LONDON BOROUGH OF TOWER HAMLETS
COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

ABDUL AGED 36 YEARS

FOUND MURDERED IN TOWER HAMLETS
IN SEPTEMBER 2015

EXECUTIVE SUMMARY

REVIEW PANEL CHAIR AND AUTHOR
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EXECUTIVE SUMMARY

This summary outlines the process taken by the London Borough of Tower Hamlets (LBTH) Domestic Violence Homicide Review (DVHR) Panel established in November 2015 under s9 Domestic Violence, Crime and Victims Act 2004, independently chaired by Bill Griffiths CBE BEM QPM, to review the death of Abdul aged 36, caused by manual strangulation about a week before his body was discovered in September 2015. In February 2016 at the Central Criminal Court, his brother, Yunus aged 29, was convicted of murder and sentenced to 12 years imprisonment.

The process began with a meeting on 12 January 2016 of all agencies that potentially had contact with the family prior to the death of Abdul. Agencies participating in the review are:

- NHS England (a Health Centre in Tower Hamlets)
- East London Foundation Trust who provide mental health services in Tower Hamlets
- Barts Health Trust who provide community services in Tower Hamlets
- Metropolitan Police
- Victim Support
- LBTH Adult Social Care (ASC)
- LBTH Housing Options
- LBTH Positive Changes Services
- LBTH Domestic Violence Forum
- LBTH Domestic Violence and Hate Crime Team
- Independent Domestic Violence Advocate, Newham Asian Women's Project

Agencies were asked to give chronological accounts of their contact with the victim prior to her death. Each agency's report covered the following:

> *A chronology of interaction with the victim and the perpetrator; what was done or agreed; and whether internal procedures were followed.*

The accounts of involvement with this victim cover different periods of time prior to their death. Some of the accounts have more significance than others. The extent to which the key areas have been covered and the format in which they have been presented varies between agencies. Of the above agencies, five provided a full Individual Management Review (IMR) that included conclusions and recommendations from the agency's point of view.

<u>Key issues arising from the review</u>

Abdul and Yunus, with their six sisters are of Bengali heritage, most of them are British born and had been raised in the family home, a 4-bedroom flat in the London Borough of Tower Hamlets. They lost their father when aged 64 in 1994 and, in 2008, their mother, Minu, suffered a stroke and was bedridden, requiring daily care provided by Adult Social Care with district nurse visits by Barts Health. In 2013, the youngest sister left to be married leaving the brothers to administer medication and other care to their mother, who required feeding by tube, alongside the provided care arrangements.

Each brother used alcohol and cannabis. Abdul was being treated for depression at the time of his death and there was also a possible diagnosis of paranoid personality disorder. Yunus was being treated for anxiety and had been referred for alcohol and cannabis dependency. As brothers they

did not get on and tended to stay in their own bedroom to drink and smoke. Responsibility for the care of their mother was often disputed and became a source of discord

Abdul's pastime and passion was horticulture and he had studied a National Vocational Qualification up to Level 2. The walkway and entrance to the flat that became the scene of the homicide was festooned with plant life, with seeds and cuttings being cultivated inside in small greenhouses. Abdul worked voluntarily for the 'Trees for Cities' charity and had made friends there, so much so, that they planted a tree in his memory nearby.

Unfortunately, this interest was also an additional cause of friction and trouble between the brothers, particularly when plants were moved or became damaged. The hobby also contributed to the untidy conditions that developed in the kitchen area and Abdul's bedroom. There were frequent disputes over who was responsible for cleanliness; the carers also raised this issue and the sisters intervened on occasion to organise cleaning.

Their arguments erupted from time to time and the police were called by either one of them on eleven occasions between 2007 and July 2014. Each brother has at some point been arrested for a relatively minor assault on the other and accepted a caution. Yunus has also been cautioned for a minor assault on his younger sister when intoxicated. There were two other occasions in 2013 when ASC noted possible domestic abuse incidents between the brothers.

In September 2013, police officers who were called regarding the impact of horticulture on cleanliness, developed concerns about the welfare of Minu and shared an 'Adult Coming to Notice' report with Tower Hamlets ASC. A family review meeting was held in November when a deep clean was organised and a cleaning Rota was agreed, but never implemented.

From April to October 2014, there were a number of concerns raised by district nurses about the correct positioning by her sons of Minu for feeding and medication. In December 2014, this culminated in unclear communication between ASC and Barts Health as to whether or not this was a safeguarding issue and that question was not resolved as it appears both agencies have a different perspective as to what was agreed.

In January 2015, Abdul posted stickers around the flat, reading "LET MY PEOPLE GO' that caused the district nurse to be fearful to enter. As a result of this incident, Abdul self-referred to the Royal London Hospital leading to the possible diagnosis of paranoid personality disorder, however, this was not confirmed because he was discharged after 24 hours. He visited his GP two weeks later when he reported the same issues with his brother but there was no indication of escalation.

Abdul was the subject of Multi Agency Public Protection Arrangements because of prior (and unconnected) sex offending conviction. This led to regular supervisory visits by police to the home to check on Abdul. The latest of these, in April, was the last time anyone in authority encountered the brothers prior to the discovery of the murder in September. This came about when Yunus attended the emergency department seeking treatment for fingers damaged six days earlier in a fight with his brother. When police and paramedics attended the flat, they discovered the decomposing body of Abdul.

<u>Conclusions and recommendations from the review</u>

In considering all the evidence from agencies involved with this family, overall there is no identifiable 'root cause', no omission or dereliction of duty by any individual or single safeguarding

agency that failed to limit or prevent the opportunity for Yunus to inflict the fatal injuries on his brother Abdul. The level of detail about the buildup in tension between the brothers available through hindsight was not available to agencies at the time of the fatal incident and we conclude that what was available would not have enabled services to predict that the level of violence would escalate to the point of homicide. There is no evidence in this review of a collective failure.

As a consequence of the review and the commissioning of Individual Management Reviews by the DVHR Panel, Barts Health conducted a full Serious Incident Review with recommendations and East London Foundation Trust implemented seven improvements to practice. There are six recommendations reported in the IMRs to be implemented. The DHR Panel has identified an additional two to be explored by Tower Hamlets Community Safety Partnership. An Action Plan has been formulated to ensure all eight are implemented.

Recommendation 1 Metropolitan Police
Tower Hamlets Senior Leadership Team (SLT) carry out a dip sample of reports to ensure that Adult Coming to Notice reports are being created where required
Recommendation 2 Metropolitan Police
All officers involved in the investigation of the domestic abused incidents reported to police should be de-briefed by the SLT in order to assess the officers' knowledge of the Vulnerable Adult Framework
Recommendation 3 London Borough of Tower Hamlets (LBTH) Adult Social Care
In complex cases, or where concerns are raised, practitioners convene professionals' meetings to share information
Recommendation 4 LBTH Adult Social Care
Where, as a result of concern around safeguarding or risk behaviour, referrals are made to other agencies, practitioners do not close casework and they monitor responses so that their support planning can respond to advice and provision of the other agency. Where responses are delayed or insufficient to manage risk, practitioners remain involved to secure a response or escalate according to the risks or concerns that trigger the original request
Recommendation 5 East London Foundation Trust
No patient should be considered for discharge from Tower Hamlets Centre for Mental Health within 24 hours of admission without the agreement of a senior member of staff. Senior members of staff include the following: the borough lead nurse and deputy borough lead nurse, the responsible clinician or duty consultant and the modern matron or ward manager
Recommendation 6 East London Foundation Trust
The senior management team of Tower Hamlets Specialist Addictions Services to review the migration strategy between EDM (ELFT Data Management system) and Nebula and analyse the risks and benefits of further migration of all EDM patient data
Recommendation 7 LBTH Adult Safeguarding Board
LBTH Community Safety Partnership to commission a task and finish group to review the specific learning from this review about effective communication between safeguarding agencies, adopting a 'think family' approach to develop a narrative case study to be shared at relevant Tower Hamlets Partnership learning events
Recommendation 8 LBTH Adult Safeguarding Board
To commission a project working group to explore the greater use of Closed Circuit Television in the context of adult safeguarding within a suspected domestic abuse environment and present findings and recommendations for consideration.