

Newham Care Services Partnership

Executive Summary: Domestic Abuse Related Death Review/ Domestic Homicide Review into the Death of

Shompa

Date of death April 2022

Note: Shompa is a pseudonym suggested by London Black Women's Project and used for the purposes of this Report.

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1. THE REVIEW PROCESS

This summary outlines the process undertaken by Newham Community Safety Partnership domestic homicide review panel in reviewing the homicide of Shompa who was a resident in their area.

The following pseudonyms¹ have been used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:

Shompa, aged 80 at the time of her death, of Bangladeshi heritage
Baseet, aged 33 at the time of the homicide, British born of Bengali heritage.

Criminal proceedings took place in March 2023 and the jury returned a verdict of guilty in relation to Baseet committing the act of killing Shompa. Baseet was sentenced to a Section 37 hospital order with a Section 41 restriction.

The process began when the Community Safety Partnership was notified of the homicide by the Metropolitan Police but it has not proved possible to locate the date of that notification. The Chair of the Community Safety Partnership consulted the Partnership Board to make a decision prior to April 2022, but unfortunately, the exact date and records of the Community Services Partnership consideration cannot be located. The Board considered and agreed to the Domestic Homicide Review before notifying the Home Office of the decision to proceed with a Domestic Homicide review on 8 April 2022.

All agencies that potentially had contact with victim and/ or perpetrator prior to the point of death were contacted and asked to confirm whether they had involvement with them. Five of the eight agencies contacted confirmed contact with the victim and/or perpetrator and were asked to secure their files. A further agency was identified late in the review process.

2. CONTRIBUTORS TO THE REVIEW

Individual Management Reviews and chronologies were requested from:

- Barts Health NHS Trust
- London Ambulance Service NHS Trust
- London Borough of Newham Safeguarding Governance Team and Mental Health Adult Social Care Service
- Mental Health – East London Foundation Trust
 - To include all relevant teams including learning disabilities (if relevant)
- NHS North East London (in respect of primary care services)
- The Metropolitan Police

¹ Pseudonyms suggested by London Black Women's Project.

A short report or further information was requested from:

- Anti-social Behaviour Unit
- Department of Work & Pensions
- London Black Women's Project

At a late stage in the review, it emerged that Barking, Havering and Redbridge University Hospitals NHS Trust had provided care for Shompa following the stroke and they were asked to provide an Individual Management Review. In addition, the Home Office was contacted to ask whether Shompa was entitled to free NHS care.

Individual Management Review authors were all confirmed to be independent of involvement in this case.

3. THE REVIEW PANEL MEMBERS

The Review Panel met five times online and all Review Panel members were confirmed to be independent of involvement in the case.

The Table below lists members of the Domestic Homicide Review Panel.

Agency	Name	Role/ job title
Barts Health NHS Trust	Clare Hughes	Head of Safeguarding
Change Grow Live (substance misuse services)	Sonia Mills Lauren Mulligan	Services Manager
Department for Work and Pensions	Laura Anderson	
East London NHS Foundation Trust (mental health services)	Fenno Outen	Deputy Borough Director, Newham
Hestia (domestic abuse support services)	Sharna Marshall Robi Bibi	
London Black women's project (representing VAWG and women from minoritised communities)	Ishrath (Tasnia) Jahan	Senior Refuge Caseworker
Adult/ Disability Services	Anna Mwiluki	Safeguarding Governance Team
Children's Social Care	Mahfuzul Khan	Head of Service, Children's MASH, EDT, NRPF and Families First Service
Domestic Abuse commissioner	Sharmeen Narayan	Domestic Abuse and Sexual Violence commissioner
Housing	Dawn Henry	Specialist Pathways Team Leader

Agency	Name	Role/ job title
Operations and Safeguarding	Emma Cockerell	Director of Operations and Safeguarding
Safeguarding	Wendie Hatt	Senior Safeguarding Governance Officer, Safeguarding Governance Team
Police - Family Liaison Officer	Elly Mitchell	Family Liaison Officer
Police - Specialist Crime Review Group	Sally Pattison	Met Police Review Officer
NHS North East London Clinical Commissioning Group	Sabeena Pheerunggee Emma Tukmachi	Named GP for Safeguarding Children & Adults
Nia (services to end violence against women and children)	J Woodward	
Probation Service	Olivia Brooks (initially but later informed she no longer sat on Newham DHRs)	Probation Officer
NHS England	Angela Middleton	Patient Safety Lead for Mental Health
Observer	Denice Sealy	

4. AUTHOR OF THE OVERVIEW REPORT

The Reviewer/ Author of the Overview Report is by professional background a psychiatrist and systemic psychotherapist specialising in work with older adults. She has broad clinical and multi-agency experience in the North West and West Midlands and undertook consultant roles in Manchester and then Wolverhampton until 2009 when she retired early from her NHS roles and developed a portfolio career in independent practice.

She has acted as Chair and/or Author, and expert medical adviser/ consultant to Domestic Homicide Reviews, Serious Case Reviews, Safeguarding Adult Reviews, and Local Case Reviews in the past on behalf of Older Mind Matters Ltd. She is a member of the Advocacy After Fatal Domestic Abuse Network and in 2024 successfully undertook the Certificate in Chairing a Domestic Homicide Review course.

She has no connections or ties of a personal or professional nature with the family, with the Community Safety Partnership, or with any other agency participating in this review.

5. TERMS OF REFERENCE FOR THE REVIEW

The terms of reference below should be considered in the context of the general areas of consideration listed in the Domestic Homicide Review guidance².

1. What information did each agency hold about the relationship between victim and alleged perpetrator, indicators of domestic abuse, mental health issues and/ or alcohol/ substance-related issues and did this information inform risk assessment and practice?
2. Did each agency follow single and multi-agency policies and procedures (including Multi-Agency Risk Assessment Conference, MARAC)? Were there any gaps in policies or procedures?
3. What risk assessments were carried out in the case of victim and alleged perpetrator, and how was risk kept under review? Were risk levels appropriate and how was risk managed?
4. What did each agency do to safeguard any children exposed to domestic abuse?
5. What services did each agency offer, were they accessible, appropriate, 'fit for purpose' and sympathetic to the needs of those involved, and were there any barriers in an agency that might have stopped them from seeking help for domestic abuse?
6. How effective was each agency's supervision and management of practitioners involved with the response to needs of those involved and did managers have effective oversight and control of the case?
7. How effectively was information shared with partner agencies about domestic abuse, mental health issues, and alcohol/ substance use - did that information inform practice, and were there missed opportunities to share information?
8. Were agencies effective at holding the alleged perpetrator of domestic abuse accountable for his behaviour, and how was this addressed?
9. Were there missed opportunities to intervene in relation to the domestic abuse?
10. How did each agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to those involved, and how were the views of victim and alleged perpetrator ascertained and taken into account?

² See <https://assets.publishing.service.gov.uk/media/5a80be88e5274a2e87dbb923/DHR-Statutory-Guidance-161206.pdf>

11. What knowledge or concerns did family, friends and/or employers have about domestic abuse and did they know what to do with it?
12. What consideration was given by agencies to the possible negative impact the COVID³ lockdown may have had on the relationship between those involved and did this inform practice? Did agency support change during the COVID lockdown, and, if so, what impact did this have on the support offered and received?
13. Were there issues in relation to capacity or resources in an agency that impacted on its ability to provide services to those involved, or on your agency's ability to work effectively with other agencies?
14. What learning has emerged for each agency?
15. Are there any examples of outstanding or innovative practice arising from this case?

This Review covers agency involvement from 2012 until the date of death in 2022 and any additional relevant information or domestic incidents known to agencies prior to this timeframe.

6. SUMMARY CHRONOLOGY

Note: information highlighted in grey refers to Shompa.

Shompa was lived in Bangladesh for much of her life. She had three daughters plus an adopted daughter, the mother of Baseet.

In 2009 Shompa travelled with her disabled daughter, Daughter 1, to the UK to visit family. Her husband was due to join her a few months later. The GP records give UK entry date as 4 September 2009. That same year Baseet was referred to the Early Intervention in Psychosis team and remained with that team for three years. He was given diagnoses of depression and somatisation disorder, but, at the time, was not felt to have a psychotic disorder.

After moving to the UK, Shompa had few belongings. We were told that she stayed with various family members for varying lengths of time depending on events taking place in that household. At the time of her death and at the time of her stroke, Shompa was living at Baseet's address, with his parents, sister and Baseet. Baseet's father worked part time in a restaurant. His mother was a carer. His sister lived with them, worked afternoons at school, and helped the family with cooking and cleaning. Baseet rarely went out. He was said to smoke too much, and spend a lot of time sleeping.

³ COVID or COVID-19 stands for coronavirus disease of 2019.

In May 2010 Shompa's husband died suddenly. She decided to stay in the UK with her daughter, and the family believe she was given the right to remain, but they are uncertain of the exact date.

Also in 2010, Baseet was referred to Adult Social Care. The referral describes him as dependent on his mother and unable to be left alone. At that point he was known to Learning Disability Psychiatry. He declined an Occupational Therapy assessment by Newham Learning Disability Team in October 2010 and was discharged from care of the Early Intervention in Psychosis team. His mother was noted to be his main carer.

In 2014 between April and August there were eight reports to the Anti-Social Behaviour team, six were from members of Baseet's family and two anonymous. They detailed noise, drug use, drinking and fighting in the street, and threatening behaviour to residents. Advisory letters were sent on three occasions; Police were said to be aware on one occasion; and officers visited on one occasion. In October Baseet saw his GP for an increase in medication and complained that noisy neighbours were getting him down and that he was unable to sleep – noise day and night.

On 11 October 2014 Baseet was arrested in relation to possession of a knife and threatening others with it. Records say that he ran out into the street with a large knife and threatened others with it, and it was alleged that he stabbed a neighbour's door causing damage. His solicitor believed he was suffering from severe mental health issues, but a police doctor deemed him fit for interview. He was charged with criminal damage, possession of a knife and a public order offence, and was remanded to prison for three months awaiting trial. At court on 22 January 2015, he pleaded guilty and received a 12-month custodial sentence, suspended for 11 months, with 12 months' supervision by probation. He was required to live with his grandmother for a short while, and it is believed that this may refer to Shompa. During the criminal justice process, he was referred to the Learning Disability team and remained open to them until March 2015. During this time, he was diagnosed with depression, somatisation disorder, unspecified psychosis and mild learning disability. Sometimes he did not attend medical appointments and family attended instead. They reported he was too frightened to leave home. He was said to be scared that 'local boys' would harm him, or would get him into trouble and he would have to go back to prison.

On 10 September 2015 Baseet's GP saw his mother who described housing issues. Baseet was described as low in mood, not leaving the house and having difficulty engaging with the community mental health team.

Later that month (24 September 2015) a mental health team attended Baseet's address. He complained about his immediate neighbours who, he said, were complaining and conspiring against him. He said that, if nothing was done, he would consider arming himself with a knife and would not be responsible for his actions. When the mental health team left the address, a group of men standing outside were overheard to comment about staff leaving the property as though giving a surveillance commentary. Though staff were not threatened, they described the atmosphere as intimidating. Baseet's care

remained open to the Crisis Team for five days in response to family concerns, but he did not like different people visiting, and declined to engage after five days. His care was transferred back to the Learning Disability Team.

On 15 October 2015 an ambulance was requested for Baseet following a report that he was out of control, moving furniture, talking to himself, not eating/ drinking, had vomited, was not taking his medication, and kept walking in and out of the house. On arrival ambulance staff found Baseet's mother chasing him down the road. They caught up and spoke with him. He agreed to get into the ambulance, and was taken to hospital, accompanied by family.

Next day, 16 October 2015, Baseet's mother and aunt took him to an Emergency Department following concerns of deteriorating mental state in the context of not taking prescribed medication for three months. He was seen by the Psychiatric Liaison Service and referred for Mental Health Act assessment. He believed that his family were imposters who were trying to poison him, and reported thoughts of hitting others. He was admitted to hospital under Section 2 of the Mental Health Act.⁴ Whilst on the ward, the Consultant wrote a letter to support an application for alternative accommodation due to ongoing locality antisocial behaviour and noise impacting on Baseet's mental state and recovery. He was discharged on medication to the care of a community mental health team with diagnoses of learning disability, somatisation disorder and unspecified non-organic psychosis. However, the day after discharge (12 November 2015) Baseet consulted his GP asking for a medication change.

In November 2015 Adult Social Care received a referral from Mental Health to support Baseet around finances and housing. Baseet's father told them that Baseet was *'unable to participate due to not understanding what was being asked.'* It was reported that the family was waiting for rehousing from the council, as the current area affected Baseet's mental health. No social care needs were identified and the outcome was no further action. He was noted to be able to manage his daily living skills with support from family and that a mental health team was supporting him with housing and benefits claims.

In May 2016 the Anti-Social Behaviour team received two reports from Baseet's family of noise and street disturbance, the second referred to the impact on Baseet's mental health. The family told the local Safer Neighbourhood Team that they had felt victimised by the neighbours since 2014 when Baseet was arrested after having a knife and threatening neighbours. The family wished to remain anonymous when reporting incidents for fear of reprisals.

On 5 Aug 2016 Baseet's mother saw the GP without him and reported that he was getting more anxious and *'can get aggressive'*. His GP subsequently carried out an in-person mental health review on 1 November and noted that Baseet was spending all his time at home. Then on 18 Nov 2016 Baseet was

⁴ Section 2 of the Mental Health Act 1983 allows a person to be admitted to hospital for up to 28 days, for assessment. See <https://www.legislation.gov.uk/ukpga/1983/20/section/2> for more details.

reviewed by a mental health doctor who increased his medication and provided a letter to support rehousing.

On 14 March 2017, an ambulance attended Baseet at his home address following a report that he was experiencing chest pain, dizziness, and had a history of psychosis. Following assessment, he was taken with his mother to hospital, where he was seen by a psychiatric liaison service. A Community Recovery Team was asked to make follow up contact and reviewed him on 10 April 2017: they found that his symptoms had worsened so his medication was changed.

The Anti-Social Behaviour team was twice contacted by Baseet's family about noise in July 2017.

On 8 Sept 2017 Baseet's GP carried out a mental health review with both Baseet and his mother, and on 9 November 2017 he was reviewed in a mental health outpatient clinic, and noted to have disabling symptoms. His diagnosis was revised to paranoid schizophrenia and major depressive episode. He was offered, and declined, referral to recovery groups and for psychotherapy. Later, following this, he was noted to be taking an antipsychotic medication, and that mental health services were involved.

Baseet was reviewed in an outpatient clinic on 26 April 2018, and noted to have a complex presentation which likely included a component of affective psychosis in addition to obsessional traits and generalised anxiety arising in the context of borderline intellectual disability. There were concerns that a change in medication may have triggered his then hypomanic presentation. On 3 May 2018 the GP asked psychiatry for further guidance and noted that a switch in medication had brought on instability in mood and behaviour – the dose of anti-psychotic was increased.

On 5 May 2018 an ambulance attended Baseet at his home following a report that he was experiencing difficulty in breathing, not taking his medication, had psychosis, schizophrenia, and was angry and pacing: new medication had started the previous day. Following assessment, Baseet was taken with his mother to hospital, where he was seen by the Psychiatric Liaison Service: family '*denied any risk of harm to themselves*'. Community Recovery Team North was asked to follow him up in the community.

On 7 June 2018 at review in an outpatient clinic the diagnosis was noted as schizoaffective disorder and mild learning disability and his medication doses were changed.

On 10 July 2018: Police called an ambulance to Baseet at his home address following a report that he believed someone was trying to kill him, and that he had taken an overdose. Following assessment, he was taken to hospital, and subsequently detained on Section 2 of the Mental Health Act⁵. Police created

⁵ Section 2 of the Mental Health Act 1983 allows a person to be admitted to hospital for up to 28 days, for assessment. See <https://www.legislation.gov.uk/ukpga/1983/20/section/2> for more details.

a Vulnerable Adult MERLIN⁶ but it was not shared with partners due to resource issues.

Seven days later (on 17 July) he was discharged from the Section 2, and on 20 July he was discharged from in-patient mental health care.

In August Baseet declined to attend a mental health outpatient appointment. His mother attended with an interpreter and reported that he was preoccupied with contamination.

On 1 Nov 2018, an ambulance attended Baseet at his home address. His family was concerned that he had been throwing things around and then gone out for 4-5 hours. Following assessment, he was taken to hospital, accompanied by his mother, and subsequently referred for a Mental Health Act assessment. No violence was reported but he was described as irritable. The outcome was an admission to mental health care under Section 2 of the Mental Health Act⁷. He was discharged from hospital after 9 days (on 13 Nov) to the care of a Community Recovery Team but they did not engage with him and he declined support. His mother was noted to be his main carer, and was dealing with medication, prompts for personal care, meal preparation, and prompts for eating owing to his lack of motivation. She was overwhelmed and struggling to cope.

Between 25 January and 25 July 2019 Police received multiple calls regarding anti-social behaviour outside the address and in the area. Actions of police included patrols in the area and increased focus on stop and search, some of which led to arrests.

On 25 July 2019 an ambulance attended Baseet at his home following a report that he was angry; violent; trying to leave the house but being restrained by his mother and aunt; had psychosis and had not been taking medication. Due to the nature of the call police were requested to attend and later cancelled the ambulance request. Police created a vulnerable adult MERLIN for Baseet but this does not appear to have been shared with Adult Social Services.

An ambulance attended Baseet at his home again on 23 August 2019 following a report that his mental health was deteriorating; he was verbally aggressive, had twice put cleaning products in his family's food; had not eaten or slept for couple of days; was not taking his medication and had a history of schizophrenia. Subsequently he was taken with his mother to hospital. Next day Baseet's sister informed the crisis team that he had thrown Mum's phone at her in an attempt to hurt her, and was pushing Dad around in an attempt to

⁶ MERLIN reports are safeguarding reports that share details about vulnerable people (children, disabled, mental health, etc.) who come into contact with police. These details can then be accessed by other police officers, and other agencies. MERLIN stands for MERLIN stands for Missing pERsons and other Linked Indices and the system is only used by the Metropolitan Police Service.

⁷ Section 2 of the Mental Health Act 1983 allows a person to be admitted to hospital for up to 28 days, for assessment. See <https://www.legislation.gov.uk/ukpga/1983/20/section/2> for more details.

hurt him. A police officer reported that family had said that he wasn't being aggressive - '*clear contradictory information*' being given. Police later took him to hospital. Police officers created a vulnerable adult MERLIN and this was shared with Adult Social Care. Family were recorded as '*possibly minimising concerns*' when police arrived according to the mental health report. Baseet was voluntarily admitted to hospital for 10 days and discharged on 4 September. Medication was reviewed and a blister pack recommended to support compliance.

On 27 Aug 2019 Adult Social Care received the MERLIN. The report stated that he had accused the family of not giving him any food and had poured a named disinfectant/ cleaning product into the food; that his sister reported that Baseet had thrown a phone at his mother, pushed his father, and touched her a sexually inappropriate manner - the family had locked themselves in a different room to call the police.

On 8 October 2019, an ambulance was called to Baseet following a report that he had taken the wrong medication, was angry, did not feel well and was hallucinating. He was taken to hospital. The GP was informed that there was no self-harm intent and that he had been discharged to the Rapid Assessment Interface and Discharge Service. However, next day (9 October) an ambulance again attended Baseet who was refusing to take his medication, unable to relax and breathing fast. He was taken to hospital. The following day (10 October) Baseet's father called police to report him missing. Baseet had attended hospital with his mother after not taking his medication, but walked out and did not return home. His father later called back to say he had returned home.

On 25 Oct 2019, Baseet's mother attended a mental health review with the GP without her son – a review home visit was arranged.

On 28 Oct 2019, an ambulance was requested by police to attend Baseet following a report that he had not taken his medication, was becoming aggressive, and had a history of schizophrenia. It was reported that he was upset as he no longer wanted to live with family because he heard voices every time, but his family wanted to stay with him to support him. He had new medication prescribed on 18 October and information about whether he was taking it is conflicting. He declined to go to hospital, was deemed to have capacity to decide, and was left at home with his family. Neighbourhood noise was said by family to have led to his agitation. Police created a MERLIN report which was shared with Adult Social Care, and contacted a mental health crisis line who confirmed Baseet was on a home treatment plan and they had scheduled a follow up appointment with him. Police MERLIN report information (as noted by Adult Social Care) was that Baseet called police from home stating he felt like hurting his family. On police attendance, he appeared calm, stated he didn't feel suicidal or want to hurt his family, but that he wanted out of the house and help with housing.

On 5 November 2019 Baseet's sister called police about anti-social behaviour. The following day (6 November) an ambulance was requested to attend Baseet who was having 'mental health problems'. After assessment,

he was referred to 111. An ambulance later attended but Baseet declined to go to hospital. Ambulance staff made him an appointment with a mental health team next day and he agreed to attend. He was left at home in his mother's care. Information from Police MERLIN report on 12 November was that Baseet called police on 6 November stating he wanted to harm someone.

At GP mental health review attended by his parents on 19 November 2019, they reported that he seemed stable. The GP then saw Baseet on a home visit on 29 November 2019 and noted blunt affect, poverty of speech and thought, apathy and anhedonia: vaccines were administered and asthma review completed.

11 Jan 2020: Police were called to the address due to anti-social behaviour: drug dealing outside the address. An Anti-Social Behaviour report was created and sent to the Safer Neighbourhood Team.

On 25 Feb 2020 a GP mental health review was carried out (not in person).

On 25 March 2020, the family contacted Mental Health Crisis Line - Baseet had stopped taking medication, was verbally aggressive and violent, breaking furniture and items at home: family advised to contact police and Community Recovery Team North. A Police MERLIN report noted they had been called by his sister, worried about her brother's welfare as he was throwing stuff around his room and not taking medication. He told officers that he wanted to be re-housed. After conversation police were satisfied that there were no immediate concerns, but thirty minutes later the family called again, and Baseet was taken to hospital by his father with police accompaniment. He was seen by a Crisis Team and 'reported difficult family dynamics': he wanted re-housing.

Ambulances were again called to Baseet on 5 April and 6 April 2020 in response to physical complaints, and, on 6 April, Baseet's father contacted a mental health crisis line concerned that Baseet was agitated and pacing. Information was forwarded to a community team for follow up.

Subsequently on 7 Apr 2020 the GP reviewed Baseet's mental health with his father and on 14 May Baseet did not attend a mental health outpatient appointment. A doctor spoke with his family who '*denied any concerns for mental state or risk*' at the time.

However, on 18 May 2020 his sister contacted police and said that Baseet was holding a knife and threatening to harm himself and others: he had not taken his medication, was going crazy, was trying to run out of the house, shaking and drinking lots of caffeine. Police and ambulance attended. Police were informed that he had a knife. When police arrived, Baseet ran at the officers and was 'red dot challenged' with a Taser: he then complied, was handcuffed and searched but no knife was found. He was detained under section 136⁸ of the Mental Health Act and taken to hospital. He said he wanted to kill people and had been going to meetings where they were telling

⁸ Section 136 of the Mental Health Act gives police emergency powers if they think someone in a public place has a mental disorder and needs immediate help.

him to stab people and kill them. A MERLIN was created and shared with adult social services. He was admitted to a Centre for Mental Health under Section 2 of the Mental Health Act⁹ and spent 20 days on Section 2. Care Act assessment was completed on 3 June and he met the eligibility threshold for support under the Care Act in three domains. Recommendations were for a care package of outreach support totalling 5 hours per week. Risk assessment indicated aggression towards family, isolation, and self-harm.

In early July 2020 (date not identified) assessment was carried out by 'Three C's'¹⁰ to explain the type of support they could offer Baseet to reduce isolation and provide structure, but he declined the offer. He stated that he thought a move from the family home would be beneficial as aspects of his relationship with his parents impact his mental health. Following this, the allocated social worker phoned his father who said the family would continue to support him. An email was sent to his consultant psychiatrist; he was referred to a Supported Employment Team and his case was closed to the mental health access and assessment team. It is not clear what happened with referral to the Supported Employment Team.

On 22 July 2020, a pharmacist reviewed Baseet as he was on the serious mental illness register and on a GP practice register for quarterly reviews (however it appears that reviews did not take place consistently).

On 1 Oct 2020 an ambulance was requested by police to attend Baseet following a report that he was having mental health issues and throwing boiling water at his family. An ambulance was also requested for a female who had been scalded, living at same address. Subsequently, a woman's burns were dressed and she was left at home in the care of family. Baseet was arrested for actual bodily harm. Officers were concerned for his mental health as he was more worried about the fact his mother would not let him have any cigarettes than the incident. He was bailed for the offence and given conditions not to contact the family or attend the home address. The officer involved made numerous attempts to obtain a statement but ultimately Baseet's sister and mother did not support a prosecution, as they were worried about Baseet's mental health and believed he was unable to look after himself. They wanted him back in the family home. There was no other evidence to support a prosecution. Multi-Agency Risk Assessment Conference (MARAC) referrals were recorded by the police as having been made¹¹ (but could not be traced), and a MERLIN was created and shared with Adult Social Care. The MERLIN report was received by Adult Social Care on 2 October and noted that police were called by Baseet's sister for a domestic violence incident – Baseet had thrown boiling water on his mother after an argument about cigarettes. Baseet was diverted from police custody to

⁹ Section 2 of the Mental Health Act 1983 allows a person to be admitted to hospital for up to 28 days, for assessment. See <https://www.legislation.gov.uk/ukpga/1983/20/section/2> for more details.

¹⁰ Three Cs stands for 'Control and Choice in the Community'. This involves providing Community Support, Supported Living, and Social Inclusion and Day Services for people with learning disabilities, autism and/or mental health challenges.

¹¹ See further information about this MARAC referral in Key issues arising– this referral could not be traced.

hospital under Section 2 of the Mental Health Act¹². He reported that his family were not his family, that they were paid to make him take tablets, and that he will stab them. He presented as guarded, thought disordered, floridly psychotic, and with homicidal thoughts. Police completed a safeguarding referral. During admission, Baseet required transfer to Psychiatric Intensive Care Unit after he assaulted a patient. He was discharged from Section 2 after 25 days and made an informal patient with plan to remain on the ward until appropriate discharge destination identified. However, he left the ward and returned to the family home. His father stated that Baseet would not be returning to the ward and Baseet declined referral for supported living.

On 22 Jan 2021 an ambulance was requested following a report that Baseet was being verbally aggressive, hallucinating and had a history of mental health problems. Baseet reported that he felt he was unable to stay in the house with his family. After an enhanced telephone assessment, an ambulance was dispatched but Baseet was not on scene: he was wandering around Newham and was not found. His father reported to police that he had gone missing in the early hours, but he later returned.

On 23 Jan 2021 an ambulance attended Baseet (anxious and depressed) but he declined to go to hospital, was deemed to have the capacity to decide, and was left at home. Subsequently an ambulance again attended following a report that Baseet's heart was beating fast and he felt uncomfortable and frightened. On this occasion, the crew felt he did not have capacity to make a decision regarding hospital and requested police to assist in his best interests. He was conveyed to a hospital. Police completed a MERLIN and shared it with Adult Social Care. In the Emergency Department his mother reported that he had not slept for a week, his hallucinations/ delusions had worsened and he believed he would be killed. He was '*violent to family members.*' He was referred to liaison psychiatry who discussed giving him intramuscular lorazepam and contacting them when 'medically clear'. The medical plan was intravenous antibiotics and fluids. Later he was noted to have high inflammatory markers and was suspicious when a doctor tried to examine him. That same day (25 January) a Learning Disabilities Nurse visited but was unable to assess him (he was asleep) and contacted the Newham Learning Disabilities team. A Charge Nurse completed a Deprivation of Liberty Safeguards (DoLS) Form and assessed him as not having capacity to agree to close observation; remaining on the ward; low rise bed; sedation; and 1:1 security. However, he was discharged on 28 January 2021 before the DoLS process could be completed. The discharge summary said that Baseet was treated for an infection with antibiotics and improved clinically. The psychiatric liaison team recommended home treatment team review after discharge and he told them that that his parents did not want him home – no reason given.

An ambulance was called for Baseet on 7 February 2021 and he attended hospital.

¹² Section 2 of the Mental Health Act 1983 allows a person to be admitted to hospital for up to 28 days, for assessment. See <https://www.legislation.gov.uk/ukpga/1983/20/section/2> for more details.

On 29 March 2021 the community team discharged Baseet from their care following a period of non-engagement.

The ambulance service received three calls regarding Baseet on 14 April 2021 but did not attend.

On 11 May 2021 an ambulance was requested to attend Baseet following a report that he was having mental health problems, had stopped taking medication and was throwing stuff around. Following assessment, he was conveyed to hospital, where he was referred for a Mental Health Act assessment on 12 May after being cleared of any physical health concerns. The outcome was an admission to mental health in-patient care that same day under Section 2 of the Mental Health Act¹³. Whilst an in-patient, his mother and sister spoke with the GP concerned that he did not take medications and therefore relapsed. He was regraded to Section 3 of the Mental Health Act after Mental Health Act assessment¹⁴ on 8 June 2021. The assessment found that he was still lacking insight and appeared pre-occupied with housing, wanting independent accommodation. Because of concerns for erratic compliance with oral medication, he was prescribed depot anti-psychotic medication¹⁵. The following day (9 June) he failed to return from Section 17 authorised unescorted leave, and on 11 June 2021 the in-patient mental health ward reported to police that he was absent without leave. He had returned home.

On 11 June 2021, an ambulance attended Shompa following a report that she had fallen off the bed, had slurred speech and numbness to left side of body. Shompa was assessed as FAST+ (Face, Arms, and Speech Test positive)¹⁶ suggesting that she had had a stroke, and was conveyed to a Hospital. Her son assisted with translation but his name was not documented in the notes. In the Stroke Unit Shompa was seen by occupational therapy who called her 'next of kin' (noted to be a grand-daughter) to request consent to carry out assessment in Shompa's best interests due to 'the language barrier'.

On 15 June 2021 an alert was added to Shompa's hospital records by the Overseas Department stating that Shompa was **not entitled to free NHS treatment** and that appointments should not be booked. Notes added to the hospital electronic system on 16 June stated that Shompa was a Bangladeshi national who entered the UK in 2009 as a visitor. Her son (name given, and the person noted on the electronic records as her next of kin) had said that her passport was lost/ missing, she had no family in her homeland, and that her son was aware that her care was chargeable.

¹³ Section 2 of the Mental Health Act 1983 allows a person to be admitted to hospital for up to 28 days, for assessment. See <https://www.legislation.gov.uk/ukpga/1983/20/section/2> for more details.

¹⁴ Section 3 of the Mental Health Act 1983 allows a person to be detained in hospital for treatment and care for up to 6 months. See <https://www.legislation.gov.uk/ukpga/1983/20/section/3> for more details.

¹⁵ Depot medication is given by injection and released slowly.

¹⁶ The FAST test looks for the common symptoms of a stroke. For further information see <https://www.nhs.uk/conditions/stroke/symptoms/>

On 16 June 2021 an ambulance was requested to attend Baseet who was reported to be refusing to take medication and aggressive: he was still absent without leave from a mental health ward and still under Section 3 of the Mental Health Act¹⁷. He did not want to return to the ward. The following day (17 June) Police were called by Baseet's father who said Baseet was detained under Section 3 and had absconded the Mental Health Centre a week ago. The family had asked the Centre to take him back but they would not collect him. His mental health had deteriorated. Police attended the address and took Baseet back to in-patient mental health care. He was described as having been found at his parents' home looking 'emaciated and scruffy'. Police completed a MERLIN and this was shared with social services. Whilst Baseet was on the ward on 18 June a risk assessment recorded that he destroyed Trust property, slapped staff and voiced sexually inappropriate words towards staff. His risk history was noted to include '*aggression towards family*'.

On 18 June 2021 Shompa was noted to be crying during a ward round on the stroke unit. The plan was to refer her to 'neuro psych' but there was no further record relating to a neuro psych referral and no exploration of the reason for her crying was noted. Later she was seen by occupational therapy using an interpreter via video link and was tearful throughout assessment. It was noted that she was confirmed as an overseas patient, and could not return to her next-of-kin's property: she was now homeless. Safeguarding was not considered.

On 22 June 2021 Shompa was seen by speech and language therapy with her 'next of kin' (said to be youngest daughter and son) who said they would manage her care at home. A new wheelchair was provided. The next day (23 June) Shompa was again seen by speech and language therapy using her son for support and translation. It was noted that her 'next of kin' (name not recorded) said she was emotional as they had not seen one another for a few years. Later that same day she was seen on the ward by physiotherapy and occupational therapy and her son (name given) translated. He reported that Shompa would be going to live with another son (name given) and the address was said to be in the front of the file but no alternative address was documented. Later that afternoon her son agreed to take her home in the family car and was given some training. The team advised that it would be beneficial for Shompa to have private physiotherapy if possible and he was given a list of equipment to purchase for her. There was no evidence that interpreting services were accessed to obtain Shompa's views and wishes.

Shompa's discharge summary gave the primary diagnosis as right middle cerebral artery and posterior cerebral artery stroke. The discharge address did not indicate a different address from admission and the plan was given as: stroke follow up; 24 hour tape and echocardiogram as an outpatient (this was cancelled on 25 June as she was housebound with no further follow up noted); advice regarding medication with GP review. However, it was known

¹⁷ Section 17 of the Mental Health Act (1983) gives the responsible clinician of a patient detained under the Mental Health Act the power to grant that patient leave from the hospital.

that Shompa had no registered GP at that time, and we were told that the discharge summary was not sent.

On 24 June 2021, it was noted that Baseet had been referred for a Care Act assessment and possible exploration of supported accommodation. The referral stated that he informed the Ward that he was in receipt of Employment and Support Allowance¹⁸ (ESA) managed by the family, and it was unclear whether he could access it, stating 'they spend my money'. A request was made to further explore this. The Care Act assessment was not completed as Baseet was discharged back to the family home. Social Workers' notes state the family did not wish to pursue supported accommodation and were satisfied that Baseet was started on depot treatment. The case was closed.

On 4 July 2021, Police were called to the Mental Health Centre by staff, who alleged Baseet had touched a female nurse's bottom over her clothing whilst she was completing her tasks. He had been following her, watching her whilst treating other patients, and making sexual remarks, causing her distress. This was the second time it had happened and she did not want him arrested. Due to concerns about Baseet's mental capacity, it was agreed that matter would be dealt with internally and action would be taken to safeguard the victim and Baseet. Police officers spoke with Baseet but he had been sedated and did not speak with clarity. Police officers created a MERLIN and this was shared with Adult Social Care. No formal capacity assessment was recorded. It was agreed that Baseet or the nurse would transfer to another ward. The Police Merlin report noted that a female nurse complained of sexual assault. The nurse stated this was the second time it had happened.

On 29 July 2021 Baseet was discharged from in-patient mental health care to the care of the Community Recovery Team North. By this time his grandmother was back at the home address being cared for by family.

On 30 July 2021 Newham's Access Team emailed the GP practice to advise that Shompa's family had declined support for her and that her son said they were happy to continue caring for her and would contact if support was needed in future. This followed a referral dated 28 July 2021 (received on 29 July 2021) from a GP practice giving the following information: Shompa had a stroke one month previously and right sided weakness. Her family was not coping with her support needs – she had difficulties mobilising and managing continence as she was unable to get to the toilet. She was then living at the address where she later died.

On 5 Aug 2021 mental health and asthma reviews were carried out for Baseet by his GP on a home visit but no learning disability review took place.

16 Aug 2021: An ambulance attended Shompa at her home following a report that she had a swollen left hand, painful and slightly numb. There was no answer at the door on ambulance arrival. On call back, the Ambulance

¹⁸ Employment and Support Allowance is a benefit that people who have a disability or health condition that affects how much they can work can claim. See <https://www.gov.uk/employment-support-allowance>

Service was told an ambulance was not needed and Shompa would see the GP.

On 7 Sept 2021 an ambulance was requested to attend Baseet following a report of headache. Enhanced assessment was attempted but Baseet declined to talk. His mother said he had been pacing all day but was not aggressive. The call was later cancelled: he was reportedly feeling better.

On 21 September 2021 the Anti-Social Behaviour team received a report from a resident of the street where the family was living, saying a '*car alarm keeps going off all day and night ... This has been going on for over a month now*': an advisory letter was sent to the family address to disable the car alarm.

A welfare check was conducted on 23 October 2021 at Baseet's address by a detective who was investigating the assault on his mother. A MERLIN was created and shared with adult social services.

On 2 February 2022 Baseet's sister called the GP practice concerned about her brother, stating that he lacked insight, was paranoid, had trashed his room, and was not compliant with medications after his depot appointment was changed. The GP signposted her to the crisis team (Baseet's father had called them twice already). Advice was given about contacting police and ambulance if fearful.

On 4 March 2022 an ambulance attended Baseet at his home following a report that he was having a mental health crisis and had stopped taking medication. He had smashed his bedroom wall with a hammer and removed plaster stating he was making room for his wife despite being single. Following assessment, he declined to go to hospital. It was deemed that he did not have decisional capacity, and discussions took place with the mental health team. He was transported to a Centre for Mental Health under the Mental Capacity Act¹⁹ with Police support. Police created a MERLIN and shared it with adult social services. Mental Health Act assessment later took place and he was admitted under Section 2 of the Mental Health Act²⁰.

Baseet was reported missing from the ward on 19 March. He left the ward whilst on un-escorted leave and went to his home address. The Centre contacted him but he refused to return. A second call was made to Police on 20 March, Baseet had not returned to the Mental Health Centre. Staff were concerned he would not take his medication and that his mental health might deteriorate. It was explained that this was not a police matter. A third call to Police was made on 21 March 2022: Baseet had still not returned. The police recorded that mental health team staff did not want to attend Baseet's home address as Baseet was a risk to their safety. Baseet's father called police and asked for assistance taking him back to the Centre. Police attended and returned him to the Centre. Whilst an in-patient, Baseet was absent without leave for 1 week, residing with family and refusing to return. His family

¹⁹ For Mental Capacity Act (2005) see <https://www.legislation.gov.uk/ukpga/2005/9/contents>

²⁰ Section 2 of the Mental Health Act 1983 allows a person to be admitted to hospital for up to 28 days, for assessment. See <https://www.legislation.gov.uk/ukpga/1983/20/section/2> for more details.

'denied' any concerns for Baseet during this time (according to mental health services) and said they were unable to convince him to return to ward.

On a date shortly before Shompa's death: Baseet was discharged from the ward back to the care of a community team. Baseet's father agreed to his discharge to the family home and Baseet was keen to return to the family home: '*no evidence of risks to self or others upon discharge*' were recorded.

On a date in April 2022 an ambulance attended Shompa at her home address following a report she had been stabbed in the neck and was not breathing. She was recorded to have multiple stab wounds. The Helicopter Emergency Medical Service attended and Shompa was later pronounced life extinct by the Helicopter Emergency Medical Service doctor and left on the scene in Police care. Whilst police were responding to the call to Shompa, other officers stopped Baseet based on a description of the offender. He was arrested and taken into custody where he was interviewed.

At the time of the attack on Shompa, Baseet and three women were present in the two-bedroomed house in addition to Shompa; her adopted daughter (Baseet's mother), Shompa's Daughter 1 who is understood to have a disability; and Shompa's adopted daughter's daughter (ie Shompa's adopted granddaughter) who is Baseet's sister. Shompa slept on a mattress in the living room. Baseet's father had left to go to work.

Later in April 2022 a forensic post mortem found that the worst of Shompa's injuries were through the chest cavity, and inflicted with a severe level of force. Many of the injuries were capable of being fatal. Baseet was subsequently charged with murder.

On 29 March 2023 a criminal trial took place at the Central Criminal Court and the jury returned a verdict of guilty in relation to Baseet committing the act of killing Shompa. Baseet was sentenced to a Section 37 hospital order with a Section 41 restriction²¹ (only the Home Secretary has authority to release).

7. KEY ISSUES ARISING FROM THE REVIEW

7.1 Domestic abuse

Key points relating to domestic abuse:

- Agencies involved with Baseet and his family were aware of domestic incidents and ongoing threats and aggression.
- It appears that this awareness did not influence practice.
- There were missed opportunities to intervene.

²¹ A Section 37 of the Mental Health Act (1983) is called a 'hospital order' and means that a court has decided that instead of going to prison a person should be in hospital for treatment of a serious mental health problem. It is called a 'hospital order'. A Section 41 of the Mental Health Act is known as a 'restriction order' and is imposed by a court because of concern about public safety. See <https://www.legislation.gov.uk/ukpga/1983/20/section/37> and <https://www.legislation.gov.uk/ukpga/1983/20/section/41>.

- It is likely that mental health services were regarded by other agencies (and possibly regarded themselves) as the agency with prime responsibility to intervene.
- Baseet was not held accountable for his behaviour.
- It is likely that Baseet's family members were not fully aware of the risks to them and available options that might have benefitted Baseet's mental health.
- At various points records note that the family '*denied*' risk to themselves. The Mental Health Trust refers to '*understatement and changeability of reporting*' and '*possibly minimising concerns*'. This use of language is unacceptable. There might have been a number of reasons why family continued to try to care for Baseet, despite the risks to themselves, and why they might have given different accounts to different people, including:
 - they may well have been afraid what might happen to him if they did not carry on caring
 - despite his actions and their fears, they did not believe he would harm a family member
 - at times he might have appeared to be ok
 - the GP individual management review notes that the family may have been fearful of criminal proceedings against him
 - they were trying to protect Baseet and to prevent him getting into trouble
- It appears that mental health staff did not involve family members in risk assessment.

7.2 Policies, practice and partnership working

Key points relating to policies, practice and partnership working:

- It appears that the response to the family's difficulties was primarily regarded as the responsibility of mental health services and that this may have influenced the practice of other agencies in response to incidents of domestic abuse.
- As a result, there was a lack of information-sharing and partnership working with the family.
- There may sometimes be tension between accepting what might be regarded as the 'cultural norm' and what would be accepted as good practice.
- The Mental Health Trust Care Programme Approach policy was not followed in that Baseet did not consistently have an allocated care coordinator.
- Longitudinal risk factors/ patterns of risk over time appear not to have been taken into account in risk assessment.
- It is good practice for practitioners to exercise professional curiosity in relation to family choices and avoid any suggestion of victim- or family-blaming.
- Baseet's and Shompa's voices were not heard or not sought in relation to their care and the views of other family members were privileged. No capacity assessments were carried out.

- Thirteen MERLINS were completed by police and all but two were shared with Newham Adult Social Care but little or no action resulted.

7.3 Systemic Issues

Key points relating to systemic issues:

- The COVID pandemic impacted on primary care contact with the family
- Service capacity/ resources are likely to have impacted on the mental health service contact with the family

7.3 Other issues raised by the Individual Management Reviews

Key points raised by other issues:

Shompa's care after the stroke raises a number of areas where good practice is important but appears to have been lacking in this case.

- It is important to check out eligibility for free NHS care with the Home Office if there are questions about it.
- It is important to employ interpretation services if necessary to access the views of patients.
- Patients views on their next of kin should be sought and the names and relationships of any relatives with whom their care is discussed should be clearly documented.
- Discharge addresses of vulnerable patients should be clearly documented in their records together with information about household composition.
- There is a risk of making assumptions about someone's wishes influenced by perceptions of their race and/or gender and/ or age.

Housing

- Baseet at times expressed a wish to move to live outside the parental home but, despite that, was repeatedly discharged back to his parents' home
- His family wanted him to stay at home and their view appears to have been privileged: it seems likely that they wanted to care for him and were concerned about his future should he not live within the family, but it is not clear whether there was ever a conversation about options for Baseet in respect of housing and support.
- The home appears to have been small for the number of people who were living there, although they may not all have been permanently resident at that address
- Housing officers were not involved in Baseet's management.

Anti-social behaviour

- Anti-social behaviour in the locality impacted on Baseet's mental health and was an issue over an extended period of time
- Members of Baseet's family were intimidated by those perpetrating the anti-social behaviour and feared reprisals.

Learning disability

- Baseet's learning disability was not taken into account by services and taking it into account might have opened up possibilities that were not considered.

8. CONCLUSIONS

Relating to domestic abuse

- Although agencies involved with Baseet and his family were aware of domestic incidents and ongoing threats and aggression there were missed opportunities for proactive intervention.

Relating to policies, practice and partnership working

- It appears that the response to the family's difficulties was primarily regarded as the responsibility of mental health services, that this may have influenced the practice of other agencies in response to incidents of domestic abuse, and, as a result, there was a lack of information sharing and no coordinated multi-agency approach to supporting this family.
- Longitudinal risk factors/ patterns of risk over time appear not to have been taken into account in risk assessment.
- Family members do not appear to have been involved in risk assessment.
- Thirteen MERLINS were completed by police: all but two were shared with Newham Adult Social Care but little or no action resulted. It is arguable that the current system is not fit for purpose.
- The voices of Baseet and Shompa were largely absent in their contact with services.
- There may sometimes be tension between accepting what might be regarded as the 'cultural norm' and what would be accepted as good practice.
- It is good practice to ensure that family carers are included in discharge planning and treatment plans.

Relating to systemic issues

- The lack of communication between agencies is a systemic issue.
- The COVID pandemic impacted on primary care contact with the family
- Capacity/ resources are likely to have impacted on mental health service contact with the family

Relating to equality, diversity and inclusion issues

- Shompa was disadvantaged and her voice not accessed, most likely because of a combination of factors including her age, gender, disability post-stroke, ethnicity, need for an interpreter, and perhaps also because of assumptions about her cultural background and where the power was assumed to lie in her family. It appears that this

combination of disadvantages led to her relative's views being privileged by both health and social care.

- Shompa's views were not sought during her admission following the stroke or in relation to her need for care support following discharge.
- Shompa's eligibility for free NHS care was not established following the stroke and this may well have had long term impacts on her health and welfare following discharge.
- Next of kin during Shompa's admission following stroke was not accurately recorded, her views were not sought, and different family members were treated as next of kin on different contacts with medical services.
- The experiences and views of those caring for Shompa and Baseet were not sought and this may well have been because of a combination of factors including gender, need for an interpreter, ethnicity and assumptions about culture.
- Baseet's learning disability was not taken into account by agencies working with him and taking account of it might have opened up other possibilities.
- Baseet at times expressed a wish to move to live outside the parental home but despite that was repeatedly discharged back to his parents' home and their expressed views were privileged over his.

Relating to anti-social behaviour and its impact

- Anti-social behaviour in the locality impacted on Baseet's mental health and was an issue over an extended period of time
- Members of Baseet's family were intimidated by those perpetrating the anti-social behaviour and feared reprisals.

9. LESSONS TO BE LEARNED

9.1 Lessons to be learnt taken from individual agency reports

The GP individual management review suggests:

- that abuse between family members as opposed to between intimate partners may be viewed differently.
- That a letter regarding a domestic incident was not coded as domestic abuse by a clinical coder and that all clinical coders should have safeguarding training (we were told that clinical coders all have level 1 safeguarding training but that further training is currently being discussed.)
- That it is important for GPs to recognise that a review with family is not a review of the patient.
- That housing pressures were not fully recognised.

The Mental Health Trust notes:

- The move away from the Care Programme Approach to all service users under secondary mental health care having a named worker
- The need to have a process to track S117 entitlement

- There is now a better system for flagging the need for Care and Treatment reviews for people with a learning disability
- The learning disability service is now managed under Newham Mental Health Directorate and it is hoped that this will enable more integrated working.

Adult Social Care notes:

- The Difficult or Non-Engagers Guidance is under review and relevant learning from this Domestic Homicide Review will be taken into consideration
- Shompa and Baseet were not linked on the Resident Recording System
- The impact that housing has on a person's mental health

Ambulance service notes:

- Recent service changes aiming to improve practice including mental health cars; increase in safeguarding team.

Acute Medical Trust

- Verbal confirmation of an individual's eligibility for free NHS care should not be accepted – only information supplied on the NHS Spine or from the Home Office.

9.2 Multi-agency lessons to be learnt

Relating to domestic abuse

- Violence/ abuse between family members who are not intimate partners (sometimes called adult family violence) may not be recognised as domestic abuse with the result that opportunities to intervene may be missed.
- Violence/ abuse seen as arising in the context of mental ill-health may be seen as the prime responsibility of mental health services and, as a result, those involved may miss out on partnership working.
- Risk assessment should take account of patterns of risk over time.

Relating to policies, practice and partnership working

- A coordinated multi-agency approach to supporting this family was absent
- It is important to always seek the views of service users and, if it is established on assessment that service users are unable to make necessary decisions at the necessary time, to follow the processes set out in the Mental Capacity Act (2005)²².
- There was no one person taking an overview of Baseet's illness, his care and its impacts on his family.
- When there is tension between accepting what might assumed to be the 'cultural norm' and what is accepted as good practice, it is important to ensure that good practice is followed, whilst being understanding of, and sympathetic to, possible cultural issues.

²² See <https://www.legislation.gov.uk/ukpga/2005/9/contents> for further information.

Relating to issues of equality, diversity and inclusion

- When someone is older, disabled and their first (or only) language is not English it is critically important that that everything possible is done to support them in being heard and their views taken into account in their care.

Relating to other issues

- Next of kin needs to be clearly identified and recorded, in line with a patient's wishes.
- Good practice in documentation involves recording discharge address, household composition, and the names and relationships of any family members involved in a patient's care.
- Taking account of Baseet's diagnosis of learning disability might have opened up other possibilities for intervention and support.
- Parents and their adult children for whom they care may have different perspectives and it is important to hear both perspectives rather than privileging one over the other.
- It is easy to under-estimate the impact of anti-social behaviour.

10. RECOMMENDATIONS FROM THE REVIEW

10.1 Single agency recommendations

Barking, Havering and Redbridge University Hospitals NHS Trust

Recommendation 1: The Trust to apologise formally to the family for the failure to check out Shompas eligibility for NHS care.

Recommendation 2: Where immigration status is in question, the patient's status must always be formally verified in writing with the Home Office.

Recommendation 3: All staff to complete safeguarding risk assessments when concerns or disclosures take place.

Recommendation 4: Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessments (DASH) to be completed where there are concerns or disclosures about domestic abuse/ abuse within the family.

Recommendation 5: Ensure safeguarding training is updated to include the importance of risk assessing vulnerabilities/ risks within the household with respect to all family members.

Recommendation 6: Domestic abuse training to become mandatory for all frontline staff.

London Ambulance Service NHS Trust

None

London Borough of Newham Safeguarding Governance Team and Mental Health Adult Social Care Service

None

Mental Health – East London Foundation Trust

Actions were recommended in the SI report - no additional recommendations were made.

Recommendation 1: that the views, wishes and concerns of hands-on carers should always be sought and evidenced in the case-notes, particularly in respect of decisions around discharge. This might necessitate using interpreters or communication aids.

Recommendation 2: that the views, wishes and concerns of patients should always be sought and evidenced in the case-notes, particularly in respect of decisions around discharge. This might necessitate using interpreters or communication aids.

NHS North East London

Recommendation 1: To use this case as a case study in level 3 training.

Recommendation 2: To look at review templates and add a note to say that they should not be completed without the patient present.

The Metropolitan Police

None

10.2 Multi-agency recommendations

Relating to domestic abuse

Recommendation 1: Safeguarding and domestic abuse training to give appropriate emphasis to the fact that domestic abuse includes abuse between family members who are not intimate partners as well as abuse between intimate partners.

The aim of this recommendation is to ensure that violence between family members who are not intimate partners (which is sometimes called adult family violence) is recognised as domestic abuse, is risk-assessed, and that appropriate interventions are considered.

Recommendation 2: All agencies to use the Domestic Abuse, Stalking, Harassment and Honour based violence Assessment Tool (DASH).

Note: Police first responders use the DARA (domestic abuse risk assessment).

The aim of this recommendation is to ensure that the DASH is embedded in practice across agencies.

Recommendation 3: All agencies to review how their risk assessments take account of longitudinal risk/ patterns of risk over time and to report back to the Care Services Partnership what changes need to be made and how to address longitudinal risk on an inter-agency level.

The aim of this recommendation is to ensure that risk events are not assessed individually without taking account of patterns over time.

Recommendations 4: All agencies to review whether practitioners consistently follow Multi-Agency Risk Assessment Conference (MARAC) processes and to ensure that practitioners are aware of the aims of, thresholds for, and process for referral to MARAC.

The aim of this recommendation is to ensure that the MARAC is used appropriately.

Recommendation 5: All disclosures of sexual abuse to be acted on and submitted to professional scrutiny: all agencies to ensure this is included in their policies and training, and that third party reporting is also included.

The aim of this recommendation is to ensure that all disclosures of sexual abuse are dealt with appropriately.

Relating to policies, practice and partnership working

Recommendation 6: When violence/ abuse is seen as related to mental ill-health it is important for all agencies to take a holistic view and to consider how partner agencies might be involved and might contribute to management.

The presence of mental ill-health, or even episodes of violence/abuse linked to mental ill-health should not preclude the need to take a holistic view of other potential factors in assessment and responses from partner agencies. The aim of this recommendation is to ensure that partner agencies can contribute to care and support in complex cases.

Recommendation 7: All agencies to ensure that Mental Capacity Act training addresses the need to take learning disability and/or severe physical disabilities into account and the importance of speaking with service users and not speaking solely with family members.

The aim of this recommendation is to ensure that complex needs are taken into account and that people with complex needs are included in decision-making and their views sought.

Recommendation 8: All agencies to review domestic abuse policies and to put in place operational and strategic domestic abuse guidance for staff covering all forms of domestic abuse in a family setting.

The aim of this recommendation is to ensure that agency guidance encompasses all forms of domestic abuse in a family setting.

Recommendation 9, a and b:

Recommendation 9a: Newham Safety Partnership to ensure that the Domestic Homicide Review/ Domestic Abuse Related Death Review process includes the requirement that agencies secure their records when notified of a Review.

Recommendation 9b: Agencies to ensure that staff adhere to the requirement to secure records in relation to a pending Review.

The aim of these recommendations is to ensure that records are secured in line with existing national guidance.

Relating to equality, diversity and inclusion

Recommendation 10: All agencies to ensure that older people and people with disabilities are supported to participate in risk assessment and to express their views, concerns and wishes whatever their gender, age, cultural heritage or diagnosis. This might necessitate using interpreters or communication aids.

The aim of this recommendation is to ensure that people like Shompa are heard and respected and that the views of family members are not automatically privileged ahead of those of service users who may be less able to contribute to discussions.

Recommendation 11: All agencies to ensure that the views, concerns and wishes of hands-on family carers are sought irrespective of their gender and cultural heritage and without the views of other family members being privileged.

The aim of this recommendation is to ensure that assumptions are not made with respect to who speaks on behalf of other family members.

Recommendation 12: All agencies to evidence that they have accessed the views of all relevant family members, avoiding situations when men in a family feel they can speak for women and younger family members feel they can speak for older family members.

The aim of this recommendation is to avoid assumptions being made about where power lies in family, to ensure that quiet voices are heard, and to ensure a gender- and age-sensitive approach.

Recommendation 13: All agencies to ensure that equality, diversity and inclusion influence practice by involving all service users and family carers in decision-making, and ensuring that they understand agency

processes including risk assessments, possible triggers, and options available to them. This might involve auditing the involvement of service users and family carers by preferred language, cultural background, and use of professional interpreters.

The aim of this recommendation is to embed good practice, to avoid cultural assumptions being made, and to recognise that inclusion is more important when there are language issues.

Additional Recommendations

Recommendation 14: To audit whether Annual Health Checks and Care and Treatment Reviews are taking place in accordance with guidance and, if they are not taking place regularly, to investigate how to improve their frequency.

The aim of this recommendation is to ensure that people who have a diagnosis of learning disability have needs related to learning disability taken into account.

Recommendation 15 a,b and c:

Recommendation 15a: Senior staff signing off individual management reviews and similar documents to be sensitive to the use of language that is or could be seen as family-blaming, to ensure that it is removed from documents and reports, and that authors who use language that is or could be seen as family-blaming are required to reflect on their use of words and practise professional curiosity in relation to family members' experiences/ context.

Recommendation 15b: Practitioners to document that they have exercised professional curiosity when families say that they do not feel at risk despite evidence of behaviour and/or ideation that appears risky to others.

Recommendation 15c: Agencies to ensure that practitioners access training addressing unconscious bias; gender-based abuse; and avoiding victim-blaming practices and language.

The aim of these recommendations is to avoid victim-blaming practices and language and to eradicate statements such as the family '*denied* any risk of harm to themselves' and to encourage practitioners to exercise professional curiosity. A family may feel they are not at risk for a number of reasons, including:

- They may not be aware of the risk they are facing;
- They may choose not to talk about it;
- They may not trust the person asking about it;
- They may not believe that a family member will harm them

Recommendation 16: To allocate dedicated administrative support to Domestic Homicide Reviews.

The aim of this recommendation is to stream-line, and increase the efficiency of, the review process.

Recommendation 17: Newham Adult Social Care should review their MERLIN processes in light of the review and ensure that

Recommendation 17a: All MERLIN reports received are saved in one place in the case management system so all staff can access and view a full chronology of the reports received to inform decision making in domestic abuse cases

Recommendation 17b: All MERLIN reports are correctly assigned to the named individuals in the Merlin report

Recommendation 17c: The Safeguarding Adults Board takes responsibility for ensuring that this recommendation is evidenced and included in all operational procedures

Recommendation 17d: The Safeguarding Adult Board carries out audits every three months to ensure this recommendation has been completed and embedded.

The aim of these recommendations is to enable practitioners to view the MERLIN reports (within a chronology) and attached to case files linked to the individual and wider family members, if they are known to adult social care, and to improve the response to MERLIN reports.

Recommendation 18: Adult Social Care to consider a quarterly review of MERLIN reports embedding professional curiosity to consider the impact of the contents of the report on other family members/older and vulnerable people within the home with a view to taking safeguarding action if required.

The aim of this recommendation is to improve the response to MERLIN reports.