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**TOWER HAMLETS COMMUNITY SAFETY PARTNERSHIP**

**DOMESTIC HOMICIDE REVIEW**

**EXECUTIVE SUMMARY**

**Report into the death of Sajwa**

**January 2019**

**Independent Chair and Author of Report: James Rowlands**

**Associate Standing Together Against Domestic Abuse**

**Date: December 2020**

**Company Logo, Standing Together
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1. Executive Summary
   1. The Review Process
      1. This summary outlines the process undertaken by the Tower Hamlets Community Safety Partnership Domestic Homicide Review (DHR) Panel in reviewing the homicide of Sajwa,[[1]](#footnote-1) a resident of the London Borough of Tower Hamlets (hereafter ‘Tower Hamlets’).
      2. Sajwa was killed by her brother Amir.[[2]](#footnote-2) She was found dead at Amir’s home on a day in January 2019 by police officers from the Metropolitan Police Service (MPS). The MPS had attended the property having been called by a neighbour, although there was a delay of around five hours between the call being made and their arrival.[[3]](#footnote-3) The London Ambulance Service (LAS) were also called to the property, but Sajwa was tragically pronounced dead at the scene.
      3. Amir was arrested and charged with murder. He was initially held on remand in prison but was transferred to a mental health institution and, in March 2019, he was diagnosed with paranoid schizophrenia. In September 2019, Amir pleaded guilty to manslaughter on the basis of diminished responsibility and was sentenced in November 2019. He was sentenced to Hospital Order under Section 37 of the Mental Health Act 1983, with a restriction under Section 41 – which means that he will be detained in a mental health institution until he is deemed fit and no longer a risk to the public.
      4. This DHR will consider agencies contact/involvement with Sajwa and/or Amir from the beginning of 2009 to the date of the homicide.
      5. This DHR has been anonymised in accordance with the statutory guidance. The specific date of the homicide has been removed. Only the chair and Review Panel members are named.
      6. The following pseudonyms have been used in this review to protect the identities of the victim, other parties, those of their family members, and the perpetrator. Three people who knew Amir, but declined to participate in the DHR, are referred to as ‘Witness’.

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| **Name** | **Relationship to Sajwa** |
| Sajwa | n/a |
| Amir | Brother/perpetrator |
| Malik | Brother |
| Rahim | Partner |
| Abdul | Ex-husband |
| Witness 1 | Former manager |
| Witness 2 | Former colleague |
| Witness 3 | Friend |

* + 1. In accordance with the December 2016 ‘*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews’* (hereafter ‘the statutory guidance’), the local Community Safety Partnership (CSP) – the Tower Hamlets Community CSP – commissioned this DHR. Having received notification from the Metropolitan Police Service (MPS) in January 2019, a decision was made to conduct a DHR in consultation in CSP partners in February 2019 and confirmed in March 2019. Subsequently, the Home Office was notified of the decision in writing in April 2019.
    2. Standing Together Against Domestic Abuse (Standing Together) was commissioned to provide an Independent Chair (hereafter ‘the chair’) for this DHR in February 2019, with this beginning in April 2019 once the decision to conduct the DHR had been made. The completed report was handed to the Tower Hamlets CSP in December 2020. On 24 November 2020, it was tabled at a meeting of the Tower Hamlets Community Safety Partnership and signed off, before being submitted to the Home Office on the 2nd November. In April 2021, the completed report was considered by the Home Office Quality Assurance Panel. In June 2021, the Tower Hamlets CSP received a letter from Home Office Quality Assurance Panel approving the report for publication. The letter will be published alongside the completed report.
  1. Contributors to the Review
     1. This DHR has followed the statutory guidance issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004.
     2. On notification of the homicide agencies were asked to check for their involvement with any of the parties concerned and secure their records. This includes agencies in Tower Hamlets. However, it was established that both the victim and perpetrator had properties in, or had previously lived in, other parts of London, specifically: the London Boroughs of Newham, Barking and Dagenham, and Redbridge. Key agencies in these boroughs (the local domestic abuse, substance use and housing department), as well as each borough’s Multi-Agency Risk Assessment Conference (MARAC), were included in the scoping exercise. Amir also had contact with several other agencies, including sexual health and Lesbian, Gay, Bisexual and Trans\* (LGBT\*) services. These too were contacted as part of the scoping exercise.
     3. A total of 58 agencies in Tower Hamlets, as well as the London Boroughs of Newham, Barking and Dagenham, and Redbridge, were contacted to check for involvement with the parties concerned with this DHR. Of these, 4 had limited contact and submitted a Summary of Engagement only. However, 11 had more extensive contact and were asked to submit Individual Management Reviews (IMRs) and Short Reports. A narrative chronology was also prepared.

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| **Agency** | **Contribution** |
| Barts Health NHS Trust | Short Report |
| King George Hospital and what was then the Sydenham Centre[[4]](#footnote-4) (both provided by Barking, Havering and Redbridge University Hospital NHS Trust (BHRUT))[[5]](#footnote-5) | Summary of Engagement |
| Chelsea and Westminster Hospital NHS Foundation Trust (ChelWest)[[6]](#footnote-6) | Short Report |
| Central and North West London NHS Foundation Trust (CNWL)[[7]](#footnote-7) | Summary of Engagement |
| City Psychology Group (CPG)[[8]](#footnote-8) | IMR and chronology |
| Gables Surgery – General Practitioner (GP) for Sajwa | Short Report |
| Guys and St Thomas’ NHS Foundation Trust (GSTT)[[9]](#footnote-9) | IMR and chronology |
| London and Quadrant Housing (L&Q)[[10]](#footnote-10) | Summary of Engagement |
| London Ambulance Service  (LAS) | IMR and chronology |
| Liberty Bridge Road Practice - GP for Amir | IMR and chronology |
| METRO[[11]](#footnote-11) | Short Report |
| Metropolitan Thames Valley Housing (MTVH)[[12]](#footnote-12) | IMR and chronology |
| Metropolitan Police Service  (MPS) | IMR and chronology |
| North East London NHS Foundation Trust (NELFT)[[13]](#footnote-13) | Short Report |
| Peabody Housing[[14]](#footnote-14) | Summary of Engagement |

* + 1. Additionally, the Home Office provided information about immigration and citizenship.
    2. *Independence and Quality of IMRs and Short Reports:* The IMRs and Short Reports were written by authors independent of case management or delivery of the service concerned. The submissions received were comprehensive and enabled the panel to analyse the contact with Sajwa and Amir, and to produce the learning for this DHR. Where necessary further questions were sent to agencies and responses were received. In the context of the DHRs, the Overview Report also addresses the role of the Named GP for Adult Safeguarding, covering the Clinical Commissioning Groups (CCGs) in Waltham Forest, Newham, Tower Hamlets.
    3. The professional services company where Amir had been employed was invited to participate in the DHR. Unfortunately, despite multiple attempts, no response was received. It is deeply disappointing that the professional services company did not respond to requests for its participation. This is described more fully in the Overview Report and the Review Panel has made recommendations to address this issue.
  1. The Review Panel Members
     1. The Review Panel members were:

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| **Name** | **Job Title** | **Agency** |
| Annette Carey | MTVH | Head of Customer Risk |
| Ben Wayland | LAS | Specialist for Adults |
| Clare Hughes | Barts Health NHS Trust | Interim Head of Safeguarding Adults |
| David Stuart | 56 Dean Street (provided by ChelWest) | Manager, Chemsex Support Services |
| Dezlee Dennis | LBTH Safer Communities - Drug & Alcohol Action Team | Substance Misuse Commissioning Manager |
| Dinh Padicala | East London NHS Foundation Trust[[15]](#footnote-15) (ELFT) | Associate Director for Adult safeguarding and Domestic Abuse |
| Elaine Cunnea | Naz Project[[16]](#footnote-16) | Head of Counselling & Safeguarding Lead |
| Emma Sharp | MPS Specialist Crime Review Group (SCRG) | Review Officer |
| Gill Williams | ELFT (Tower Hamlets Adult Mental Health and Learning Disabilities Services) | Borough Director |
| Greg Ussher | METRO | CEO |
| Harry Johnston | Community Intervention Service | Contract Manager |
| Janice Cawley | MPS | Specialist Crime Review Group |
| Ken Andrew | Peabody Housing | Area Community Safety Lead South |
| Lauren Hoy | L&Q | Team Manager |
| Marcus Barnett | MPS | Commander, Central East Basic Command Unit (BCU)[[17]](#footnote-17) |
| Melody Williams | NELFT | Integrated Care Director for Barking & Dagenham |
| Menara Ahmed | Senior VAWG and Hate Crime Manager | Tower Hamlets VAWG and Hate Crime Team |
| Michael Fullerton | GSTT | Safeguarding Adults Lead Nurse |
| Milli Rahman | Victim Support | Senior Independent Domestic Violence Advisor (IDVA) |
| Natalie Blagrove | Peabody Housing | Domestic Abuse Lead |
| Raoul Barducci | CPG | Operations Manager & Director |
| Roisin Gavin | Barts Health NHS Trust | Safeguarding Coordinator |
| Ruth Blackburn | NELFT | Safeguarding Lead |
| Samantha Spillane | Barts Health NHS Trust - Adults Safeguarding | Head of Safeguarding Adults |
| Sarah Murphy | Clinical Commissioning Group (CCG) and Adult Social Care | Joint Senior Strategic Safeguarding Adults Lead in Tower Hamlets CCG and Local Authority |
| Sharon Benoit | Hestia Domestic Abuse Service (Refuge) | Manager |
| Sufia Alam | London Muslim Centre[[18]](#footnote-18) | Maryam Centre Manage |

* + 1. The Review Panel is grateful for the participation of the following agencies, who provided their expertise despite having no involvement in the case: the London Muslim Centre and the Naz Project. Their contribution (alongside METRO, which had contact with Amir) is a reminder of the importance of being able to access local community expertise and knowledge during a DHR. Additionally, a draft of the report was shared with the Patient Safety Lead Mental Health for NHS England (London).
    2. *Independence and expertise*: Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.
    3. The Review Panel met a total of four times, and the first meeting was on the 29th July 2019. There were further meetings on the 9th January 2020, the 24th April 2020, and the 14th July 2020. Thereafter, the Overview Report and Executive Summary were agreed electronically, with Review Panel members providing comment on, and signing off, a final draft by email during September 2020.
    4. The chair wishes to thank everyone who contributed their time, patience, and cooperation.
  1. Chair of the DHR and Author of the Overview Report
     1. The chair and author of the review is James Rowlands, an Associate DHR Chair with Standing Together. James has received DHR Chair’s training from Standing Together. He has chaired and authored 11 previous DHRs and has previously led reviews on behalf of two Local Authority areas in the South East of England. He has extensive experience in the domestic violence sector, having worked in statutory, voluntary and community sector organisations.
     2. Standing Together is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors’ safety, hold perpetrators to account and ultimately prevent domestic homicides. Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 80 reviews.
     3. *Independence:* James has no connection with the local area or any of the agencies involved, although he is concurrently chairing another DHR in the borough.
  2. Terms of Reference for the Review
     1. At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from the beginning of 2009 to the date of the homicide. This date was chosen because this was when Amir arrived in the UK, and it was also the year in which agencies had their first contact with Amir and Sajwa.
     2. *Key Lines of Inquiry:* The Review Panel considered both the ‘generic issues; as set out in the statutory guidance and identified and considered the following case specific issues:
* The communication, procedures and discussions, which took place within and between agencies;
* The co-operation between different agencies involved with Sajwa and/or Amir [and wider family];
* The opportunity for agencies to identify and assess domestic abuse risk;
* Agency responses to any identification of domestic abuse issues;
* Organisations’ access to specialist domestic abuse agencies;
* The policies, procedures and training available to the agencies involved in domestic abuse issues;
* Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.
  + 1. The Review Panel also considered the following issue: Immigration.[[19]](#footnote-19)
  1. Summary of Chronology

*Sajwa*

* + 1. Sajwa had relatively limited contact with services. In her own right, she had contact with her GP and housing providers.
    2. Concerning Sajwa’s contact with her GP, this was for routine medical issues. The Review Panel has identified no evidence of any disclosures by Sajwa nor any opportunity for concerns to be identified by professionals. As a result, no learning has been identified or recommendations made.
    3. Sajwa and Amir, had extensive contact with several different housing providers, reflecting multiple tenancies that Sajwa and Amir either held in common or separately. It appears that both sub-let. This was seemingly a way that Sajwa could support herself, allowing her the flexibility to care for Amir. Amir himself was able to reduce his debt. It is beyond the scope of the DHR to consider this matter further but there has been learning in this DHR for all these housing providers about how they conduct pre-tenancy checks to identify what was potentially social housing fraud. The Review Panel also considered whether having multiple tenancies may have meant Sajwa would have been reluctant to approach agencies for fear of this being identified. However, in practice, this does not appear to have been the case with Sajwa (and Amir) having contact with housing providers.
    4. The only substantiative contact Sajwa had with the LAS and the MPS was regarding Amir. These reflected her concerns about Amir’s behaviour on various occasions. Concerning the MPS, there was a single incident when Sajwa reported Amir missing in 2009, but the relevant contacts were in 2016 (twice) and 2017 (once). Meanwhile, LAS had contact with Sajwa several times, most pertinently in 2016 and 2017 (when LAS attended incidents alongside the MPS) and in 2018. In these contacts, Sajwa shared her concerns about Amir but, broadly, the focus of professionals appears to have been on Amir, not her. However, this did not trigger the identification of safeguarding concerns about Amir (with this being discussed below). Significantly, Sajwa was, in a sense, ‘invisible’ in these contacts. Despite her having called emergency services, and noting discussions with her about her concerns, there does not appear to have been any exploration or consideration of her possible carer status. Key learning in this context is then the importance of both identification of someone as a possible carer but also barriers for that same person identifying themselves as a carer.
    5. More broadly, this contact has highlighted how Adult Family Violence (AFV) is less well understood than intimate partner violence. While there is no evidence that any professional or agency was aware of any domestic violence or abuse, or indeed any evidence that Amir was ever violent or abusive before the homicide, the Review Panel has identified important learning about ensuring that the local area has a robust response to AFV. As a result, a recommendation has been made for the local area to build on its existing work around AFV to further develop responses.

*Amir*

* + 1. Amir had contact with a range of different agencies. Most significantly, this included the emergency services: LAS and the MPS.
    2. Amir had multiple contacts with the MPS. As noted above, there was contact in 2016 and 2017. The MPS has identified that there were missed opportunities to identify concerns for Amir, including considering his potential vulnerability. These contacts could have led to a MERLIN ACN (Adult Come to Notice) being completed, triggering an onward referral to adult social care. Reflecting these findings, recommendations have been made by the MPS.
    3. Amir also had contact with the LAS, most pertinently in 2016 and 2017 (when LAS attended incidents alongside the MPS) and in 2018. At these contacts, while there were concerns about Amir, when he was seen by ambulance crews, he declined interventions (like being conveyed to hospital). There were no immediate concerns and he did not meet the threshold for further action to be taken, including a safeguarding referral.
    4. Bar the emergency service, most of Amir’s contact was with mental health services, LGBT+ services, other health providers and his GP. This contact was varied, reflecting different needs or referral routes. Broadly, this contact identified one or more of the following: the intersection of his sexual orientation, faith, and cultural background; his treatment for a communicable disease; substance use; and mental health. He also talked about other issues including, for example, his job. It appears that professionals and agencies responded appropriately to these contacts, by undertaking assessments and providing advice. However, for the most part, this contact was brief, and Amir did not follow it up or did not complete planned sessions. A significant issue in some of this contact was that Amir declined permission to share information with his GP. However, there were examples of good practice. For example, GSTT was able to secure Amir’s consent to contact his GP when they identified concerns about his mental health in December 2018 (although these did not suggest an imminent mental health crisis or any risk to others).
    5. The broad learning that arises from this range of contact relates to how agencies managed referrals to other agencies for a range of issues. There was often a presumption that providing information to Amir was sufficient, rather than seeking his consent to make a referral on his behalf or making a referral with him. As is clear from this DHR, Amir often did not take these ‘referrals’. The key learning in this contact is that referrals should be meaningful, and professionals should consider what is most likely to result in a positive outcome for a service user and what direct or indirect support may enable this.
    6. Amir did have sustained contact with one service, which was the CPG. He saw a psychologist for 25 sessions, and this explored a range of issues, ranging from his childhood, current situation, and several health issues (including his diagnosis with a communicable disease and his substance misuse). However, Amir’s goals in therapy were mostly around stopping smoking. As a result, while the psychologist was able to explore other issues in some cases, and encourage Amir to engage with different services, these were not the focus of his treatment plan. Additionally, Amir declined to give consent for the psychologist to contact his GP for most of this contact with CPG, which meant the psychologist was unable to liaise with them over Amir’s treatment.
    7. Additionally, Amir had contact with different housing providers. This is summarised above generally, but there has been significant learning for MTVH, which was the landlord of the address in Tower Hamlets were where Amir lived, and where Sajwa had temporarily moved to before the homicide. Sajwa had moved in to help Amir move out of the property, as Amir had agreed to surrender his tenancy after being found to be sub-letting. MTVH has identified that it had relatively little information about Amir and that staff could have demonstrated more professional curiosity, including considering his financial difficulties, sickness and employment, as well as concerns about alternative accommodation. As a result, MTVH has made several recommendations.
    8. A final reflection is relevant in this summary of what was known to agencies and professionals. The DHR has had limited information about Amir’s employment situation because the professional services company for which he worked had chosen not to participate in the DHR (or, indeed, to even respond to multiple approaches). This means some issues, including how Amir was supported in his workplace, have not been explored. Recommendations have been made to address employer involvement.

*Analysis*

* + 1. Sajwa was killed by Amir in January 2019. The Review Panel has concluded that this tragedy was the result of a single, fatal act of AFV.
    2. In accounting for the killing of Sajwa by Amir, it appears that the key factor was Amir’s mental health. The relevance of Amir’s mental health is reflected in the acceptance of Amir’s plea to manslaughter on the basis of diminished responsibility.
    3. Based on the information available to the Review Panel, it is clear that Amir’s mental health had been deteriorating for some months and, at the time of the homicide, he was unwell. However, this deterioration was not wholly evident to professionals. For example, he had contact with both the CPG and GSTT in December 2018. While a doctor at GSTT was sufficiently concerned about his presentation to contact Amir’s GP, they did not identify any evidence of an imminent mental health crisis or any risk to others. Rahim (Sajwa’s partner) also said that neither he nor Sajwa had imagined Amir could be a risk.
    4. It is beyond the purview of the Review Panel to speculate as to what triggered the killing of Sajwa; however, it is of note that at the time Amir would have been under intense stress (given he was losing his tenancy). Also, some months after the homicide, in March 2019, Amir was diagnosed with paranoid schizophrenia.
    5. However, taking into account the government definition of domestic abuse, information gathered by the MPS as part of the murder investigation, as well as provided by agencies and family, there is no evidence to suggest that Amir had previously perpetrated AFV towards Sajwa. While there were evidentially challenges in the relationship, largely because of Amir’s declining mental health and drug use, this does not though appear to have included a wider pattern of violence or abuse. Certainly, Sajwa never made disclosures to any agency or her partner about this, but she did contact services to ask for help to manage specific incidents i.e. the MPS and LAS.
    6. This does not of course mean that violence (or the threat of violence) was not an issue. Sajwa did contact the LAS on one occasion and reported that Amir had become violent after taking Crystal Meth. Sajwa’s response on this occasion – seeking medical assistance – illustrates her sense of responsibility towards Amir, with both her partner Rahim and Amir himself describing the significant role she had in Amir’s life. Similarly, when Sajwa contacted the LAS or MPS this always related to concerns about Amir.
    7. Supporting Amir impacted on Sajwa in several ways, including meaning she did not work so she could care for him, as well as financial pressures because of debts that Amir had occurred. The Review Panel felt that while Sajwa’s experiences were problematic and impactful, they did not constitute economic abuse, which is when an abuser restricts how someone acquires, uses, and maintains money and economic resources.[[20]](#footnote-20) Instead, the Review Panel felt it was more appropriate to consider this as an example of how people with a caring responsibility can be affected by their caring role.[[21]](#footnote-21) The issue of whether Sajwa was a carer, and whether she could have been identified as such and/or offered support, is a key finding in this DHR.
    8. On the day she was killed, Sajwa was only in Amir’s home because she had gone to stay with him to help him move out. It is unclear what triggered Amir’s fatal attack, but by his own account, there was an argument (although he cannot recall what this was about).
    9. Research into fatal AFV has identified the potential for violence and abuse in a familial caring relationship where a carer is supporting a relative with a mental health problem: a review of family adult family homicides reported that most of the perpetrators of fatal AFV had mental health issues. Another common issue was alcohol or substance use. [[22]](#footnote-22)
  1. Conclusions and key issues arising from this DHR
     1. Sajwa’s death was a tragedy. The Review Panel is grateful for the participation of her partner (Rahim), which has enabled the Review Panel to get a sense of her as a person. In addition to talking about their relationship, including their planned marriage, Rahim described Sajwa as caring, compassionate, and creative.
     2. Unfortunately, it has not been possible to substantively engage with Sajwa’s brother (Malik) during this DHR. There may be any number of reasons for this, but the Review Panel has identified an absence of provision for specialist and expert advocacy for the families of victims who reside outside of the UK. While resolving this issue may be challenging, and could take different forms, clearly if the involvement of family is considered a central element of the DHR process, then this is an issue that should be addressed.
     3. Yet, because Sajwa had such limited contact with other agencies, it has been hard to keep her at the centre of this report. In some senses that parallels Sajwa’s experience in life: Amir’s needs meant he was the focus of most of the contact Sajwa had with agencies and so she became, to some extent, invisible.
     4. Shortly before Sajwa was killed by Amir, she had moved in with him temporarily to help him move out of his rented property. It is unclear what triggered the attack on Sajwa by Amir. While it does not excuse the killing, it is of note that at the time Amir would have been under intense stress (given he was losing his tenancy and had a range of challenges in his life). While those agencies that had contact with him around this time had not identified imminent mental health crisis or any risk to others, Amir was diagnosed with paranoid schizophrenia.
     5. The Review Panel has sought to try and understand Sajwa’s lived experiences and consider the issues she faced to try and understand the circumstances of the homicide and identity relevant learning.
     6. Amir is solely responsible for Sajwa’s murder. Nonetheless, there has been significant learning identified during this DHR, which the Review Panel hopes will prompt individual agencies, as well as the appropriate partnerships, to further develop their response to domestic violence and abuse. This learning is summarised below.
  2. Lessons to be learnt
     1. The learning in this DHR relates to several areas:
     2. First, it has drawn attention to the issue of *vulnerability*. Agencies had different contact with Amir. This ranged from the MPS and LAS, who were more aware of Amir’s level of need in moments of crisis, to other agencies who had a different sense of his circumstances and needs depending on how they came to be in contact. At points, for example in contact by the MPS, this contact could have triggered an assessment of vulnerability, which may have led to a referral to adult social care. At others, contact was an opportunity to explore issues in more depth (for example, MTVH could have shown more professional curiosity in their contact with Amir as a tenant). While it is beyond the scope of the DHR, the Review Panel is also conscious of the broader evidence of the extent of Amir’s needs, including reconciling his sexual orientation to this cultural and religious heritage, as well as his extensive substance misuse (including concerns about chemsex), and his work-based experiences. However, there is no evidence that agencies could have responded to these differently, nor in a way that would have affected the homicide itself. Where appropriate individual agencies have made recommendations to address agency-specific learning.
     3. Second, this DHR has identified an issue with *referral*. Many agencies identified issues that were beyond their purview and felt that another service could support Amir. However, for the most part, referrals were passive in so far as information was simply provided to Amir. While a recommendation has not been made to address this issue, the key learning that should be taken from this case is that simply providing information about other services may not be an adequate response, particularly for someone like Amir who had multiple needs. Instead, professionals should ensure that onward referral is meaningful by considering what is most likely to result in a positive outcome for a service user and what direct or indirect support may enable this.
     4. Third, Sajwa was providing care to Amir. However, she was not identified as a *carer*, despite sharing her concerns about Amir with both the MPS and LAS. It is possible that Sajwa did not consider herself to be a carer, but it seems likely that her options for help and support would have felt limited. In this case, only the contact by the MPS and LAS could have provided a link to services, although that assumes both consideration of vulnerability and identification of Sajwa as having needs in her own right. Tower Hamlet’s has a carer strategy and so recommendations were not made in this context, so no recommendations have been made. However, the learning that should be taken from this case is that agencies should be mindful of the barriers that may prevent carer’s self-identification or identification by professionals.
     5. Fourth, the *understanding and response to AFV.* There is no evidence to indicate that Amir had previously been violent and abusive towards Sajwa (although there were occasions when Sajwa was concerned about his behaviour). Nonetheless, the Review Panel has considered the local response to AFV. While there is positive work ongoing, the Review Panel felt that responses to AFV are less well developed than in relation to intimate partner violence. As a result, a recommendation has been made to address this issue.
     6. Finally, as the fifth area of learning, this DHR has identified the challenge of *engaging employers* in DHRs. In this case, Amir’s employer from 2010 to 2018 chose not to respond to repeated contact attempts. The Review Panel considered naming the professional services company, given the disrespect to Sajwa as a victim of homicide – and the discourtesy to the chair, the Review Panel, and the Tower Hamlets CSP – shown by its failure to respond. However, it decided not to do so, given this would have compromised the anonymity of the DHR process. Instead, recommendations have been made both for the Tower Hamlets CSP to take this up with the professional services company, as well as for the Home Office to consider how to support employer involvement in the future.
     7. Following the conclusion of a DHR, there is an opportunity for agencies to consider the local response to domestic violence and abuse in light of the learning and recommendations. This is relevant to agencies both individually and collectively. Tower Hamlets was able to share information on its strategy and action plan, which will provide a basis on which to feed in learning from this DHR and to continue to develop local processes, systems and partnership working. The Review Panel hopes that this work will be underpinned by a recognition that the response to domestic violence is a shared responsibility as it is everybody’s business to make the future safer for others.
  3. Single Agency Recommendations:

*MPS*

* + 1. “The MO12 SLT task the CPIC to review the policies and procedures whereby callers to MO12 MPS Contact Centre are recorded as having perceived vulnerabilities but no ACN or MERLIN record is completed. This is in order to ensure that sufficient safeguarding measures are taken in these circumstances”.
    2. “The North East SLT reinforce the requirement for all staff:
* To understand the Vulnerability and protection of adults at risk policy;
* To understand the VAF; and
* To complete ACN Merlin reports where they have identified vulnerability whether they are a victim, witness, suspect or member of the public they have encountered using VAF”.
  + 1. The Central East BCU SLT reinforce the requirement for all staff:
* To understand the Vulnerability and protection of adults at risk policy;
* To understand the VAF; and
* To complete ACN Merlin reports where they have identified vulnerability whether they are a victim, witness, suspect or member of the public they have encountered using VAF”.

*MTVH*

* + 1. “The processes for Intermediate Market Rent Tenancy sign-ups to be reviewed. The Review to ensure that our internal and external checks include identification of multiple tenancies and subletting. This action to be added to MTVH’s Operational Risk Register”.
    2. “The Sustainability and Vulnerabilities Questionnaire will be included as part of the standard operating procedure for all new tenancies”.
    3. “A Learning from Experience case study to be prepared and shared through reflective practice sessions. This will include a refresher in tenancy management for sublets; reporting compliance for violent & unexplained deaths; Safeguarding emphasis on professional curiosity with focus on debt, financial hardship and related vulnerabilities”.
    4. “Operational team meetings to have an item on required reporting compliance for violent & unexplained deaths”.
    5. “Briefing on violence between siblings and inter-generational conflicts in the context of domestic abuse, to be added as good practice in our DA training content”.
    6. “Information about the availability of structured & clinical supervision to support colleagues who experience traumatic events at work, to be publicised as part of the Employee Assistance Programme”.
    7. “All recommendations to be added to the Multi-Agency Recommendations Action Plan”.

*METRO*

* + 1. “That METRO Charity staff and volunteers are provided with training on the intersection of culture, faith, sexual orientation, gender and family, particularly those who are in mentoring and counselling roles.”
  1. Multi Agency Recommendations:
     1. **Recommendation 1**: The Home Office to review funding arrangements for the provision of specialist and expert advocacy for the families of victims who reside outside of the UK.
     2. **Recommendation 2**: The Tower Hamlets CSP to write to the professional services company to share the findings of the DHR. In writing this letter, the Tower Hamlets CSP should express their disappointment at the professional services company’s failure to participate in the DHR and request they review their procedures to ensure they can participate in DHRs in the future.
     3. **Recommendation 3:** The Home Office to engage with the Corporate Alliance Against Domestic Violence and the Employers’ Initiative on Domestic Abuse to review the effectiveness of existing guidance and support for employers in order to promote involvement in DHRs.
     4. **Recommendation 4:** The Tower Hamlets CSP to work with local partners to review the findings from this DHR and develop the response to AFV locally. This should include considering evidence of need locally and identifying the actions that agencies can take individually and collectively and completing a training needs assessment to identify the skills and training that professionals require to respond.

1. Not her real name. [↑](#footnote-ref-1)
2. Not his real name. [↑](#footnote-ref-2)
3. Subsequently, it established that Sajwa was likely killed 3:20 hours and 3:50 hours prior to the MPS first being called by a neighbour and so this delay is unlikely to have contributed to her death. An investigation was carried out in relation to this matter. The investigation is summarised below (in 1.11), with the police contact on the day of Sajwa’s death described in the chronology and the reasons for the delay considered in the analysis. [↑](#footnote-ref-3)
4. The Sydenham Centre Is now known as The Sexual Health Clinic at Barking Community Hospital. [↑](#footnote-ref-4)
5. An NHS Trust which provides neuro, stroke, and maternity services, as well as elective and emergency care. For more information, go to: <https://www.bhrhospitals.nhs.uk>. [↑](#footnote-ref-5)
6. An NHS trust which provides a range of specialist and general hospital services including sexual health and Human Immunodeficiency Virus (HIV) / Genitourinary Medicine (GUM) clinics (56 Dean Street and the John Hunter Centre). For more information, go to: <https://www.chelwest.nhs.uk/services/hiv-sexual-health>. [↑](#footnote-ref-6)
7. CNWL provides a range of NHS services at GPs, in hospitals and in the community. For more information, go to: <https://www.cnwl.nhs.uk>. [↑](#footnote-ref-7)
8. A private healthcare provider, offering psychological services. For more information, go to: <https://www.city-psychology.co.uk/about-us/>. [↑](#footnote-ref-8)
9. An NHS trust which provides a full range of health services for residents of Lambeth, Southwark and Lewisham, as well as specialist services for patients from across London. This includes outpatient support for care and treatment for people living with the communicable illness with which Amir had been diagnosed. For more information, go to: <https://www.guysandstthomas.nhs.uk/about-us/about-us.aspx>. [↑](#footnote-ref-9)
10. A housing association. For more information, go to: <https://www.lqgroup.org.uk>. [↑](#footnote-ref-10)
11. METRO provides health, community and youth services, promote health and wellbeing for people experiencing issues relating to sexuality, gender, equality, diversity and identity more information, go to: <https://metrocharity.org.uk>. [↑](#footnote-ref-11)
12. A housing association. For more information, go to: <https://www.mtvh.co.uk>. [↑](#footnote-ref-12)
13. Provided community and mental integrated community and mental health services. For more information, go to: <https://www.nelft.nhs.uk/>. [↑](#footnote-ref-13)
14. A housing association. For more information, go to: <https://www.peabody.org.uk>. [↑](#footnote-ref-14)
15. Provides mental health services in the City of London, Hackney, Newham and Tower Hamlets and, Bedfordshire and Luton. For more information, go to: <https://www.elft.nhs.uk/About-Us>. [↑](#footnote-ref-15)
16. Although the Naz Project had no contact, they invited to sit on the Review Panel to provide expertise in relation to LGBT+ BAMER communities (see1.5.9 above). [↑](#footnote-ref-16)
17. Covers the London Boroughs of Newham and Waltham Forest. [↑](#footnote-ref-17)
18. The East London Mosque, which incorporates the London Muslim Centre and the Maryam Centre, offers a wide range of services including advice and counselling. For more information, go to: <https://www.eastlondonmosque.org.uk>. [↑](#footnote-ref-18)
19. During the course of the DHR, no information was shared to indicate that immigration was a current issue either Sajwa or Amir, as both had obtained British Citizenship. However, as discussed in in the analysis, specific issues around race and religion and their country of birth may have been relevant. [↑](#footnote-ref-19)
20. For a complete definition, go to: <https://survivingeconomicabuse.org/economic-abuse/what-is-economic-abuse/>. [↑](#footnote-ref-20)
21. A carer is anyone who provides regular unpaid care to one or more people who cannot manage without their help. This could be due to age, physical or mental illness, addiction or disability. Often people don’t think of themselves as ‘carers’. For more information locally, go to: <https://www.towerhamlets.gov.uk/lgnl/health__social_care/ASC/Adults_Health_and_Wellbeing/Caring_for_someone/Carer_needs_assessment.aspx>. [↑](#footnote-ref-21)
22. Sharp-Jeffs, N. and Kelly, L. (2016) *Domestic Homicide Review (DHR) case analysis*. Available at: <http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf> (Accessed: 28th March 2020). [↑](#footnote-ref-22)