1. In the immediate aftermath of the death, toxicology tests were administered to both Senai and Amaris. The only substance identified in Amaris was his depot injection which he was prescribed to manage his schizophrenia. Senai's blood sample revealed that he had consumed high doses of cannabis in the hours prior to his death. He may have been experiencing some of the associated effects of cannabis at the time of the incident, but this cannot be stated with absolute certainty. Neither party had consumed any alcohol in the hours before the death.

12.6. Establish where Senai was living (agency records are contradictory)

12.6.1. Senai's tenancy started in May 2007 when he was allocated a flat on the 17th floor of a tower block in Fulham. During the sign up, there were no concerns around vulnerability and no support needs were raised.

12.6.2. Following the sign up, an early tenancy check (ETC) was undertaken at four weeks into the new tenancy. There were no concerns raised around vulnerability during this visit or any support needs identified. Subsequently, there was intermittent contact between housing management service and Senai, none of which raised any concerns.

12.6.3. When his mental health later deteriorated, this was not known to his landlord (London Borough of Hammersmith & Fulham). Senai reported to his mental health team that he was hearing voices telling him to jump from his balcony. When he felt particularly unwell, he would stay with his brother, Amaris.

12.7. When and why was a care co-ordinator first assigned to Amaris? Why did Senai not have a care co-ordinator?

12.7.1. Amaris was first allocated a care co-ordinator in May 2014 following his detention under the Mental Health Act (see paragraph 10.5)

12.7.2. Senai was not allocated a care co-ordinator as he did not meet the criteria until December 2019. Unfortunately, Senai died before this could be achieved. This was a missed opportunity to gain a fuller understanding of Senai's needs, and risks may have been identified had there been a more robust contribution of relevant stakeholders. Assessment under CPA would have been more comprehensive, including appropriate identification that the victim was living with his brother, and, that both were known to the secondary mental health service – a fact which only came to light after the death of Senai.

12.8. Review the brothers' mental and physical health care plans/risk assessments and risk management plans to establish whether they met their overall needs.

12.8.1. West London NHS Trust identified that a comprehensive risk assessment was not completed in respect of the victim, and whilst risk to others was broadly considered, risk *from* others was not. There was a reference to plans for a forensic risk assessment to be sought, but this did not appear to happen.

12.8.2. West London NHS Trust also found that in line with guidance from the National Institute for Health & Care Excellence[14] both Amaris and Senai should have been offered a family intervention and individual cognitive behavioural therapy (CBT) as they

[14] https://www.nice.org.uk/guidance/cg178

both had a diagnosis of schizophrenia. This may have revealed to West London NHS Trust that the two patients were related.

12.8.3. Overall, care planning and risk assessment were not applied/did not meet Senai's needs and there was a lack of timely follow-ups. His care was not provided in line with the Care Programme Approach despite Senai presenting to both psychiatric liaison services and the team asking for help and support.

12.8.4. With the benefit of hindsight, it is perhaps regrettable that more sustained efforts were not made to gain further details in response to Senai's assertions of being subjected to financial abuse. However, in the context of Senai's overall presentation on those two occasions, (hearing voices, fearing for his safety and in dire need of basic furniture) it is understandable that these were the focus of interventions rather than the alleged financial abuse that Senai did not wish to discuss (as investigated in 10.26 and 10.32).

12.9 Establish the sequence of events for both brothers, leading up to the death in May 2020 from January 2005 with any relevant previous events summarised).

12.9.1. This has been set out in details above and is not repeated here.

12.10. Establish whether there was effective and appropriate communication and liaison within and between agencies

12.10.1. No agency was aware of any pre-existing abuse between the brothers. In assessing the abuse perpetrated by Senai against his former partner and family members, all information was appropriately shared.

12.10.2. West London NHS Trust identified that referrals should have been made to Adult Social care and to housing on behalf of Senai. Moreover, West London NHS Trust should have taken more detailed family histories from both brothers which would have brought to light their relationship.

12.11. Consider whether policies and protocols were in place, whether they were followed and if these were fit for purpose – in particular whether staff readily consider family abuse and not just partner abuse.

12.11.1. There were no occasions on which agencies needed to follow policies and protocols relating to any abuse between the brothers. Nevertheless, a comprehensive check was made of existing policies and protocols and recommendations have been made to increase awareness and understanding of family abuse.

12.11.2. However, West London NHS Trust did find that although required policies and procedures appeared to be in place, not all of them were followed. For example, Senai should have been on the CPA[15] due to his complex and chaotic presentation, compounded by substance misuse. Furthermore, Senai should have had an assessment under The Care Act as he appeared to have housing and other social care needs. In addition, safeguarding adults and MARAC referrals should have been considered. Had any of these happened, it is probable that the brothers' relationship would have come to light and possible that Senai's housing needs may have been addressed so that he was not at his brothers flat in May 2020.

[15] The Care Planning Approach should be used for individuals who are at high risk of suffering deterioration in their mental condition and need multi agency support.

12.12. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

12.12.1. There were no opportunities for assessments to take place in relation to abuse by Amaris towards Senai. There were several occasions when Senai's behaviour gave rise for concern – several instances involving his abuse of his former partner and once when he threatened to kill his uncle. On these occasions, expected policies and protocols were followed in relation to assessments, decision making and information sharing.

12.13. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

12.13.1. There were no assessments made in relation to abuse by Amaris towards Senai and consequently no risk management plans. In those instances when it was Senai's behaviour which gave rise to concerns, the risk management plans were appropriate.

12.14. Were responses sensitive to the ethnic, cultural, linguistic, and religious identity of the brothers and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

12.14.1. This is addressed in section 11 above.

12.15. Were senior managers or other agencies and professionals involved at the appropriate points?

12.15.1. This was not deemed to be relevant in light of the lack of information held by agencies about any trail of abuse between the brothers.

12.15.2. Nevertheless, it should be noted that due to other concerns around the brothers' vulnerabilities and in the case of Senai, other relationship dynamics, senior managers were involved where appropriate.

12.16. Are there any implications for ways of working, training, management, and supervision, working in partnership with other agencies and resources?

12.16.1. The need for more emphasis on family violence within domestic abuse work across agencies was identified. More understanding is needed of the difference between family violence and intimate partner violence, what risk may look like and how to apply thresholds. It was also noted that some agencies subsume domestic abuse work under general safeguarding and that this does not always afford domestic abuse the focus that is needed to achieve effective responses.

12.16.2. See also paragraph 12.19 below.

12.17. Did any restructuring during the period under review and / or the pandemic have an impact on the quality of the service delivered?

12.17.1. Recent data[16] released by the National Police Chiefs Council has shown that domestic homicides did not appear to increase dramatically during the pandemic, with 163 recorded in the 12 months to 31 March 2021. This was very similar to the previous year's figure of 152 and is in line with the 15-year average. Nevertheless, it is easy to imagine how tensions might spiral under lockdown with three adult men living together in a one-bedroom flat. Widespread impacts on mental health and well-being have also been reported across the population as a consequence of pandemic restrictions. This was particularly true for those who experienced mental ill-health prior to the onset of the pandemic restrictions.[17]

12.17.2. West London NHS Trust reported that the pandemic had a significant impact on their ability to respond in a timely fashion. These impacts were especially felt in the transitions team albeit that exacerbated pre-existing problems with staff shortages and staff sick leave. Prior to the pandemic, there were also delays in recruitment for Specialty Registrars which led to Senai not being seen on a regular basis in late 2019.

12.18. How accessible were the services for the brothers?

12.18.1. No issues were identified with the accessibility of services. In some instances, more pro-active contact by agencies already in contact with one or both brothers would have been appropriate (see next paragraph).

12.19. Consider whether any actions taken in this case give rise to serious concerns about the way in which local professionals and/or services worked together to safeguard adults at risk.

12.19.1. West London NHS Trust concluded that their provision of care was fragmented -particularly for Senai - and the liaison with local authority and other parties was inadequate including regarding the housing issue. Furthermore, Safeguarding Adults and MARAC referrals were not considered.

12.19.2. Closely related to this was the lack of assertive engagement by several agencies. Commonly known as the 'DNA policy', most organisations operate a 'three strikes and you're out' approach. In practice this means if you miss three appointments, case closed. Don't respond to three voicemails? Case closed. Whilst this may be a pragmatic way of dealing with the volume of cases, a blanket application of such a policy ignores that those most likely to fall out of receiving a service are the most vulnerable. At the very least, additional efforts to engage should be made at the third attempt whether this be contact via a different method, a reminder of an upcoming appointment or implementing a policy of checking contact details are current at each successful contact.

12.19.3. The Panel also noted that it took almost a decade for Amaris to be provided with stable accommodation. Whilst this was not wholly the fault of services, Amaris's mental health issues cannot have been helped by this constant instability. Indeed, it is noteworthy that Amaris stabilised considerably after he became a tenant of the Guinness Partnership.

12.20. To highlight and learn from any positive practice.

[16] https://news.npcc.police.uk/releases/domestic-homicides-show-no-significant-increase-during-lockdown-says-new-police-report

[17] See, for example, https://www.mind.org.uk/media/8962/the-consequences-of-coronavirus-for-mental-health-final-report.pdf

12.20.1. This is addressed in section 13 below.

13. Good practice

13.1. West London NHS Trust identified that although Amaris was habitually late for his depot over the years, the team and CPN continued to consistently and assertively follow up with him until he had his treatment administered every month.

13.2. West London NHS Trust further identified that the responsible Consultant appeared to have acquired a comprehensive understanding of Amaris despite having only met him once.

13.3. The Guinness Partnership Lettings Team explored Amaris's mental health and previous convictions prior to him becoming a customer to ensure that the let was suitable. The property met need in terms of size and was supported by the Mental Health team. These additional checks ensure that customers have the support they require before moving into a TGP property.

13.4. London Borough of Hammersmith & Fulham Children's and Young People's Service noted that the good quality of the first Child and Family assessment and the understanding of the impact of mental health on parenting and family relationships demonstrates the benefit of experience and training in mental health work. There was also good communication and information sharing between the social worker and the mental health professionals.

13.5. The improvement seen in practice in relation to assessing domestic abuse between the 2nd and 3rd Child and Family assessment in this case is evidence of how the approach to domestic violence and multi-agency working has continued to improve since 2017. Training has taken place on the Safe & Together model and an audit undertaken of domestic abuse case files. This has resulted in more robust assessments, engagement and interventions with perpetrators.

14. Key findings by the DHR Panel and recommendations

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

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

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

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

Recommendation 2: Hammersmith & Fulham CSP to formally write to the Royal Colleges to suggest that domestic abuse training be afforded a separate intercollegiate

document that would detail how domestic abuse training should be delivered and to whom within heath care settings and that such training should become a mandatory requirement for all health staff (as recommended by NICE in 2014).

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

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

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

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

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

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

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

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

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

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

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

Finding 7: In common with many young black men in London, both brothers had been subjected to multiple stops and searches. The victim had been stopped 17 times and the other brother on four occasions. It is acknowledged that on six occasions, the victim was found to be in possession of small amounts of cannabis. Nothing was ever found

on Amaris. When each incident is viewed in isolation, it may seem as if the stop and search was justified, and it is certainly true that each individual incident was correctly recorded with a reason provided. Nevertheless, when viewed cumulatively, it seems unlikely that Senai and Amaris experienced them as justified and that it probably felt as if they were being – and may even have been – racially profiled.

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

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

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

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

Single agency recommendations

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

West London NHS Trust

- Staff should follow the Trust Clinical Risk Assessment and Management Policy in that risk plans must be updated when moving between services and relevant factors clearly identified
- Clear processes must in place to obtain forensic risk assessments and guidelines as to referral to assessment timelines made available. This should include taking a full history of new patients to identify any past traumas and potential triggers.
- The Trust should review its commitment improving awareness of, and engagement with, relatives and carers involved in the care of a service user.
- The service raises awareness of the importance of safeguarding adults and actioning recommendations made by external agencies such as MARAC.
- The appropriate MDT (Multi-Disciplinary Team) function should be engaged in considering and progressing housing requirements of service users.
- The service ensures patients requiring care coordination are appropriately allocated as soon as is practicably possible. Capacity issues should be escalated to relevant commissioners.

- The service complies with the Trust CPA policy including making sure staff understand the threshold for managing patients with mental disorder under the Care Programme Approach. This will also serve to enhance care planning.
- Recovery teams to offer family intervention and individual CBT to all patients with schizophrenia in line with the NICE guideline on psychosis and schizophrenia. If the service is not funded to be able to provide this, this is to be brought to the attention of the commissioners.
- Medical vacancies within the service should be filled and appropriate mechanisms in place with the Medical HR department of the Trust to ensure that recruitment strategies are in place to reduce vacancies. The Training Programme Director should also be sighted on trainee gaps.
- There should be in place the following, understood by all healthcare professionals of the service:
    - Operational policy for transitions team including referral process
    - Operational policy for recovery services including assessment of referrals in
    - Roles and responsibilities re duty function
    - Clear understanding of zoning. If any professionals have concern in relation to the safety of the service, for whatever reason, there should be appropriate escalation protocols in place.
- The service should adhere to a DNA policy that is understood by all members of staff that outlines clearly, expectations in relation to follow up of patients who Do Not Attend (DNA) appointments (to include nursing, medical, psychological and/or social work appointments

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

London Borough of Hammersmith & Fulham Housing Management:

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

Victim Support:

- Recommendation 1: Review of internal DA training to include training module on family violence and child to parent violence. This will be undertaken by Victim Support's Training and Development team with the assistance and oversight of the IDVA Community of Practice. Date for inclusion January 2021.
- Recommendation 2: Victim Support's Training and Development team to track changes to learning packages in the same way that policy and procedure is tracked and reviewed. This is to ensure full understanding of when staff would need to have refresher training. Date for action December 2020.
- Recommendation 3: Audit of case reviews in DA cases both for those allocated to IDVAs and Independent Victim Advocates. Due April 2021.

Mind

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

Imperial College

- All handovers between Liaison Psychiatry Service and Imperial College Healthcare NHS Trust should be clearly documented in patient record, detailing whether this was able to take place face to face, or via telephone, and who spoke with whom. This is currently the agreement although formal Standard Operating Procedure to be drawn up. This will be drawn up and then agreed at the next Mental Health Governance group (December 2020)
- All new psycho-social assessments, or those carried out in the Emergency Department, whether by psychiatry or triage, especially where a person has a history of domestic abuse (whether as victim / survivor or alleged perpetrator) should include an overview of where the person is staying, who is there with them and any relevant information about their current residence.

Appendix A: Terms of reference

DOMESTIC HOMICIDE REVIEW (DHR)
INTO THE DEATH OF SENAI

TERMS OF REFERENCE

Subjects of the DHR

	Name	**Relationship**	**Address**
Victim	Senai	Brother (victim)	Address 1
Alleged Perpetrator	Amaris	Brother (Alleged perpetrator)	Address 2 and location of death

Overarching aim

The over-arching intention of this review is to learn lessons from the homicide in order to change future practice that leads to increased safety for potential and actual victims. It will be conducted in an open and consultative fashion bearing in mind the need to retain confidentiality and not to apportion blame. Agencies will seek to discover what they could do differently in the future and how they can work more effectively with other partners.

Principles of the Review

1. Objective, independent & evidence-based
2. Guided by humanity, compassion, and empathy with the victim's voice at the heart of the process.
3. Asking questions, to prevent future harm, learn lessons and not blame individuals or organisations
4. Respecting equality and diversity
5. Openness and transparency whilst safeguarding confidential information where possible

Key lines of enquiry

The Review Panel (and by extension, IMR & short report authors) will consider the following:

For anyone with relevant information:

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

For specific agencies:

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

For all agencies:

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

Panel Membership[18]

- Homelessness prevention
- Neighbourhood Services
- The Guinness Partnership
- LBH&F Adult Social Care

[18] Membership was reviewed throughout the process, so the agencies listed here do not match those listed as panel members at paragraph 4. LAS kindly provided a chronology but declined to become a panel member due to their limited involvement.

- WL NHS Trust
- MPS
- Victim Support
- CSC
- Imperial College Hospital Trust
- GP / CCG
- Mind
- Standing Together
- London Ambulance Trust

Family involvement

The review will seek to involve the family of both brothers in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process.

We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

We will identify the timescale and process and ensure that the family are able to respond to this review endeavouring to avoid duplication of effort and without undue pressure.

Contact with the family and other members of their social networks will be led by the Chair.

Disclosure & Confidentiality

- Confidentiality should be maintained by organisations whilst undertaking their IMR. However, the achievement of confidentiality and transparency must be balanced against the legal requirements surrounding disclosure.
- The independent chair, on receipt of an IMR, may wish to review an organisation's case records and internal reports personally, or meet with review participants.
- A criminal investigation is running in parallel to this DHR, therefore all material received by the Panel must be disclosed to the SIO and the police disclosure officer
- The criminal investigation is likely to result in a court hearing. Home Office guidance instructs the Overview Report will be held until the conclusion of this case. Records will continue to be reviewed and any lessons learned will be taken forward immediately.
- Individuals will be granted anonymity within the Overview Report and Executive Summary and will be referred to by a pseudonym.
- Where consent to share information is not forthcoming, agencies should consider whether the information can be disclosed in the public interest.

Timescales

The Review will aim to conclude within six months in line with the statutory guidance. However, a period of suspension may be necessary to allow for criminal proceedings to conclude and thus opportunities for family involvement to be maximised.

Media strategy

- Up until the trial concludes, all media enquiries should be directed to the Metropolitan Police.

- Once the trial concludes and up until the report is signed off, media enquiries should be directed to the Chair
- Once the final report has been signed off, any media enquiries should be directed to the CSP.

Panel members should be mindful that:

- They are representing their agency and as such, no-one from their agency should be commenting to the media on this case
- This also applies to self-generated publicity e.g., tweets, Facebook posts etc. if unsure, please check with the Chair.

Appendix B: Cross-Government definition of domestic violence[19]

The cross-government definition of domestic violence and abuse is:

any incident or pattern of incidents of controlling, coercive, 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. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour

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

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.

[19] This was the definition in place at the time of undertaking this DHR. Towards the very end of the process (October 2021), the new statutory definition included in the Domestic Abuse Act 2021 was enacted.

Appendix C: Further information about the chair and report author

Davina James-Hanman has been an independent Violence Against Women Consultant since 2015. She was formerly the Director of AVA (Against Violence & Abuse) for 17 years (1997-2014), which she took up following five years at L.B. Islington as the first local authority Domestic Violence Co-ordinator in the UK (1992-97). From 2000-08, she had responsibility for developing and implementing the first London Domestic Violence Strategy for the Mayor of London. A key outcome of this was a reduction in domestic violence homicides of 57%.

She has worked in the field of violence against women for over three decades in a variety of capacities including advocate, campaigner, conference organiser, crisis counsellor, policy officer, project manager, refuge worker, researcher, trainer and writer. She has published innumerable articles and three book chapters and formerly acted as the Department of Health policy lead on domestic violence (2002-03). She was also a Lay Inspector for HM Crown Prosecution Service Inspectorate (2005-10).

Davina has authored a wide variety of original resources for survivors and is particularly known for pioneering work on the intersections of domestic violence and alcohol/drugs, domestic violence and mental health, child to parent violence, developing the response from faith communities and primary prevention work.

She acted as the Specialist Adviser to the Home Affairs Select Committee Inquiry into domestic violence, forced marriage and 'honour' based violence (2007-08) and Chairs the Accreditation Panel for Respect, the national body for domestic violence perpetrator programmes. From 2008-09 she was seconded to the Home Office to assist with the development of the first national Violence Against Women and Girls Strategy. Davina was also a member of the National Institute of Health & Care Excellence group which developed the domestic violence recommendations and subsequent Quality Standards. She remains an Expert Adviser to NICE.

Davina is a Special Adviser to Women in Prison and a Trustee of the Centre for Women's Justice.

Appendix D: Snapshot questions

Do you have:

A separate domestic abuse policy? Yes / No

If yes, when was this last reviewed?

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

If yes, when was this last reviewed?

Domestic abuse training for staff? Yes / No

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

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

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

Do you attend local domestic abuse partnerships? Yes / No

If yes, please specify:

Appendix E: Action Plan (see separate document)