Domestic Homicide Review
Overview Report

Review into the death of Hassan in January 2019

Review Panel Chair and Report Author:
Mark Wolski

Report Complete: August 2022

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1. INTRODUCTION

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

1.2 This report of the DHR (hereafter 'the review') examines agency responses and support given to Hassan (pseudonym), a Bristol resident who lodged with Omar (pseudonym) until his death in January 2019. Hassan was aged [redacted] at the time of his death. He was of Somali origins and came to the UK in 2014 via Holland. Omar aged [redacted] is also of Somali origin and has resided in the UK for over 20 years. This review was commissioned on the basis that Hassan was a member of the same household as Omar.

1.3 Following a call to police from Omar's cousin stating that Omar had killed someone, police attended and located Omar, forced entry to their address and found Hassan deceased, having suffered multiple stab wounds.

1.4 Omar was arrested and charged. He subsequently pleaded guilty to murder and was sentenced to life imprisonment with a minimum tariff of two years.

1.5 This Domestic Homicide Review was commissioned by Safer Bristol Partnership (now known as the Keeping Bristol Safe Partnership) to consider agencies contact/ involvement with Hassan and Omar for the 5 years prior to Hassan's death in January 2019. In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.6 The primary 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. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.7 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.

1.8 The review panel expresses its sympathy to the family, and friends of Hassan for their loss.

1.9 The panel are mindful; they have not been able to speak to any of Hassan's friends or family and are reliant on the perspective of Omar's friends and family.

1.10 The review panel also extend thanks to the family of Omar, for their contributions and support for this process.

2. TIMESCALES

2.1 The Keeping Bristol Safe Partnership (the Bristol Community Safety Partnership), commissioned this DHR in accordance with the 'Statutory Guidance for the Conduct of Domestic Homicide Reviews'. The Home Office were notified of the decision in writing on 19th March 2019.

2.2 Mark Wolski was commissioned to provide an Independent Chair (hereafter 'the chair') for this DHR in September 2019. The completed report was passed to the Community Safety Partnership in July 2022. It was submitted by the Community Safety Partnership to the Home Office Quality Assurance Panel in September 2022.

2.3 Home Office guidance states that a review should be completed within six months of the initial decision to establish one. The timeframe for this review was considerably extended for a number of reasons:

- The first panel meeting was not held until 5th September 2019 to ensure agencies could attend.
- The criminal trial was ongoing when the first panel meeting was held, and sentencing was subsequently delayed pending psychiatric reports of Omar. This delayed initial attempts to contact him.
- To enable contact with friends, colleagues and seek wider community opinion.
- The coronavirus pandemic placed considerable demands upon agencies.

2.4 One of the main delays in progressing this DHR has been the considerable delay in sentencing of Omar. The chair considered it highly desirable to speak to him, to gain an understanding of his relationship with Hassan. However, the chair did not want to provide any external influences on Omar's ongoing psychiatric assessments, and therefore risk interfering with the judicial process. The first opportunity to make contact was after sentencing on 14th August 2020, but was further delayed when Omar's solicitor informed the chair that an appeal was pending.

3. CONFIDENTIALITY

3.1 Details of confidentiality, disclosure and dissemination were discussed and were agreed between Panel Member Agencies at the first Panel Meeting.

3.2 All information discussed was agreed as strictly confidential and was not disclosed to third parties without the agreement of the responsible Agency's Representative.

3.3 All Agency Representatives agreed to be 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.

3.4 It was recommended that all members of the review panel use a secure email system and that documents be password protected.

3.5 To protect the identity of family members, the following anonymised terms and pseudonyms have been used throughout this Review. The pseudonyms were selected by the panel as being familiar with the Somali community.

3.6 Parts of this report have been redacted to protect the identity of those involved in this report.

Table 1

Pseudonym	Relationship	Age at the time of incident	Ethnicity
Hassan	Deceased - Lodger	[redacted]	Black African (Somali)
Omar	Registered tenant at the scene of homicide	[redacted]	Black African (Somali)

4. TERMS OF REFERENCE

4.1 The full Terms of Reference are included at ***Appendix A***. This review aims to identify the learning from the homicide, 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.

4.2 The review panel comprised of agencies from the Bristol area, as the victim and perpetrator were living in that area at the time of the homicide.

4.3 The timeframe for this DHR was agreed as at least 5 years prior to the death of Hassan in January 2019, except for any other relevant information relating to domestic abuse prior to this date. Where appropriate, information outside of this time period is included to provide context and also to explore noteworthy events prior to the relevant period.

4.4 Key lines of enquiry and examination within the terms of reference were set agreed as.

Term 1 – Family awareness of abuse and barriers to reporting.

4.4.1 Whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim, prior to the homicide (any disclosure, not time limited).

4.4.2 In relation to the family members, whether they were aware of any abuse and of any barriers experienced in reporting abuse? Or best practice that facilitated reporting it?

Term 2 – Interagency Communication

4.4.3 Could improvement in any of the following have led to a different outcome for Hassan considering: -

a) Communication and information sharing between services with regard to the safeguarding of adults.
b) Communication within services

c) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services

Term 3 – Standards and Policy

4.4.4 Whether the work undertaken by services in this case are consistent with each organisation's:

a) Professional standards

b) Domestic abuse policy, procedures and protocols

Term 4 – Agency Actions (Assessment, Actions, Relevance and Timeliness)

4.4.5 The response of the relevant agencies to any referrals relating to Hassan concerning domestic abuse or other significant harm from 2013. It will seek to understand what decisions were taken and what actions were or were not carried out and establish the reasons. In particular, the following areas will be explored:

a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with victim or perpetrator.

b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made.

d) The quality of any risk assessments undertaken by each agency in respect of Hassan, children or perpetrators.

Term 5 - Thresholds

4.4.6 Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

Term 6 – Cultural Sensitivity

4.4.7 Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

Term 7 – Escalation

4.4.8 Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

Term 8 – Training and Awareness issues

4.4.9 Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

5. METHODOLOGY

5.1 The decision to undertake this DHR was taken by the Independent Chair of Bristol Community Safety Partnership.

5.2 The Review has been conducted in accordance with Statutory Guidance under S9(3) Domestic Violence, Crime and Victims Act (2004) and the expectation of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016.

5.3 Criminal proceedings were ongoing at the time the review commenced, but at the time the first panel meeting had commenced, Omar had pleaded guilty, and sentencing awaited the result of psychiatric assessments.

5.4 This review has followed the statutory guidance. On notification of the homicide, agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all the organisations and agencies that had contact with Hassan and Omar during the relevant time.

5.5 A full list of agencies who were asked to examine their records and an indication of whether they had contact with either Hassan or Omar is shown at **Appendix B**.

5.6 A total of 37 agencies were contacted to check for involvement. Eleven agencies reported contact. Written contributions are outlined at Table 2. Of the agencies who had contact, but had not completed any formal report, this was owing to the historic nature of their contact.

5.7 The review panel comprised of agencies from Bristol, as the victim and perpetrator were living in that area at the time of the homicide. 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.

5.8 At the first meeting, the review panel considered the overview of the circumstances. The panel learned that this was the second DHR commissioned within the Somali community. At the chair's request, Bristol Community Safety Partnership identified a local specialist representative to assist engaging with BAME groups and communities.

5.9 The terms of reference were agreed and to be kept under review to take advantage of any, as yet, unidentified sources of information or relevant individuals or organisations.

5.10 The first panel meeting took place on 5th September 2019. Subsequent panel meetings took place on 16th January 2020, 6th November 2020, 29th July 2021,10th December 2021,17th May 2022 and 20th July 2022.

5.11 A number of delays impeded progress of this review, including the coronavirus pandemic. In addition, there was a delay in identifying a local panel representative with the reach into the local Somali community who was able to commit to panel meetings or meetings with the chair. In July 2021, the chair asked that a new representative be identified. This person successfully facilitated a round table discussion with community representatives, and contact with Hassan's family. The chair would like to acknowledge this representative's support and how vital their contribution has been in informing this review.

5.12 Notwithstanding these delays, a number of other meetings and conversations took place outside the full panel meetings. This included two meetings between the chair, police and ambulance service, and two meetings between the chair, CCG and AWP.

Documents Reviewed:

5.11 In addition to the documents reviewed at table 2, the chair has also been provided with access to the following;

- Root cause analysis report by AWP
- Police MG5 (summary of key evidence)
- A published account of the Judge's summing up
- Local "Violence Against Women and Girls" strategy documents
- Demographic information from the local Joint Strategic Needs Analysis
- Local ward profile
- South Western Ambulance Service: Mental Health and Capacity Considerations in Patients Who Present as Having Self-Harmed or Attempted Suicide (October 2020)
- Joint Strategic Needs Assessment
- Covid – Equalities Impact Assessment Form for Bristol

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

Hassan's Family

6.1 The police have been working with a cousin of Hassan throughout this investigation and had no contact with Hassan's parents and four siblings, an older brother, a younger brother and two younger sisters who according to police information live in Somalia.

6.2 The chair spoke to the family liaison officer (FLO) before sending letters and learned that the cousin had declined the offer of any support from the Homicide Support Service. The chair arranged for the police FLO to deliver his letter and the formal notification of the DHR from the Bristol Community Safety Partnership in late October 2019. The letters outlined the support available through Victim Support and Advocacy After Fatal Domestic Abuse (AAFDA) along with Home Office leaflets.

6.3 The chair followed up the letters with a number of phone calls on the 31st October 2019, then from the 4th through to the 10th November before finally speaking to the cousin. In this conversation, the cousin said that the family were trying to move on with their lives and did not want to take part in the process.

6.4 At around this time, criminal proceedings were still ongoing, and the chair maintained monthly contact with the FLO as proceedings and hearings took place. During the period November through to February it became clearer that the cousin and family were not attending court and no longer welcomed contact from the FLO. At this stage, the chair decided to give a period of time to the nominated family lead, a period to allow the review to continue and other enquiries to continue, in order to respect his decision to try and move on.

6.5 The chair sought information from the police regarding wider family in the UK and learned that there were no other family details known to them, and they did not have contact details for direct family in Somalia.

6.6 The Bristol Community Safety Partnership sought the assistance of a local community expert to assist with identifying family members and providing a community perspective. Efforts were thwarted during 2020 by the coronavirus pandemic.

6.7 In April 2020, the chair identified the funeral directors responsible for Hassan's funeral service and sought their assistance. Following a number of telephone conversations and emails (4th,6th,12th May) the funeral director's intention had been to try and identify family and community members who knew Hassan. The chair sent further emails on 20th June and 26th July. In the absence of any response, this line of enquiry was concluded.

6.8 The chair also wrote to the Somali Embassy in November 2020, seeking assistance in contacting Hassan's family. No response was received.

6.9 During the summer of 2021, the chair again phoned the cousin, who re-iterated his position. Recognising potential cultural barriers, the chair requested further support to reach out to the family. A new community specialist was identified who spoke Somali was identified and following a discussion with the chair once again reached out to the family. Whilst he declined to be involved, he was able to provide a perspective on Hassan, but again re-iterated that the family wished to move on, expressing a view that they had accepted what 'Allah' had ordained for Hassan.

Omar's family, friends and wider community

6. 10 The chair sought the assistance of the police and agencies to identify family and friends' community and was able to speak to four individuals, including a brother, cousin and friends.

Wider community

6.11 The second community specialist appointed in the summer of 2021 was able to reach out to wider community representatives from two organisations that have strong links with the local population. These were 'CaafiHealth' and the 'Somali Recourse Centre'. The community specialist hosted a meeting between the chair and these organisations in January 2022.

Perpetrator

6.12 The review process began when the criminal proceedings had not been completed and so the chair decided not to make initial contact in order not to interfere with those proceedings.

6.13 Whilst Omar pleaded guilty to manslaughter, there were considerable delays in sentencing from December and through the spring of 2020, as Omar was being assessed and receiving treatment for his mental illness and owing to the lockdown restrictions resulting from the coronavirus pandemic. Given broader delays resulting from the lockdown, the chair delayed making contact until assessments of Omar and sentencing had been completed, again in order to avoid any interference in proceedings.

6.14 Following sentencing, the chair wrote to the governor of the prison, asking for a letter to be passed to Omar. Whilst the chair did not receive a response, he arranged an initial discussion with Omar on 6th October. A video call took place and Omar asked that he speak

to his solicitor. The interview was curtailed, and the chair spoke to his solicitor who asked that the interview was delayed pending a potential appeal against sentence.

6.15 Following further communication with the solicitor, a further attempt was delayed pending an appeal. Upon notification that the appeal had been unsuccessful, the chair wrote to Omar in January 2021, asking to meet again and received no response.

7. CONTRIBUTORS TO THE REVIEW

7.1 Individual Management Reviews or Factual Reports were requested from the following agencies, all of whom were invited to form the panel.

Table 2

Agency	Nature of the contribution	Completed and submitted by
Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG) on behalf of GP practice	IMR and Chronology	Kirsten Bowes
Avon and Wiltshire Mental Health Partnership NHS Trust	IMR and Chronology	Elizabeth Bessant, Bristol Clinical Lead
Bristol City Council Housing and Landlord Services (BCC H&LS)	IMR and Chronology	Krystal Presland
Avon and Somerset Constabulary	IMR and Chronology	Iain Jamieson, Safeguarding Review Officer
South Western Ambulance Service NHS Foundation Trust (SWASFT)	Concise Investigation Report	Jon Hurt
University Hospitals Bristol and Weston NHS Foundation Trust	Chronology	Not recorded
Bristol City Council Children and Family Services	Factual Report	Elena Castenares

Independence and Quality of IMRs

7.2 The IMRs were written by authors independent of case management or delivery of the service concerned. The IMRs received enabled the panel to analyse the contact with Hassan and Omar.

7.3 On receipt of IMR's and chronologies, the chronologies were combined, and questions were sent with panel papers, for consideration at panel 2 and subsequent answering.

8. THE REVIEW PANEL MEMBERS

8.1 The review panel included the following agency representatives:

Table 3

Agency	Name	Job Title
Bristol City Council Public Health	[redacted]	Senior Public Health Specialist
Bristol City Council Public Health	[redacted]	Senior Public Health Specialist
Bristol City Council Adult Social Care	[redacted]	Head of Service, Safeguarding Adults and Specialist Teams
Foundry Risk Management	[redacted]	Chair

Foundry Risk Management	[redacted]	Co-chair
Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG) on behalf of GP practice	[redacted]	Head of Adult Safeguarding
Bristol, North Somerset and South Gloucestershire Clinical	[redacted]	Named GP Adult Safeguarding
Bristol, North Somerset and South Gloucestershire Clinical	[redacted]	Authoring for CCG
Avon and Wiltshire Mental Health Partnership NHS Trust	[redacted]	Head of Safeguarding
Bristol City Council Housing and Landlord Services (BCC H&LS)	[redacted]	Policy and Project Officer
Bristol City Council Housing and Landlord Services (BCC H&LS)	[redacted]	Interim Head of Estate Management
Bristol City Council Children and Family Services	[redacted]	Consultant Social Worker
Avon and Somerset Constabulary	[redacted]	Partnership Liaison Manager
Avon and Somerset Constabulary	[redacted]	DI
Avon and Somerset Constabulary	[redacted]	DCI Policy and Support
Avon and Somerset Constabulary	[redacted]	DCI (Senior Investigating Officer)
South Western Ambulance Service NHS Foundation Trust (SWASFT)	[redacted]	Head of Safeguarding
Bristol City Council Community Safety	[redacted]	Community Co-ordinator
Victim Support	[redacted]	Contract Account Manager

8.2 Agency representatives were of appropriate level of expertise and were independent of the case.

8.3 The review panel met a total of six times, with the first meeting on 5th September 2019 and subsequent meetings on 16th January 2020, 6th November 2020, 29th July 2021,10th December 2021 and 17th May 2022.

8.4 The chair of the review wishes to thank everyone who contributed their time, patience and cooperation to this review.

9. AUTHOR OF THE OVERVIEW REPORT

9.1 The chair of the review was Mark Wolski. Mark has completed his Home Office approved training and has attended subsequent training by Advocacy After Fatal Domestic Abuse. He completed 30 years exemplary service with the Metropolitan Police Service retiring at the rank of Superintendent. During his service he gained significant experience leading the

response to Domestic Abuse, Public Protection and Safeguarding. (See Appendix C for Statement of Independence).

10. PARALLEL REVIEWS

Criminal trial:

10.1 Criminal proceedings were ongoing when the DHR process commenced. Omar pleaded guilty to manslaughter and was subsequently sentenced on 14th August 2020 sentenced to life imprisonment with a minimum time to serve of 2 years.

10.2 Delays in sentencing were owing to psychiatric evaluations of Omar and in summing up, His Honour Judge Blair QC provides a useful insight for the purposes of this Review.

I have to sentence you for the manslaughter of Hassan, [redacted] who you had, as I understand it, given some accommodation because he had nowhere to live at the time and so he was staying at your address in [redacted] Easton as a result of your kindness to him by providing that accommodation.

You have a history of psychiatric problems which appear, certainly, to have become evident in 2008 when you were convicted of an offence contrary to Section 20 of the Offences Against the Person Act and were sentenced to 6 months' imprisonment. Ten years before that, you had served a 3-month prison sentence for another Section 20 offence.

Neither of them, obviously, have anything of the seriousness of what you now face before me but I am told that it was in 2008 that you began to take an anti-psychotic medication. That had a number of side effects which were troubling you. You took that medication, it would seem from what I have read, for something like nine or ten years and it does seem that the side effects were such that you were advised by medics to stop using that drug. That may have been sometime in the summer of 2017, it might have been in the spring of 2018. Whichever it was, certainly, it would seem that for six months or so before this killing, you had not been taking anti-psychotic medication. It would appear that you were taking some anti-depressant and something to deal with those side effects that you had previously been suffering from anti-psychotic medication.

You, it seems, were noted by the community and your family of having a deterioration in your mental health after you stopped that medication. Dr H, in her report, describes how you and your family provide consistent and unerring accounts of a deterioration, which include paranoid and grandiose delusional beliefs, auditory hallucinations, agitated and threatening behaviour and self-harm prior to your arrest and, in the days leading up to this offence, the family described an increase in threats of serious violence towards family members, including threats to kill and threats to set afire.

That was very much corroborated by a prison psychiatric nurse, who soon after your admission to prison after your arrest, made it absolutely beyond any doubt that you were clearly mentally unwell, psychotic, paranoid and really ill. It is the case, it seems, that you did see your general practitioner a week before this killing, when you were going to see the doctor for another pain that you were suffering. It seems there was a conversation of a general nature, and it does seem that you were saying that you were generally OK.

It is said on your behalf that in fact, you plainly were not and that may, indeed, have been because you did not have the insight by then as to just how unwell you were, having stopped taking the medication many months earlier. There was a gradual deterioration and the stage at which you became less aware of that, because of your psychosis, is not clear.

It cannot be overlooked that, at the police station, when interviewed for this offence, you acknowledged that you heard voices, became extremely confused and that you had stopped taking medication because you had felt well again and would go back to it when feeling unwell, and understood that it was a drug, when it had been prescribed, that should be taken consistently and acknowledged you were a fool for stopping taking it, the voices returning when you stopped the drug so you had some insight, in my view, into how things were beginning to deteriorate. What I do not know is how long it was before this incident that you really lost insight into it.

Coroner:

10.2 The Coroner following conclusion of criminal proceedings decided that further coronial proceedings were not required, and the case closed without an inquest.

11. EQUALITY AND DIVERSITY

11.1 The review panel considered 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.

11.2 At the first meeting of the review panel, it identified that the protected characteristics of sexual orientation, race and disability needed to be considered in this review.

Sexual orientation

11.3 Hassan and Omar were sharing a home as tenant and lodger, there was no information presented to the review to suggest they were intimate partners.

Race

11.4 Race and ethnic origin was considered important, as both Hassan and Omar were of Somali origin, living in a ward with a significantly higher BAME population, but also showing higher than average crime rates, the highest premature mortality rates and with high indices of deprivation.[1] A further report entitled “Community Profile, Somalis Living in Bristol’ shows a very clear focal point for the Somali population for this ward.

11.5 The panel learned that Hassan and Omar were from different areas of North Africa (16.7.3), one from British Somaliland and the other the Italian administered ‘United Nations Trust Territory of Somalia’ that merged into the Republic of Somalia. This was considered important in terms of exploring whether that may in any way explain the tragic events, but also in terms of considering why the chair found it problematic engaging with Hassan’s family, as opposed to Omar’s family.

Disability

11.6 Disability was considered as it was apparent that Omar suffered from diagnosed Mental Health illnesses. The Human Rights Act 2010 defines disability as “A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities”. [2]

11.7 The panel also considered the social and medical models of disability, which is usefully summarised by the University of Leicester; “There are a number of ‘models’ of disability which have been defined over the last few years. The two most frequently mentioned are the ‘social’ and the ‘medical’ models of disability. The medical model of disability views

[1] Source: https://www.bristol.gov.uk/documents/20182/436737/Lawrence+Hill.pdf/bec15541-2bf1-4702-9d70-c9f5d54f8bb2 (Accessed 28th December 2019)

[2] Source: https://www.equalityhumanrights.com/en/equality-act/protected-characteristics#disability (Accessed December 2019)

disability as a 'problem' that belongs to the disabled individual. It is not seen as an issue to concern anyone other than the individual affected. For example, if a wheelchair using student is unable to get into a building because of some steps, the medical model would suggest that this is because of the wheelchair, rather than the steps. The social model of disability, in contrast, would see the steps as the disabling barrier. This model draws on the idea that it is society that disables people, through designing everything to meet the needs of the majority of people who are not disabled. There is a recognition within the social model that there is a great deal that society can do to reduce, and ultimately remove, some of these disabling barriers, and that this task is the responsibility of society, rather than the disabled person."[3]

11.8 The panel agreed Omar meets the Human Rights definition and prefers the social model of definition and in so doing reflects the importance of the Equality Act and the duty on public authorities to;

- remove or reduce disadvantages suffered by people because of a protected characteristic.
- meet the needs of people with protected characteristics.
- encourage people with protected characteristics to participate in public life and other activities[4]

11.9 The panel has paid due regard to these requirements and whether intersectionality was apparent, that is the theory that various social identities contribute to systemic discrimination.[5]

12. DISSEMINATION

12.1 Once finalised by the review panel, the Executive Summary and Overview Report will be presented to the Community Safety Partnership for approval. Once agreed, they will be sent to the Home Office for quality assurance.

12.2 The recommendations will be owned by Community Safety Partnership, which will be responsible for disseminating learning through professional networks locally, as well as receiving reports on the progress of an action plan. The full list of recipients and agencies is shown below.

Table 4

Agency
DHR Panel members
KBSP DHR sub-group
KBSP Domestic Abuse and Sexual Violence Delivery Group
Keeping Bristol Safe Partnership Executive Group
Keeping Bristol Safe Partnership - Independent Chair
Bristol City Council - Chief Executive
Bristol City Council - Deputy Mayor with responsibility for Children's Services, Education and Equalities
Bristol City Council - Cabinet Member with responsibility for Public Health, Communities and Bristol One City
Bristol City Council - Cabinet Member with responsibility for Adult Social Care and Integrated Care System
Bristol City Council - Executive Director of People
Bristol City Council - Director: Children, Families and Safer Communities

[3] Source: The social and medical model of disability — University of Leicester (Accessed January 21)
[4] Source: https://www.citizensadvice.org.uk/law-and-courts/discrimination/public-sector-equality-duty/what-s-the-public-sector-equality-duty/ (Accessed December 2019)
[5] Source: https://www.dictionary.com/browse/intersectionality (Accessed January 2020)

Bristol City Council - Director of Public Health and Community Safety
Bristol City Council - Director: Housing and Landlord Services
Avon and Somerset Police - Bristol Police Commander
Avon and Somerset Police - Chief Constable
Office of the Police and Crime Commissioner for Avon and Somerset Police - Police and Crime Commissioner
Bristol, North Somerset South Gloucestershire Integrated Care Board - Director of Nursing
Bristol, North Somerset South Gloucestershire Integrated Care Board – Head of Safeguarding

13. BACKGROUND INFORMATION (THE FACTS)

13.1 Principal People

The table below summarises the key facts regarding individuals referred to in this review.

Table 5

Name in Report	Relationship to Victim	Age at time of Homicide	Ethnic Origin	Faith	Disability
Hassan	The Victim	[redacted]	Black African	Muslim	None apparent
Omar	Perpetrator	[redacted]	Black African	Muslim	Mental Health

13.2 Background Information

Contextual Information relating to the locality

13.2.1 The flat where they lived is in one of 34 wards in Bristol and the local ward profile shows a number of challenges such as;

- higher levels of deprivation than other wards
- the third highest crime rate
- highest rate of overcrowded households
- highest percentage of population belonging to a Black or Ethnic Minority group and with a higher rate of people having been born outside the UK, of which the Somali community is over three times higher than others. In addition, English is not the first language of 30% of this local population.[6]

Background Information relating to Victim

13.2.2 Hassan was [redacted] at the time of his death. He was of Somali origin and believed to be a Dutch national. Having arrived in the UK in 2014, he was a self- employed as a mini cab driver.

13.2.3 He lived with Omar, occupying one of two bedrooms in a Bristol City Council Housing and Landlord Services flat. Omar was the only registered tenant and Hassan was not registered as living at the address.

13.2.4 Hassan was only known to a local GP. There was very limited contact with other agencies.

[6] Source: Lawrence Hill statistical ward profile 2021 (bristol.gov.uk) (Accessed July 2021)

Background Information relating to Perpetrator

13.2.5 Omar was [redacted] at the time of Hassan's death. He was of Somali origin and immigration records indicate that he had been in the UK for over 20 years. He was not in employment at the time of the homicide.

13.2.6 He was the registered tenant and occupier of the flat where the Homicide took place.

13.2.7 During the relevant period he was known to the police for a small number of domestic incidents with a former partner. Prior to the relevant period in 1996 and 2008 he had been convicted for acts of violence. He was well known to his GP and specialist mental health care professionals owing to mental illness including diagnosed Post Traumatic Stress Disorder (PTSD). PTSD is a mental disorder that may develop after exposure to exceptionally threatening or horrifying events. [7]

13.3 Family Make Up

13.3.1 Hassan is one of five siblings. His two brothers, two sisters and his parents still reside in Somalia. The family are from the 'Hawiye tribe' in Somalia. Police dealt with a cousin of Hassan resident in the Bristol area as his direct family. They did not attempt to speak to his family in Somalia.

13.4 Events of the Murder

13.4.1 In January 2019, police had called at Omar's address to speak to him regarding an allegation that he had threatened another person. Having left a calling card, Omar attended the local police station, and the matter was dealt with by way of informal advice.

13.4.2 Later that day a cousin of Omar called the police and reported that Omar had knocked on the door and said that he had just murdered someone in his property. Omar was covered in blood.

13.4.2 Police were called and arrived shortly afterwards at Omar's home address. They forced entry and found Hassan lying on the floor of one of the bedrooms with a wound to his chest. Paramedics attended and could not find a pulse.

13.4.3 Within the hour, a registered doctor attended and pronounced that Hassan was dead.

13.5 Post Mortem

The post mortem determined the cause of death as multiple stab wounds, including wounds to the arm, face and wound close to the heart.

13.6 Investigation and Outcome

13.6.1 Following investigation, Omar was charged with Hassan's murder. He subsequently appeared at Bristol Crown Court. He pleaded guilty to manslaughter and underwent psychiatric assessment. Following a number of adjournments, on the 20th August 2020, he was sentenced to life imprisonment and recommended to serve a minimum of two years.

13.7 Coronial Process

13.7.1 No coronial proceedings took place following the criminal trial.

14. CHRONOLOGY

[7] Source: https://www.bmj.com/content/351/bmj.h6161 (Accessed May 2020)

The chair has sought the views of Hassan's family as described at section 6 above. Regrettably, it has not been possible to determine any great detail about him and the acknowledged the challenge this presented in terms of representing the experience and perspective of the victim in this case. Conversely, the chair has been able to speak to a number of friends and family of the perpetrator Omar.

14.1 Background History of Hassan

14.1.1 The background detail provided has been arrived at through the local knowledge of the second community representative assigned to work with the chair on this review, and from their contact with the next of kin that the police were dealing with.

14.1.2 He arrived in the UK a few years before the homicide, settling in the Bristol area owing to contacts and relatives in the area. It is understood that he worked in the UK to support his family in Somalia. He was not and never had been married.

14.1.3 Hassan is described by his cousin as being 'kind and gentle' always willing to help others. He was devoted to his family, striving to better the lives of his mother and siblings in Somalia.

14.2 Background History of Omar

14.2.1 It is understood that Omar's family are from a different tribe in Somaliland, that is in an area within the Former British Somaliland Protectorate. It is further understood that whilst Omar and Hassan were from different tribes, their tribes share some common experiences from North Africa in terms of familial experience of war and trauma.

14.2.2 In March 2020 the chair spoke to some of Omar's family and friends, asking for an overview of Omar's life.

Family/Friend member 1

He explained that Omar had arrived in the UK about 30 years ago in the 1990's and had been suffering from some form of trauma owing to the war. Upon arrival in the UK, he began to show signs of mental illness that he described as psychosis. He also said that Omar *had witnessed a cousin being killed in Cardiff that had an effect on his mental health.*

He recalls Omar spending some periods of hospital receiving treatment for his mental illness. It seems that Omar did not always take his medication and one of the reasons related to some side effects that included involuntary facial movements. For a man like Omar who was very proud, this was very difficult, and he said this was very distressing for Omar. He further described that when he didn't take his medication, Omar would begin to hear voices and also accuse him of spying on Omar.

When asked about what other help Omar had, he explained that a cousin used to go to the doctors with him and also help him. In effect acting as an advocate, carer or support worker.

The chair asked him, if Omar had attempted any traditional Somali therapies[8], but as far as he knew, Omar hadn't.

He spoke about an incident in December, where Omar had been armed with a big knife, cutting himself. He had called 999 and he says that the police had said nothing to do with them and to call an ambulance. He thinks that the ambulance service just knocked on the door and didn't see him.

[8] **Traditional** treatments of **mental illness** in **Somalia** – People with **mental illness** are treated through religious and social support (e.g., family and clan) including methods and ritualistic dancing. – Ziyara (visiting) local shrines or a living wali (a friend of God) are also used as healing. Source: CSO-M.Health Report.pdf (councilofsomaliorgs.com)

He then went on to describe what he knew of the events before the homicide and that there had been a dispute about money Omar had leant many years previously. Following an allegation, he understood that Omar went to the police station and that after a few questions he was allowed to leave.

Upon asking about Hassan, he said that Omar was a very kind man and that he had taken Hassan in. He said that Hassan was basically homeless and had lived with Omar for about a year. He says that the community had advised him to leave owing to Omar's behaviour, but Hassan had said Omar was ok with him and hence remained. He also explained that other men had been staying at the address, but they had left owing to Omar's behaviour.

On speaking further about Hassan and his family, he said that the families of both Omar and Hassan had spoken, and some elders had been involved and as far as the families were concerned, an agreement had been reached.

In summary he took the view that the police response was inadequate and that matters had been swept under the carpet

Family/Friend member 2

She had known Omar *for about 30 years, describing him as a nice, kind person who had struggled with his mental health over the years including an attempted suicide about 20 years ago.*

On enquiring about treatment, she spoke about his GP and that she had attended with him on occasion, when he was struggling with a condition that resulted in facial tics and involuntary movements of his face. He couldn't close his mouth properly and his tongue would hang out.

She explained that she had also been with him when he visited the hospital. We spoke about traditional Somali treatment, and she did not think that he had tried any such therapies

On exploring how his condition affected him, she said there was considerable stigma about mental illness in the Somali community and that no-one wanted to be known as suffering from a mental illness.

She reflected that Omar had tried very hard to manage his condition, but on occasion he had episodes of agitation. She went on to say that he sometimes threatened people in the community, and she was aware that this had sometimes been reported to the police. She said that people in the community had been saying that he could kill somebody, and that people were afraid of him. She continued that the police didn't care to look for information that was logged about him when they were dealing with him. Asked about any examples when she felt this was the case, she explained this was when he had threatened to kill someone.

She then went on to say that the issues with Omar were the tip of an iceberg of mental health problems in the Somali community and that it was her feeling that the community are not listened to, that there is no information of where to seek help. She said that 'they' the Somali community unsure how to present themselves/seek help.

The conversation of mental health and the Somali community continued and she volunteered that she felt the end result was young Somali men suffering with mental health problems and ending up in prison and that an examination of murders in Bristol involving young Somali men would demonstrate the scale of the issue.

Asked about how the police and other authorities engaged with the Somali community, it was her feeling that engagement took place in the moment of a crisis as opposed to being more planned.

Family/Friend member 3

They had known Omar *for around twenty years, coming from the same clan, he described himself as being a good friend.*

He said that Omar had serious mental health issues and didn't know how to control himself, having had problems with a previous partner and spent time in jail.

In the period immediately before the murder, he says that Omar had made threats to others. He says that he had received calls from the community about his behaviour, looking to stab someone. He himself called the police, told them where Omar lived and believes that not sufficient weight was put behind what he what he was saying.

Upon asking where Omar had got support from, he said that he knew a cousin had helped him, that he had a GP and took medication. He also explained that Omar had told him he had missed his medication and that he had said to him that he had been given the wrong medication.

On asking about Omar's home circumstances, he said that there were two or three others who had been living with Omar along with Hassan. They had moved out a few weeks previously because of Omar's behaviour and others had advised Hassan he ought to move out. He was unaware how long Hassan had lived with Omar and didn't know Hassan himself, he was new to the area, having come from the Netherlands.

Family/Friend member 4

They had known Omar *for about thirty years, and they had been good friends. Over the years they lost contact until* Omar *saw him in the street and threatened him, a matter that was reported to the police. This is his account.*

They had arrived in the UK in around 1989 and Omar *came about a year later. They met in Bristol and became good friends. He describes Omar as a good man, very hard working but who had some kind of mental illness. Sometimes he was ok, other times he was unwell. They used to hang out together and go places, but over time they went their own ways, with their own families and he said Omar had his own business.*

On recalling Omar's mental illness, they thought it was some kind of PTSD and that his personality would change. He was aware that Omar used to get assistance from the hospital and had some form of medication.

On describing the incident where Omar had threatened him, he said that he had not seen Omar for a very long time, but one evening when he was going home from work at around 10pm, Omar called him out from a café. He was very angry, almost hysterical. He threatened me and yet the last time we had spoken, we had shaken hands. He says that he was frightened and took the threats seriously and so went to the police station. He told the police about his background and described to them Omar s mental health problems. The police said they would talk to Omar. He describes 'they went to his flat, he spoke to the police. He left the police station and then he stabbed his flat mate'.

He went on to explain that the police had called him, after they had spoken to him and said that Omar had not meant to harm him and that everything would be ok. Then a few hours later he got some phone calls and learned that Omar had stabbed someone.

Upon exploring the investigation into his allegation of crime, the chair asked for further details. He explained that he had provided a statement and the police said they would talk to him. The chair explored whether they had asked him whether he had been informed what was going to happen. He replied that he had explained that Omar was unwell and that he thought Omar may harm himself or someone else. The chair enquired whether there was a

conversation about attending court and he didn't recall this, continuing that he was very frightened, and that Omar was much bigger than he was.

The chair explored what the friend knew about where Omar had sought help and he explained that he sought help from his doctor and the hospital. He did not believe that Omar had tried any traditional Somali therapies. He continued that Omar had suffered with his issues for many years, and whilst he was normally very chatty, he did on occasion become very angry. He had heard from other people that Omar was not taking his tablets.

Upon exploring the relationships between the authorities and the Somali community, they explained that he felt it was always 'too late', that there were a lot of social problems and that on the whole there are a lot of social problems and that the community mistrust the local authority and police.

14.3 Combined Narrative Chronology

14.3.1 The following section summarises contact between Hassan and Omar with agencies. In order to assist the reader, the table below summarises the names of the organisations and their role in this case. The paragraphs within the narrative chronology are pre-faced with the lead agency to identify the primary source of information and assist the reader.

Table 6

Organisation	Role	Abbreviation
Clinical Commissioning Group	Omar Primary care GP	GP1
Clinical Commissioning Group	Hassan Primary Care GP	GP2
Avon and Wiltshire Mental Health Partnership NHS Trust	Mental Health Services	AWP
Bristol City Council Housing and Landlord Services	Omar Housing Provider / Landlord	HOUSING
Avon and Somerset Constabulary	Police	POLICE
South Western Ambulance Service NHS Foundation Trust		SWASFT
University Hospitals Bristol NHS Foundation Trust	Local Hospital	HOSPITAL

Prior to Relevant Period (pre- 19th January 2014)

GP

14.3.2 In 2004, the GP chronology shows that Omar was shown on the GP's records as being on the Serious Mental Illness (SMI) register. The phrase severe mental illness (SMI) refers to people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired. [9]

14.3.3 Omar was diagnosed in 2008 with post-traumatic stress disorder. Prior to that his illness was described as both agitated depression and depressive episodes and this was managed and reviewed on a regular basis for symptom control between his GP and psychiatrist and referrals to AWP.

AWP

14.3.4 Omar has been treated by AWP for a number of years owing to mental health illness. In 1998, he was suffering from paranoia and being treated with antipsychotic medication at a

[9] Source: https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing (Accessed May 2020)

time when he was subject to court proceedings linked to a charge of attempted murder on his previous partner.

14.3.5 In 2003, he was assessed under the Mental Health Act, suffering from paranoia. This followed an incident of him allegedly chasing someone down the road with a knife. He was released the following day.

14.3.6 A year later, in 2004, he was treated following an overdose after an argument with his partner. He was discharged back into the care of his GP.

14.3.7 In October 2013, he was seen twice by the Mental Health Liaison Team, having self-inflicted cuts to his arms. He was diagnosed with reactive depression following the death of his grandmother.

Housing

14.3.8 There appears to be an extensive case history in relation to the management of rent payments.

14.3.9 The IMR reports that their BCC H&LS management system showed a credible threat warning code regarding an incident in 2008 whereby Omar was charged and served a term of imprisonment for grievous bodily harm (GBH).

14.3.10 The rent management case history for the address also shows that on 28th January 2010 Omar was hospitalised for his mental health.

Avon and Somerset Police

14.3.11 Omar was known to the police, having been convicted of GBH in 1996 and sentenced to a period of imprisonment, following an incident with a previous partner. He was also convicted of GBH in 2008 and sentenced to a period of imprisonment.

Children's Social Care

14.3.12 Children's Social Care have records in relation to Omar as being the former partner of a mother of seven children who arrived in the UK in 2001. It seems, though inconclusively that Omar may be the father of her youngest child who was aged 11 at the time of the homicide. There is no evidence of contact between Omar and any of the children.

14.3.13 In 2016, during an unrelated matter, the mother mentioned visits by the father of her younger children, but no details are shown of who this refers to.

2014

14.3.14 There was only one contact between Hassan and agencies in 2014, when he registered with his GP on 1st December 2014.

14.3.15 ***GP1:*** Omar had a number of contacts with his GP and Bristol City Council Housing and Landlord Services (BCC H&LS) during 2014.

14.3.16 ***HOUSING:*** On **27th January 2014**, Omar phoned BCC H&LS and agreed to pay a monthly amount. During further conversation that same day, a message was left for Omar advising him of a £12.35 under 'occupancy charge' and that the Department of Workplace and Pensions were making deductions for arrears. This charge relates to legislation introduced in 2013, known as the bedroom tax[10]. The practical effect of this tax being that one's eligible

[10] Source: https://www.gov.uk/government/news/housing-benefit-reform-removal-of-the-spare-room-subsidy-fact-sheet (Accessed 17th January 2020)

housing benefit or housing element of universal credit is cut by 14% for one extra bedroom and 25% for two or more extra bedrooms.

14.3.17 ***HOUSING:*** On the **6th March 2014**, BCC H&LS called Omar and left a voicemail advising him to claim discretionary housing payment (DHP). A DHP can provide extra money when a council decides that a tenant needs extra help to meet housing costs[11]. All local authorities are granted a DHP fund that allows payments to residents in the local authority area who are in financial difficulties. The aim is to provide this assistance for an interim period until the financial burden is alleviated.

14.3.18 ***HOSPITAL:*** On the **10th June 2014**, Omar was admitted to hospital owing to an accidental overdose of painkillers for a bad back that he attributed to lifting his 8-year-old daughter. It is noted there is no corresponding entry suggesting contact with any children at this time. A link on children's records shows Omar as being a former partner of a woman with a number of children, one of which may have been Omar's.

14.3.19 ***HOUSING:*** On the **18th June 2014** records show that the customer service standards form was completed with the tenant. The notes record that he was in receipt of a number of benefits that included; Income Support, Job Seekers Allowance, Employment Support Allowance (ESA), Disability Living Allowance (DLA) Tax credits and pension credits. He was advised that the next payment was due on the 1st July and that the next stage would be to secure a possession order.

14.3.20 ***GP1:*** On **21st June** he did not appear for a GP appointment.

14.3.21 ***HOUSING:*** Between June and July, there was some contact with BCC H&LS regarding routine repair works including a fire door upgrade subsequently completed in October.

14.3.22 ***HOUSING:*** On the **26th August**, Omar contacts BCC H&LS regarding a pre-court letter in respect of overdue rent. He paid £50 that day and agreed to pay £50 per fortnight. Records show he did not want to claim discretionary housing payment, though he knows he is subject to the 'bedroom tax'.

14.3.23 ***HOUSING:*** On the **6th November**, Omar phoned BCC H&LS following a text message and agreed to pay £50 the following day at a pay point. A DHP form was sent to him.

2015

14.3.24 ***HOSPITAL:*** There was only one contact with Hassan during 2015, when he attended his local hospital emergency department for an unrelated matter.

14.3.25 ***HOUSING:*** The majority of Omar's contact with agencies was with BCC H&LS regarding his tenancy/rent situation and also regarding a cousin moving in to care for him as described below. There was one contact with his GP.

14.3.26 ***GP1:*** On the **27th May**, Omar saw his GP and discussed exercises and walking regarding back pain. There was no further contact with his GP in 2015.

14.3.27 ***HOUSING:*** On the **1st June 2015**, Omar attended BCC H&LS offices regarding his tenancy with his cousin. In conversation he mentioned his cousin had moved in with him on the 1st May to care for him. A change of circumstances was completed and his cousin was given a self-employment questionnaire to complete.

[11] Source: https://www.gov.uk/government/publications/claiming-discretionary-housing-payments/claiming-discretionary-housing-payments (Accessed 17th January 2020)

14.3.28 ***HOUSING:*** On the **8th June** BCC H&LS received a letter from Omar asking that his cousin deal with his tenancy issues. This did not mean that the cousin held tenancy responsibility, rather gave permission for BCC H&LS to speak to him regarding tenancy sustainment.

14.3.29 ***HOUSING:*** On the **7th July** BCC H&LS attempted to call Omar twice and a letter was also sent requesting urgent contact in respect of his rent. Housing benefit was suspended as his cousin had moved in and a revised housing benefit calculation was needed. Consideration was given to serving a notice of seeking possession at this time. This was followed up on the 20th July with another unanswered phone call to Omar. Another voicemail was left requesting payment for a non-dependent who is a self-employed taxi driver.

14.3.30 ***HOUSING:*** There were no further attempts at personal contact with Omar in 2015, though on the 5th August it is recorded that BCC H&LS are considering court action.

2016

14.3.31 There were no agency contacts with Hassan during 2016 and all Omar's contacts were with BCC H&LS or his GP. The BCC H&LS records may be broken down into two parts, those related to maintenance and those related to his tenancy and rent.

14.3.32 ***GP1:*** In early 2016, between the 12th February and the 4th March, Omar saw his GP in relation to feeling unwell [redacted] Blood tests were taken and there was no further contact regarding these concerns.

14.3.33 ***HOUSING:*** On the **4th August**, a housing officer contacted Omar in respect of a payment plan for his rent. An affordable plan was agreed against a background of a Notice of Seeking Possession that was due to expire on the 24th August. It was noted that he suffered from depression, but that he had the support from his cousin.

14.3.34 ***HOUSING:*** Further contact was made on the **15th November** regarding his rent. He explained that he was unable to pay as his disability living allowance had stopped. It was noted that he sounded a "little confused". He was phoned back and a customer contact services standard form was completed. The notes record him as suffering from depression. This was not elaborated on.

14.3.35 ***HOSPITAL:*** Later that year, local hospital records show that around the 2nd December, Omar was admitted to a local hospital for pneumonia. After treatment, he was discharged a few days later. It was noted that he lived at home with his cousin and that he had visited Somalia in 2015.

14.3.36 ***HOUSING:*** On the **14th December** a female friend phoned BCC H&LS trying to speak on behalf of Omar. The notes reference the call handlers concern about Omar's health, suggesting that the friend phone for an ambulance or the NHS. The friend also said that Omar did not always allow her access to the flat and perhaps he needed a tenancy support officer. This does not appear to have been followed up.

2017

14.3.37 During 2017, there was no agency contact with Hassan and Omar's contact was with BCC H&LS and his GP.

14.3.38 ***HOUSING:*** Between the **4th and 24th January** there are three entries on BCC H&LS systems, all of which relate to his tenancy and rent arrears. On the 12th January a housing officer phoned and left a voicemail for Omar to contact them. This was followed up with a text message and it wasn't until the 24th January that he phoned and completed a customer contact services standard form. This showed that his cousin was resident and that Omar

was in receipt of Employment Support Allowance (ESA) and Disability Living Allowance (DLA). A payment plan was agreed on the understanding that if the plan was not kept to, BCC H&LS would proceed to County Court and seek possession.

14.3.39 ***HOUSING:*** On **20th March**, Bristol City Council Internal Audit Team gained a court order against Omar based on evidence of alleged non occupation of [redacted] and suspected sub-letting. This order did not appear on the BCC H&LS system until it expired in 2018. The agreement made in court was that in the period up to 16/3/18 the defendant, Omar, would provide the claimant, Bristol City Council, every 3 months, documents showing his continued physical occupation of his flat.

14.3.40 ***HOUSING:*** From the **28th March** roughly until the end of the year, there is one text message to Omar reminding him to make payment and then a number of entries of payments being made, on 18th April, 27th May, 2nd July, 21st September and 20th November.

14.3.41 ***GP1:*** On **21st April**, Omar saw his GP [redacted]

14.3.42 ***GP1:*** On the **8th May**, he attended a Post-Traumatic Stress Disorder review. Omar explained he was appealing benefits claim and also asked for a sick note. He attended a further PTSD review on the 2nd June.

14.3.43 ***GP1:*** On the **24th July**, he attended the surgery with his sister and disclosed that he had been drinking heavily every evening with former soldiers. There was a discussion about him stopping taking a drug olanzapine that he had been taking for 14 years. The risks to his health of abrupt withdrawal were discussed.

14.3.44 ***GP1:*** On the **27th July**, Omar was referred to Recovery Orientated Alcohol and Drugs Service (ROADS) and it has subsequently been learned he did not take up this referral, there being no trace on their systems.

14.3.45 ***GP1:*** On the **31st July**, a review was undertaken of Omar's tardive dyskinesia as it was noted his mental health was deteriorating. tardive dyskinesia is a condition where your face and/or body make sudden, jerky or slow twisting movements which you can't control. It can develop as a side effect of medication, most commonly antipsychotic drugs.[12] It was agreed that the GP would discuss the case with another doctor and the GP would revert back to Omar.

14.3.46 ***GP1:*** Following a practice meeting on the **23rd August**, Omar again attended his GP with his sister when the decision to stop his medication was taken to alleviate the symptoms of tardive dyskinesia, with a view to reviewing the patient at the health centre and discuss psychiatry.

14.3.47 ***GP1:*** On the **31st August** he attended the GP [redacted]

14.3.48 ***GP1:*** Omar is not seen until the **22nd September**, [redacted] He declines any offers of support.

14.3.49 ***GP1:*** On the **5th October**, Omar attends his GP for a PTSD review.

2018

[12] Source: https://www.mind.org.uk/media/23932654/tardive-dyskinesia-2018.pdf (Accessed 19th January 2020)

14.3.50 In 2018, Omar had more frequent contact with agencies, including treatment with mental health specialists and the police. There continued to be unremarkable contacts with BCC H&LS including contact and repairs for household maintenance issues and notes regarding rent payments and his GP in respect of routine medical health concerns.

14.3.51 Hassan also had a number of contacts with his GP and one with the police and hospital regarding a road traffic collision that is unrelated to this review.

14.3.52 ***POLICE:*** On the **5th January**, Omar's ex-partner called police and made an allegation of assault, allegedly causing a bleeding nose. On the arrival of police, she appeared intoxicated and both said they were not in a relationship and the victim was dropped off at another address. A domestic abuse stalking and harassment risk identification checklist (DASH-RIC or DASH) was not completed.

14.3.53 ***HOUSING:*** During January through to March, there were five entries on records regarding Omar, two related to rental payments and five related to routine home maintenance issues.

14.3.54 ***GP1:*** On the **10th January** Omar attends the GP for a further post-traumatic stress review and over the following two days other routine medical testing.

14.3.55 ***GP2:*** In March, the first recorded contacts with Hassan are recorded, with the first appointment on the **6th March**, blood tests a week later. Hassan was diagnosed with Hepatitis B and a series of entries on his records document treatment and notification to Public Health England. As a result, it was recommended that household members ought to be vaccinated against Hepatitis.

14.3.56 ***GP2:*** In relation to this, on the **15th March**, he was referred via a social prescribing route to "Wellspring Healthy Living Centre" a local charity that 'exists to address the health inequalities experienced by residents'[13] in the immediate locality. The GP practice noted on 25th April that Hassan did not engage with this service.

14.3.57 ***GP2:*** In April, Hassan was referred to hepatology services and the medical records in May show that he failed to attend a follow up GP appointment as well as his hepatology appointment., not seeing his GP again until December.

14.3.58 ***GP1:*** During April and May there are a number of entries in respect of a condition Omar had been diagnosed with tardive dyskinesia. On the **23rd April** he attended with a carer and there was a discussion around his medication and it was agreed that a referral would be made in respect of his condition. In mid-May Avon and Wiltshire Mental Health Partnership Trust (AWP) receive a referral for PTSD regarding historical war experiences [redacted] and ongoing issues with tardive dyskinesia. This resulted in a face-to-face assessment until June.

14.3.59 ***AWP:*** On **10th May** Omar's GP made a referral via Bristol Mental Health Single Point of Entry for assessment of historical war related PTSD, [redacted] and continuing problems with tardive dyskinesia.

14.3.60 ***POLICE:*** On the **29th May** Before his appointment with AWP, Omar reported a domestic incident to the police. There had been a verbal argument between Omar and his ex-partner. She was intoxicated and wanted her belongings and he wanted her to leave his address. Omar was happy to hand over the property and she then left the address. A DASH was not completed in respect of this incident.

14.3.61 ***AWP:*** On the **7th June**, Omar attended an appointment at AWP with a friend that resulted in a number of actions. These included referring Omar to Nilaari for culturally sensitive talking therapy, writing a letter of support in respect of Personal Independence Payments and

[13] Source: Source: Wellspring Healthy Living Centre - Health and Wellbeing Services in Bristol - About us - (wellspringhlc.org.uk) (Accessed May 2021)

providing contact details for Bristol Crisis Line and Sanctuary. In addition, it was concluded that Omar's symptoms were not consistent with tardive dyskinesia and that physical investigations ought to take place regarding the symptoms. It was further recommended that there ought to be a change of medication (anti-depressant) to Mirtazapine. There are a number of 'log entries' regarding correspondence between medical professionals (AWP and GP Practice), but Omar was not seen again until the 3rd January 2019. Omar did fail to attend an appointment on the 20th July. Omar failed to attend appointments with Nilaari on 28th June and 1st August. They left a voicemail for him on 30th August and on a further attempt to contact him on 5th September, the number did not connect.

14.3.62 ***POLICE:*** On the **7th September** police were called to a domestic incident, with a report of Omar's former partner turning up unannounced and intoxicated. She had left by the time police arrived, but nevertheless, police conducted a search of his flat to make sure she wasn't there. Police offered to complete a DASH, but Omar declined not wanting to waste police time.

14.3.63 ***GP2:*** On the **5th December**, Hassan was seen by the GP regarding chronic viral hepatitis.

14.3.64 ***POLICE:*** On the **12th December** just before midnight a number of calls were logged the ambulance service and the police, as well as calls between the agencies.

14.3.65 ***SWASFT:*** At just before midnight, a person claiming to be a distant relative called the ambulance service saying that people in the community had rung him to say that Omar had been out in the street showing signs of psychosis an hour earlier and had self-harmed his hand. Ambulance control called the police who said they were not attending, but advised that they had a number of calls regarding Omar and were able to provide the ambulance service some mobile phone numbers for potential contacts for friends of Omar. They spoke to a friend and the original informant, despatching an ambulance that arrived at around 6:45am on the 13th December. The crew spoke to Omar over the flat intercom system and he insisted that he was fine and did not require their help. They recorded that he sounded coherent and did not seem in distress. The crew stood down and the incident was closed.

14.3.66 ***POLICE:*** The ambulance service had phoned the police to report a concern for the welfare of a 45-year-old male (later identified as Omar), who an hour ago was in the street and had self-harmed his hand. The caller to the ambulance was a distant relative and said he thought Omar had psychosis. The caller advised the ambulance service that he thought Omar was now at home and the caller was concerned that Omar could be self-harming. The ambulance service were not yet on scene at the time of the call but were due to attend Omar's address and wanted to inform police as they were unsure what might happen when they arrived. They also wanted to inform the police about Omar's recent behaviour an hour previously, namely that Omar was self-harming, being aggressive towards people and showing signs of psychosis.

14.3.67 The police call handler advised ambulance staff to recall police when they were at the address should they require police assistance as everything else happened in the past and the male was now at home. No police resources were assigned to the incident and no further record was made on Niche.[14] The call handler has recorded that this incident was a purely medical issue and there was nothing to indicate that Omar was not going to engage with the ambulance crew.

14.3.68 ***POLICE:*** Another caller "Person 1" contacted police saying he had received phone calls from other people approximately 20 minutes ago to say that his friend (later identified as Omar) was in the street and he had mental health issues, was being aggressive and was cutting his hand with a knife. "Person 1" believed that Omar was now at his home address with the knife and had concerns that Omar would either harm himself or someone else. He

[14] Niche is a modern, full-featured police records management system.

said he hadn't spoken to Omar himself and he was not sure if Omar had forgotten his medication. He advised that Omar lived alone.

14.3.69 "Person 1" also said that earlier that morning on 12th December, Omar had a knife with him and he had gone to a café and the café had closed because they were all scared of him. He claimed that Omar was now harming himself but there were no details of how or when.

14.3.70 "Person 1" passed on Omar's phone number to the call handler. He asked if the police could find Omar and take him away because he was going to be a danger to himself or the public. "Person 1" wanted to be contacted again regarding progress as he wanted to update his family and he said he was Omar's next of kin. The call handler advised that he would make a request for "Person 1" to be contacted. The call handler also said he would pass the matter on to colleagues to establish what was happening. The call handler passed the callers details to the ambulance service and the call log was closed as 'Mental health, other agency dealing'. No officers were sent to the scene and no further record was made on Niche.

14.3.71 It is worth noting that "Person 1" had a strong accent and it was a poor phone line which made communication difficult.

14.3.72 ***POLICE:*** A request for details of "Person 1" previous call was made by the ambulance service. The previous call and relevant phones numbers were given to the ambulance service and the location of Omar was read out to the caller. The police call handler advised the ambulance service that police were waiting for a call from them before attending and records were updated to reflect this.

14.3.73 ***SWASFT:*** On the following day, **14th December**, the ambulance service was called by Omar's partner who had found him at home and thought he was unconscious and not breathing. Upon arrival, they found Omar asleep in bed. He was annoyed that his partner had called the ambulance service. The ambulance technician assessed that he was alert and well orientated with a normal level of consciousness. He declined a full check over and signed a disclaimer to this effect.

2019

14.3.74 In 2019, there was no agency contact with Hassan until the homicide. However, there was renewed contact between Omar with his GP, the first since September 2018 and a police investigation into an allegation of crime where Omar was the suspect.

14.3.75 ***GP1:*** On the **3rd January** Omar attended his GP [redacted] A PTSD review was carried out and no further treatment was required.

14.3.76 ***POLICE:*** On the **8th January** an associate of Omar "Person 2" attended a local police station in person. He made an allegation that Omar had called him out from a local café and threatened to kill him over a £300 debt. He explained he could not remember ever borrowing money from Omar and he did not know what this was in relation to. As there was a criminal offence of harassment/threats a Niche record was created. The allegation was supervised and owing to there being an incorrect phone number recorded for "Person 2" it was decided that the incident required police attendance at his address.

14.3.77 On the **10th January** an officer attended the address given by "Person 2". It was discovered that he did not reside at the address but his family did. They informed the officer that he had no fixed abode and gave a mobile number for him. Later that day "Person 2" attended the police station and repeated the initial allegation and told the officer that Omar had mental health issues, believing this incident happened due his mental illness. He stated that Omar had been violent when he was younger and that whilst he was scared of him and unpredictable due to his mental health issues, he did not believe that Omar would kill him.

14.3.78 The officer explained it would be unlikely to end up with a positive outcome, with Omar facing charges. It was agreed that the officer would speak to Omar informally regarding the incident in order to resolve the matter. The officer attended Omar's address and left a calling card asking Omar to contact him.

14.3.79 Later Omar attended the station and explained he believed that "Person 2" had been lent money by him years ago and any threats were made in the heat of the moment. He was now willing to leave the matter. Omar appeared very calm and eloquent to the officer and gave the impression that the threats were not intended to be carried out.

14.3.80 The officer informed Omar that "Person 2" did not want to get Omar into trouble and that he had declined the option of Omar being formally interviewed. The officer advised Omar that if he was owed money, he should seek legal advice and not make threats. The matter was closed with no further action. "Person 2" was updated.

14.3.81 ***POLICE:*** Later in the afternoon, that same day, police received a call from a family member saying that Omar had come round to his address and claimed that he had murdered someone.

14.3.82 Officers attended Omar's address and forced entry where they found Hassan's body lying on the floor, with a wound to his chest.

14.3.83 Paramedics were on scene at the same time and could not find a pulse. Shortly afterwards, Hassan was declared dead by a doctor.

14.3.84 Within fifteen minutes of the original call, police were stopped in the street nearby by Omar, who declared that he had murdered someone. Omar was wearing blood-stained clothing and was arrested.

14.3.85 Omar was interviewed three times during the course of his detention before charge in the presence of a solicitor and appropriate adult. During his interview he says that he could not remember having said that he had murdered someone. He says he didn't remember wearing blood-stained clothing or how he had sustained an injury. During the interview he acknowledged suffering from PTSD and taking medication. He also says that he had stopped taking his medication a few weeks earlier and that when he doesn't take his medication, he hears voices.

15. OVERVIEW

15.1 Summary of Information from Family, Friends and Other Informal Network

Family and Friends of Hassan

15.1.1 Regretfully very little is known about Hassan or his family. His immediate family are resident in Somalia and a local cousin with whom the police engaged has not engaged in the DHR process.

Family and Friends of Omar

15.1.2 The chair was able to speak to a number of family and friends, who describe Omar as a proud man, who found difficulty in managing his mental illness. He was known to have PTSD and other issues and to have regularly attended his GP and taken medication for his condition.

15.1.3 At times, he became agitated and it is believed this occurred when he didn't take his medication.

15.1.4 Family have expressed dissatisfaction with emergency service responses to two incidents. The first relating to information that Omar had been armed with a knife and self- harming in the street. The second response to an investigation of a threats to kill allegation, when it is said the police were made aware of Omar's problems.

15.1.5 They have further expressed broader concerns as to mental illness in the Somali community and the response of the 'system' to these issues.

15.2 Summary of Information from Perpetrator

15.2.1 The chair arranged a virtual meeting with Omar from prison and briefly met with him in the Autumn of 2020. He said that he wanted to speak to his solicitor first. The chair contacted his solicitor, and it was agreed that a meeting should wait until an appeal had been heard. Following the failed appeal, the chair spoke to the solicitor again, and he advised that he would be content for the chair to meet Omar. By this time, he had moved prisons. The chair wrote to the prison governor in August 2020 and twice to Omar in 2021, seeking a meeting. There was no response.

15.3 Summary of Information known to the Agencies/Professionals Involved

Overview

15.3.1 The following section summarises contact between Hassan and Omar with agencies. Omar had frequent contact with his GP, mental health services and his housing provider, and less frequent contact with the police, hospital and ambulance service. Conversely, Hassan had infrequent contact with any agency. The panel acknowledged the challenge this presented in terms of representing the experience and perspective of the victim and/or perpetrator.

Hassan

15.3.2 Hassan only had limited contact with statutory services, having arrived in the UK in 2014.

Health Agencies

15.3.3 In relation to health, there was limited contact with his GP from the point of registration in 2014 until 2018. Appointments appear to be routine in nature, with reference to the management of a blood Hepatitis and on the 21st March 2018 referral to the Social Prescribing Service at Wellspring Healthy Living Centre, that he did not attend. There were also two contacts with the local hospital, neither of which are relevant to this review.

Police

15.3.4 Police only had one contact with Hassan that related to an unrelated road traffic collision in 2018.

Omar

15.3.5 Omar has had a number of contacts with statutory agencies since arriving in the UK in the late 1980's.

Health Agencies (GP and Avon & Wiltshire Mental Health Partnership Trust)

15.3.6 In relation to his health, he suffered from a number of challenges with his mental health. He was diagnosed with post-traumatic stress disorder and prior to that period his illness had been described as agitated depression and depressive episodes.[15] His illness was managed

[15] Agitated depression is a type of depression that involves symptoms like restlessness and anger. People who experience this type of depression usually don't feel lethargic or slowed-down. Agitated depression used to be called "melancholia agitata." It's now known as "mixed mania" or "mixed features." And it can be seen in people with bipolar disorder. But psychomotor agitation can also be seen in major depressive disorder. Source: https://www.healthline.com/health/agitated-depression (Accessed June 2020)

between his general practitioner and specialist mental health practitioners of Avon and Wiltshire Mental Health Partnership Trust (AWP).

15.3.7 Prior to the relevant period, Omar had periodic contact with AWP that had included an admission for two weeks in 1998 following a psychotic episode and further mental health assessments in 2003 and 2004, following episodes of apparent paranoia. A period of stability followed until 2013, when he was diagnosed with reactive depression following the death of his grandmother.

15.3.8 In 2018, he was referred by his GP to AWP in respect of his PTSD and ongoing management of tardive dyskinesia. He was discharged and did not follow up a referral to culturally sensitive talking therapies.

Housing

15.3.9 Omar had lived in his council flat since November 1999. There is a lengthy case management record on Bristol City Council Housing and Landlord Services (BCC H&LS) records dealing with rent management. BCC H&LS records show that there was 'credible threat' marker on their system owing to a previous conviction for a violent offence. Their records also note that in 2010 he spent some time in hospital owing to his mental illness. In the summer of 2015, he gave permission for BCC H&LS to speak to his cousin to help maintain the tenancy. In March 2017 a court order was obtained seeking possession owing to concerns regarding sub-letting. This was not acted upon and the case was closed in March 2018.

Police

15.3.10 Omar has a history of violence that has been associated with his mental health. Prior to the relevant period this included a conviction for grievous bodily harm in 1996 for driving his car into his estranged wife.

15.3.11 During the relevant period 2014 to 2019 he had contact with the police on five occasions as summarised below;

- Three involved Omar having disputes with a female he had a relationship with between January and September 2018.
- One related to Omar suffering a mental health issue and being in possession of a knife in December 2018.
- One in January 2019 involved Omar being in dispute with a male he claimed owed him money and was threatening towards him.

South Western Ambulance Service NHS Foundation Trust (SWASFT)

15.3.12 The ambulance service had two relevant contacts with Omar during the relevant period. The first, just before midnight on the 12th December 2018 related to Omar reportedly self-harming. The ambulance service attended early the next day, following a number of conversations with the informant and police service. Omar was spoken to via intercom, and the ambulance service did not examine him.

15.3.13 The following day, the ambulance service attended after his apparent partner reported him as unconscious. He was annoyed at them being called, did not want to be examined and signed a disclaimer to that effect.

Children's Social Care

15.3.14 The contacts Children's Social Care (CSC) have, related to Omar being a possible father to one of seven siblings in a family. Records indicate that he left the family around 2008 and contacted CSC in 2010 to make an allegation of neglect that was unsubstantiated. There is

no definitive contact recorded thereafter. There are notes of an episode in 2004 that alludes to mental illness, but nothing of note during the relevant period.

16. ANALYSIS

The analysis of this Domestic Homicide Review explores the reasons why events occurred, how and whether information was shared and, subsequently, whether the sharing informed decisions and actions taken

16.1 Domestic Abuse/Violence

16.1.1 This review relies upon the definitions of domestic abuse at the time of the incident and commissioning of this review.

The Government definition of domestic 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 the following types of abuse: psychological, physical, sexual, financial, emotional.

Controlling behaviour is defined as: - 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 defined as: - 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.

16.1.2 Hassan died as a result of a single, fatal act of violence perpetrated by Omar.

16.1.3 Regrettably, it has not been possible to build a picture from Hassan's perspective of the surrounding circumstances. The panel have been entirely reliant on information made available from the police investigation, the IMR's and contact with agencies and the accounts of Omar's friends and family.

16.1.4 Considering an article, "Murder and society: why commit murder?"[16] it is suggested that murder may be condensed into the four motives of, lust, love, loathing or loot. However, there is no clear indication as to motive that are described within the trial judge's summary, nor from agency or family contact that enables this homicide to be categorised within these criteria. On considering lust, there is nothing to suggest that the murder was committed for sexual pay off or to kill a rival. There is nothing to suggest a mercy killing, nor is their evidence to suggest financial gain or loot. The remaining possibility would be that Omar loathed Hassan. Again, there is nothing obvious to suggest this as a motivation.

16.1.5 The panel learned that Hassan and Omar were from different tribes, from Somalia and Somaliland respectively. However, it seemed to Omar's family that rather than difference, shared experience may explain why Omar took Hassan in as a lodger, recognising that he was unable or didn't know how to access housing. In this context shared experience referring to familial or personal experience of the trauma of war and displacement.

16.1.6 Exploring the relationship further, there is no information available that indicates that the relationship between Omar and Hassan was more personal than an occupier/flatmate relationship. This is supported by the accounts of friends and family of Omar who suggested that there were other guests staying at the flat, who had moved out owing to Omar's

[16] Source: 09627250608553401.pdf (crimeandjustice.org.uk) (Accessed July 2021)

behaviour deteriorating. Apparently, the community had advised Hassan to leave, but he had said that Omar was 'ok with him'.

Pattern of Abuse

16.1.7 There is also no evidence that suggests that Hassan was the victim of a wider pattern of domestic violence and abuse perpetrated by Omar whilst he lived with him or whether there was a pattern of behaviour toward Hassan that was escalating before the fatal attack. This conclusion is based on the information gathered by Avon and Somerset Police as part of the murder investigation, as well as provided by agencies, friends and family.

16.1.8 In the absence of evidence as to a pattern of domestic abuse, the review panel considered whether there were other ways of understanding the circumstances of this case.

Homicide Timeline

16.1.9 The panel considered whether Omar had previously had thoughts about homicide in other words some form of homicidal ideation, whether there was a journey to homicide through a timeline, and/or whether the act of murder was a compulsive act, triggered by circumstances or an event. Tragically, without further information that reflects Hassan's perspective this is impossible to determine.

16.1.10 Recent research[17] into domestic homicide has suggested the relevance of homicide triggers. When considered together with a person's psychological state and the presence of acknowledged high risk factors, these triggers may indicate homicide is a real threat. These triggers include; failing mental health; and losing control of the victim. Once again analysis is thwarted without the perspective of Hassan.

Mental Health

16.1.11 One apparent explanation was the extent to which Omar's mental health may account for the homicide. It is clear that Omar had suffered from mental illness for some years and that during the relevant period he had routinely undergone PTSD reviews and had sought help in relation to medication whose side effects included involuntary facial movements. It is also a matter of fact that concerns had been raised by others regarding Omar's mental health in December 2018 and January 2019 that must be considered.

16.1.12 All Omar's friends and family that the chair spoke to were aware of his mental illness. They spoke about Omar's difficulties managing his condition, saying sometimes he was OK, but there were also episodes of agitation. One of the apparent themes was Omar not taking or missing his medication that would have an adverse effect on his wellbeing. They also referenced him suffering from tardive dyskinesia, that is an involuntary movement of various facial muscles, that was a particularly distressing condition for a proud man such as Omar.

16.1.13 In the police interview, Omar answered questions in relation to his mental illness and spoke about hearing voices that were telling him to kill in the weeks and days prior to the homicide. The prevalence of psychosis associated with homicide has been subject of a number of studies and in a review of all Domestic Homicides between 1997 and 2008, 'Mental Illness and Domestic Homicide: A Population-Based Descriptive Study' it was found that; a significant minority of domestic homicide perpetrators had symptoms of mental illness at the time of the homicide, with adult family homicide more likely to be associated with psychosis.[18]

16.1.14 Omar's mental health was certainly a factor in the criminal trial. The sentencing was delayed to allow for psychiatric reports to be completed and Omar was convicted for manslaughter as opposed to murder on the grounds of diminished responsibility. This is summarised in the

[17] Source: http://eprints.glos.ac.uk/4553/1/NSAW%20Report%2004.17%20-%20finalsmall.pdf (Accessed June 2020)
[18] Source: https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201200484 (Accessed June 2020)

judge's summing up in paragraph 10.2. The extent to which Omar's mental illness explain the tragic events has been a key factor considered in the review.

16.1.15 The links between homicide and mental health has also been subject to recent media interest, with a news article published in August 2020 stating, 'There were 111 homicides committed by people receiving mental health services in the year to 19 March and a new report by NHS England warns the lack of joined-up services, poor communication and poor access to crisis care for seriously ill people were all factors in the killings. It comes as research shows the proportion of homicides committed by mental health patients, while extremely rare, is rising as a share of overall killings. Up to March 2019 homicides committed by a person with mental health problems made up a sixth of the 671 total that year'.[19]

16.1.16 The chair has attempted to find further material to consider the links between patients living with mental illness committing homicide and the following were noted.

a) The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (July 2013), reported "During 2001-2011, 615 people convicted of homicide (10% of the total sample) were identified as patients, i.e., the person had been in contact with mental health services in the 12 months prior to the offence, an average of 56 homicides per year"[20]

b) In an article "People with severe mental illness as the perpetrators and victims of violence: time for a new public health approach"[21] reported a number of findings including; - 5.3% of all violent incidents in England & Wales in 2015–16 were committed by people with severe mental illness, which represents a considerable concern in terms of public safety, but relatively speaking, represents only a small proportion of the total number of violent acts committed in the whole population; - Regarding homicides in particular, which are often portrayed as the greatest concern in the media, those committed by people with psychosis are extremely rare; - people with triple morbidity (i.e., individuals with severe mental illness and substance use disorder and antisocial personality disorder) are substantially more likely to be violent than people with severe mental illness alone

c) In the Home Office Publication, "Domestic Homicide Reviews Key Findings from Analysis of Domestic Homicide Reviews" it found that in the case of interfamilial domestic homicide, mental health issues were factors in all seven cases and that mental health issues were present in 25 of the 33 intimate partner homicides.

16.1.17 Whilst these articles all report the prevalence of mental illness associated with serious harm, the author was unable to find information regarding people living with mental illness, who have previously shown the capability to harm someone seriously and go on to commit homicide. This is pertinent in this case, as pointed out by the judge when summing up. The panel considered the merits of recommending the Home Office commission research into this subject and concluded that such a recommendation would be impractical for a local partnership to progress. However, the panel acknowledge and welcome plans for a repository of domestic homicide reviews that will enable chairs and panels to research findings for statutory domestic homicide reviews.

(LO1) Learning Opportunity/Consideration; Accessing information/research into whether patients living with mental illness, who have previously shown capability of causing serious harm and go on to commit homicide.

[19] Source: https://www.independent.co.uk/news/health/homicide-mental-health-services-nhs-england-a9655281.html (Accessed October 2020)

[20] Source: *display.aspx (manchester.ac.uk) (Accessed May 2021)

[21] Source: People with severe mental illness as the perpetrators and victims of violence: time for a new public health approach - The Lancet Public Health (Accessed May 2021)

Response: Overview report shared with Home Office and the planned repository of reviews will prove helpful in informing future reviews.

16.2 GP/CCG perspective

16.2.1 The same GP practice served both Hassan and Omar. Whilst the most recent CQC Inspection of the practice conducted in July 2019[22], reports 'requires improvement', an examination of the inspection data tables did not raise matters requiring exploration when seen against dealings with Hassan and Omar.

16.2.2 With regard to the GP surgery's approach to domestic abuse, it was noted that its website advises clients to phone the police, the National Domestic Abuse helpline and makes a positive offer for patients to make an appointment to see their GP.

16.2.3 The practice is located in an inner-city area of Bristol serving a diverse population. It's website has links to a breadth of foreign languages including Somali and Arabic, indicating an awareness and adjustment to local need.

16.2.4 The practice is an Identification and Referral to Improve Safety (IRIS) practice and the practice staff are trained to recognise and support patients who are victims of domestic violence.[23] IRIS is a specialist domestic violence and abuse training, support and referral programme for GPs that has been positively evaluated in a randomised controlled trial and is recognised as best practice.

Hassan

16.2.5 Hassan had very limited contact with the surgery, attending in relation to unrelated health matters. There were no attendances that would have prompted questions in respect of domestic abuse, such as attendance regarding an unexplained injury.

Omar

16.2.6 Having first registered at the GP practice in 2002, Omar had an extensive medical history suffering from mental illness and diagnosed post-traumatic stress disorder (PTSD). He was on the GP practice serious mental illness register. This is a register of 'people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired.'[24]

16.2.7 Omar attended his GP around fourteen times during the relevant period, with three further entries when he did not attend. Attendance through the relevant period were unremarkable save for; incidents early in 2014 regarding him taking a deliberate and then accidental overdose; [redacted] and also in 2017 when he attended on a number of occasions regarding the side effects of medication and linked consultations in 2018. It was noted that between 20th July 2018 and the 3rd January 2019 there were no records of any GP visits or involvement.

<u>Deliberate Overdose</u>

[22] Source: https://www.cqc.org.uk/location/1-558155440 (Accessed June 2020)
[23] Source: https://irisi.org/iris/about-the-iris-programme/ (Accessed June 2020)
[24] Source: Severe mental illness (SMI) and physical health inequalities: briefing - GOV.UK (www.gov.uk) (Accessed January 2021)

16.2.8 There are two entries in 2014 regarding a deliberate overdose and an accidental overdose. These are not subject to commentary within the IMR and were explored outside the panel.

16.2.9 The first overdose was subject to assessment by the liaison psychiatry service in the Accident and Emergency department at University Hospitals Bristol and Weston NHS Foundation Trust and it was deemed there was no need for changes to his medication as it was felt that the crisis trigger had passed and no further action was required. The second overdose occurred 5 months later and related to the use of paracetamol for pain relief, when he was reminded about the risks of using paracetamol. In any event, he was not seen by the practice for around 11 months.

PTSD

16.2.10 Numerous entries during the relevant period relate to PTSD reviews. The chair learned these reviews are in essence follow-ups to a previous diagnosis, i.e. The diagnosis of PTSD has already been made, and in Omar's case this diagnosis was made in 2008. They were not in-depth clinical reviews, rather referring to the production of an ongoing fit note for a chronic condition. The outcome of these entries on multiple occasions being the production of a statement, a 'fit note' enabling someone to claim benefits and be off work. *The conclusion of which is that Omar was not employed for many years.*

16.2.11 On considering whether more in-depth PTSD reviews were conducted, the chair was informed that 'in most cases issues would already have been undertaken by secondary mental health care services'. By reference to the AWP IMR, Omar was not seen during the relevant period by secondary mental healthcare services until his referral in May 2018. From AWP records, the reasons for referral (trigger), being the need for assessment of historical war related PTSD, [redacted] and continuing problems with tardive dyskinesia.

[redacted]

[redacted]

[redacted] [redacted]

[redacted] [redacted]

[redacted] [redacted]

[redacted] [redacted]

[redacted] [redacted]

[redacted] [redacted]

[redacted]

[27] Source: Recommendations | Post-traumatic stress disorder | Guidance | NICE (Accessed May 2021)

[redacted]

Mental health, medication and side effects

16.2.22 It was during his attendance at the GP practice in July 2017 that Omar was displaying the symptoms of tardive dyskinesia (TD), that is an involuntary movement of various facial muscles and can be seen with some medications, typically the anti-psychotic medications such as olanzapine. The involuntary movements may include grimacing, sticking out the tongue, smacking the lips, rapid jerking movements or slow writhing movements. In about 20% of people, the disorder interferes with daily functioning.[29] Upon exploration with the GP practice, it was reported that "TD is especially unpleasant and can, and often does have a considerable impact upon the patient's life and importantly their compliance with medication regimes and services".

16.2.23 It seems that TD is often irreversible and this had been discussed with Omar and a decision taken to stop the medication, with the main risk being a deterioration of the patient's mental health. On exploring how this risk is approached, it was learned that the approach to changes in medication in general is 'patient centric', in other words discussing options and making decisions based upon the discussion. In this case the plan for review was to discuss the outcome of stopping the medication with a psychiatrist and either the medication may be restarted, or an alternative option discussed and trialled. In Omar's case there were no apparent adverse side effects.

Communication between GP and AWP

16.2.24 On exploring how the outcome of the assessment was communicated, it was learned that this was undertaken via email and telephone conversation and with an expectation these records were recorded contemporaneously. Omar had been seen on the 7th June 2018, the practice received a letter on 11th June and there was a discussion between psychiatry and the GP practice on the 27th June. The AWP risk assessment was also emailed to the GP. It seems that this flow of information was timely, though his GP acknowledged that the subject of risk was not discussed.

(LO2) Learning Opportunity/Consideration: Ensure that the handover from secondary to primary care includes explicit reference to risk.

Risk Assessment

16.2.25 It was also learned from his GP, that risk assessments are not routinely completed, whilst AWP adopted a more formulaic approach, assessing risk to self, risk from others and to others. Whilst this is subject to further discourse under AWP analysis, it was noted that they carried out six risk assessments over a period of time and that they consider risk as

[28] Source: Recommendations | Post-traumatic stress disorder | Guidance | NICE (Accessed May 2021)
[29] Source: https://en.wikipedia.org/wiki/Tardive_dyskinesia (Accessed June 2020)

transitional, in other words not a steady state, with AWP conducting risk assessments when there are significant events or at the point of transition.

16.2.26 For the GP practice the question may arise as to the purpose of any risk assessment and, when they should be conducted. In Omar's case, we know that there were significant events (taking overdose, [redacted] also suffering from side effects) and there was a point of transition from secondary care back to primary care. We also know there was a significant gap in time, from the summer of 2018 to January 2019 when Omar was not seen by his GP.

16.2.27 Upon further consideration as to the approach to risk management, a useful guide by the Department of Health entitled Best Practice in Managing Risk, whilst directed towards mental health professionals provides a useful summary of approaches to risk assessment and also risk factors.[30]

Approaches to Risk

16.2.28 The guide summarises three approaches to risk management.

- An anecdotal approach where information obtained in the course of an ongoing clinical assessment is considered. This information is not gathered systematically and any information considered relevant is not entered into the formulation of risk in a consistent and standardised way.
- The actuarial approach to risk assessment focuses on static risk factors that have been shown to be statistically associated with increased risk in large samples of people. A formulaic approach is usually used: an overall score is calculated as an indicator of presumed risk over a specific time period, generally measured in years. This approach should be used with caution with individual patients in clinical practice. Errors are likely to occur if tools based on this approach are used to predict individual risk rather than to manage it. They should only be used as one part of an overall risk assessment.
- Structured clinical (or professional) judgement is the approach that offers the most potential where violence risk management is the objective. This approach involves the practitioner making a judgement about risk on the basis of combining: – an assessment of clearly defined factors derived from research; – clinical experience and knowledge of the service user, including the carer's experience; and – the service user's own view of their experience.

Risk Factors

16.2.29 The guide summarises risk factors for violence and includes a number of categories; demographic factors; background history; clinical history; psychological and psychosocial factors; and context. Within each of these categories are a number of features including his history of violence that The Royal College of Psychiatrists in its publication 'Assessment and management of risk to others' states 'A history of violence or risk to others is vitally important'.[31] In Omar's case we know some history of his experience as a war veteran from Somalia. We also know of a criminal history that was also noted in a risk assessment shared with the GP in June 2018.

16.2.30 Risking the counsel of perfection that is hindsight bias, the question arose as to whether in similar circumstances, that rather than relying on a change of circumstances, a new event, a 'post -transition' risk assessment ought to be completed. This is supported by the

[30] Source: Best Practice Managing Risk Cover (publishing.service.gov.uk) (Accessed January 2021)
[31] Source: assessmentandmanagementrisktoothers.pdf (rcpsych.ac.uk) (Accessed March 2021)

Department of Health Best Practice in Managing Risk that advises, "risk management plans should include scheduled dates for reassessment, so that they are not simply amended as a reaction to crisis or other events."[32]

16.2.31 The matter of scheduled risk assessments was explored with Omar's GP and he was of the opinion that it may be difficult to get patients to engage with this, though it was acknowledged that waiting for a trigger event presents its own risks. In Omar's case, even when he did see the GP in January 2019, there were no triggers or alerts apparent that would have merited a new risk assessment within current guidance. The GP did suggest that perhaps patients should be informed or educated about recognising at an early stage if they feel they are at risk to themselves or others. The challenge of this approach would be the reliance on a patient possessing sufficient insight to recognise that something was awry, a factor that the judge commented on regarding Omar's state of mind in his summing up. "*It is said on your behalf that in fact, you plainly were not and that may, indeed, have been because you did not have the insight by then as to just how unwell you were, having stopped taking the medication many months earlier. There was a gradual deterioration and the stage at which you became less aware of that, because of your psychosis, is not clear.*"

16.2.32 The panel considered the gap in time (June 2018 to January 2019), and whether the practice would have been expected to follow up with Omar. On the one hand this may have indicated a period of stability, but on the other hand following his engagement with AWP, it may have indicated a change of circumstances. In either case, his attendance at the practice remained one of personal choice and the panel concluded it would be unreasonable to follow up the number of patients who decide not to seek further medical advice.

16.2.33 However, we know that when Omar was seen in January 2019, a PTSD review was conducted, but also that these are not in-depth reviews. Given that it is also suggested that Omar had lost insight into how unwell he was, it is suggested this adds weight to the need for scheduled risk assessments for patients such as Omar after transitioning from secondary back to primary care, i.e., to 'check in', as recommended in the publication 'Department of Health Best Practice in Managing Risk' cited at 10.3.31. It is suggested this is a matter for primary and secondary health care colleagues to consider together.

(LO3) Learning Opportunity/Consideration: To consider benefits of scheduled risk assessments.

Time lapse

16.2.34 By reference to the wider chronology, it seems there were only two agency contacts with Omar between September and mid-December. These are considered on the basis of whether they may have prompted any concerns in relation to his mental health and therefore any sort of alert or dialogue with other agencies. The first related to a domestic incident in September when his former partner turned up intoxicated. There is nothing to indicate that this ought to have prompted any safeguarding alert or otherwise. The second incident where he had reportedly been self-harming in the street would have raised concerns in respect of his mental health. No safeguarding alerts were made and the ambulance service did not refer Omar to his GP. Therefore, the GP was not aware of this 'trigger' event.

Communication between other agencies and GP

16.2.35 Omar was also referred to Recovery Orientated Alcohol and Drugs Service (ROADS) in July 2017 and Nilaari in July 2018. He did not engage with either of these services. Whilst he did

[32] Source: Best Practice Managing Risk Cover (publishing.service.gov.uk) (Accessed March 2021)

not engage, the panel considered how the practice would find out about how successful these referrals had been.

16.2.36 The chair followed up with the director of Nilaari who confirmed Omar had not attended appointments in June and August and failed to respond to a voicemail in August. There was no record of the GP having been informed that Omar had not engaged. This would have been expected in accordance with Nilaari standards of professional practice. The second CCG panel representative (a GP) also confirmed that the expectation would be that non engagement would be fed back to the referrer.

16.2.37 In discussion with the commissioning service for ROADS, it was explained that ROADS would attempt to make contact with clients three times and that if engagement failed to succeed, they would contact the referring agency if that had been requested. They would also leave messages or texts to the client to the effect that 'If you would like support from ROADS please contact us on…."

16.2.38 The subtle variation in policy between Nilaari expecting referrers to be advised of non-engagement and ROADS only feeding back if requested appears to be an opportunity to systemise and strengthen the feedback loop to GP's, thereby prompting professional enquiry by a GP, when they next see a patient.

16.2.39 On exploring this at the fifth panel meeting, it became clear that these circumstances also presented a unique challenge. Omar had been referred to Nilarri by AWP and yet was discharged by AWP at the same time. This raises the question, who would the service inform if the client did not engage? The panel identified a need for a robust feedback loop between agencies referred to and primary and secondary healthcare professionals.

(LO4) Learning Opportunity/Consideration; Primary and secondary healthcare professionals to be provided with information/updates from referrals to other organisations.

Support from family

16.2.40 The GP chronology shows that Omar attended the surgery on the 24th July 2017 with his sister and 23rd April 2018 with his carer. Whilst details are not recorded, it seems likely that the carer is the same family member who supported Omar with BCC H&LS and AWP. This is the cousin with who the chair has spoken to.

Safeguarding

16.2.41 The subject of safeguarding was considered on the basis that Omar lived with a long-term mental illness that prevented him from seeking employment. These two pieces of information prompted the panel to ask whether there were other factors that may have merited a referral to social services. After all, eligibility for care and support needs are determined by a three-stage test.

- **Condition 1**- The adult's needs for care and support arise from or are related to a physical or mental impairment or illness and are not caused by other circumstantial factors;
- **Condition 2**- As a result of the adult's needs, the adult is unable to achieve two or more of the outcomes specified in the regulations and outlined in the section, and;
- **Condition 3** - As a consequence of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the adult's wellbeing.

16.2.42 In Omar's case, we know that Condition 1 was satisfied, but when considering the ten eligibility criteria, the only information that was clearly apparent was that he was unable to

sustain employment as at his PTSD reviews, sicknotes were written. There were no clear indicators to the GP of Omar not being able to achieve any of the other outcomes.

Equalities

16.2.43 On considering the issue of equalities, a number of protected characteristics are pertinent in this case and to how the practice treated Omar. These include race and disability as outlined at section 11.

16.2.44 It is noted that the practice website clearly caters for a breadth of cultures including for those who come from Somalia. On its website it states, "We have translators who work with our clinical team to provide translation services in Somali and some speak Arabic as well. If your first language is from another part of the world then we use a telephone translation service. Patients can also bring a relative to translate." In Omar's case a translator was not required for the purposes of the medical consultations, and the family members who attended his consultations acted as support.

16.2.45 We know that Omar was referred to a culturally suitable organisation for talking therapies and notwithstanding his non-engagement, this is recognised as positive practice. However, in a conversation between the chair and Nilaari in the summer of 2021, it was acknowledged that there was no specialist Somali talking therapy available.

16.2.46 An examination of the local ward profile, reports that the local ward contains the highest proportion of population in Bristol that is Black or Minority ethnic.

16.2.47 The same document reports that Somalia is the top country of origin/place of birth, three times higher than Jamaica and almost five time higher than Pakistan. This suggests an opportunity to examine local provision in respect of the local Somali community.

(LO5) Learning Opportunity/Consideration; Ensure provision of accessible specialist Somali talking therapy in the area.

Summary Analysis in Respect of Key Lines of Enquiry

Term 1 – Family awareness of abuse and barriers to reporting.

16.2.46 There is no evidence of either Hassan or Omar having been involved in an abusive relationship.

Term 2 – Interagency Communication

16.2.47 The practice referred to secondary mental healthcare services and was promptly informed of the outcome of the referral. The chronology also shows that the practice also has regular liaison meetings with mental health specialists.

16.2.48 The practice also referred him to ROADS and Nilaari. There does not appear to have been any feedback from either agency and the panel concluded it would be impractical for the practice to follow up as there is no compulsion for patients to attend and the volume would make this an impractical task to undertake without good reason. However, the panel concluded that the feedback loop from agencies to whom patients were referred could be strengthened by alerting the GP practice.

(LO4) Learning Opportunity/Consideration; Primary and secondary healthcare professionals to be provided with information/updates from referrals to Nilaari and ROADS.
Recommendation 1: Take steps to ensure that Nilaari and ROADS, with appropriate consent provide updates about patient referrals to primary care (GP).

16.2.49 The outcome of risk assessments was communicated in a timely fashion, though the GP acknowledges the subject of risk was not subject of specific conversation.

Term 3 – Standards and Policy

16.2.50 There is no evidence suggesting the practice didn't work to standards of professional practice and domestic abuse policies and procedures were not applicable in this case.

Term 4 – Agency Actions (Assessment, Actions, Relevance and Timeliness)

16.2.51 The GP does not routinely carry out risk assessments regarding risk to self or others, regarding patients living with PTSD or mental illness. Referrals are made to secondary mental healthcare, who conducted a risk assessment that was passed on to the GP, though was not subject to a specific conversation.

(LO2) Learning Opportunity/Consideration: Ensure that the handover from secondary to primary care includes explicit reference to risk.

16.2.52 Omar was known as man who had been exposed to serious violence in Somalia and within his documented risk assessment, having taken part in serious acts of violence in that war and also other acts in the UK.

16.2.53 The panel recognise the merits of scheduling risk assessments in accordance with Department of Health Best Practice in Managing Risk, but mindful of the resource implications of delivering this for all patients. They also recognise the potential to educate patients to be alert to signs/alerts of the need to seek help, whilst acknowledging the challenges of patients having the insight to recognise these signs.

(LO3) Learning Opportunity/Consideration; *Benefits of scheduled risk assessments and educating patients to recognise early signs of changes in behaviour and when to seek medical attention.*
Recommendation 2: Review the protocols for risk assessment and management, ensuring that (a) medicine compliance is considered for patients with a history of violence, (b) that post transition assessments are scheduled/conducted for this cohort, (c) fluctuations in patient insight are considered and (d) that this is explicitly documented in the handover between AWP and GP.

16.2.54 The panel recognise the need for further research regarding mental illness, those who have shown capability of committing acts of serious harm and who go on to commit homicide.

16.2.55 [redacted]

Term 5 - Thresholds

16.2.56 Omar challenges and deterioration in mental health was appropriately treated in primary care for his ongoing PTSD [redacted] Referrals were made to ROADS; discussions took place with

psychiatrist colleagues and changes were made to his medication. As his condition deteriorated, he was referred to secondary mental healthcare appropriately in May 2018.

Term 6 – Cultural Sensitivity

16.2.57 The GP practice shows itself to be culturally sensitive, through its public facing website and provision of translation services for its local community.

16.2.58 Omar was referred to a culturally suitable organisation for talking therapies and notwithstanding his non-engagement, this is recognised as positive practice. However, the panel learned there was no specialists Somali talking therapy available at the time, indicating a potential gap in provision for the largest minority group in the locality.

(LO5) Learning Opportunity/Consideration; Ensure provision of accessible specialist Somali talking therapy in the area.
Recommendation 3: Improve the understanding of the specific needs of the local Somali Community (SC) in respect of mental health that includes; - what enables/hinders the SC accessing support and that clearly identifies the gaps in provision.

Term 7 – Escalation

16.2.59 See 16.2.47

Term 8 – Training and Awareness issues

16.2.60 The practice is an IRIS practice, and no training requirements were identified regarding domestic abuse awareness.

16.3 AWP Perspective

16.3.1 The chair had two meetings with AWP and CCG, outside the formal panel meetings to seek clarity on technical matters and also the IMR findings. As a result, the chair was provided with details of the Root Cause Analysis report that was concluded swiftly following the murder.

16.3.2 During the relevant period, AWP had one contact with Omar on 7th June 2018. This was an assessment by two registered mental health nurses, following a referral from the GP. A friend of Omar's accompanied him for this assessment.

16.3.3 As an outcome of the assessment, a letter was sent to Omar's GP outlining the following plan:

- Referral to Nilaari for culturally sensitive talking therapy and contact details given.
- Letter of support written for upcoming PIP
- discuss medication with the Consultant Psychiatrist
- Contact details given for Bristol Crisis Line[33] and the Sanctuary for face-to-face support[34].

The case was closed by AWP.

[33] A crisis phone number available 24/7 for those in an emotional or mental health crisis, operated by Bristol MIND. (May 2021)
[34] An organisation that offers single session support on an ad-hoc basis for people suffering with severe emotional distress. (May 2021)

16.3.4 AWP followed up with an email to the GP, which concluded that Omar's symptoms were probably not consistent with tardive dyskinesia and suggested a change to his anti-depressant medication from Citalopram to Mirtazapine 30mg. They also advised that Omar stop taking Tetrabenazine and recommended further physical investigations regarding problems with his jaw.

16.3.5 A GP liaison meeting took place a few weeks later and as Omar's symptoms of tardive dyskinesia had now subsided, they re-iterated advice to stop Tetrabenazine, and orientated towards the plan as recommended from recent assessment.

16.3.6 The chair confirmed with the GP that Omar was not seen by the practice until around 6 months later. His medication was not changed, and Omar continued to receive repeat prescriptions for his original medication. He also confirmed that risk was not discussed.

Risk Assessment

16.3.7 The panel learned that AWP had conducted six risk assessments during the period September 2011 through to June 2018, only one of which occurred during the relevant period. The risk assessment covers a number of areas that includes; risk to self; risk from others; risk to others. Upon exploration, the panel learned that AWP noted the details of Omar's conviction history and contact with police.

16.3.8 The matter of how a mental health and risk assessment is conducted was explored, and the panel learned that the structure followed is known as the 5 P's, that is.

- Presenting Problem – What are the main difficulties at the moment?
- Predisposing factors – Is there anything from the past that might be influencing how the patient feels now?
- Precipitating factors – Has anything happened that has made the patient feel worse?
- Perpetuating factors – What might help keep the problem going?
- Protective factors – Is there anything that helps?

Forensic History

16.3.9 Omar had been known to AWP prior to the relevant period. Previous contacts include:

a) in 1998 having had a two-week admission regarding a khat induced psychosis characterised by paranoia with second and third person derogatory auditory hallucinations
b) in 2003 an informal assessment when he reported low mood, paranoia, hearing voices and plans to commit suicide. He was admitted informally to a local ward and self-discharged the following day.
c) in 2004 an assessment after an overdose, following argument with his partner. A cousin reported that he had been withdrawn and paranoid during previous 10 days, thought people were trying to poison him.
d) in 2011 he was taken on by the by the Community Mental Health Team for CBT and vocational services. He did not engage.
e) in 2013 he was seen having self-inflicted cuts to his arms, (requiring transfusion), and was diagnosed with reactive depression, triggered by the death of his grandmother.

Risk to Others

16.3.10 Whilst outside the relevant period, these events show the enduring nature of Omar's mental illness, during which he was convicted of two offences of grievous bodily harm contrary to Section 20 of the Offences Against the Person Act (as noted by His Honour Judge Blair QC).

These events that were known to AWP demonstrate his previous capability to cause serious harm to others. It was also noted that Omar whilst in the Somali army had been involved in extreme violence.

16.3.11 However, these events also show that whilst Omar had suffered from mental illness over many years, there were periods of relative calm, when he did not come to notice.

16.3.12 AWP concluded that there were static risk factors that were contained and not dynamically active. His risk of harm to others was assessed as low.

Risk to Self

16.3.13 Omar's previous dealings with AWP were noted, as were other events of self-harm in 2006 and 2004 when he had self-harmed. It was concluded that at the time his risk to self was rated as low.

Risk from Others

16.3.14 Whilst there had been previous violent altercations between himself and others, at the time the risk assessment was rated as low.

Risk Summary

16.3.15 Overall, the Root Cause Analysis had concluded that risk factors were static, contained and not dynamically active. It summarises that "There was no recorded prediction as to future risk" suggesting a need to consider future risk. In its publication 'Assessment and Management of risk to others' the Royal College of Psychiatrists says, "A formulation and plan should specifically describe the current situation and say what could be done to mitigate the risk in future."[35] It therefore appears that there was a missed opportunity to consider future risks, including risk to others.

16.3.16 The same guidance highlights "A history of violence or risk to others is vitally important", and the Root Cause Analysis clearly references that Omar's violent history as known to the criminal justice system and also that his exposure to violence in Somalia was known.

Timeliness of Risk Assessments

16.3.17 In discussion the panel agreed that any risk assessment is an assessment at a moment in time, and that any risk may fluctuate. This prompted discussion as to when AWP complete risk assessments. It was reported that they take place at (a) 'times of transition' or when there are any (b) 'new events.' In effect, this relies upon there being a trigger as opposed to a scheduled risk assessment.

16.3.18 Risking hindsight bias, the question arose as to whether in similar circumstances, that rather than relying on a change of circumstances, a new event, a 'post -transition' risk assessment ought to be completed. This is supported by the Department of Health Best Practice in Managing Risk that advises, "risk management plans should include scheduled dates for reassessment, so that they are not simply amended as a reaction to crisis or other events."[36]

(LO3) Learning Opportunity/Consideration; The scheduling of risk assessments after exiting service.

[35] Source: Source: assessmentandmanagementrisktoothers.pdf (Accessed August 2021)

[36] Source: Best Practice Managing Risk Cover (publishing.service.gov.uk) (Accessed March 2021)

16.3.19 The guidance continues that risk management plans should anticipate what circumstances would trigger a review, providing scope for a service user or carer to request a review. Whilst, neither the RCA or IMR specifically comment on this, the RCA does reference Omar having been provided details for crisis support within AWP and via the third sector (16.3.3). It also references Omar being accompanied by a 'support worker' who it was later identified as being a friend having been present during consultation. It is unclear what the role of the friend was, and what advice and guidance was provided to them, giving rise to the opportunity of ensuring that accompanying friends, support workers and carers are provided with specific information.

Sharing of Information

16.3.20 Notwithstanding the above, we know that Omar did experience periods of transition and/or events after this final risk assessment. The first on the 13th December 2018, when there were reports of him having self-harmed and the second on the 8th January 2019, when he attended the police station in relation to threats to kill, he had made to a third party. We know that in both cases, safeguarding alerts were not completed that are considered within the analysis of police contact. Similarly, neither a safeguarding or GP alert were undertaken by SWASFT at their attendance on the 13th and 14th December. The only route, by which AWP may have had further involvement would have been had Omar been detained under the Mental Health Act (MHA) or if information had been received prompting an assessment under the MHA. It is a matter of fact that at no time was this considered by first responders in their interactions, nor considered necessary by primary care.

16.3.21 During meetings between the chair, AWP and the CCG, it was apparent that whilst AWP was aware of Omar's previous convictions, the GP was not aware until a risk assessment was shared in June 2018. However, the GP does not recall nor was it documented that any specific discuss about risk took place.

16.3.22 On considering best practice and guidance, the Royal College of Psychiatrists states "If the responsibility for a management plan is passed on to another clinician or service, it must be handed over effectively and explicitly accepted."[37] In this case, the consultant psychiatrist emailed the GP regarding his psychiatry assessment on 12th June 2018 and also discussed findings on 27th June 2018 at a GP liaison meeting with the consultant. It is not clear from the IMR or the RCA whether information included explicit discussion on risk, that together with the GP's records, suggests the need to always ensure that risk is subject to formal handover.

(LO2) Learning Opportunity/Consideration; Ensure that the handover from secondary to primary care includes explicit reference to risk

<u>Medication</u>

16.3.23 The question of Omar not taking his medication was subject to discourse. On the one hand, it assisted in managing his mental illness, on the other hand it had been believed to be contributing to his tardive dyskinesia and not taking his medication was recognised as having a detrimental effect on his condition. Whilst the treatment and prescription of medicine is outside the scope of this review, the effects and potential risk of not taking his medication was subject to discourse. A number of matters were considered including:

a) the circumstances at which a patient may be compelled to take medication,

[37] Source: https://www.rcpsych.ac.uk/docs/default-source/members/supporting-you/managing-and-assessing-risk/assessmentandmanagementrisktoothers.pdf?sfvrsn=a614e4f9_4 (Accessed October 2020)

b) "Medicine Compliance",
c) linked to medicine compliance, whether the condition of Anosognosia was a factor.

Compelling a patient to take medication.

16.3.24 There are limited circumstances in which it might be lawful to give a patient medicine without their consent when treating patients for physical or mental health concerns. In so doing it may be useful to keep in mind the difference between mental health and mental capacity.[38] The reasons are described below

- If a patient had been admitted to hospital under the Mental Health Act (sometimes called being sectioned).
- If a patient had been discharged from hospital under certain sections of the Mental Health Act, and are being treated on a community treatment order (CTO).
- If a patient had been assessed under the Mental Capacity Act as not having capacity to consent to treatment and are given medical treatment in their best interests, even though they object.

None of these points were deemed applicable in Omar's case.

Medicine Compliance

16.3.25 In the judges summing up, His Honour Judge Blair QC observed, "*you did not have the insight by then as to just how unwell you were, having stopped taking the medication many months earlier*". It is therefore apparent that medication compliance was deemed important in explaining the homicide.

16.3.26 It is unclear and has not been possible to actually determine, whether Omar took his medications prior or post AWP review. What is known from his GP, is that Omar was not actually seen by the GP after the AWP assessment for around 6 months and that his medication was not changed, but that he continued to obtain previously prescribed medication on repeat prescription.

16.3.27. However, in considering the RCA and in discussion with the panel representative, medicine compliance was either not contemplated in the RCA, and/or did not form any part of the risk assessment. In either case it seems that it ought to feature as part of any risk assessment at a moment in time, and as part of any future scheduled risk assessments.

(LO6) Learning Opportunity/Consideration; Ensure medicine compliance features as part of risk assessment protocols and recording

Anosognosia

16.3.28 This condition is described as "a lack of ability to perceive the realities of one's own condition. It's a person's inability to accept that they have a condition that matches up with their symptoms or a formal diagnosis".[39] Whilst it is unclear whether this was a feature of Omar not taking medication, looking at the circumstances and judges summing up, it is

[38] The difference between mental capacity and mental health is broadly speaking that mental health encompasses a person's psychological and emotional wellbeing whereas mental capacity relates to their ability to make decisions in different situations. The two often interact and if a person's mental health is such that it is affecting their decision making capability then they may lack mental capacity. Mental health and mental capacity (hcsolicitors.co.uk) (Accessed April 2022)

[39] Source: Anosognosia: Definition, Causes, Symptoms, Treatment, and More (healthline.com) (Accessed August 2021)

important to consider as an explanation for him not taking his medication. There are a number of articles to be found that suggest it as a reason for not taking medication, such as an American site the National Alliance on mental Illness that explains "Lack of insight also typically causes a person to avoid treatment. This makes it the most common reason for people to stop taking their medications. And, as it is often combined with psychosis or mania, lack of insight can cause reckless or undesirable behaviour".[40] A further article suggests, "Impaired awareness of illness (anosognosia) is a major problem because it is the single largest reason why individuals with schizophrenia and bipolar disorder do not take their medications."[41] This same source references a number of academic reports linking lack of insight to violent behaviour.

16.3.29 Whilst "cause and effect" of anosognosia and homicide cannot be concluded from this review, it seems that it merits improved curiosity in terms of risk assessment.

(LO7) Learning Opportunity/Consideration; Ensure that fluctuations in a patient's insight are considered as part of risk assessment protocols.

Treatment and Referral

16.3.30 The outcome of the AWP assessment was ultimately a plan of primary care-based intervention as described at paragraphs 16.3.2 to 16.3.5 as Omar did not meet the threshold for secondary care and his main concern was with what appeared to be side effect symptoms of tardive dyskinesia. This triage response was appropriate to the level of need and urgency signalled in the referral and presentation at the time.

16.3.31 Helpfully the IMR references observes that there was (a) no audit assurance loop regarding referral to Nilaari and (b) there was a missed opportunity to refer to Improving Access to Psychological Therapies (IAPT) whereby Omar may have accessed specialised PTSD psychological therapy in primary care.

Audit assurance loop regarding referral to Nilaari

16.3.32 These observations were explored in a meeting between the chair, CCG and AWP representative. Regarding the first learning point, Omar was directed towards Nilaari with whom there was initial contact but did not progress further. The lack of an 'audit loop' is understood as a means of checking and testing whether a client, Omar in this case accessed services. These matters are subject to observation under CCG/ GP analysis.

(LO4) Learning Opportunity/Consideration; Improving the assurance loops following referrals to other agencies that ensures feedback on client

Access to IAPT

16.3.33 Regarding the second learning point it was clarified that secondary care clinicians were unaware of IAPT, as opposed to primary care not knowing about it. This particular point is subject to an individual agency recommendation;

- *To raise awareness of complete PTSD pathway in Primary Care*

(LO8) Learning Opportunity/Consideration; Ensure staff are aware of IAPT intervention for PTSD in primary care.

[40] Source: Anosognosia | NAMI: National Alliance on Mental Illness (Accessed August 2021)
[41] Source: Impaired Awareness and Anosognosia in Mentally Ill: Study Summaries : Mental Illness Policy Org (Accessed August 2021)

Equalities

16.3.3 The AWP IMR made a recommendation "to identify link role within access services into local Somali community". *The author of the RCA explained 'the Somali community is known to be reluctant to engage with statutory services and a role within the access arm of statutory provision, to engage outreach and liaison to that community, for instance with Standing Against Racism and Inequality (SARI), may be a way to improve awareness both ways and take up.' The RCA author made the recommendation "to work with SARI to identify link role within access services into local Somali community" with a specific action point "to identify and support one or two individuals to develop link worker role to outreach/network in Somali community".*

16.3.35 The suggestion that SARI may play a role in respect of tackling the reluctance of the Somali community to engage with statutory services in respect of mental health, prompted a number of considerations, that includes understanding the role of SARI and wider Equalities.

16.3.36 SARI was established in 1988 and its role is described as "a service user/community-oriented agency that provides support and advice to victims of hate and promotes equality and good relations between people with protected characteristics as defined by law." [42]

16.3.37 The challenge with engaging the Somali community to engage with mental health services is complex. It is an issue recognised by friends and family members of Omar who highlighted the stigma associated with diagnosis.

16.3.38 The Human Rights Act 2010 defines disability as "a person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities". [43] Omar undoubtedly met this definition. The Equality Act 2010 places a duty on public authorities to:

- remove or reduce disadvantages suffered by people because of a protected characteristic.
- meet the needs of people with protected characteristics.
- encourage people with protected characteristics to participate in public life and other activities[44]

16.3.39 Given the IMR and RCA recommendations, it is apparent that there is an obligation to seek to improve the pathways between the Somali community and mental health service provision that ensures agencies meet obligations under the Equality Act and improve the confidence of the Somali community to engage with services. This is subject to an individual agency recommendation.

- *To identify link role within access services into local Somali community*

(LO5) Learning Opportunity/Consideration; Improvement to accessing culturally sensitive service in the community,

Summary Analysis in Respect of Key Lines of Enquiry

[42] Source: https://www.sariweb.org.uk/who-we-are/about-sari/ (Accessed October 2020)
[43] Source : https://www.equalityhumanrights.com/en/equality-act/protected-characteristics#disability (Accessed December 2019)
[44] Source: https://www.citizensadvice.org.uk/law-and-courts/discrimination/public-sector-equality-duty/what-s-the-public-sector-equality-duty/ (Accessed December 2019)

Term 1 – Family awareness of abuse and barriers to reporting.

16.3.40 There is no evidence of either Hassan or Omar having been involved in an abusive relationship.

Term 2 – Interagency Communication

16.3.41 There is evidence of timely communication between AWP consultant and GP practice in respect of Omar's treatment, though the GP acknowledged that the subject of risk was not subject of specific conversation.

16.3.42 There is an opportunity to document explicit communication on the subject of risk assessment including the sharing of the actual risk assessment.

Learning Opportunity/Consideration; Ensure that the handover from secondary to primary care includes explicit reference to risk.
Recommendation 2: Review the protocols for risk assessment and management, ensuring that (a) medicine compliance is considered for patients with a history of violence, (b) that post transition assessments are scheduled/conducted for this cohort, (c) fluctuations in patient insight are considered and (d) that this is explicitly documented in the handover between AWP and GP

16.3.43 Having referred Omar to Nilaari, there was no subsequent assurance loop as to the efficacy of that referral.

(LO4) Learning Opportunity/Consideration; Consider the merits of implementing assurance loops following referrals to other agencies.
Recommendation 1: Take steps to ensure that Nilaari and ROADS, with appropriate consent provide updates about patient referrals to primary care (GP).

Term 3 – Standards and Policy

16.3.44 There is no evidence suggesting the practice didn't work to standards of professional practice and domestic abuse policies and procedures were not applicable in this case.

Term 4 – Agency Actions (Assessment, Actions, Relevance and Timeliness)

16.3.45 Assessments and actions were made in a timely fashion and considered risk to self, others and from others, taking into account a range of factors that included Omar's violent history.

16.3.46 AWP were not made aware of any transitions or events that may have prompted a further risk assessment after discharge from their service such as the incidents of self-harming or threat to another (December 2018 and January 2019).

16.3.47 The panel acknowledged that Omar's violent history was considered in risk assessments. However, there were opportunities to improve the process of risk assessment by scheduling risk assessments in accordance with guidance, also recognising other factors such as medicine compliance and fluctuating patient insight would merit specific inclusion in the process. These observations are to be seen in conjunction with the CCG/GP analysis.

(LO6 and LO7) Learning Opportunity/Consideration; To improve the risk assessment protocols, by ensuring assessments take into account medicine compliance, fluctuations in patient insight and also ensuring that assessments are scheduled post transition for patients with a documented violent history.
Recommendation 2: Review the protocols for risk assessment and management, ensuring that (a) medicine compliance is considered for patients with a history of violence, (b) that post transition assessments are scheduled/conducted for this cohort, (c) fluctuations in patient insight are considered and (d) that this is explicitly documented in the handover between AWP and GP

16.3.48 Secondary care clinicians lack of awareness of IAPT opportunities was identified by the IMR author and was subject of an individual agency recommendation.

(LO8) Learning Opportunity/Consideration; Ensure staff are aware of IAPT intervention for PTSD in primary care.
Response: Individual agency recommendation to raise awareness of PTSD pathway in primary care refers

Term 5 - Thresholds

16.3.49 There was no evidence of apparent domestic abuse to be considered.

16.3.50 The thresholds for medical intervention appear proportionate and were acted upon in a timely fashion. (GP to AWP).

16.3.51 AWP were not made aware of further incidents indicating a deterioration in Omar's mental health.

Term 6 – Cultural Sensitivity

16.3.52 AWP acknowledged in their IMR that there was a lack of awareness of culturally accessible specialist psychology intervention for PTSD in primary care and have made a single agency recommendation in this regard. The absence of local specialist Somali talking therapies noted under GP analysis (paragraph 16.2.58) is also relevant at this point.

(LO5) Learning Opportunity/Consideration; Improvement to accessing culturally sensitive service in the community,
Single agency recommendation: To identify link role within access services into local Somali community.
+
Recommendation 3: Improve the understanding of the specific needs of the local Somali Community (SC) in respect of Mental Health that includes; - what enables/hinders the SC accessing support and that clearly identifies the gaps in provision.

16.3.53 An alternative narrative may be that statutory services need to work to engage and build the confidence of the Somali community.

Term 7 – Escalation

16.3.54 There was no evidence presented indicating that Omar's case merited escalating to senior management.

Term 8 – Training and Awareness issues

16.3.55 There was no evidence regarding training and awareness in respect of domestic abuse apparent.

16.4 Bristol City Council Housing and Landlord Services perspective

16.4.1 Only Omar was known to BCC H&LS, having been a tenant for a number of years. Their involvement with Omar is limited and mainly in relation to standard repairs and rent management case history. Other apparent matters include support from a cousin and reference to his mental health and the potential risk to others.

Rent Management

16.4.2 BCC H&LS have an extensive history in relation to Omar keeping up with his rent payments. One of the contributory factors to financial difficulty was the imposition of an 'under-

occupancy charge, otherwise known as a 'bedroom tax'. [45] Under the changes, tenants in social housing have their benefit reduced by 14% if they have a spare bedroom or 25% if they have two or more. He did not wish to seek Discretionary Housing Payment and began to accrue further arrears. However, in 2015, when Omar's cousin began living with him, this meant he was no longer under-occupying his home and this charge ceased to be applicable. The IMR identified in individual agency learning point in relation to this point, as the BCC H&LS management system was not updated to show an additional occupant residing. This is subject to an agency recommendation.

- *Training to ensure that officers know how and when to update occupant lists within the BCC H&LS management system.*

(LO9) Learning Opportunity/Consideration: To ensure housing occupancy data is updated.

Internal Communications

16.4.3 In March 2017 it was suspected that Omar was not living at his flat as a main and principal home and was subletting the whole property. Bristol City Council Internal Audit Team gained a court order against Omar. This order did not appear on BCC H&LS systems until the order had expired. It was agreed in court that Omar would provide documents showing his continued physical occupation of the address to Bristol City Council every three months. This is referenced as there were periods when Omar was not in contact with agencies and during this period of 2017 to 2018 there were no significant incidents of note, but also because it has identified a learning opportunity for BCC H&LS in that the existence of the court order did not appear on BCC H&LS systems until some months later. This is subject to an individual agency recommendation.

- *Refresh with Internal Audit Team and BCC H&LS sharing information practices and storing this correctly when BCC properties have actions undertaken e.g. in this instance a court order to prove occupancy.*

(LO10) Learning Opportunity/Consideration: ensure that local records from audit appear on BCC H&LS systems.

Professional Curiosity and Support from others

16.4.4 It was noted that Omar's cousin moved in with Omar in May/June 2016. This meant he was no longer under-occupying his home and the 'bedroom tax' ceased to be applicable. This assisted Omar financially and it was noted that his cousin was helping to care for him. This was explored and the panel learned Omar and the cousin attended BCC H&LS offices and a letter was written to the effect that he wished for the cousin to speak on his behalf about tenancy issues. Notwithstanding this letter, the extent of the cousin's involvement was explored with BCC H&LS, as Omar received letters directly from them. It was explained this was an informal support arrangement, but Omar remains the tenant to whom BCC H&LS address regarding tenancy matters. The cousin was not legally acting on behalf of Omar, rather it formalises the fact that tenants are allowing someone to have a conversation on their behalf. It seems that the relatives acting on the behalf of a tenant is not commonplace.

16.4.5 The panel further considered the extent to which the cousin was 'caring for Omar and sought to understand to what degree was care required. It may have been that the care was minimal and was no more than support, such as help with the shopping. Conversely, the requirements may have been more significant. At this point in time, BCC H&LS knew that Omar had previously suffered from mental illness and therefore it is arguable that the degree of support required may have benefitted from greater professional curiosity to ascertain why

[45] Source: https://www.gov.uk/government/news/housing-benefit-reform-removal-of-the-spare-room-subsidy-fact-sheet (Accessed 20th September 2019)

he needed support and in turn whether these may have amounted to care and support needs. Further opportunities to explore his circumstances arose later in the year.

16.4.6 On the 4th August 2016, during a conversation with Omar regarding his rent, it was noted that he had support from his cousin and that he suffered from depression. On the 15th November, a further conversation took place about his rent and during the initial conversation, the chronology notes 'to be honest he sounds a little confused about the whole situation. Please can someone give him a call back. A call was made back and discussions continued about his rent. During the call back a 'customer contact service standard form (CCSS) was completed, and this noted that Omar suffered from depression. However, this was not expanded upon. The IMR author noted that there was a similar contact in 2010 (before the relevant period) when Omar notified BCC H&LS of having been hospitalised for his mental health, and no further information was sought. The completion of the CCSS has been recognised as an opportunity to secure further information that may provide information to help understand a tenant's circumstances and is subject to an individual agency recommendation that has resulted in new scripted questions within the customer support service;

- *The rent management service CCSS form to be reviewed to ensure relevant further questions are being sought with the customer. This is so that the form is doing as it was created and intended; to act as a method to support tenancy sustainment going forward with the tenant.*

(LO11) Learning Opportunity/Consideration: To be 'professionally curious'' and try and understand a client's circumstances in greater depth.

16.4.7 Whilst the recommendation is welcome, one may argue that there were a number of potential alerts i.e. that Omar was known to have been treated for issues with his mental health previously, he had someone helping to care for him, he suffered from depression and during one phone call, he had sounded confused; which could have benefited from improved professional curiosity to consider his situation more holistically.

16.4.8 The Care Act 2014 describes eligibility for care and support needs in terms of a three-stage test;

Condition 1- The adult's needs for care and support arise from or are related to a physical or mental impairment or illness and are not caused by other circumstantial factors;
Condition 2- As a result of the adult's needs, the adult is unable to achieve two or more of the outcomes specified in the regulations:

- Managing and maintaining nutrition
- Maintaining personal hygiene
- Managing toilet needs
- Being appropriately clothed
- Being able to make use of the adult's home safely.
- Maintaining a habitable home environment
- Developing and maintaining family or other personal relationship
- Accessing and engaging in work, training, education or volunteering
- Making use of necessary facilities or services in the local community, including public transport, and recreational facilities or services
- Carrying out any caring responsibilities the adult has for a child.

Condition 3 - As a consequence of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the adult's wellbeing. [46]

16.4.9 We know that Omar was unable to seek employment and that is one of the specified outcomes, but it is not known, nor immediately apparent, if he was unable to achieve other outcomes. Moreover, the Social Care Institute for Excellence also notes that any significant impact could be a consequence of a cumulative effect. This means that the individual may have needs across several of the eligibility outcomes, perhaps at a relatively low level, but as these needs affect the individual in various areas of their life, the overall impact on the individual is significant.[47] These considerations are never clear cut and require professional curiosity and an inquisitive mindset. For Omar, this would have meant considering his case holistically versus focusing on the presenting factor of him struggling to pay his rent. Moreover, consideration may also have been made to consider a safeguarding alert and/or signposting Omar and his friend/carer to adult services. That is not to say that he would have been eligible.

16.4.10 Upon exploring the local training regime, the panel representative advised that there is mandatory safeguarding training for housing staff, along with the offer of Mental Health Awareness and Mental Health First Aid training available.

16.4.11 On 14th December 2018, a further opportunity arose to consider Omar's situation when a friend called to discuss getting permission to discuss his circumstances. In this conversation, Omar's friend shared that they were worried about him, and that sometimes he does not allow her to access his home, so she wasn't sure he was ok. The friend described that Omar was unable to speak or breathe. She was given sound practical advice about speaking to the NHS or calling an ambulance. By reference to the chronology, we know that the ambulance service was called and that the day before the police and ambulance service had received calls regarding his self-harming. The BCC H&LS chronology poses the question, 'possibly he needs a TSO (tenancy support officer)?' There is no further documented information that a referral was made for Omar to secure support from a TSO though it was clearly a consideration.

16.4.12 It is agreed by the panel representative that this was a missed opportunity to find out more information, and ensure follow up and support. However, the new 'scripting' within the customer service centre that would now ensure Omar was signposted for follow up contact and/or would create a safeguarding alert.

(LO12) Learning Opportunity/Consideration: To encourage 'professionally curiosity', seek additional information concerning tenant welfare and to 'Think Safeguarding' when working with their tenants/clients.

Support for Tenants

16.4.13 Support and advice to tenants facing difficulty sustaining their tenancy was explored in the review. A number of options for tenants were highlighted, including; customer advisors at the Bristol City Council Citizen Service Point or by a housing officer making a referral for support via the Housing Support Register whereby Welfare Rights and Money Advice Services (WRAMAS)/ Tenant Support Service could be sought to assist a tenant with their tenancy sustainment, maximising benefits, referral to the Bristol Somali Resource Centre.

16.4.14 On the Bristol City Council website, the role Housing Officers for council tenants are described as to

[46] Source: https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/criteria-adults-care.asp (Accessed November 2019)

[47] Source: What does significant impact mean? | Eligibility determination for the Care Act 2014 | SCIE (Accessed March 2021)

- help council tenants understand what's expected of them as a tenant.
- talk to tenants at their pre-tenancy assessments and six weekly new tenant visits about what to expect from the council.
- make sure council properties are looked after and maintained.
- make sure tenants can get the right support if they have learning difficulties or physical or mental health issues.
- take enforcement action against tenants involved in anti-social behaviour or in breach of their tenancy conditions.
- work with other services such as the Police, Social Services and SARI to make sure tenants are safe and supported.
- work with tenants to apply for funding for projects to improve their community.[48]

16.4.15 Whilst the website helpfully signposts support from culturally sensitive agencies such as Stand Together Against Racism and Inequality (SARI), it is observed that initial navigation of the website is solely in English. However, BCC H&LS have alerts on their systems where language barriers may cause difficulty in effective communication. BCC H&LS also reported that they do work with the community development team regarding planed programmes of work, to ensure all their tenants are aware of development and improvement works.

Risk to Others

16.4.16 BCC H&LS systems alerted staff to Omar being a credible threat. This related to an entry in 2008 where he had been charged and served a term of imprisonment for Grievous Bodily Harm. Upon exploration, it was learned these threat markers are reviewed every 18 months. Whilst there did not appear to have been any reviews documented on the BCC H&LS system, it has been confirmed these did take place on another corporate system. This omission risks new staff who are unfamiliar with circumstances being aware of the most recent reviews.

Summary Analysis in Respect of Keylines of Enquiry

Term 1 – Family awareness of abuse and barriers to reporting.

16.4.17 There is no evidence of either Hassan or Omar having been involved in an abusive relationship.

Term 2 – Interagency Communication

16.4.18 BCC H&LS has identified that when internal audit took out a possession order owing to suspected sub-letting, BCC H&LS records were not updated in a timely fashion.

(LO9) Learning Opportunity/Consideration: To ensure BCC H&LS occupancy data is updated.
Response – single agency recommendation: Training to ensure that officers know how and when to update occupant lists within the BCC H&LS management system.

16.4.19 They also identified records were not updated when his cousin began living with him. This is subject to an agency recommendation.

(LO10) Learning Opportunity/Consideration: ensure that local records from audit appear on BCC H&LS systems.
Response – single agency recommendation: Refresh with Internal Audit Team and H&LS sharing information practices and storing this correctly when BCC properties have actions undertaken e.g., in this instance a court order to prove occupancy.

[48] Source: Housing officers for council tenants - bristol.gov.uk (Accessed March 2021)

Term 3 – Standards and Policy

16.4.20 See Term 4 below.

Term 4 – Agency Actions (Assessment, Actions, Relevance and Timeliness)

16.4.21 There were no opportunities to engage with Hassan, though there were opportunities to consider Omar's situation more widely as noted under Term 2.

16.4.22 It was a matter of fact that Omar was known to have been treated for mental illness, that at a point in time was living with depression, that a friend had moved in to care for him and that an observation he sounded confused about the situation and on one occasion his friend expressed concern for his welfare. Whilst it is not suggested that he conclusively had care and support needs in accordance with The Care Act, these potential concerns were not explored holistically to understand his situation as the focus appeared to be on tenancy sustainment and his rent issues. An agency recommendation has been made linked to this learning opportunity, that relates to the completion of a customer contact service standard form (CCSS) that may prompt more information being gathered. It is also suggested there is an opportunity to keep in mind The Care Act/Safeguarding, to improve professional curiosity considering Omar's case holistically, versus focusing on the presenting factor of him struggling with his rent. After all, he had someone authorised to speak on his behalf, it was known he suffered from depression and a comment was made about him possibly needing a tenancy support officer. This may have resulted in the completion of an alert and/or signposting Omar and his carer to further support.

(LO11) Learning Opportunity/Consideration: To encourage 'professionally curiosity', seek additional information concerning tenant welfare and to;
(LO12) 'Think Safeguarding' when working with their tenants/clients.
Individual Agency Recommendation refers: The rent management service CCSS form to be reviewed to ensure relevant further questions are being sought with the customer. This is so that the form is doing as it was created and intended; to act as a method to support tenancy sustainment going forward with the tenant.
+
Recommendation 4: That the learning from this review is shared through mandatory safeguarding training to encourage increased professional curiosity when presented with potential client welfare concerns

16.4.23 The panel also learned that owing to Omar's known history, he was noted as presenting a credible threat. It has been confirmed that this marker was reviewed every 18 months, but on a separate system.

Term 5 - Thresholds

16.4.24 See term 2 for consideration in respect of care and support needs.

Term 6 – Cultural Sensitivity

16.4.25 BCC H&LS ensure that there are alerts on their systems that highlight when tenants may have language difficulties that enable arrangements for interpreters as required.

Term 7 – Escalation

16.4.26 There were no apparent matters requiring escalation to a supervisor that had not already been alerted to internal audit.

Term 8 – Training and Awareness issues

16.4.27 Whilst mandatory training takes places in respect of safeguarding and other training offers are available and processes for customer services staff have evolved, it is apparent that an

opportunity to improve professional curiosity was apparent in dealings with Omar. (*See 16.4.22*)

16.5 Avon and Somerset Police Perspective

16.5.1 During the relevant period police had contact with Omar and/or Hassan on six occasions prior to Hassan's death on the 10/01/2019. None related to any matters between Omar and Hassan and the only contact with Hassan has no relevance to this review.

- Three contacts involved disputes between Omar and a female he had a relationship with between January and September 2018.
- One contact was related to Omar suffering a mental health issue and being in possession of a knife in December 2018.
- One contact was related to a dispute between Omar and another male. Omar claimed the male owed him money and threatened him in January 2019.

16.5.2 The following incidents are between Omar and a former partner.

First Incident

16.5.3 Omar's partner alleged that he had assaulted her. She was outside Omar's address. She was intoxicated and there were no injuries apparent. There was positive practice in respect of using body worn video (BWV),though no Domestic Abuse, Stalking and Honour Based Violence (DASH) checklist was completed.[49] She presented as intoxicated and abusive and gave officers conflicting accounts, whilst Omar presented as calm allowing officers into his flat to retrieve property for her. This case did not result in a domestic abuse investigation, when it could have been considered, as they had been in a previous relationship. It seems the officers took the decision and did what they thought was right under the circumstances at the time to deal with the matter informally as a property dispute, diffusing the situation by giving her a lift to another address thereby limiting the extent of any domestic abuse investigation such as neighbour enquiries and listening to 999 tapes.

Second Incident

16.5.4 Omar called police as he wanted his partner to leave. She was intoxicated and wanted to have property returned that she had left there. It does not seem that BWV was used, and a DASH was not completed.

Third Incident

16.5.5 Omar called police and alleged that the same female was harassing him. Police did not see her and searched his flat to make sure she was not there. She had apparently been intoxicated. Police offered to complete a DASH, but it was not completed.

16.5.6 Whilst the use of BWV is seen as best practice in respect of the initial investigation of domestic abuse offences, the police did not complete a DASH for any of the domestic incidents. Only one would have been completed with Omar as the alleged perpetrator and two with him as the victim. Upon exploration, it seems that at the third incident, an attempt was made, but he refused to answer the set questions and thus it was not completed.

[49] Source: The Domestic Abuse, **Stalking** and **Honour Based Violence** (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council (NPCC): Dash Risk Checklist – Saving lives through early risk identification, intervention and prevention (Accessed February 2021)

16.5.7 Upon exploration the panel were informed that DASH completion rates had improved for the police force to approaching 90%. Avon and Somerset Police provided the following data for DASH completion rates in relation to ethnicity in 2019:

The below data is a review of Niche occurrences (including crime and non-crime incidents) created between 1st January 2019 to 31st December 2019 that contain a domestic abuse (DA) qualifier and the frequency of DASH completion across ethnic groups.
The below table and chart show that, during the period, 36% of DA occurrences related to White British victims, 5% to Non-White British victims and in 59% the ethnicity was not recorded.

Row Labels	Number of DA Occurrences by Ethnicity
Non-White British	1813
Not Recorded	21124
White British	12805
Grand Total	**35742**

The below data displays the DASH completion rates across the ethnic groups on DA occurrences and shows there is only a marginal difference in the percentage completion rates between White British and Non-White British groups (8.1% vs 7.8%). A Chi-squared statistical test reveals that there is no significant relationship between ethnicity and the completion of DASH forms (P>0.05).

DASH Completion on DA Occurrences by Ethnicity			
Ethnicity	**No**	**Yes**	**Grand Total**
Non-White British	142	1,671	1,813
Not Recorded	2,718	18,406	21,124
White British	1,039	11,766	12,805
Grand Total	**3,899**	**31,843**	**35,742**

16.5.8 The tables show only a marginal difference in completion rates between White British and non-white British groups. This is not statistically significant, though 59% of DASH completions are not measurable in terms of ethnicity of the victim.

(LO13) Learning Opportunity/Consideration; Improvement in recording of ethnicity may assist the police in analysing DASH completion rates for different ethnic groups.

16.5.9 This series of three incidents show limited learning opportunities in respect of the tragic murder of Hassan, they do reinforce the need for continued effort regarding the approach to domestic abuse through completion of DASH RIC and comprehensive investigation. Whilst in three out of three cases a DASH was not completed, the force data does not suggest that any inferences may be drawn as to why this was the case.

Fourth Incident

16.5.10 The fourth incident at midnight on 13th December 2018 may be seen in three parts. The first part was a communication from the ambulance service, regarding a call they had received just prior to midnight, the second part was receipt of information from a family member just after midnight and a third party, subsequent contact between the police and ambulance service in the early hours.

Fourth Incident - Part A

16.5.11 It seems the purpose of the call by the ambulance service to the police was to notify them of the information received. The police IMR author reports that a risk assessment was completed based upon the THRIVE model, which is a risk assessment tool that stands for Threat, Harm, Risk, Investigation Opportunities, Vulnerability of the victim and the

Engagement level required to resolve the issue. The elements are used to assign a priority level to an incident. It may also be used to reach and justify an operational decision.[50] The following factors were noted.

- Omar was aggressive to members of public recently and there was a possibility that he could be aggressive again.
- Omar's exact location was unknown though he was believed to be at home address.
- Omar had a cut to his hand (self-harm) and it was unknown how serious the wound was
- Omar was in possession of a knife and the location of the knife at the time was unknown
- Omar was suffering from psychosis.

16.5.12 The police operator closed the call, as a mental health issue being attended to by another agency. The IMR author reports that this call may have been escalated to a supervisor and attracted an immediate response.

16.5.13 It was further noted that the rational for not deploying resources was that this was mental health issue and given control room staff trying to manage a high volume of demand, the police IMR concluded this was not considered unreasonable. Whilst not presented with the demand picture at the time, a recent national inspection of police contact management through call handling and control rooms in 2018/19 found that "demand is in danger of overwhelming the police service", noting that "crimes and incidents involving vulnerable people are rising".[51]

16.5.14 Mindful of the counsel of perfection that is hindsight bias and understanding that Omar was allegedly suffering from mental health issues, one could argue reasons for immediate deployment. After all, he presented a risk to himself and potentially to others and had been in the street in possession of a knife and self-harming. At its lowest level, this initial call amounted to an allegation of a crime that merited investigation. At the higher level of risk, was the potential for Omar seriously harming himself. However, the police operator did advise the ambulance service to advise when they were on scene, should they require further assistance.

16.5.15 On exploring with the panel representative, it was discovered that this call, was actually passed to despatch, but owing to its low priority grading was not actioned, sitting at the 'lowest priority' grading.

(LO14) Learning Opportunity/Consideration; Escalation of calls for despatch and/or supervision where there are risk factors of weapons and mental illness.

Fourth Incident - Part B

16.5.16 Within ten minutes of the first call, a distant relative phoned police and explained that Omar had been seen in the street self-harming himself with a knife and he had concerns that Omar would either harm himself or someone else. Whilst he hadn't spoken to Omar himself, he expressed concern that he may have forgotten his medication. He also said that earlier that morning (12/12/2018) Omar had a knife with him and he had gone to a café and the café had closed because they were all scared of him. He further asked that if the police could find Omar, and take him away because he was going to be a danger to himself or the public. He also asked for an update as he was a concerned next of kin. He did not receive an update and may be considered as a missed opportunity to secure further information and more broadly engage with the community to secure trust and confidence through providing timely feedback.

[50] Source: https://www.justiceinspectorates.gov.uk/hmicfrs/glossary/thrive/ (Accessed June 2020)

[51] Source: *A call for help: Police contact management through call handling and control rooms in 2018/19 (justiceinspectorates.gov.uk) (Accessed Jan 21)

16.5.17 On discussion with the panel representative, there is no specific guidance in relation to calling members of the public back, and return calls are generally dependent upon the level of demand. The Victims Code of Practice is however in place, once a police investigation has commenced, though in this case the informant would not have been determined as a victim.

16.5.18 The call handler passed the callers details to the ambulance service and the call log was closed as 'mental health, other agency dealing'. No officers were sent to the scene and no further record was made on Niche. A revised THRIVE was not completed.

16.5.19 The IMR author notes that the THRIVE should have considered the following factors as indicative of the potential need for an immediate response.

- Omar was thought to be in possession of a knife.
- Omar was self-harming and had been described as being aggressive to members of public.
- The risks posed were unknown, such as his state of mind, current location and the seriousness of the injury he had.
- Police needed to know the location of Omar so that he could receive treatment to his injury.
- He was vulnerable with mental health issues.
- He had been seen in public with a knife and we needed to make the community a safe place.

16.5.20 The IMR author helpfully identified that an offence may have also been committed, that is; Having an article with a blade or point in a public place, Criminal Justice Act 1988 Section 139(as amended by the Offensive Weapons Act 1996).

16.5.21 The author also indicates that further intelligence checks were not completed and that these would have indicated previous calls to the address.

16.5.22 The author noted that there did not appear to be any supervisors' details shown on the police command and control system (STORM)[52] and police analysis says that 'sometimes calls do not reach supervisor scrutiny'.

16.5.23 The panel representative has confirmed that this additional detail was handled by a different call handler and that the details were recorded on the original call to the police made by the ambulance service.

(LO15) Learning Opportunity/Consideration; Seeking assurance regarding completion of THRIVE assessments and supervision.

16.5.24 The police IMR noted that refresher training on use of THRIVE is currently being delivered so emphasis on risk assessment and appropriate call grading will be addressed through this training and that the calls from this incident will be used to support that training.

Fourth Incident – Part C

16.5.25 The third part relates to a request for details by the ambulance service only in relation to the call by the family member (part B). The police call handler advised the ambulance service that police were waiting for a call from them before attending and records were updated to reflect this.

16.5.26 The police have acknowledged and sought to understand opportunities to learn from this incident, highlighting four issues below. Each has resulted in local agency recommendations.

[52] System for Tasking and Operational Resource Management. (Source NOT PROTECTIVELY MARKED (staffordshire.police.uk))

- Incorrect call grading and deployment, possibly due to diagnostic overshadowing
- Possible lack of professional curiosity/confidence by the call handler to go 'off-script' and gain absolute clarity on Omar's behaviour towards others with the knife.
- Poor data quality through incorrect recording of Omar's details
- Incorrect crime recording of a disclosed offence - possession of an offensive weapon in a public place.

16.5.27 The medical phrase 'diagnostic overshadowing' has been introduced as a concept and is defined as 'a process where health professionals wrongly presume that present physical symptoms are a consequence of their patient's mental illness. As a result, the patient with mental illness gets inadequate diagnosis or treatment'.[53] In these circumstances the result has been to rely on another agency to deal with the issues presenting.

(LO16) Learning Opportunity/Consideration; That the phenomenon of diagnostic overshadowing be subject to training and awareness raising in the force control room.

16.5.28 Police single agency recommendations have been made to address these issues.

- Training on 'diagnostic overshadowing' should be extended to call handlers in addition to Control Room supervisors. *Please note that this recommendation has already been agreed by the Force Incident Manager (FIM) and plans are in place to arrange protected time for call handlers to receive this training.*
- The Command-and-Control department should review call script questions and call handlers' use of 'off-script' questions in relation to calls where mental health and weapons is a feature. The department should take appropriate action to improve in this area as required.

16.5.29 Whilst these two local agency recommendations have been made, further matters were explored with the panel.

Risk Assessment

16.5.30 It is a matter of record that the second call, did not result in a revised risk assessment. The IMR notes the call handlers appear to have not properly assessed the calls using THRIVE and the Constabulary's Procedural Guidance for Deployment and Crime Allocation. The THRIVE[54] model is utilised to determine how calls are managed. Moreover, given that police training and decision making, including deployment is based upon the National Decision-Making Model (NDM), it may be argued that failure to apply THRIVE and NDM resulted in the missed opportunity to deploy.

[53] Source: https://www.psychologytoday.com/gb/blog/two-takes-depression/201510/depression-and-diagnostic-overshadowing#:~:text=Clinically%2C%20it%27s%20called%20diagnostic%20overshadowing,diagnosis%20or%20treatment%5Bi%5D. (Accessed June2020)

[54] THRIVE: Threat, Harm, Risk, Investigation, Vulnerability & Engagement

16.5.31 It would seem that a further learning opportunity arises from this incident, that is to remind staff to use the NDM and document those considerations.

(LO17) Learning Opportunity/Consideration; To highlight the importance of using the NDM for effective decision making and deployment of resources.

16.5.32 Whilst recommendations have resulted in respect of recognition of diagnostic overshadowing, the alternative solutions perhaps lie more directly, in the flagging of calls with multiple vulnerability factors (mental health, self-harming, carrying a knife) for mandatory attendance or perhaps mandatory supervision. This is subject of comment below.

(LO18) Learning Opportunity/Consideration; Escalation of calls for despatch and/or supervision where there are multiple risk factors; weapons, mental illness and self-harm

Professional Curiosity/Intelligence & Information

16.5.33 The police IMR acknowledges that this incident would have merited from improved professional curiosity and any information learned would have assisted subsequent decision making. As well as encouraging control room staff to go off script, it seems that there was other information knowable, but not sought as noted earlier. In this case a check of intelligence databases may have revealed Omar's criminal and broader history and would have revealed the previous domestic incidents. It seemed to the panel, that had this previous history been known, it may have been more likely to result in the deployment of resources. However, it is not certain they would have identified these incidents as the spelling of names given and different recording of addresses may have hindered identifying Omar correctly.

(LO19) Learning Opportunity/Consideration; To ensure that in reaching decisions as to despatch resources, call handlers carry out intelligence checks with the information available.

16.5.34 The panel learned of the 'Mental Health Triage Team' that used to be based within the police control room, is now available via the phone Monday to Friday, from 9am to 10pm. They can access mental health records and disclose information if the situation allows for this or even speak directly to the person suffering a mental health crisis. In Bristol, South Gloucestershire and North Somerset they may even be able to deploy a nurse to the scene, make referrals or update services. This partnership approach is acknowledged as good practice, though in

panel discussions it was learned that patients do have the option of opting out of the NHS Spine that would make it impossible to search for their information.

16.5.35 Given that the decision had been taken that this was a medical issue and dealt with by SWASFT, it is probable that further checks may have been completed had the team been available, though acknowledged that any information may not have been available if a patient had opted out of the NHS Spine that makes information accessible. It was also learned that the 'Triage Team' do not follow up, or investigate, they assist in triage only at the time of the call (if available). During panel discussions, it became apparent that outside these hours, there are gateways to accessing this information. Whilst understanding that resources are finite, it is recognised that not accessing medical information at the time was a barrier to informing decision making and offer fast time advice to the force control room.

(LO20) Learning Opportunity/Consideration; Restricted operating hours of Mental Health Triage Team, restricts immediate access to medical information and advice to inform decision making.

Demand

16.5.36 Whilst not presented with data to show the levels of demand at the times of these calls, it is accepted that call handling at around midnight is likely to be in a period of high demand and therefore challenging. The IMR author acknowledged that these incidents were a potential missed opportunity to engage with Omar and at the very least would have led to him being properly identified and incident recorded correctly. Upon exploring this challenge, the question of supervision was raised and whether a fresh pair of eyes may have steered a different response. However, in this case, the calls did not reach a supervisor, though the operator had the option to speak to a supervisor.

Supervision

16.5.37 On exploring the supervision of call handling, it was learned that supervisors use a quarterly quality assurance toolkit to assess performance. However, this does not include more live intrusion and supervision at the time. The IMR author in discussion with the Head of Command and Control observed more could be done to monitor call handlers' use of professional judgement to make a specific recommendation. This poses a challenge as when operators seek advice or as to how supervisors identify calls requiring supervisory intrusion.

16.5.38 The IMR mentions the use of 'weapons tags' and the Force Incident Manager had advised that calls of this nature (where somebody with a blade is in a public place and the assumed threat is more towards self-harm) tend to be recorded as Concern for Welfare with a weapons tag added to the call card. Given that these calls featured a number of key phrases such as, 'knife, 'harm', 'mental health' it is suggested that any one of these could, but certainly all three collectively may serve as 'tags' or 'flags' to prompt supervisory intrusion. It seems this presents an opportunity for the force control room to examine and put in place a more systematic method of call supervision for calls with risk flags/tags, to provide a secondary level of oversight and potentially authority for 'closing' such calls as complete. Considering the Avon and Somerset Police and Crime Commissioner's local response to a national report on call handling by Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS)[55] it was commented that three categories of call are mandated to have supervisory oversight including, missing persons, those suitable for desktop resolution, and firearms incidents. It was suggested that calls with multiple risk factors ought to be considered for mandatory supervision. This would support a comment made within the HMICFRS report on national call handling that 'forces need to have objective and consistent supervision to manage risk and avoid backlogs.'

[55] Source: PCC-Response-A-Call-For-Help.pdf (avonandsomerset-pcc.gov.uk) (Accessed March 2021)

(LO18) Learning Opportunity/Consideration; Escalation of calls for despatch and/or supervision where there are multiple risk factors; weapons, mental illness and self-harm

Policy

16.5.39 Notwithstanding the observation above, the police have examined its policy in relation to welfare checks that may reasonably be associated with calls as described above. Within that policy, it describes the core duties of policing to include;

- To save life and limb - There is an identifiable and immediate risk to life or property and/or the vulnerable person or child is suffering or are at risk of suffering immediate and significant harm.
- To keep the Queen's peace - Attendance of a police officer is necessary to prevent a breach of the peace.

16.5.40 The same policy continues "the Constabulary will respond to requests for assistance from external agencies and members of the public to conduct 'checks' where the following criteria are met;

- There is an identifiable and immediate risk to life or property.
- The vulnerable person or child is suffering or are at risk of suffering immediate and significant harm.
- It is reasonably believed that a crime has been committed, is being committed or is about to be committed."

16.5.41 In the series of calls listed above, it is suggested all three points are present and that the policy supports the police duty to protect life under Article 2 of the European Convention on Human Rights, incorporated by the Human Rights Act 1998.

16.5.42 The development of this policy is seen as positive and that the learning opportunity under supervision would serve to ensure adherence to that policy.

Fifth Incident

16.5.43 The final incident, where Omar made threats to kill was reported on the 8th January 2019 two days before the murder of Hassan. Whilst two days elapsed before the appointment of an investigating officer, that officer swiftly spoke to the victim, took a statement from the victim, researched police intelligence systems and spoke to Omar. The officer outlined options for dealing with the case and was candid that an investigation would be unlikely to result in a prosecution, as there were no witnesses. When the officers spoke to the victim, he said that he did not want to get Omar into trouble, that he just wanted to be left alone and thought the problems related to Omar's mental health issues. The matter was in effect resolved as a dispute and the officer agreed to try and resolve the issue and speak to Omar.

Data Recording

16.5.44 The police IMR notes that the incident on the 13th December was not identified on the officers' checks of two systems, STORM and NICHE, owing to a mis-spelling of Omar's surname. This resulted in the investigating officer not knowing of the recent incident regarding Omar's mental health and self-harming with a knife. One cannot know what decision the investigating officer may have made regarding this incident, had he been aware of this relevant information.

16.5.45 On exploring the level of searches and what it did reveal, it only showed the previous domestic incidents, and arguably this would have satisfied the officer that he was able to identify who he was dealing with. On discussion with the panel representative, only a forensic search, attempting different permutations of the address would have revealed the incidents in December. In this case, the actual discrepancy arose owing to the use of the

number and name of a block of flats or number and name of the road. In other words, there was an issue with data quality.

Mental Health, Professional Curiosity and Signposting

16.5.46 The police record of events shows that the victim told the police about Omar suffering from a mental health illness and did not want to get Omar in to trouble. The matter was in effect resolved as a dispute, saying that he wanted to be left alone. The result of this was that the officer agreed to try and resolve the issue and speak to Omar.

16.5.47 The chair has spoken to the victim in this case, who had known Omar for many years and with whom he had been friends. He said that he had told the police about Omar's mental health over the years and the police IMR confirms that the officer was aware of the victims concerns over Omar's mental health.

16.5.48 The police IMR notes that when the investigating officer spoke to Omar, he was calm and eloquent. He seemed rational and said he had no intention of carrying the threat out. Together with the fact that the officer was unable to identify the recent events in December, the outcome of the investigation is understandable. Risking hindsight bias, it seems from the IMR that the subject of Omar's mental health was not broached with Omar, in other words ask him directly whether he was suffering from any mental health problems or needed help in that regard. In part this may be seen as a consequence of dealing with the matter informally, but given how fearful the victim was and even if the threshold for a formal interview and prosecution was not met, this was an opportunity to ask him about his mental health and 'how he was feeling' and signpost him to support.

16.5.49 Had the matter been dealt with formally, police would have been obliged to speak to Omar in accordance with the Code C of the Codes of Practice that relates to voluntary interviews, that states within a notice to persons being interviewed, "If you are under 18 or are vulnerable, for example if you have learning difficulties or mental health problems, then you have a right to have someone with you during interview. This person is called your "appropriate adult" and they will be given a copy of this Notice".[56]

16.5.50 Whilst Omar was not arrested and formally interviewed, the National Appropriate Adult Network reported that "Clinical interviews have shown that 39% of adults in police custody have a mental disorder and 25.6% have psychosis, major depression, intellectual disabilities or lack capacity to consent to a research questionnaire" (McKinnon and Grubin 2013, 2014), and found that the police recorded the need for an appropriate adult in 5.9% of cases in 2017/18. [57] However, it is also noted that there is no statutory duty to provide appropriate adults, even though there is a legal duty to ensure that a child has an appropriate adult.

16.5.51 This is not to suggest the outcome would have been any different, but greater consideration of mental illness may have improved their understanding of Omar and/or may have alerted Omar to consider the need to seek help.

(LO21) Learning Opportunity/Consideration; To be professionally curious when dealing with individuals who allegedly suffer from mental health problems in order to ensure opportunities to signpost for support are identified.

Mental Health and Effects of Medication

16.5.52 During panel discussions in respect of the murder, the question arose as to whether Omar had given reasons or an explanation for not taking his medication and would it have been

[56] Source: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/761390/2018_CodeC-NoRE-_Voluntary__HO__Final__NoHighlights_18-12-04.pdf (Accessed June 2020)

[57] Source: Vulnerable Adults (appropriateadult.org.uk) (Accessed May 2021)

possible to determine on the basis of what was found on scene, what medication had or had not been taken. These were explored outside the panel meeting by the police panel representative.

16.5.53 In respect of taking his medication, Omar had given vague indications that he would stop his medication when he started to feel ok, but no specifics were given. He was asked several times why he stopped his medication and what would make him start again but his responses did not make sense and he was getting very confused. He indicated that he became very low, feeling paranoid and hearing voices if he stopped taking his medication. He said the medication could make him feel a little tired but did not link this to why he stopped taking it.

16.5.54 It has not been possible to determine what medication Omar had or had not taken. Whilst in custody Omar explained that he had taken four medications for his mental health, but that he did not know the names. This line of enquiry has therefore not been possible to follow up.

Summary Analysis in Respect of Key Lines of Enquiry

Term 1 – Family awareness of abuse and barriers to reporting.

16.5.55 There was no information available to police or others regarding Hassan residing at the address.

Term 2 – Interagency Communication

16.5.56 Police received the information from SWASFT and a family member. There was no other communication with agencies and the Mental Health Triage Team whose operating hours are restricted were unavailable to access information from medical records, nor offer professional medical advice.

(LO20) Learning Opportunity/Consideration; Restricted operating hours of Mental Health Triage Team, restricts immediate access to medical information and advice to inform decision making.
Recommendation 5: Seek to ensure that staff are aware of how to access medical information out of hours.

Term 3 – Standards and Policy

16.5.57 The police did not complete DASH RIC's on all three of the domestic incidents they attended. An examination of data showed that there were gaps in completing ethnicity data, but on the reported data, there was not a statically significant difference for BAME communities.

16.5.58 The overall force completion rates for DASH are at nearly 90% and the panel are aware that this performance is subject to scrutiny, through the Police and Crime Commissioner and a number of performance meetings.

16.5.59 The call handling centre did not complete the THRIVE risk assessment on the call received by the member of the public, therefore did not work to the force guidelines and did not re-consider the risk in accordance with the National Decision-Making Model.

(LO17) Learning Opportunity/Consideration; To highlight the importance of using the NDM for effective decision making and deployment of resources.
Response: Refresher training on use of THRIVE was being delivered when this review had commenced and was using this incident to support training.

16.5.60 The recent development of a new welfare policy is seen as a positive development for the police, that will assist in providing the guidance to call staff in making decisions to deploy staff.

Term 4 – Agency Actions (Assessment, Actions, Relevance and Timeliness)

16.5.61 There were no concerns raised by any agency regarding Hassan and domestic abuse.

Term 5 - Thresholds

16.5.62 The missed opportunity to complete THRIVE resulted in a missed opportunity to consider the risk.

16.5.63 There were a number of apparent risk markers, including 'mental health', 'knife' and 'self-harm' as well as an apparent crime of possessing a knife in a public place. These were summarised in the IMR, and it was noted as a missed opportunity to deploy resources, in part explained by the fact that the call operator was reliant on the ambulance service. The technical term 'diagnostic overshadowing' was used to describe the potential phenomenon and individual agency recommendations have been made to highlight this potential and also consider how to go 'off script' and seek further information. Single agency recommendations have been made regarding this learning.

(LO15) Learning Opportunity/Consideration; Seeking assurance regarding completion of THRIVE assessments and supervision.
(LO16) Learning Opportunity/Consideration; That the phenomenon of diagnostic overshadowing be subject to training and awareness raising in the force control room.
Single Agency recommendations:

- Training on 'diagnostic overshadowing' should be extended to call handlers in addition to Control Room supervisors. Please note that this recommendation has already been agreed by the FIM and plans are in place to arrange protected time for call handlers to receive this training.
- The Command-and-Control department should review call script questions and call handlers' use of 'off-script' questions in relation to calls where mental health and weapons is a feature. The department should take appropriate action to improve in this area as required.
  +
- Refresher training on use of THRIVE was being delivered when this review had commenced and was using this incident to support training.

16.5.64 Notwithstanding the phenomenon of diagnostic overshadowing, an alternative opportunity was identified, of flagging calls with multiple vulnerability factors (mental health, self-harming, carrying a knife or weapon) for mandatory attendance and/or supervision.

(LO14) Learning Opportunity/Consideration; Escalation of calls for despatch and/or supervision where there are risk factors of weapons and mental illness.
(LO18) Learning Opportunity/Consideration; Escalation of calls for despatch and/or supervision where there are multiple risk factors; weapons, mental illness and self-harm.
Recommendation 6: Avon and Somerset Police to review call handling policy where there are multiple apparent risk factors and implement a systemic approach that mandates these calls being supervised.

16.5.65 It seems that information was not used to check police databases and an opportunity to consider previous domestic calls was not considered in making any decision to deploy resources.

(LO19) Learning Opportunity/Consideration; To ensure that in reaching decisions as to despatch resources, call handlers carry out intelligence checks with the information available.
Recommendation 7: Avon and Somerset Police to review their systems of call handling to ensure that intelligence checks are carried out and recorded within the call handling system.

Term 6 – Cultural Sensitivity

16.5.66 It was noted in discussion that the caller who reported the incident in December spoke with a heavy accent, but this did not preclude his concerns being recorded or present as a barrier.

16.5.67 Omar's specialist needs related to his mental health. This was not an apparent issue nor identified whilst managing the domestic incident calls and whilst clearly stated as part of the reason for calling police in December, did not result in police deployment as this was deemed at the time as being a medical issue being dealt with by SWASFT. The decision not to attend therefore precluded the police having the opportunity to consider and address any specialist needs that Omar had.

16.5.68 The police dealt with the threats to kill informally, as the victim had said he did not want to get Omar into trouble. Notwithstanding the fact that police spoke to Omar, they did not directly address concerns raised by the victim about his mental health. This was a missed opportunity.

(LO21) Learning Opportunity/Consideration; To be professionally curious when dealing with individuals who allegedly live with mental health problems in order to ensure opportunities to signpost for support are identified.
Recommendation 4: That the learning from this review is shared through mandatory safeguarding training to encourage increased professional curiosity when presented with potential client welfare concerns.

Term 7 – Escalation

16.5.69 The IMR author noted the potential to deploy resources and to raise any concerns to a supervisor. Given that the calls were handled by different members of staff and the apparent risk features of the calls described above, there seems to be an opportunity to introduce a more systematic live method of call supervision, rather than reliant on what has been described as quarterly dip sampling. Such a regime could be achieved through triangulated use of flags and tags. (See 16.5.63)

Term 8 – Training and Awareness issues

16.5.70 Whilst there are no direct training and awareness raising issues regarding domestic abuse, the issues of diagnostic overshadowing have been subject of an individual agency recommendation.

16.5.71 It is further suggested that the circumstances of this homicide would merit sharing with police officers and call handling staff.

16.6 South Western Ambulance Service NHS Foundation Trust Perspective

16.6.1 This analysis has been considered by reference to the SWASFT chronology, a concise investigation report, conversation between the chair and panel representative where specific questions were asked. The completion of full IMRs is ordinarily reserved for incidents under the scrutiny of the coroner, regulators or otherwise fall within the ambit of the 'Serious Incident Framework'.

16.6.2 The ambulance service had two contacts with Omar during the relevant period within a short period of time and none with Hassan.

Incident 1

16.6.3 The first incident occurred related to Omar reportedly self-harming just before midnight on the 12th December 2018.The caller advised that they had contacted the police and were advised to call for an ambulance.

16.6.4 On reviewing the call log, the ambulance service was presented with some initial difficulties, in that the informant was a third party, who had not directly witnessed Omar self-harming. His whereabouts were unclear, so the ambulance service spoke to the police within five minutes of the initial call. The police reported that they had received a number of calls and were not attending. The police provided some potential contact numbers that were attempted and voicemails were left. They spoke to the original informant and the log shows that he was concerned about Omar, but he himself had no contact number for him. It was the callers concern for Omar that contributed to the decision to deploy an ambulance, though this was not a high priority call. This shows that the ambulance service was proactive in trying to find out further information.

Intelligence and Information

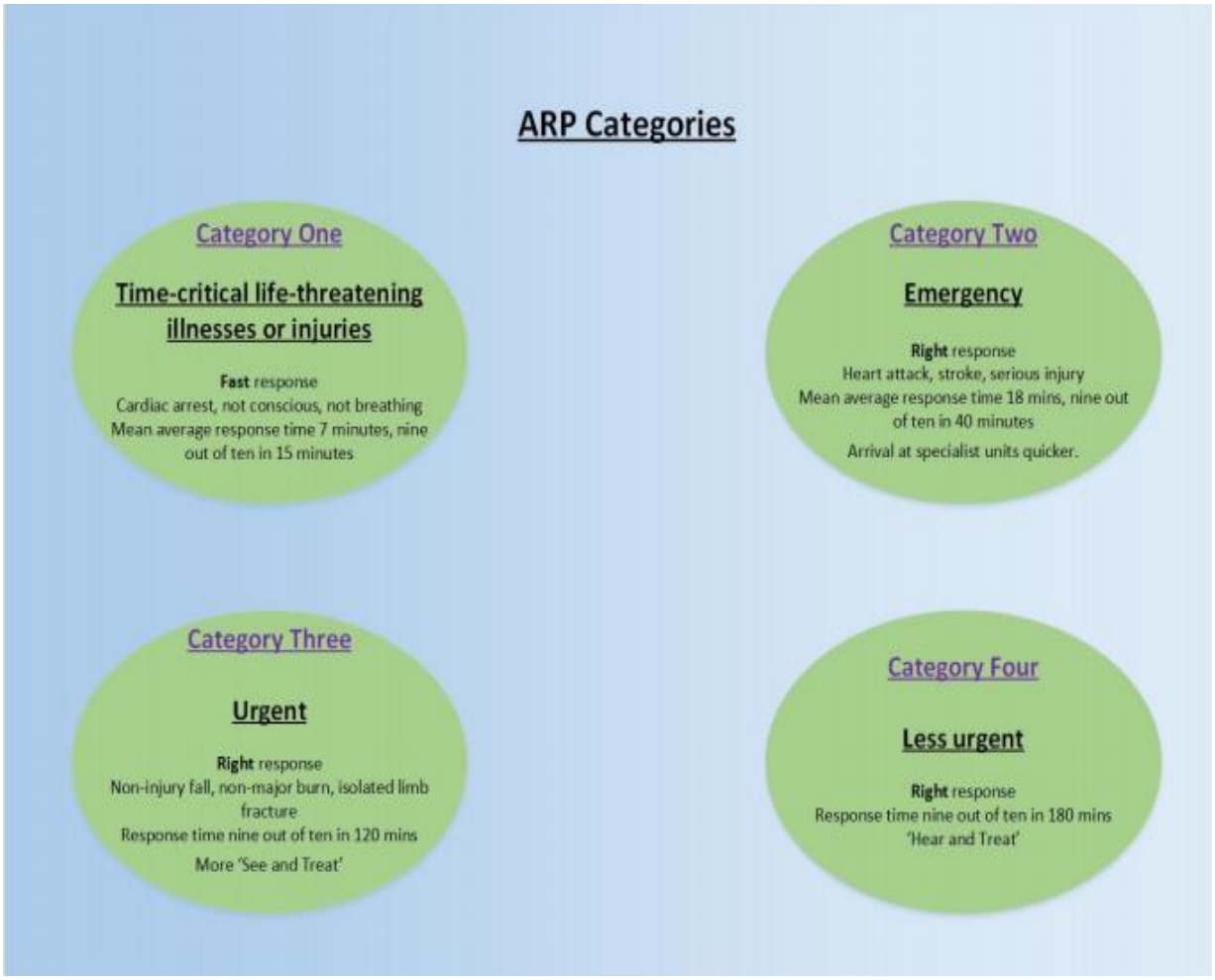
16.6.5 The ambulance service spoke to the police within five minutes of the original call and this is recognised as effective practice. A further call to the police was made later and details were obtained for a possible phone number for Omar and for the original informant.

16.6.6 Whilst efforts were made to establish details from the police and the public, the question arose as to broader information seeking, after all Omar had been described as psychotic. The panel learned that at that time of day, there are no other sources of information available and the ambulance service is reliant on seeking information from the police in this kind of situation. See 16.5.35.

Urgency of Response

16.6.7 The panel explored the urgency attributed to this call and referred to a policy entitled "Requests for Assistance and/or Support Regional Collaboration Agreement Between the South West Regional Police Forces, Fire & Rescue Services and South Western Ambulance Service NHS Foundation Trust". This describes four categories of response as shown in the diagram below. This is reflective of the National NHS categories as outlined by the NHS Ambulance Response Programme.[58]

[58] Source: https://www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/arp/ (Accessed August 2020)



16.6.8 This incident was categorised as 'Category 3' that is patients who are in urgent need of medical assistance and attracts a target response time of 120 minutes. The final code given to this call is summarised as; "patient is suffering from a mental health issue, with unknown status, however there is potential for them to be violent".

16.6.9 The ambulance service made twelve calls in advance of their final attendance, attempting to contact Omar on a phone number given, as well as the original informant and engaging with the police. These attempts were made between 2.29am and 5.51am and included contact with another friend who did not know where Omar was.

16.6.10 The concise investigation report observed that the first attempt at a welfare call (at 2.29am) to the patient was outside the two-hour standard of the service standing operating procedures. At this point, Omar's phone number was not available and didn't become available until 3.21am. Since the date of this incident, the standing operating procedure has been rewritten and released on the 20th April 2020 and renamed 'Procedure of ensuring the safety of Unallocated Calls'. The concise investigation reported "It was re-written because there 'needs to be an understanding that as demand continues to increase, our capacity to respond in a timely manner to some patients decreases, as does our ability to maintain welfare calls to all patients. As such, we need to adapt our approach and ensure we continue to operate a safe as possible service." This procedure was further updated in January 2021. Guidance is now based on the size of the 'stack' (the queue of outstanding 999 calls). It should be noted that the demand profile during the coronavirus pandemic has been so unique and unpredictable that many procedures have had to be redesigned. Commissioners and regulators have oversight of the risk management of the stack.

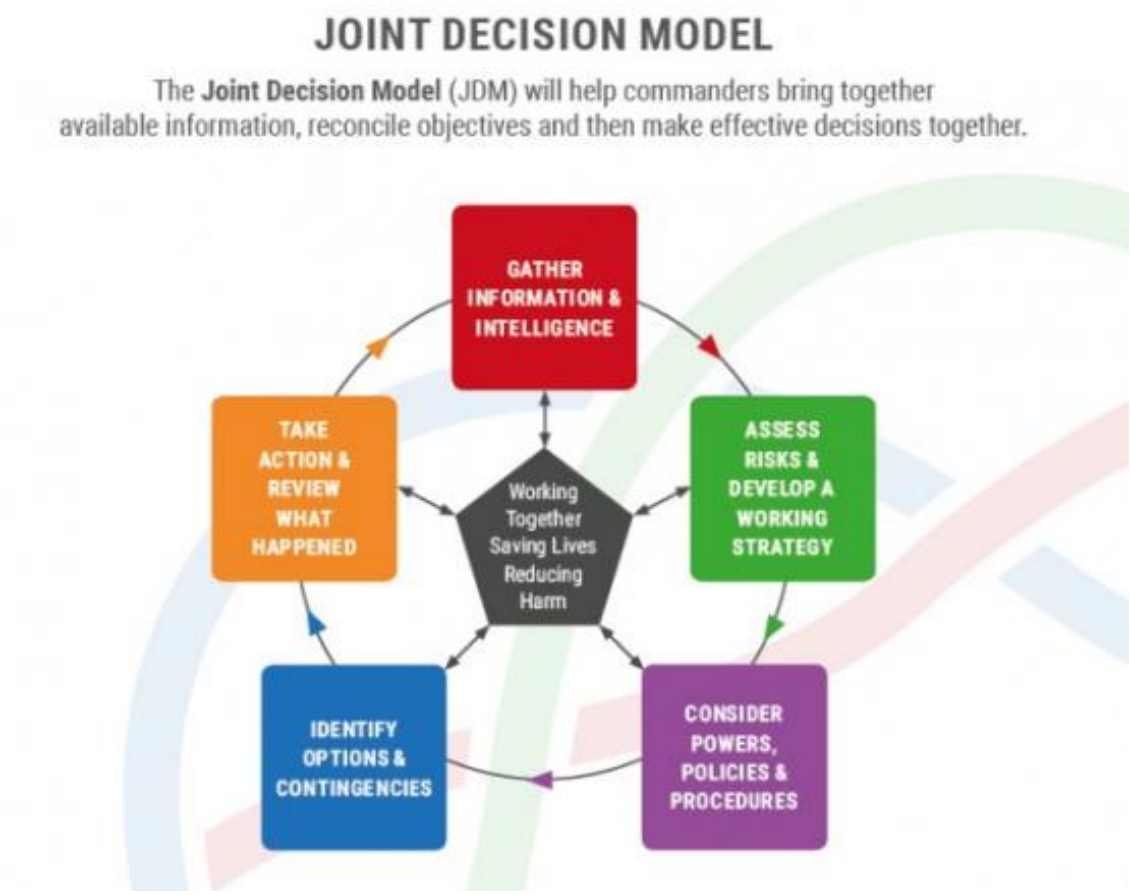
16.6.11 The final time of arrival was 6 hours 53 minutes later. The ambulance concise investigation report examines the delays and it is noted that this call was escalated and reviewed by a supervisor who maintained the call as a category 3. The responsiveness has to be seen against a background of increasing demand. Between midnight and 1am, there were ten category 2 calls awaiting deployment. Furthermore at 1.08am the duty manager notes there were 48 active calls and 68 awaiting allocation. These issues were also compounded by handover delays at hospitals across the region. One may therefore conclude that the service response time was understandable and whilst maintaining the call at a category 3, attempted to make contact with the patient and others throughout the deployment period.

Action on Scene

16.6.12 The ambulance service attended a number of hours after the initial call and a number of matters arose. The first matter relating to the decision to speak to Omar via an intercom and not seek to speak to him in person. On the one hand, it was reported that at the time of SWASFT attendance he sounded coherent and did not seem in distress, and yet on the other hand he was reported earlier as having been psychotic, self-harming and others were worried about him.

16.6.13 On discussion with the panel representative, it was learned that it is a relatively frequent occurrence for ambulance crews to get stood down at the door without getting access to patients with ambulance crews having to make dynamic decisions about risk. In conversations at the door, the crew would have been observing for any evidence that a person was in need of immediate assistance and either couldn't communicate or was being prevented from communicating their distress. If any evidence was present, the crew would have recalled the police and asked them to arrange forced entry to the property.

16.6.14 To assist panel understanding of the decision making of the attending ambulance crew, the SWASFT representative drew the panels attention to the joint decision- making model as shown below. It was noted that this is in effect the same decision-making model used by the police service.



16.6.15 In this particular case, the ambulance crew would have been weighing up the 'reported information' versus the 'information observed'. And in this case, as we have learned at 16.6.6 above, the only other information available was that supplied by the police.

16.6.16 Notwithstanding, the attending crews decided no further immediate action was required, it seemed that Omar had at the very least presented to others some degree of vulnerability and this raised the question as to whether any alerts were considered and/or reported such as a safeguarding alert.

16.6.17 In order to consider the necessity for such an alert, one has to consider, the totality of information available and in this case, it was deemed there was insufficient information available to merit a safeguarding alert, being reliant on information reported and communication with Omar via the intercom.

16.6.18 The attending clinicians, would have also considered a number of powers and policies available at the time. These would likely have included;

- the need to seek police assistance to exercise powers to safe life and limb under the Police and Criminal Evidence Act 1984
- powers under the Mental Health Act 1983 where there are concerns regarding a subject's suffering from a mental disorder.
- the Human Rights Act including specifically the right to life and rights to a private life.

Given, that the physical injury did not require treatment the following day when SWASFT attended and there are no other medical records, it may reasonably be concluded the decision not to use powers to secure entry to save life and limb was correct.

16.6.19 The panel explored what other mechanisms may have been available to alert agencies as to Omar's behaviour and the only other option would have been to refer the patient to the GP. Such decisions are made on a case-by-case basis by frontline clinicians depending on the amount of information available, whilst working through the decision-making model in the diagram above. The chair was informed that express consent is required for such a referral when patients have the capacity to consent. Matters arising, therefore include (a) mental capacity, (b) whether he was asked and (c) the matter of consent.

16.6.20 Issues of mental capacity are guided by five principles, the first of which is "A person must be assumed to have capacity, unless it is established that he lacks capacity".[59] It is therefore acknowledged that it was Omar's right not to be examined, nor to consent to any alert being made.

16.6.21 Whilst it has not been possible to determine whether Omar was asked if he consented to his GP being alerted, a number of pertinent points from the Annual Report of the SWASFT Safeguarding Service 2018/19 [60] show a positive direction of travel for safeguarding referrals and alerts to GP's. Mental health, self-harm and suicide were in the top ten of reported markers for submitting safeguarding alerts for adults. [61] The levels of safeguarding training achieved stood at 92% and 95% for staff requiring training. The level of safeguarding alerts and referrals to GP's had increased incrementally for the past 5 years, adult alerts went up 20% in the last year alone, and GPs received almost 50% more referrals than the next nearest agency adult social care.

16.6.22 The law regarding sharing of information is complex. The Information Commissioners Office (ICO) describe six reasons for sharing, one of which is consent. Another lawful basis that one may consider is 'vital interests' but goes on to describe the necessity being borne of a reason to 'protect your life or the life of someone else'[62]. However, if this argument were used, then the ambulance service would have sought police assistance and forced entry to save life and limb, and arguably a referral could then have been made without consent.

16.6.23 Mindful of the risks of hindsight bias, considering the first part of the decision-making model on 'gathering information and intelligence' and in the knowledge that Omar had received treatment from specialist mental health clinicians in the last six months, it could be argued that the attending crew's inability to access information limited the holistic view of the circumstances.

16.6.24 In discourse with the SWASFT panel representative, an alternative view was put forward that 'the trust knows that pre-hospital clinicians are prone to bias from analysis arising from patient risk investigation. Consequently, as part of human factors training, frontline clinicians are encouraged to see each episode of contact as a fresh event' It is recognised that medical and social history is important, but it is more important to assess pre-hospital clinical risk on a case-by-case basis using the presenting signs and symptoms.

16.6.25 However, it seems to the chair and panel, that the lack of an available forensic history limited the information picture upon which to make decisions at the time. It is not possible to conclude an alternative decision about seeking police assistance to force entry and then alerting Omar's GP would have been made, but that the basis would have been better informed. It is also not suggested that, approximately 1 million calls to the ambulance trust

[59] Source: Mental Capacity Act 2005 (legislation.gov.uk) (Accessed August 2021)
[60] IBID
[61] Source: https://www.swast.nhs.uk/assets/1/swasftsafeguarding_service_annual_report2018-19.pdf (Accessed August 2020)
[62] Source: Does an organisation need my consent? | ICO (Accessed June 2021)

result in an alert to a GP. After all, of the Safeguarding alerts, only 569 were made on the basis of self-harm or suicidal ideation.[63] However, it is acknowledged such events would be of interest to a patient's GP and an opportunity my arise to consider whether self-harm/suicidal ideation incidents may meet the 'vital interests'' criteria of the ICO.

16.6.26 The challenges of responding to incidents of self-harming and suicidal ideation is subject to specific comment in a revised version 5 of the SAWS clinical guidance entitled 'Mental Health and Capacity Considerations in Patients Who Present as Having Self-Harmed or Attempted Suicide', wherein it specifically advises consideration must be made with the patients consent to refer to or access support including Mind, mental health crisis team, Samaritans or GP. This guidance is recognised as informative and good practice.

16.6.27 The guidance further comments on decisions to alert GPs without consent.

"Patient refuses referral to other health and social care professionals … the patient may express that they do not consent to other healthcare professionals being contacted. However, if the patient is at risk of serious harm to themselves (or others) and is at risk from deterioration from their condition, this is a justifiable reason when confidentiality may be over-ridden in the patient's best interests, as the risks posed by non-disclosure likely outweigh the risks posed by disclosure to specialist healthcare professionals".

16.6.28 The above statement of identifying that a patient is at risk of harm, is in part reliant on possessing all the information available. It therefore adds weight to the argument of ensuring attendant clinicians have available relevant medical information.

Incident 2

16.6.29 The second contact with the ambulance service took place the following day, in the early hours when Omar's apparent partner reported Omar had gone to bed as normal and when she had tried to wake him thought that he was unconscious and not breathing so rang 999. On exploring this incident with SWASFT, they reported Omar was annoyed at his partner having called them, he appeared to be healthy, alert and orientated scoring 15/15 on the Glasgow Coma Scale that is described as 'a practical method for assessment of impairment of conscious level in response to defined stimuli'. [64] His capacity was assessed via the CURE test and found to have full capacity. The CURE test is a four is a four-stage assessment of a patient's ability to; communicate a decision; understand the information that would enable them to make the decision; retain the information in order to make the decision; employ the information to make the decision effectively. [65]

16.6.30 Furthermore, Omar said he did not want to be checked over and signed a disclaimer to that effect. This is recognised as positive practice.

16.6.31 The question arose as to whether Omar was identified by SWASFT as the patient experiencing a mental health crisis and self-harming in the street the service had spoken to the previous day. Whilst commentary at 16.6.21 applies, it seems that this presented an opportunity to consider the events of the previous day, it would also seem that the outcome would have been the same, in that he was spoken to, underwent the four-stage assessment and declined assistance.

[63] IBID

[64] Source: https://www.glasgowcomascale.org/ (Accessed August 2020)

[65] Source: https://mentalhealthcop.wordpress.com/2012/05/09/the-cure-test/ (Accessed August 2020)

16.6.32 Notwithstanding, whether he was identified as the same person, it seems that these events that in effect took place within a day demonstrate the changeable nature of Omar's behaviour.

Summary Analysis in Respect of Key Lines of Enquiry

Term 1 – Family awareness of abuse and barriers to reporting.

16.6.33 There is no evidence of either Hassan or Omar having been involved in an abusive relationship.

Term 2 – Interagency Communication

16.6.34 The ambulance service contacted police within five minutes of the initial call. This is good practice. A further call was made at 3.21am and potential contact details were obtained for the patient. This allowed for numerous attempts to be made to try and speak to Omar.

Term 3 – Standards and Policy

16.6.35 The service was unable to meet its policy to make welfare calls within 2 hours as, on the first attempt at 2.29am, they did not have a potential phone number for Omar. This only became available at 3.21am, after a further call to the police, suggesting an opportunity to try and gain more information earlier. This policy has subsequently been reviewed.

Term 4 – Agency Actions (Assessment, Actions, Relevance and Timeliness)

16.6.36 Two incidents arose for potential assessment. With regard to the first incident of self-harming, there was insufficient information available to consider a safeguarding alert and it was not clear if consent was given to alert Omar's GP. It was recognised that decisions made on attending the first incident were based on presenting facts in accordance with training, but that had Omar's forensic history been available, decisions would have been better informed, though not necessarily different. In this case Omar had sounded lucid and coherent, and the option of seeking further police assistance to force entry was not deemed necessary.

16.6.37 Ultimately a decision made precluded an alert being made to his GP that there had been an event of concern indicating a change in the steady state of Omar's mental health.

16.6.38 Ambulance crews did speak to him on the second incident, and he was dealt with again on the basis of presenting symptoms and no further information was sought as to forensic history, nor was the call the previous day identified. However, he did undertake a four-stage test in respect of decision making and declined assistance.

16.6.39 Whilst attempting to avoid the counsel of perfection 'hindsight bias', there was relevant information in existence, but not immediately available that would have been helpful. The panel note the reliance on police information at paragraph 16.6.6 that is subject of other learning opportunities (LO19 & LO20).

Term 5 - Thresholds

16.6.40 Ambulance crews have worked in accordance with training and in accordance with safeguarding legislation and guidance as to only alerting GPs. It was determined there was insufficient information to merit a safeguarding alert and no information has subsequently come to light that would have merited an alert.

16.6.41 On further consideration an alert to GP with a patient's consent, it seemed to the panel that Omar's GP would have wanted to know of this incident as a 'trigger event' as it may have

aided ongoing treatment in primary care. The panel are also mindful of the progress and significant reported increases in GP alerts.

16.6.42 The panels attention was drawn to SWASFT's Revised Clinical Guidance 'Mental Health and Capacity Considerations in Patients Who Present as Having Self-Harmed or Attempted Suicide' that adds weight to the argument that clinicians would benefit from having as much information as possible to inform their decision making.

Term 6 – Cultural Sensitivity

16.6.43 The ambulance crews were able to communicate with Omar, via intercom and then in person on two separate occasions. There were no barriers apparent.

Term 7 – Escalation

16.6.44 The calls were subject to continued assessment and supervision against a background of changing demand.

Term 8 – Training and Awareness issues

16.6.45 The trust's safeguarding training has demonstrable (95%Level 1, and 92% Level 2). Effectiveness is translated in respect of significant increases in alerts over 5 years prior to 2018/19.

Good Practice

16.6.46 SWASFT were tenacious in their response to the first incident, making twelve calls, before being able to deploy a unit.

16.6.47 Improved training compliance and resultant outcomes regarding safeguarding alerts are acknowledged.

16.6.48 SWASFT Revised Clinical Guidance 'Mental Health and Capacity Considerations in Patients Who Present as Having Self-Harmed or Attempted Suicide' is recognised for its detail and comprehensive consideration of factors to inform clinician decision making.

16.7 Broader Considerations Arising from Family Engagement

16.7.1 On speaking to the friends and family of Omar, this enabled a broader understanding of some of the cultural issues that may be pertinent to this review.

Clans

16.7.2 A useful reference document entitled "Culture, context and mental health of Somali refugees"[66] provides some narrative of relevance to this review, that added understanding to the accounts of four/five family members/friends of Omar.

16.7.3 The chair learned that Omar and Hassan came from different clans and geographic areas of Africa, with Omar coming form an area previously known as British Somaliland and the other the Italian administered 'United Nations Trust Territory of Somalia' that merged into the Republic of Somalia.

16.7.4 The chair has been able to speak to those associated with Omar, but not Hassan. In part this may be owing to the fact that Hassan had only recently arrived to the UK but may in part also be explained by the strong clan system that exists within the Somali community.

[66] Source: https://data2.unhcr.org/en/documents/download/52624 (Accessed April 2020)

16.7.5 On attempting to speak to Hassan's family, the chair was informed that the family wanted to put matters behind them. Other family members explained that elders had become involved and as far as the families were concerned, an agreement had been reached. It may be that a traditional approach to resolving disputes had been used that is, usefully described in a UNHCR publication 'Culture, context and mental health of Somali refugees', describing "Xeer and diya Somali customary law (xeer/heer) is an oral system of pre-Islamic origin and is often practiced for resolving social problems, for example when conflicts arise between families. When a problem has occurred, the elders (xeer beegti) come together to find an agreement between the parties involved".[67]

Mental Illness and Somali Community

16.7.6 Each of Omar's friends and family members were well aware that he suffered from mental illness, and some referred to some kind of PTSD. They spoke about periods when he was well, but also periods when he became agitated. One spoke of a psychosis and of Omar hearing voices and Omar accusing them of spying on him. They had also said this became worse when Omar didn't take his medication. This was confirmed by another that they had heard he didn't like taking his tablets. What was clear from these friends was that Omar had problems with his mental health for many years and certainly since he arrived in the UK in around 1989.

16.7.7 The chair explored what help Omar had, his friends and family members were aware that he had been on some medication and was under the treatment of his doctor. They were also aware that he had spent some time at a psychiatric hospital. One family member explained that there was a stigma in the Somali community about mental illness. They went on to say that Omar's issues in respect of mental illness were the tip of an iceberg of mental health problems in the Somali community. They further expressed a view that the Somali community were unsure of how to present themselves and seek help for mental illness.

16.7.8 One of Omar's cousins explained how they had sought to help Omar, how they had attended the GP surgery as support for him. This was at a time, when he was particularly suffering from facial tics, having difficulty closing his mouth and his tongue would hang out. Upon asking whether this led to other help, or whether Omar had sought any traditional Somali treatments, they said he relied on the GP and recalls he had been to the hospital for help but did not seek help from other sources.

16.7.9 The concept of mental illness is referenced in the UN Refugee Agency document "Culture, context and mental health of Somali refugees". This document explains that a person affected by a severe mental illness is described as "waali", literally translated as 'craziness' or 'madness'. Furthermore, the document explains "labelling someone as being waali may lead to social exclusion, isolation and stigmatisation. Persons who are waali have an almost total lack of access to marriage and employment and are usually excluded from taking any form of responsibility within the family or community." That is not to say that Omar's conditions and presentations were that extreme, but when also seen alongside tardive dyskinesia, one can imagine the negative effect on Omar, a man whose friends describe as very proud.

16.7.10 The Council of Somali Organisations reported that stigma is the biggest challenge for the Somali community in the UK in the context of mental health. Though labelling and stigma attached to people with mental illness is rather common among other societies, it is more intense and more evident in communities that hold the kinship network in high regard. In a nutshell, people with mental illness are stigmatised and accused of being incurable.[68]

[67] Source: 5bbb73b14.pdf (unhcr.org) (Accessed December 2021)

[68] Source: https://www.councilofsomaliorgs.com/sites/default/files/resources/CSO-M.Health%20Report.pdf (Accessed April 2020)

16.7.11 Whilst the overall narrative from the conversations with friends and family related to mental health, it was also apparent there was a sense of grievance in how agencies handled Omar's mental health. When considering Omar as an individual the authorities had let him and Hassan down. One said, 'they didn't care to look for information logged about him when they were dealing with him'. This observation made independently links with learning opportunities noted in paragraphs16.5.56 & 16.5.65.

16.7.12 One family member shared that one only had to look at the numbers of Somali men in prison with mental health problems to demonstrate the scale of the issue. This issue has received some attention in the local news, Bristol Live reported in April 2019 "There is a mental health crisis in the Bristol Somali community with ten related deaths recorded".[69] This was followed up in October with an article reflecting some of the challenges including the stigma associated with mental illness in the Somali community.

16.7.13 More recently, a publication "Improving Mental Health Support for the UK Somali Community'[70] explores a number of the challenges confronting the Somali Community, that includes (a) inequality and mental health and (b) mental health in the Somali community. It is beyond the scope of this review, to analyse the findings of this report, suffice to say that there are factors identified that are congruent with observations from this review, such as 'the trauma of civil war, the effects of which still remain' and 'barriers to seeking help such as a tendency to lump together all BAME communities'. After all, we know Omar was a war veteran and we have learned that both his and Hassan's clan came from areas directly affected by civil war. We have also learned that Omar had been referred to Nilaari, a 'BAME led, community-based charity'.[71] Whilst an IMR was not completed by Nilaari, the chair spoke to a senior manager and learned there is no specialist Somali talking therapy provision in the organisation. This is recognised as having been a potential barrier to Omar engaging with services.

(LO23) Learning Opportunity/Consideration: To seek assurance that authorities are sufficiently engaged with the Somali community in regard to managing mental illness.
Recommendation 3: Improve the understanding of the specific needs of the local Somali Community (SC) in respect of Mental Health that includes; - what enables/hinders the SC accessing support and that clearly identifies the gaps in provision.

Domestic Circumstances

16.7.14 On enquiring about his home circumstances, Omar's family and friends explained that, not only had Hassan lived with him, but two or three other men. Whilst the details were unclear, two said that the other men had left due to Omar's behaviour leaving Hassan alone with Omar. Hassan had apparently said that Omar was OK with him. No one was able to describe in greater detail the nature of Omar's behaviour which persuaded the other tenants to leave.

16.8 A Community Perspective

16.8.1 In January 2021, the chair spoke to four representatives from two organisations with close links to the Somali community in Bristol. In the absence of first-hand knowledge of the individuals, the chair sought to gain a perspective on the homicide based upon what they knew as part of the community.

[69] Source: https://www.bristolpost.co.uk/mental-health-crisis-bristol-somali-2767603 (Accessed May 2020)
[70] Source: ATM-Improving-Mental-Health-Support-for-the-UK-Somali-Community.pdf (theatm.org) (Accessed September 2021)
[71] Source: Nilaari_Annual_report_2019-2020.pdf (Accessed September 2021)

Community

16.8.2 On considering how single men may find accommodation, it was commented on that it was not unusual for the Somali community to take people in and provide accommodation. They recognised that of course, payment may be made for lodgings, but that this practice was relatively common, given the rental costs of accommodation in the area.

Mental Illness

16.8.3 The representatives were aware that Omar was living with mental illness, had been in contact with agencies shortly before the incident, and that this was a key feature of this homicide. They suggested that there may have been a systemic failure in providing the support, and taking the action required in respect of Omar and his mental illness. As the representatives did not have first-hand knowledge of Omar and his interaction with agencies interaction, the chair explored broader themes pertinent to the Somali community and 'enablers' and 'barriers' to the community accessing support and help for mental illness.

General Comment

16.8.4 They observed that the majority of the community had been affected by war, trauma of some description and displacement. They spoke of their own experience through their organisations of human trafficking, exploitation and modern-day slavery. They further observed that once individuals had achieved settled status, there was a lack of understanding and support for them. A result of which, is that individuals then lived without their traumatic experiences and impact on mental health having been properly addressed through treatment/ therapy.

16.8.4 When asked whether there was any evidence to support their personal observations, a comment was made that the provision of 'talking therapies' was low locally and this was supported in various papers, including 'Racial disparities in mental health: Literature and evidence review'. [72] . This article makes a specific recommendation to "provide better access to talking therapies according to local need, and engagement with black and minority ethnic communities to ensure the therapies are culturally appropriate and geographically accessible".

Barriers

16.8.5 A number of factors reflected the observations noted above, such as stigmatisation (16.7.9), with added commentary about fear, language barriers, fear of medication and a degree of illiteracy regarding medications, mistrust of statutory agencies exacerbated by a lack of cultural representation within the system.

Language

16.8.6 It was explained that sometimes, there was a risk of misunderstanding and communication difficulties between the Somali community and medical professionals. This is also noted in the article; "Crazy person is crazy person. It doesn't differentiate": an exploration into Somali views of mental health and access to healthcare in an established UK Somali community". [73] The article explains that expectations from mental health services may be hampered by "communication difficulties due to misinterpretation of different uses of language and gestures". Further misinterpretation may also arise owing to the need to label certain

[72] Source: *mental-health-report-v5-2.pdf (Accessed January 2021)

[73] Source: *"Crazy person is crazy person. It doesn't differentiate": an exploration into Somali views of mental health and access to healthcare in an established UK Somali community (biomedcentral.com) (Accessed January 2021)

conditions, that may not be easily translatable within the Somali community and understanding of mental illness.

Cultural Representation

16.8.7 Upon exploration, the observation related to the apparent lack of Somali professionals providing the care, support and advice, be that GP's or other specialists. It is beyond the scope of this review to test this notion and is reported as the reality being experienced by representation from community organisations.

Fear of medication

16.8.8 In discussion, this related to an inherent mistrust of some medicines, and given the cultural worries and stigmas regarding mental illness, this created particular challenges. When asked how this manifested itself, one representative spoke about clients having significant amounts of unused medication, as it seemed the prescriptions changed frequently. They did however note, this same concern did not apply to antibiotics.

Enablers

16.8.9 The chair notes that his conversations with family and friends of Omar took place approximately two years before the conversation with community representatives, and it is clear that many of the same observations around barriers were apparent. On exploring what would enable or improve how the Somali community engaged with mental health services, the subject of pathways to support arose.

16.8.10 It was explained that many people within the community would approach their mosque or Somali organisations as a first port of call, and that this may involve more traditional approaches such as prayer. With that in mind, it was suggested there was an overarching enabler of the need to strengthen the links between grass-roots organisations and mainstream services, with an aspiration for improved communication and collaboration, ensuring an accessible, culturally competent service for those living with mental illness. It was further suggested that by strengthening the links between the community, grass-roots organisations and mainstream services, the impact of barriers such as stigma and language may be mitigated. It is further suggested therefore that the learning opportunity in paragraph 16.7.13 is further validated.

17. CONCLUSIONS and LESSONS LEARNED

17.1 Conclusions

17.1.1 The chair and panel are mindful of 'hindsight bias', highlighting what might have been done differently and avoiding the 'counsel of perfection'. The review panel has attempted to view what happened as broadly as possible, to understand the circumstances of Hassan and Omar's lives to help explain the circumstances of Hassan's death. The panel has unfortunately been unable to gain an understanding of Hassan's life, as the chair has been unable to identify family or friends willing to speak to him or the panel. The chair has however been able to consider the views of friends and family of the perpetrator, Omar.

17.1.2 Hassan was a single man, whose immediate family lived in Somalia and who had some family who lived in England. He lodged with the perpetrator, and were no indicators known to agencies or that otherwise came to notice of difficulties between him and the perpetrator Omar.

17.1.3 Omar is an older man, had experienced war in Somalia, and had a forensic history of mental illness, post-traumatic stress disorder (PTSD) and tardive dyskinesia (TD). In the two years before the homicide, TD that can develop as a side effect of medication, most commonly

antipsychotic drugs became problematic, and his mental health deteriorated. According to Omar's friends and family, medication compliance became an issue and effected his behaviour. In the judge's summing up statement, he commented on the issue of medication compliance, the deterioration in Omar's behaviour and how he had lost insight into how unwell he had become. In such circumstances, it may be concluded that Omar had two competing priorities of managing his mental illness versus the potential side effects of medication. It is therefore concluded that his mental illness was a pivotal factor in this homicide.

17.1.4 It is clear that Omar found living with his mental illness and TD difficult. There were a number of reports in the six months prior to the incident which made reference to Omar's deteriorating mental health. This coincided with a period when he wasn't engaged with medical professionals and they were not alerted to incidents (December 2018 and January 2019) which may have indicated a deterioration in Omar's mental health. Nor was there a scheduled, formal assessment of his mental health following a period of assessment and changes in medication in the summer of 2018.

17.1.5 The absence of any relevant history of the 'familial' relationship of a tenant and his lodger has been a challenge for the panel, and one may argue the homicide as being 'out of the blue'. However, there was a journey to the final act, that it is concluded was the deterioration in Omar's mental health.

17.1.6 Whilst the review has highlighted learning opportunities, it is not suggested that the tragic events were foreseeable.

17.2 Learning

17.2.1 This review has benefitted from detailed chronologies, candid IMR's and open conversations with panel representatives and other professionals. Whilst it has not been possible to speak to Hassan's family, the review has benefitted from a community perspective provided by friends and family of the perpetrator. Collectively, this has added weight to the identification of a number of learning opportunities/considerations that are contained within the overall analysis for each agency. The review of this case has shone a light on circumstances, enabling thematic learning described below that resulted in this panels review recommendations that have built upon individual agency recommendations where necessary. Without doubt, a significant focus of learning surrounds the mental health of Omar.

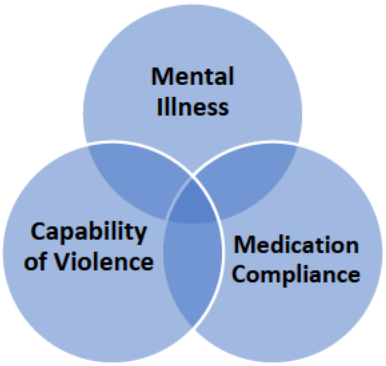
Mental Illness. Capability of Violence and Medication Compliance *(LO1, LO6 refer)*

17.2.2 Omar's forensic history of mental illness and a deterioration in his mental health is central to the final act of homicide.

17.2.3 Omar had experienced extreme violence in Somalia and had shown himself capable of extreme violence in England, having been sentenced to two offences of Grievous Bodily Harm. The absence of easy access to information and research on homicide committed by those living with mental health issues (and who had previously committed acts of serious violence), hindered the panels understanding of this phenomenon.

17.2.4 It is recognised that mental illness still carries some stigma in wider society, but particularly in the Somali community. Omar's mental illness and physical manifestation of tardive dyskinesia potentially linked to medication, was likely particularly embarrassing. In such circumstances, it would seem the subject of medicine compliance requires greater vigilance, not having been considered in the risk assessment completed.

Schematic 1.



17.2.5 The intersection of mental illness, a capability of violence and medication compliance are three important markers in understanding this homicide. They provide an opportunity to understand why such events take place in the longer term and how to minimise the reoccurrence of similar events.

Risk Assessment, Mental Illness and Capability of Violence *(LO2, LO3, LO6 & LO7 refer)*

17.2.6 The approach to assessing the risk to self and risk to others is more overt by secondary care mental health professionals (AWP), having conducted a number of formal assessments in dealing with Omar. Risk assessments are conducted at moments in time, reportedly at times of transition and upon events taking place. There was not an assessment of future risk in accordance with Department of Health Best Practice in Managing Risk[74] and medication compliance was not considered as a risk factor. Drawing upon the analysis of GP and AWP engagement, there are opportunities to strengthen the overall approach to risk management by ensuring that factors such as medicine compliance and fluctuating insight are considered, particularly for patients who have shown the capability of extreme violence previously, and that working together risk assessments are scheduled in accordance with best practice.

Feedback Loop and Information Sharing *(LO4)*

17.2.7 The panel identified opportunities to strengthen the feedback loop from other agencies such as Nilaari that Omar had been referred to. In one example he had been referred to Nilaari by AWP and discharged back to his GP. Omar did not engage with Nilaari and whilst not suggesting this was pivotal, non-engagement may have prompted enquiry by his GP.

Risk Assessment, Information Sharing and Decision Making *(LO16 to LO22 refer)*

17.2.8 The panel were able to consider a number of emergency calls the month before the homicide and the panel recognised the challenges of having to make decisions in fast time, being reliant upon staff professionalism, procedures and information. This review shone a light on the availability of information to agencies and the dependency of the ambulance service on police information.

17.2.9 Police highlighted opportunities for more effective decision making, through more robust procedural use of THRIVE (risk assessment model), but conversely reported on the concept of 'diagnostic overshadowing' as a potential explanation for not deploying resources, though there were multiple factors that should/could have resulted in deployment. In part this may have been through following procedure and 'scripted' call handling questions.

17.2.10 Notwithstanding these observations by the police, the panel learned of limitations in accessing medical information and expertise outside office hours that may have informed the decision to deploy. There was also a missed opportunity to search for information from police intelligence databases. Though it is not certain that 'knowable' information would have been found owing to the potential for misspelling etc, it would have assisted both the police

[74] IBID

and SWASFT's decision making about deployment and action. Therefore, the access to, and active seeking of more information is seen as an 'enabler' for effective decision making.

17.2.11 There were multiple risk factors present that the panel agreed merited closer consideration. There is precedent in national call-handling procedures for certain types of call to be subject to mandatory supervision (see paragraph 16.5.37) and it seems there is an opportunity to enable the same approach for calls where all three risk factors shown below are present.

Schematic 2

Alerting Agencies and Information Sharing *(LO21 &LO23 refer)*

17.2.12 There was insufficient information available to the police or ambulance service at the time of incidents in the months prior to the homicide to merit a safeguarding alert and from what the panel learned; it was unlikely that a threshold would have been reached. The panel explored why a GP referral was not completed in this case and the doctrine of consent. Whilst it is not known if Omar's consent was sought, the panel learned of a significant growth in the volume of safeguarding and GP alerts over recent years made by SWASFT and of the continued efforts to inform professional practice in this regard such as recent guidance "Mental Health and Capacity Considerations in Patients Who Present as Having Self-Harmed or Attempted Suicide'.

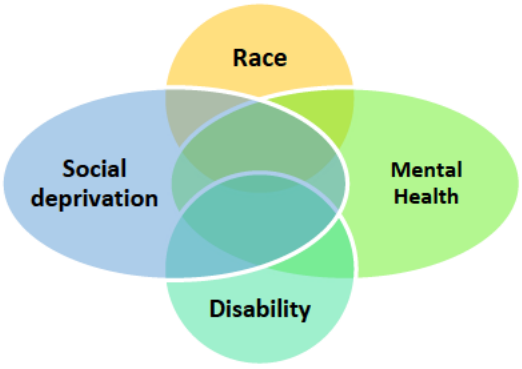
Professional Curiosity *(LO11, LO12 & LO22 refer)*

17.2.13 The panel have resisted the temptation to apply hindsight bias to the final interaction with the police on the day of the homicide. To do so, would lead us to a gross over-simplification of a complex set of circumstances, seeing cause and effect in a linear fashion, where the focus sits with one police officer investigating an allegation of crime, within a complex framework of procedures and policy. The broad learning from this final interaction, as with other interactions, is one of recognising the complex nature of dealing with mental illness. In this instance, the police had been alerted to Omar's mental health problems, yet he presented as lucid and calm. This required enhanced professional curiosity to enquire and to ensure that an opportunity to signpost a potentially vulnerable individual for support. However, it is emphasised, Omar did not appear to be in crisis at this final interaction with the police.

17.2.14 Similarly, Omar presented to other agencies including BCC H&LS with a family member. In dealing with BCC H&LS, a comment was made about him possibly needing a tenancy support officer, but the reasons why were not explored. It was therefore recognised by the panel, that as with many such reviews, there are often opportunities for greater professional interest to identify support needs and signpost as required, along with wider learning of this review.

Equalities and Intersectionality *(LO5 & LO24 refer)*

Schematic 3.



17.2.15 Hassan and Omar were Somali, living in a socially deprived area of Bristol area with a number of challenges set out at 13.2.

17.2.16 It is apparent that Omar was disabled by virtue of living with PTSD and mental illness (see 11.6), being unable to sustain long term employment. Hassan was employed as a cab driver.

17.2.17 The review identified that the Somali community faced multiple challenges when dealing with mental illness, ranging from the specific needs of individuals who have experienced significant trauma, through to a range of barriers in addressing these needs. These included, stigma, isolation from the community, language and more.

17.2.18 Whilst the ward profile showed that a large proportion of the local population did not speak English as their first language, this was not a factor for either Hassan or Omar. Notwithstanding this, the review found that agencies showed an awareness of language being a barrier, with the GP using an accessible website and multi-lingual staff. BCC H&LS showed an awareness through flagging addresses where English was not a first language and ensuring multi-lingual communications when considering developmental work for their properties.

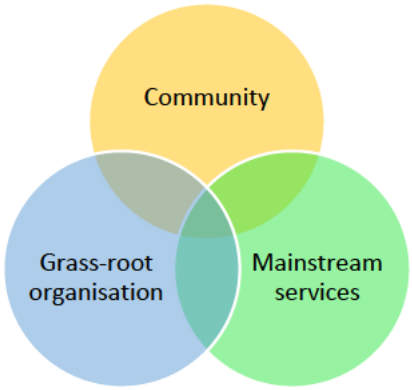
17.2.19 There are culturally sensitive organisations available, that Omar had cause to be referred to, such as Nilaari, and though AWP acknowledged in their IMR a need to raise awareness of such services availability, it remains that Omar did not access these therapies. Indeed, the AWP Root Cause Analysis commented that service users from the Somali community may not find services accessible or acceptable and that the Somali community are known to find mainstream mental health services difficult to access. These observations are also consistent with the general comments of Omar's friends and family and community representatives who spoke to the chair.

17.2.20 The comment within the RCA is further triangulated with (a) the information that there was a lack of Somali speaking talking therapies provision at Nilaari to whom Omar had been referred and (b) the findings within a publication 'Improving mental health support for the UK Somali community' [75] that found that 78% of respondents from the Somali community did not feel that available services understood the Somali community. (c) the community perspective of multiple barriers facing members of the Somali community living with mental health challenges including; stigma, mistrust, the language used to describe mental illness and a lack of culturally representative professionals.

17.2.21 It therefore seems that the overlaying of a number of social characteristics risks intersectionality, that is that various social identities contribute to systemic discrimination.[76] The panel agree that there has been and remains an ongoing need to strengthen the links between the community, grass-roots organisations and mainstream services.

[75] Source: ATM-Improving-Mental-Health-Support-for-the-UK-Somali-Community.pdf (theatm.org) (Accessed Dec 2021)
[76] Source: https://www.dictionary.com/browse/intersectionality (Accessed January 2020)

Schematic 4.



17.2.22 As the review was concluding, the panel learned of a recent local initiative, that is described as a place-based partnership of local health, social and community organisations and individuals. This is made up of GP Practices/Primary Care Networks; voluntary sector organisations; including social prescribers; social services and other local authority services including BCC H&LS, public health; mental health provision; community services and our local population. Its aims are to improve outcomes and reduce health inequalities. The panel acknowledge this as a positive development that recommendation 3 will compliment.

17.3 Good Practice

17.3.1 Bristol City Council Housing and Landlord Services

- The signed letter of authorisation by Omar to allow cousin to discuss tenancy issues relating to his tenancy was saved within the shared person module of the H&LS management system. This was good practice since all officers from BCC H&LS would be able to access this and be able to see and respond to the tenants wishes e.g., rents/ repairs.
- The repairs jobs listed for the address over the time period were completed on time unless access was denied.

17.3.2 Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG) on behalf of GP practice

- GP practice is Iris trained.
- Close working relationship between Consultant Psychiatrist and GP

17.3.3 Avon and Wiltshire Mental Health Partnership NHS Trust

- Assessment was well formulated and well documented.
- Close working relationship between Consultant and GP.
- Consideration of cross-cultural issues in assessment outcome.

17.3.4 Avon and Somerset Police

- The use of Body Worn Video in practice is noted as good practice.

- The introduction of a revised Welfare Policy to assist call handling is noted as a positive development.

17.3.5 South Western Ambulance Service NHS Foundation Trust

- The increased volume of safeguarding and GP alerts is acknowledged as is the relevant safeguarding training rates.

18. RECOMMENDATIONS

18.1 Local IMR Recommendations

18.1.1 Bristol City Council Housing and Landlord Services

- Training to ensure that officers know how and when to update occupant lists within Civica Cx (new BCC H&LS management system) for tenancy records and the importance of doing so in relation to financial impact on the tenant and in terms of managing tenancies/ homes. Also, confirm that all officers know the best place to share an authorisation note as done positively in Northgate previously in this case.
- The rent management service CCSS form to be reviewed to ensure relevant further questions are being sought with the customer. This is so that the form is doing as it was created and intended; to act as a method to support tenancy sustainment going forward with the tenant.
- Refresh with Internal Audit Team and H&LS sharing information practices and storing this correctly when BCC properties have actions undertaken e.g., in this instance a court order to prove occupancy.

18.1.2 Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG) on behalf of GP practice

- No recommendations

18.1.3 Avon and Wiltshire Mental Health Partnership NHS Trust

- To raise awareness of complete PTSD pathway in Primary Care
- To identify link role within access services into local Somali community

18.1.4 University Hospitals Bristol and Weston NHS Foundation Trust

- No recommendations

18.1.5 Bristol City Council Children and Family Services

- No recommendations

18.1.1 Avon and Somerset Police

- Training on ‘diagnostic overshadowing’ should be extended to call handlers in addition to Control Room supervisors. Please note that this recommendation has already been agreed by the Force Incident Manager and plans are in place to arrange protected time for call handlers to receive this training.
- The Command-and-Control department should review call script questions and call handlers’ use of ‘off-script’ questions in relation to calls where mental health and weapons is a feature. The department should take appropriate action to improve in this area as required.

18.1.x South Western Ambulance Service NHS Foundation Trust

- No recommendations

18.2 Panel Recommendations

The following recommendations have been agreed by the panel. A detailed supporting action plan is to be found at ***Appendix D***.

- **Recommendation 1**: Take steps to ensure that Nilaari and ROADS, with appropriate consent provide updates about patient referrals to primary care (GP) and referrer (if not GP) Public Health

- **Recommendation 2:** Review the protocols for risk assessment and management, ensuring that (a) medicine compliance is considered for patients with a history of violence, (b) that post transition assessments are scheduled/conducted for this cohort, (c) fluctuations in patient insight are considered and (d) that this is explicitly documented in the handover between AWP and GP AWP

- **Recommendation 3:** Improve the understanding of the specific needs of the local Somali Community (SC) in respect of Mental Health that includes; - what enables/hinders the SC accessing support and that clearly identifies the gaps in provision. Public Health

- **Recommendation 4:** That the learning from this review is shared through mandatory safeguarding training to encourage increased professional curiosity when presented with potential client welfare concerns. BCC H&LS /Police

- **Recommendation 5:** Seek to ensure that staff are aware of how to access medical information out of hours. Police/SWASFT

- **Recommendation 6**: Avon and Somerset Police to review call handling policy where there are multiple apparent risk factors and implement a systemic approach that mandates these calls being supervised. Police

- **Recommendation 7**: Avon and Somerset Police to review their systems of call handling to ensure that intelligence checks are carried out and recorded within the call handling system. Police

APPENDIX A

Terms of Reference

1. The purpose of this review

- Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.

- Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

- Contribute to the Prevention of Homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

- Highlight any fast-track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life.

2. Overview and Accountability:

2.1 The decision for Bristol to undertake a Domestic Homicide Review (DHR) was taken by the Chair of the Bristol Community Safety Partnership on the 18th March 2019. The Home Office were informed on 19th March 2019.

2.2 The Home Office Statutory Guidance advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review.

2.3 This Domestic Homicide Review is committed to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner, within the spirit of the Equalities Act 2010

3 The Domestic Homicide Review will consider:

3.1 Each agency's involvement with Hassan at least 5 years prior to his death on 10/01/19, except for any other relevant information relating to domestic abuse prior to this date. Whilst checking these records we will aim to identify any other significant individuals who may be able to help the review by providing information.

Term 1 – Family awareness of abuse and barriers to reporting.

3.2 Whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim, prior to the homicide (any disclosure, not time limited).

3.3 In relation to the family members, whether there were aware if any abuse and of any barriers experienced in reporting abuse? Or best practice that facilitated reporting it?

Term 2 – Interagency Communication

3.4 Could improvement in any of the following have led to a different outcome for Hassan considering: -

a) Communication and information sharing between services with regard to the safeguarding of adults.

b) Communication within services

c) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services

Term 3 – Standards and Policy

3.5 Whether the work undertaken by services in this case are consistent with each organisation's:

a) Professional standards

b) Domestic abuse policy, procedures and protocols

Term 4 – Agency Actions (Assessment, Actions, Relevance and Timeliness)

3.6 The response of the relevant agencies to any referrals relating to Hassan concerning domestic abuse or other significant harm from 2013. It will seek to understand what decisions were taken and what actions were or were not carried out, or not, and establish the reasons. In particular, the following areas will be explored:

a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with victim or perpetrator.

b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made.

d) The quality of any risk assessments undertaken by each agency in respect of Hassan, children or perpetrators.

Term 5 - Thresholds

3.7 Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

Term 6 – Cultural Sensitivity

3.8 Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

Term 7 – Escalation

3.9 Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

Term 8 – Training and Awareness issues

3.10 Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

3.11 Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

3.12 Keep these terms of reference under review to take advantage of any, as yet unidentified sources of information or relevant individuals or organisations.

4. Media Strategy

4.1 A single point of contact has been identified to field all media enquiries in relation to this DHR and a position statement of “no comment” will be offered until the conclusion of the DHR process and sign-off of the overview report by the Home Office Quality Assurance Panel.

APPENDIX B – Result of Agency Contact Trawl

Organisation	Hassan	Omar
Adult Care Bristol City Council	No	Yes
Addiction and Recovery	No	No
Avon and Somerset MAPPA	No	No
Avon and Somerset Police	Yes	Yes
Avon and Wiltshire Mental Health Partnership NHS Trust	No	Yes
BSDAS part of ROADS	No	Yes
BCC Substance misuse service Theseus records	No	No
BDP [redacted]	No	No
BRI IDSVA	No	No
Bristol CCG – Primary Care	Yes	Yes
Bristol Community Health [redacted]	No	No
Bristol Drug Project [redacted]	No	No
Bristol People Directorate – Children Services	Yes	Yes
Bristol Royal Infirmary Emergency Dept (IDSVA)	No	No
BSCB	No	No
DHI [redacted]	No	No
First response /Early help service, Bristol City Council	No	No
Green House [redacted]	No	No
Housing Options, Bristol City Council [redacted]	No	No
Bristol City Council Housing and Landlord Services (BCC H&LS)	No	Yes
Homelessness Prevention Service	No	No
Liverty (formally Knightstone Housing Association)	No	No
Next Link, Safe Link, Missing Link [redacted]	No	No
NHS NBT [redacted]		
One 25 [redacted]	No	No
OPOKA [redacted]	No	No
National Probation Service	No	Yes
Probation -Bristol and South Gloucestershire LDU	No	Yes
SARSAS [redacted]	No	No
Substance Misuse Team [redacted]	No	No
Stand Against Racism & Inequality [redacted]	No	No
Specialist HPT&HCB Advisors, Housing Options	No	No
South Western Ambulance Service NHS Foundation Trust [redacted]	No	Yes
Southmead project [redacted]	No	No
St Mungos- Paul Sargent	No	No
The Bridge Sexual Assault Referral Centre	No	No
University Hospitals Bristol NHS Trust [redacted]	Yes	Yes
Victim Support [redacted]	No	No
YOT [redacted]	No	No

APPENDIX C - Independence statement

Chair of Panel

Mark Wolski was appointed by Somerset Community Safety Partnership as Independent Chair of the DVHR Panel and is the author of the report.

He is a former Metropolitan police officer with 30 years operational service, retiring in February 2016.

He served mainly as a uniformed officer, holding the role as Deputy Borough Commander at the Boroughs of Haringey, Harrow and at the Specialist Operations command of Aviation Security.

During his service he gained significant experience leading the response to Domestic Abuse, Public Protection and Safeguarding

Mark has subsequently acted as a consultant in the field of Community Safety, Independent Chair of a Marac Steering Group, strategic lead and commissioner of VAWG services and as a DHR chair/co-chair.

During and since his MPS service he has had no personal or operational involvement with Bristol Community Safety Partnership.

APPENDIX D Live Action Plan

Recommendation	Scope of recommendation; Local, Regional or National	Action to Take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
Recommendation 1: Take steps to ensure that Nilaari and ROADS, with appropriate consent provide updates about patient referrals to primary care (GP) and referrer (if not GP)	Local	Learning from this review is shared with Nilaari and ROADS Agencies review/amend internal protocols, to ensure information sharing with consent to referring agency. Agency staff briefed and trained. Information sharing/updates to referrer commences.	Public Health	Learning Event delivered Number of agencies and staff attending Protocol amended and published. Agency staff briefed Agencies report on compliance, (such as 90% of referrers updated)	June 2024 December 2024 January 2025 February 2025	(Outcome of referrals to agencies reported to referrer)
Recommendation 2: Review the protocols for risk assessment and management, ensuring that (a) medicine compliance is considered for patients with a history of violence, (b) that post transition assessments are scheduled/conducted for this cohort, (c) fluctuations in patient	Local	Review existing protocols and identify the improvements to be made. Amend the protocols/policy. Create templates to incorporate the improvements.	AWP	Local governance approves changes. Protocols amended. Templates revised / Case Management system amended.	October 2022 November 2022 November 2022	Completed July 23: Risk assessment protocol was reviewed in 2020, new tools/templates to reflect changes were issued by July 2023.

insight are considered and (d) that this is explicitly documented in the handover between AWP and GP		Engage with GP's to adopt. Implement new protocols. Evaluate impact		Communication with GPs Revised case management system goes live and management audit to ensure compliance. Evaluation undertaken.	Decembe r 2022 January 2023 July 2023	Evaluation of impact is ongoing.
Recommendation 3: Improve the understanding of the specific needs of the local Somali Community (SC) in respect of Mental Health (MH) by carrying out a MH needs assessment that includes; - what enables/hinders the SC accessing support and that clearly identifies the gaps in provision	Local	Complete a Needs Assessment of the mental health experiences, service needs and barriers to treatment-seeking of the Somali population in Bristol.	Public Health	Presentation at Health and Wellbeing Board/ICB Locality Partnership Boards Dissemination of learning to members of Keeping Bristol Safe Partnership ICB Locality Partnership Boards to consider recommendation	Dec 2024 Jan 2025 May 2025	(Outcome: Comprehensi ve understandin g of enablers and hindrances to Somali community seeking MH treatment to inform service delivery.)
Recommendation 4: That the learning from this review is shared through mandatory safeguarding training to encourage increased professional curiosity when presented with potential client welfare concerns.	Local	Learning from this review is shared with the training departments of agencies. Agree learning objectives. Incorporate into organisational training on M.Health / Safeguarding	BCC H&LS Police	Learning shared Training/learning devised. Training / learning shared with staff	October 2022 Decembe r 2022 January 2023	Completed Jan 23: The concept of professional curiosity is now covered within all the relevant courses and linked into NDM. UWE

						have ensured their lesson plans reflect this and it has been added into the PIP lessons. This case has been shared with training and is mentioned in PCDA, Comms, MH TacAd training and also in the LPA input (700 officers).
Recommendation 5: Seek to ensure that staff are aware of how to access medical information out of hours	Local	KBSP to seek assurance from all agencies that frontline staff are aware of how to access medical out of hours services and obtaining relevant medical information at times of crisis for service users.	Police/ SWASFT	Overview report findings shared.	December 2024	(Outcome: Professionals are able to access medical information out of hours)
Recommendation 6: Avon and Somerset Police to review call handling policy where there are multiple apparent risk factors and implement a systemic approach that mandates these calls being supervised.	Regional	Learning from this review is shared with quality assurance/governance area responsible for call handling. Review best practice across UK and identify options to implement 'flagging' of multiple 'risk factors' that automate mandatory supervision.	Police	Overview report findings shared. Task and finish group formed, and terms of reference agreed. Policy and systems changes made.	October 2022 December 2022 June 2023	Completed Feb 2023: Since this case in 2018 we have undertaken the following to address the recommendation and learning:

		Make necessary changes to policy and systems. Train call handlers and roll out. Test / audit compliance		Staff trained. Audit of compliance commences and monitored.	July 2023 August 2023	• We have had training in diagnostic overshadowing • We have delivered refreshed THRIVE training and NDM training. • We have reviewed call gradings. • Call handlers and dispatchers assess weapons incidents for severity and will transfer to the FIM for a decision around tactical response. Currently this process elicits a review by the FIM cadre of approximately 10000 weapons jobs a year.

						This results in approximately 450-500 incidents a month deemed appropriate for officers to attend with Taser and 35-60 incidents a month where armed officers are deployed under an armed authority. • We have improved our access to mental health support through staff being based in ambulance control. • We have reviewed the incidents that Comms Supervisors are asked to review due to them becoming overwhelmed

						by transfers due to increase in overall demand, particularly 999 calls. I don't deem it suitable to task Comms Supervisors to review incidents based purely upon PNC markers – the volume would be overwhelming. PNC markers should rightly be considered as part of the bigger picture through THRIVE and NDM but not on their own. • Based upon DSI referrals (our highest is concern for welfare) our current process ensures all concern for

						welfare incidents are reviewed by a comms supervisor. • We accept 'learning the lessons' from locally managed and independent investigations, cascading departmental and individual learning where appropriate. Some of this has been around greater clarity between police and ambulance as to who will take primacy where both agencies have open incidents. • Call scripting will be renamed 'call guides' to encourage call handlers

						to be 'professionally' curious and ask questions beyond ' a script'.
Recommendation 7: Avon and Somerset Police to review their systems of call handling to ensure that intelligence checks are carried out and recorded within the call handling system.	Regional	Learning from this review is shared with quality assurance/governance area responsible for call handling. Review best practice across UK and identify options to implement. Make necessary changes to policy and systems. Train call handlers and roll out. Test / audit compliance		Overview report findings shared. Task and finish group formed, and terms of reference agreed. Policy and systems changes made. Staff trained. Audit of compliance commences and monitored.	October 2022 December 2022 June 2023 July 2023 August 2023	Completed Feb 23: A new CAD and/or CRM system is being scoped and a project team are in place with discovery work and demo's taking place at present.

APPENDIX E – ONE PAGE SUMMARY

1. Domestic Homicide Review

The Keeping Bristol Safe Partnership commissioned this DHR following the homicide of Hassan in January 2019.

2. Case Summary

Hassan was aged [redacted] at the time of his death. He was of Somali origins and came to the UK via Holland. He lived with Omar as a lodger in a two bedroomed flat who was aged [redacted] at the time of Hassan's death.
Omar had lived in the UK for over twenty years.

Following a call to police from Omar's cousin stating that Omar had killed someone, police attended and located Omar, forced entry to their address and found Hassan deceased, having suffered multiple stab wounds.

3. The Facts – an overview

The flat where they lived is in one of 34 wards in Bristol and the local ward profile shows a number of challenges such as; - higher levels of deprivation than other wards; - the third highest crime rate; - highest rate of overcrowded households ; - highest percentage of population belonging to a Black or Ethnic Minority group and with a higher rate of people having been born outside the UK, of which the Somali community is over three times higher than others. In addition, English is not the first language of 30% of this local population.
Regrettably, little is known about Hassan, save he worked as a cab driver.
Omar had previous convictions for acts of violence, was known to his GP and specialist mental health care professionals.
There had been recent contact with the authorities in the months leading up to the homicide.

- In January 2019, Omar was involved in a dispute with a male he claimed owed him money. It was suggested by the victim that Omar had mental health problems. The victim chose not to substantiate the allegation.
- In December 2018, Omar came to the notice of police suffering a mental health issue, whereby he was self-harming in the street with a knife. The matter was dealt with as a medical issue and the ambulance service attended.
- In May 2018, Omar was referred to AWP in respect of PTSD associated with his experience of war, a recent incident where he was a victim of crime, and an ongoing medical issue.
- Prior to this period, Omar had been in contact with his GP, and there had been unsubstantiated domestic incidents with a girlfriend.

In the judges summing up when sentencing, reference is made to a conviction history including serious violence, and a history of mental illness. It was further noted that he had failed to take his medication, lived with the side effects of medication he was taking, and was losing insight leading up to the homicide.

4. Learning Points

The intersection of mental illness, a capability of violence and medication compliance are three important markers in understanding this homicide. They provide an opportunity to understand why such events take place in the longer term and how to minimise the reoccurrence of similar events.
There is an opportunity to strengthen the overall approach to risk management by ensuring that factors such as medicine compliance and fluctuating insight are considered, particularly for patients who have shown the capability of extreme violence previously, and that working together risk assessments are scheduled in accordance with best practice.
The lack of engagement with agencies outside primary and secondary care, showed an opportunity to close the feedback loop between those agencies and primary care.
On calling the police and ambulance service, there were multiple risk factors present of 'self-harm, weapons and mental health' that merited closer consideration for police attendance.
There is an opportunity to improve accessing police intelligence and medical information to inform decisions to deploy and take action in emergency call handling.
There were opportunities for improved professional curiosity in respect of Omar's mental health.
The overlaying of a number of social characteristics risked intersectionality, that is that various social characteristics contribute to systemic discrimination, and there remains a need to strengthen the links between the community, grass-roots organisations and mainstream services. Conversations with community groups and a review of local research, suggest there remain multiple barriers facing the Somali community in respect of mental illness.

5. Recommendations

Recommendation 1: Take steps to ensure that Nilaari and ROADS, with appropriate consent provide updates about patient referrals to primary care (GP) and referrer (if not GP).
Recommendation 2: Improve the protocols for risk assessment and management, ensuring that (a) medicine compliance is considered for patients with a history of violence, (b) that post transition assessments are scheduled/conducted for this cohort, (c) fluctuations in patient insight are considered and (d) that this is explicitly documented in the handover between AWP and GP.
Recommendation 3: Improve the understanding of the specific needs of the local Somali Community (SC) in respect of Mental Health that includes; - what enables/hinders the SC accessing support and that clearly identifies the gaps in provision.
Recommendation 4: That the learning from this review is shared through mandatory safeguarding training to encourage increased professional curiosity when presented with potential client welfare concerns.
Recommendation 5: Seek to ensure that staff are aware of how to access medical information out of hours.
Recommendation 6: Avon and Somerset Police to review call handling policy where there are multiple apparent risk factors and implement a systemic approach that mandates these calls being supervised.
Recommendation 7: Avon and Somerset Police to review their systems of call handling to ensure that intelligence checks are carried out and recorded within the call handling system.

6. Links and further information

To be inserted post publication.

APPENDIX F – HOME OFFICE FEEDBACK LETTER

Home Office

Interpersonal Abuse Unit Tel: 020 7035 4848 2
Marsham Street
London
SW1P 4DF
www.homeoffice.gov.uk

[redacted]
Statutory Review Project Officer
Keeping Bristol Safe Partnership
KBSP Business Unit (City Hall),
Bristol City Council, PO Box 3399,
Bristol
BS1 9NE

11 September 2023

Dear [redacted]

Thank you for submitting the Domestic Homicide Review (DHR) report (Hassan) for Bristol Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 25th July 2023. I apologise for the delay in responding to you.

The QA Panel is grateful to the partnership for their review of what is clearly a challenging case. The QA panel praised the drafting, structure, and detail of the report, and specifically noted: the steps taken to involve the perpetrator's family and friends in the review; the compassionate approach taken to the case overall; the consideration of psychiatric reports on the perpetrator, the involvement of Victim Support and the NHS, and a clear set of findings and recommendations.

The equality and diversity section of the report is seen to be thorough in making links to underlying factors which included intersectionality, identifying age, race, and disability as protected characteristics.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published. **Areas for final development:**

- For key contextual information, it would be helpful to state the ages, ethnicity and immigration status of Hassan and Omar in the introductory section of the report as opposed to it been mentioned later in the report. For instance, Hassan's age was first mentioned at paragraph 10.2, and Omar's age was not stated until paragraph 13.1. Similarly, the Equality & Diversity discusses that both were Somalian, but there is no further information on their ethnicity until paragraph 13.

- The date of death was mentioned in both paragraph 1.5 and 13.4.1 with different dates. Only the month and year is required. The front page of the report should have the month and year of Hassan's death.
- At paragraph 6.13, it states that Omar was found guilty of manslaughter, but at paragraph 10.1, it states that Omar pleaded guilty to manslaughter. Clarification is required.
- At paragraph 13.2.2 it is stated that Hassan's entry to the UK has not been determined, but at paragraph 15.3.2 it was clearly stated that hie entered the UK in 2014.
- The review notes the context in which the victim and perpetrator were living, a socially deprived area, with high unemployment and wider issues pertaining to mental health, and which effectively would have a great impact on unemployment. However, it may be beneficial to look deeper at how the Somali community is supported and integrated in this area – there are no recommendations pertaining to ensuring that people from the Somali community know that they can access help and where to get it from the range of issues identified here. That might be worth exploring in more detail.
- It is unclear why it took 5 years to review Hassan's death.
- It would be helpful to know how the panel selected the pseudonyms.
- The action plan needs to be more detailed with intended outcomes, and the expected change we want to see should be more articulated in the action plan with review dates for follow ups.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at

DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Lynne Abrams

Chair of the Home Office DHR Quality Assurance Panel