FULL REPORT:

THE DOMESTIC HOMICIDE OVERVIEW REPORT INTO THE DEATH OF TEKIA

NAME[1]	Age of time of the homicide	Relationship to victim
Tekia	46	Victim
Abdullah	39	Son-in-law and perpetrator
Adult 1[2]	25 (NB Some agency records say 26)	Daughter of victim and wife of perpetrator
Adult 2	45	Wife of victim
Adult 3	20	Son of victim
Child 1	16	Daughter of victim
Child 2	5	Daughter of victim

INTRODUCTION

This Domestic Homicide Review (DHR) report examines agency responses and support given to Tekia, a resident of London Borough of Waltham Forest prior to the point of his murder on 28th October 2012.

The London Borough of Waltham Forest is outer North East London. The south of the borough contrasts markedly with the north (split by the North Circular Road) in terms of its mixed ethnicity and socio-economic indicators, and is often regarded as part of London's East End. As a whole, Waltham Forest comprises built-up urban districts in the south with inner-city characteristics, and more affluent residential development in the north with a variety of reservoirs, open space, small sections of Epping Forest, parks, and playing fields, which together cover a fifth of the borough.

It is located between Epping Forest District Council in the north, London Borough of Redbridge in the east, London Boroughs of Newham and Hackney in the south, and London Boroughs of Haringey and Enfield in the west (where the River Lea and the surrounding parkland forms a green corridor, traditionally separating north and east London). Waltham Forest was one of the six London boroughs that hosted the 2012 Summer Olympics.

[1] Not their real names

[2] Consent was not given to share records of the four children or the victim's wife.

Waltham Forest Council currently has a growing population of 262,000 with women making up 51%. Waltham Forest ranks in the bottom quartile in London in relation to the rate of domestic violence crimes reported per 1000 population, and has done so for some years.

Waltham Forest Council has commissioned several support services for victims and survivors and these consist of:

- Victim Support: provides the Independent Domestic Violence Advisory Service (IDVA) for medium to high risk victims/survivors of Domestic Violence and Abuse
- Ashiana Network: provides the following services – refuge accommodation for single women fleeing Domestic Violence and Abuse and harmful practices, domestic and sexual violence counselling services,
- Kiran Project: provides refuge accommodation for women with children fleeing domestic violence and abuse and harmful practices.
- Domestic Violence Intervention Project (DVIP): provides a perpetrator programme for young people and adults.

Waltham Forest Children and Adult Social Care and Waltham Forest Community Safety Partnership have identified the following priorities:

- Reduce the number of children and young people with child protection plans where domestic violence and abuse are the main issues.
- Reduce the number of vulnerable adults that have disclosed domestic violence and abuse.
- Reduce the number of repeat victim-survivors of domestic violence and abuse
- Hold perpetrators to account for their behaviour
- Improve the detection rates for domestic violence and abuse
- Improve our early detection and intervention processes.

SUMMARY OF THE CASE

At 21:24 hours on Sunday 28th October 2012, Police were called to a corner shop in Walthamstow by the London Ambulance Service who were on route to reports of a stabbing. On arrival at the address, the police and ambulance service were alerted to a nearby residential property where they found Adult 1, who had sustained a stab wound to the torso, Adult 3 who had also been injured, as well as Tekia, her father, who had stab wounds to the throat. All injuries were inflicted by Abdullah. Tekia was pronounced dead at the scene. Adult 1 was taken to hospital; her injuries were severe but not life threatening.

Abdullah was arrested nearby on suspicion of murder and causing grievous bodily harm. He had sustained some injuries and taken to an East London Hospital under Police guard.

Abdullah pleaded guilty to manslaughter, by virtue of diminished responsibility. He was sentenced on 15th April 2014 to be indefinitely detained at a secure psychiatric hospital.

POST MORTEM

On 29 October 2012 Home Office Pathologist, Dr Fegan-Earl, carried out a post mortem at East Ham Mortuary and gave as the cause of death for Tekia 'shock and haemorrhage by a stab wound to the neck'.

INQUEST

On 5 November 2012 the Coroner for the Eastern District of London opened and adjourned the Inquest pending police investigations. In view of the trial result, it is not expected to resume.

COURT DATES

On 15 April 2013 at the Central Criminal Court Abdullah pleaded guilty to the manslaughter of Tekia guilty to Assault with Intent to commit Grievous Bodily Harm to Adult 3 and Adult 1. The plea was entered on the grounds of Diminished Responsibility and he was sentenced to be held at a secure psychiatric hospital limit of time under a hospital order.

SCOPE OF THE REVIEW

The period for review was set at January 2005 until April 2012 although participating agencies provided additional information outside this time frame where it was thought to be relevant.

TERMS OF REFERENCE

The terms of reference were set by the Panel as follows:

The DHR Panel will consider:

1. Each agency's involvement with the following family members between 1st January 2005 and the murder on 28th October 2012:

NAME	Age of time of the homicide	Relationship to victim
Tekia	46	Victim
Abdullah	39	Son-in-law and perpetrator
Adult 1	25 (NB Some agency records say 26)	Daughter of victim and wife of perpetrator
Adult 2	45	Wife of victim
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Child 1	16	Daughter
Child 2	5	Daughter

Author's note: NB Due to the insecure immigration status of the entire family, several spellings of each name and some varied dates of birth were compiled. This meant checking agency records was a more complex task than usual.

2. Whether, in relation to the family members, standards were met or exceeded and whether there were any gaps in services or processes that might have led to a different outcome for Tekia. The areas to be considered include:

(a) Communication between services

(b) Information sharing between services with regard to the safeguarding of children

3. Whether the work undertaken by services in this case was consistent with each organisation's:

(a) Professional standards

(b) Domestic violence policy, procedures and protocols

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

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards. This should include full consideration of any issues which may have been a contributory or aggravating factor to the murder such as gambling, substance use or mental health issues.

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

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

(d) The quality of the risk assessments undertaken by each agency in respect of the above named people.

5. The training provided to adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done so as to safeguard and promote the welfare of children or vice-versa.

6. Whether thresholds for intervention were appropriately calibrated and applied correctly, in this case.

7. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any special needs on the part of either of the parents or the child were explored, shared appropriately and recorded.

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

9. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies ' ability to respond effectively.

10. In relation to this Review the children are not identified as a victim as specified in paragraph 3.3. 3.4 and 3.6 of the DHR Guidance. The primary role of this element of the Review in relation to the child affected is to highlight any learning from this case which would improve safeguarding practice in relation to domestic violence and its impact on children. In particular the Review should identify whether there is any learning in relation to effective communication, information sharing and risk assessment for all those children's services involved in LB Waltham Forest and also any other agencies and local authorities. It should also highlight any good practice that can be built on.

11. Whether practitioners in all agencies were aware of the needs of the children involved, knowledgeable about potential indicators of abuse and neglect and what to do if they had concerns about a child's welfare.

TIMESCALES

This review began in June 2013 and was concluded in July 2014..

It was hoped that members of the family would be involved in the Review so proceedings were suspended to await the outcome of the trial. Unfortunately during this period, several family members relocated abroad. However, the oldest son did contribute to the DHR.

The extended time period to conclude this Review did not prevent agencies from implementing emerging lessons learned as is evidenced in the information below.

PARALLEL INVESTIGATIONS

In addition to the trial, an internal investigation was undertaken by North East London NHS Foundation Trust as both victim and perpetrator were in receipt of their services. A copy of the final report was made available to the Panel to assist in their deliberations.

DISSEMINATION

DHR Panel members have all received a confidential copy of this report as have family members.

CONFIDENTIALITY

The findings of this review are confidential and all parties have been anonymised. For ease of reading, the victim and perpetrator have been allocated alternative names.

Information has only been made available as described above. The report will not be published until permission has been given by the Home Office to do so.

INDEPENDENCE

Davina James-Hanman, Chair and report author, is the Director of AVA (Against Violence & Abuse), a second tier charity which works to improve responses to survivors, perpetrators and their children of all forms of violence against women.

She has worked in the field of violence against women for almost 30 years in a variety of capacities including advocate, campaigner, conference organiser, crisis counsellor, policy officer, project manager, refuge worker, researcher, trainer and writer. Davina is also a Trustee of Women in Prison.

The Chair had no contact with the victim or perpetrator and is not associated with any of the participating agencies.

None of the IMRs report writers had any contact with the victim or perpetrator and each IMR was signed off by a senior manager within the organisation. All Panel members were similarly independent.

THE REVIEW PROCESS

The Domestic Homicide Review Panel was initially convened in June 2013 with all agencies that potentially had contact with the victim, perpetrator and their children prior to the murder. A total of 5 meetings took place.

CONTRIBUTORS TO THE REVIEW

DHR panel members were as follows:

Davina James-Hanman (Chair of DHR Panel)
Designed Nurse, Safeguarding Children WF CCG
Home Office - Immigration Enforcement
IDVA Manager, Victim Support
Kiran Support Services
LBWF – Adult Social Care
LBWF – Community Safety
LBWF – Coronets Court Service

LBWF - Corporate Communications
LBWF – Education Welfare
LBWF – Local Safeguarding Board
LBWF- Children Social Care
London Fire Brigade (Co-Chair of Reducing Victimisation Programme Board and rep for SafetyNet)
Metropolitan Police Service
NEFLT - Assistant Director for Mental Health Services & Learning Disability

Agencies were asked to give chronological accounts of their contact with the victim and perpetrator prior to the murder and to complete an IMR in line with the format set out in the statutory guidance. Where there had been no involvement, agencies were asked to consider why that might be the case and what changes might be needed to make their services more accessible. In total, nine agencies were requested to search their records for any contact they may have had with the family prior to the critical incident:

- Ashiana Network (Domestic violence and abuse (DVA) and refuge support)
- Kiran Project (DVA and refuge support)
- LB Waltham Forest Adult Social Care
- LB Waltham Forest Children Social Care
- LB Waltham Forest Environmental Health
- North East London Foundation Trust (NELFT)
- Report It (Legal and Advocacy Service)
- Victim Support (Independent Domestic Violence Advisory Service)
- Waltham Forest Haven the Survivors Network (Domestic and Sexual Violence Service)

Each agency's report covers the following:

A chronology of interaction with the victim and/or their family;
What was done or agreed
Whether internal procedures and policies were followed
Whether staff have received sufficient training to enact their roles
Analysis of the above using the terms of reference
Lessons learned
Recommendations

Most agencies reported no contact with any family members. However, two had significant contact and a third minor contact. These agencies were requested to complete an IMR. These were commissioned from the following agencies:

- North East London NHS Foundation Trust (this included both Community Care and Mental Health Services)
- Metropolitan Police
- Waltham Forest Council Children's Social Care

The Panel also received a report from the UK Border Agency regarding migration records of the family. It should be noted that there are no records at all of Tekia entering the UK.

INVOLVEMENT OF FAMILY AND FRIENDS

The family was contacted early in the process and informed of the DHR. Subsequent to the trial, the family were contacted again and Adult 4, the designated family spokesperson met with the Chair. The family views on events have been integrated into the report but they asked for the following to be included within the report:

'My father [Tekia] was a hard worker who did mainly manual work on building sites. He always cared for and looked after his children, spending most of his spare time with his family. He was

exceptionally kind and generous; if someone needed help, he would always go out of his way to try and assist. He also did charity work that he really enjoyed. We still miss him every single day'.

Issues of concern that were raised by the family included:

- The lack of action taken by the mental health staff who visited Abdullah two days before the murder when they knew he had stopped taking his medication
- The policy of LAS of treating the first victim they see which meant that they continued attending to Abdullah whilst Tekia lay dying. The second ambulance arrived twenty minutes later but by then it was too late.

The first of these issues is addressed in the report. The second has been addressed by the family writing directly to the London Ambulance Service (prior to the DHR beginning) who replied with a detailed description and rationale for their policy.

CHRONOLOGY

A full chronology is available in the full report. Below is a summary of the key events:

21st June 2005: Community Alcohol and Drug Team (CDAT)

Tekia is referred to the Community Drug & Alcohol Team (CDAT) with dependence on illicit drugs. An assessment is undertaken stating that Tekia was a 39-year-old unemployed man who spoke hardly any English with limited comprehensive and had been homeless for 15 months.

His issue was the use of heroin and occasional crack, he had started using heroin aged 22 years, injecting, and when he withdraws he reported he had cold sweating restlessness, watering eyes and runny nose. He funds his habit through help from certain people.

He had never been registered with a GP but had been seen by a psychiatrist dealing with addictions in Mauritius. He was prescribed Subutex.

Tekia continued to attend appointments with occasional relapses until his final appointment on 11th October, almost three weeks before he was murdered.

During this period, he told staff about his wife's pregnancy and subsequent birth of their daughter, Child 2 the fact that he was in over-crowded accommodation and that he was an illegal migrant which hampered his attempts to find employment and thus experienced financial difficulties. He also missed a number of appointments due to the ad hoc nature of his work (mostly labouring). In 2008 he also mentioned the forthcoming wedding of his daughter, Adult 1, to Abdullah which he did not seem to approve of.

Staff arranged appointments with the Citizen's Advice Bureau and Refugee Council in an attempt to stabilise his immigration status and to access benefits but Tekia did not always attend these appointments out of a fear of deportation. Concerns in regard to his immigration status, accommodation circumstances and the vulnerability of his children were raised with Social Services but the referral was badly managed by CDAT. CDAT records show that a follow up letter was sent a few weeks later but there is no evidence of escalating concerns to the Safeguarding Lead. Children's Social Care has no record of the follow up letter nor of additional letters sent in September 2008 and May 2009. On each occasion, CDAT did not appear to pursue the matter further.

Following his death, the autopsy found a number of illicit substances in Tekia's system including heroin and cocaine. Morphine, codeine and methadone were also found. It was not possible to say with any certainty whether all of these substances would have been affecting Tekia's judgement on the day of the murder although the levels detected suggest both cocaine and heroin use on the day he died and that he was almost certainly under the influence of cocaine at the time of his death.

10th October 2005: Metropolitan Police

Abdullah was stopped in a vehicle and was found to be in possession of cannabis. As he had no criminal record, he was given a formal warning.

6th December 2006: Metropolitan Police

Abdullah reported to police that he had been receiving threatening and silent phone calls.
The details of the threats were recorded and attempts made to identify the suspect.
No suspects were identified. Abdullah changed his telephone number.

29th August 2007: North East London NHS Foundation Trust

This was Abdullah's first appointment with the Waltham Forest Access team having been referred des to paranoia. He identified that he was unwell and required medication and also asked for support with his financial problems and accommodation. An urgent appointment was arranged for 7th September which he attended, as well as the follow up appointment on 5th October. Abdullah was also referred to the Citizens Advice Bureau surgery.

23rd November 2007: North East London NHS Foundation Trust

Abdullah did not attend his follow up appointment. This would usually result in a home visit but did not in this case as the case was transferred to EIP.

9th January 2008: North East London NHS Foundation Trust

EIP had attempted to contact Abdullah by phone several times but to no avail. He was written to offering an appointment with the EIP service on 15/01/2008. The team discussed that if Abdullah failed to make contact with EIP that the team would not chase up the referral until he contacted them or unless they were contacted by other teams about him, otherwise the referral would be put on hold. There is no evidence that Abdullah attended on 15 January 2008, or any evidence of any further follow up by EIP or of any decision to close the case.

16th June 2008: North East London NHS Foundation Trust

Abdullah fails to attend his outpatient appointment

14th August 2008: North East London NHS Foundation Trust

Abdullah fails to attend his follow up outpatient appointment. As a consequence and in line with policy, he is discharged.

12th September 2008: North East London NHS Foundation Trust

Abdullah is referred for a mental health assessment by his GP.

3rd October 2008: North East London NHS Foundation Trust

Abdullah and Adult 1 had a religious marriage at a local Mosque. This information only came to light after the death of Tekia and was not mentioned by Abdullah at the time.

22nd January 2009: North East London NHS Foundation Trust

Abdullah fails to attend outpatient appointment. A letter is written on 05/02/2009 to GP informing him of discharge after three missed appointments. Whilst this in line with policy, there is no evidence of any reflection or formulation of this case prior to discharge.

Nor is there any evidence that the case was discussed with the Consultant psychiatrist prior to discharge.

August 2009: North East London NHS Foundation Trust

Abdullah and Adult 1 move into the basement. Again, this information only came to light after the murder and was not known to services at the time.

Author's note: Tekia and his family resided at their address in LB Walthamstow from 2009. The property is a two storey building and the ground floor was converted into separate dwellings. The front room was converted into a studio flat and rented to a single male whilst upstairs was also converted to a flat and rented to a single male. The back area of the property, comprising of a single room (with access to a shared kitchenette) was occupied by Tekia, his wife and their children. Tekia's family also rented the lower ground floor (basement).

In August 2009, Adult 1 and Abdullah moved into the windowless basement of the property. Their marriage was in difficulties and money was also short.

21st September 2009: North East London NHS Foundation Trust

Abdullah attends his outpatient appointment. His medication is increased and a follow up appointment offered.

10th December 2009: North East London NHS Foundation Trust

Abdullah is seen in the clinic and reported a low mood since his last appointment. He reported compliance with his medication. Abdullah also identified problems with his accommodation. A letter of support was sent to the housing department.

1st April 2010: North East London NHS Foundation Trust

Abdullah did not attend clinic appointment

17th May 2010: North East London NHS Foundation Trust

Abdullah was seen at the clinic. Stated he was okay when he takes his medication but heard voices if he did not. Felt low, wanted to lock himself in his room, appetite low. He said he had had a loss of libido since starting Paroxetine but denied any suicidal or homicidal thoughts. He stated that he drank two cans of beer a day and had last used cannabis three months ago. His medication was adjusted although the following month, a letter was received from his GP asking for it to be changed again. Several attempts were made on different days by the Dr to contact the GP and Abdullah to discuss the issues raised.

17th August 2010: North East London NHS Foundation Trust

Abdullah missed another appointment.

7th October 2010: North East London NHS Foundation Trust

Abdullah attended clinic. There was some confusion over medication as his GP had changed his medication from Paroxetine back to Duloxetine due to Abdullah experiencing side effects.

Throughout the appointment Abdullah maintained good eye contact and was able to establish a rapport. His speech was normal in all modalities and his mood was subjectively 'low' and objectively ' euthymic. There was evidence of paranoid delusions and auditory hallucinations.

He also complained about his housing and doctor agreed to write to housing

14th February 2011: North East London NHS Foundation Trust

Abdullah is seen in the outpatients' clinic. He reported being low in mood, paranoid about people around him and continued to have auditory hallucinations, mainly intrusive, calling him names. He said he had no suicidal or homicidal thoughts. He also reported housing and financial concerns. A further letter was sent to housing supporting Abdullah's application.

1st August 2011: North East London NHS Foundation Trust

Abdullah did not attend his appointment. Six days later he rang to apologise for missing his appointment. Another was made for 1st November 2011.

19th October 2011: North East London NHS Foundation Trust

GP wrote to clinic after Abdullah visited the surgery complaining of erectile dysfunction which has been going on for a year. GP suggested the most likely cause was antipsychotic and anti-depressant medication. Receipt acknowledged and the plan was to discuss at next appointment with Abdullah on 01/11/11. There is no record of this appointment.

14th November 2011: North East London NHS Foundation Trust

Abdullah attended outpatient appointment where he reported that he would like to stop taking his medication as it was causing him excessive sedation, increased appetite and weight-gain, and sexual side-effects. He also reported poor sleep, less paranoid than before and remained low in mood. He expressed a lot of unhappiness at his housing situation, as he occupies a room in a shared house.

Abdullah admitted on-going regular alcohol use and some sporadic cannabis use.

The outcome was to reduce and stop all medication slowly under GP. Guidance was given in GP letter with the recommendation to commence another anti-psychotic if mental state deteriorated. Abdullah was given a 5-day script for Temazepam and was strongly advised him to use it sparingly (not every night) to reduce the likelihood of tolerance. The GP could issue further short-term scripts to use as required basis, if needed. A letter to support his move to more appropriate housing was sent 17/11/2011 and the GP informed regarding the medication changes.

21st May 2012: North East London NHS Foundation Trust

Abdullah failed to attend his clinic appointment.

2nd July 2012: North East London NHS Foundation Trust

Abdullah attended clinic for his appointment. He was diagnosed with paranoid schizophrenia. He reported deterioration in his mental state. He appeared to have good insight and agreed to re-commence medication. He still reported problems with housing and requested support from CDAT for alcohol misuse. These matters were all addressed.

3rd July 2012: North East London NHS Foundation Trust

Abdullah contacted the clinic requesting that the letter regarding his medication and diagnosis be sent to his home as soon as possible. The letter was written on 02/07/2012 stating that he had a diagnosis of paranoid schizophrenia and was under the care of a consultant psychiatrist. He regularly attended for outpatient appointments and sees his care coordinator. He was on 5-10mgs Aripiprazole daily. When he is unwell, he has paranoid and persecutory ideations causing him to become stressed with poor sleep and eating.

3rd September 2012: North East London NHS Foundation Trust

Abdullah cancelled his appointment.

13th September 2012: North East London NHS Foundation Trust

Abdullah did not attend his follow up appointment.

10th October 2012: Metropolitan Police

Abdullah telephoned police twice and reported that he had won a large amount of money, a small amount of fame and was concerned he may be targeted by the community. He was advised to call back if anything suspicious happened.

15th October 2012: Metropolitan Police
Abdullah telephoned police, and made rambling statements about being owed 5 trillion dollars in the USA. He was identified as a repeat caller with mental health issues.

16th October 2012: North East London NHS Foundation Trust

Abdullah did not attend outpatient appointment. Plan from Dr to call the patient and understand the reasons for non-attendance. If no response, a home visit would be arranged as he was relapsing at his last appointment when medication was started. A letter was also sent to his GP explaining that Abdullah had failed to attend his appointment. Attempts were made to contact Abdullah on 23/10/13.

16th October 2012: Metropolitan Police

Abdullah telephoned the police and stated that his Facebook and Yahoo accounts had been hacked and expressed concern about unknown people accessing his details. An email was sent to the Safer Neighbourhood Team (SNT) requesting that Abdullah be visited to 'ascertain his health' and complete a 'CrimInt'. The email sent to the SNT was opened the following day by a PCSO who forwarded it onto a police officer colleague. Attempts were then made to contact Abdullah by telephone without success.

Abdullah was flagged on the police systems as both vulnerable and a repeat victim.

17th October 2012: Metropolitan Police

Abdullah telephoned police and stated that he had won a lot of money and would call the police if any trouble came his way. He checked his reference numbers and stated he 'doesn't feel safe'. The police operator recorded on the system that Abdullah may have mental health issues but did not generate a flagging code.

Author's note: Around this time, Adult 1 left her husband due to his violence and abuse although she did not tell her family of this until after the murder. She moved upstairs to join her family. Abdullah continued to live in the basement on the understanding that he would pay rent and find somewhere else to live although he did neither.

26th October 2012: North East London NHS Foundation Trust

Abdullah was visited at home for an assessment. Part of the assessment was conducted in Urdu and 50% of it in English. Only one of the two professionals visiting spoke Urdu.

Abdullah was polite and appropriate. He reported not attending appointments as they were not helpful. He also was no longer attending at his GP surgery. Abdullah presented with low mood, tearful and socially isolated. There were no psychotic symptoms elicited. There were no suicidal or homicidal ideas expressed. He reported that he remained unhappy in his accommodation and reported getting angry at times.

Abdullah denied having any family in the UK. He said the people upstairs were family friends not family and that he was sub-letting from them and is paying for it through housing benefit.

Abdullah only agreed to take medication with no side effects. A plan was made for Abdullah's situation to be reviewed the following week at the outpatient clinic, for medication to be re-commenced and to review his housing situation.

28th October 2012: Metropolitan Police

On the day of the murder, Adult 1 went downstairs to the basement room to talk to Abdullah about his non-payment of rent or contribution to household bills.

Voices became raised, attracting the attention of Adult 3 who went downstairs to assist his sister. They were asking him to leave because he was no longer welcome in the family home.

Abdullah had a knife in the basement room that he used for cutting fruit and he picked this up whilst shouting and swearing at Adult 1 and her brother.

At this point, Tekia arrived home from work and heard the disturbance coming from the basement. He too went downstairs.

When Tekia arrived downstairs and he saw Abdullah was struggling with his daughter and son who were attempting to disarm him.

During the struggle Adult 1 and Adult 3 received injuries to their hands and Adult 1 was stabbed in her torso. In intervening, Tekia received a stab wound between his neck and shoulder and was bleeding quite heavily.

Abdullah left the house and walked to the local corner shop for assistance. He was covered in blood and told staff that he had been attacked. He was bleeding from a wound on this hand that he had sustained during the struggle. The staff in the corner shop called for an ambulance.

The ambulance arrived and began treating Abdullah. It was at this point that a family member ran out of the house shouting for assistance. The Ambulance Service called for another ambulance as well as the police. On arrival they found Tekia, still in the basement, with a severe injury to his neck.

Due the narrow width of the stairs down to the basement, the Ambulance Service had to move Tekia to attend to his injuries. They carried him outside of the house into the street so that they could continue treatment but Tekia died from his injuries.

EQUALITY AND DIVERSITY ISSUES

All nine protected characteristics in the 2010 Equality Act were considered by IMR authors and the DHR Panel and several were found to have relevance to this DHR. These were:

Disability: Abdullah had mental health problems of sufficient longevity and severity to be classed as a disability. He was in receipt of services for his mental health issues and shortcomings in this provision are covered within this report.

Marriage and civil partnership: The marriage of Abdullah and Adult 1 had recently come to an end which is a well-established time at which domestic homicides often occur.

Race: The victim and his family were illegal migrants from Mauritius although the family state that this fact was not known to them until after the murder. It is not known how this may have impacted on Adult 1 seeking help for the abuse she was experiencing although she did tell the Family Liaison Officer that she had a 'wifely' duty towards

Abdullah which prevented her reporting the domestic violence not only to the police but also to her own family until after the murder.

INDIVIDUAL AGENCY RESPONSES

Individual Management Reviews were provided by North East London NHS Foundation Trust, the Metropolitan Police and LB Waltham Forest Children's Social Care The first two of these reports were extremely detailed and thorough, setting out lessons learned and action to be taken. In both instances, recommendations have been fully implemented. An action plan is provided to evidence the measures taken. The IMR from Children's Social Care was no less detailed but only found evidence of one referral.

According to North East London NHS Foundation Trust, the referral letter was as follows:

Dear Sir/Madam

Re: Mr and Mrs Tekia, address 2

Tekia is currently attending our services for support with his drug dependency he has been in treatment with us for quite a long time. He is currently prescribed Subutex 12mgs daily, he has remained stable on this amount with no use of additional illicit drugs on top.

Tekia is unemployed man originally from Mauritius he lives with his wife and their three children in a single room in a flat in Walthamstow. One of his sons is in Mauritius.
He has no access to any financial support and he tends to do odd jobs to support the family.

The two children are attending school; the older girl stays at home since she suffers from epilepsy.

Recently Tekia informed me that his wife is six months pregnant, she is currently attending ante-natal clinics at Whipps Cross hospital. I am not aware if she uses drugs but Tekia told me she does not use any street illicit drugs.

I have discussed their case in our team meeting in terms of what sort of support systems could be available for this family given their current circumstance. It was felt that your service would be very much suitable to carry out an assessment at this material time and ascertain any form of support for this vulnerable family.

It is would seem appropriate if a proper needs assessment is carried out by your services bearing in mind that there is already two children living under hoarse condition in a single congested room and they are expecting a baby who will ultimately be vulnerable under these conditions.

I spoke to XXX at Whipps Cross she advised me to make a formal referral given the vulnerabilities of the children living in an unsuitable accommodation coupled with the parent history of drug use.

I would be grateful if you could kindly consider assessing Tekia's family.

Children's Social Care state that the above referral does not raise any safeguarding concerns and that they considered this referral to be a housing matter. As such, no CSC assessment took place. They advised the referrer to complete a Common Assessment Framework but this does not appear to have happened.

CDAT records show that a referral was made to Children's Social Care and it is recorded that CDAT staff were under the impression that Social Services could not help due to the illegal immigration status of the family. It is unclear how CDAT staff reached this conclusion. There is no evidence on record to support this view and it is wholly rejected by Children's Social Care as the reason for their non-involvement. The letter sent in response clearly stated:

'I would like to confirm that a referral has been taken but there is no role for Social Services at this stage as there do not appear to be any child protection concerns disclosed in your letter. It seems that the main issue in this family is their housing needs and we advise you to complete a CAF assessment.'

CDAT have a record of the Manager having sent a follow up letter on 17th January but Children's Social Care have no record of it having been received.

10th September 2008: CDAT records show that they planned to liaise with Children's Social Care to find out if there has been any recent link for support with the family. A further record on 17th September states that no contact had been made by Children's Social Care. It is not clear why this matter was not followed up by CDAT although records show further referrals were made in September 2008 and May 2009. Children's Social Care has no record of having received these referrals.

LESSONS LEARNED

North East London NHS Foundation Trust

On examination of records, it became clear that neither Tekia nor Abdullah had not been fully honest and open with Trust staff which obviously affected the degree to which interventions could be fully effective. In addition, Abdullah was extremely difficult to engage causing difficulty in assessing his condition both comprehensively and regularly. As this was the case he might have been considered for CPA and received more appropriate care.

An important issue in regard to Tekia concerned the vulnerability of the four children living with him and his wife in one room. Although this was referred for an assessment to Children's Social Care as detailed above, this did not result in any further action. As a consequence, no formal safeguarding alert was ever raised.

The psychiatric services found Abdullah reluctant to engage with the services offered. He frequently missed appointments throughout the five years he was under their care. He was referred to services appropriate to his care needs such as the EIPT but discharged from their caseload after not attending any appointments, as per their protocol, and without any review of his mental state. He was also then discharged from the XXX community team's caseload as he had not attended their appointments.

They did however accept further referrals via Abdullah's GP but the first and only home visit was undertaken in October 2012 two days before Tekia was killed. Whilst this was good practice, the meeting itself was poorly managed with half of it being conducted in a language that one of the professionals didn't speak.

There were areas of poor practice in regard to Abdullah's management by the outpatient service. It is acknowledged that he often did not attend appointments but there was no contingency plan in place to review his care more frequently than the routine three monthly clinic appointments which at times stretched to six and nine months between reviews.

Abdullah's medication was often changed at these infrequent reviews and to rely upon his GP to monitor the effect these had on his mental state was not considered to be adequate.

In February 2011 Abdullah was allocated to Cluster 12 and in June 2012, Cluster 13. The IMR considers that the Cluster levels allocated seemed appropriate, but that the level of care offered to Abdullah did not correspond to this level of need.

There appeared to be some confusion following the introduction of the Health of the Nation Outcome Scale (HoNoS) and clustering for the individuals in receipt of services from the Trust, with

some staff considering that this process was solely to secure additional funds for the Trust from their commissioners.

The IMR also found that the clinical records did not provide a great deal of information about Abdullah. There was no indication as to any relapse indicators or how his mental state improved with concordance with prescribed medication. A comprehensive risk assessment would have provided the opportunity for active care planning agreed with Abdullah.

The IMR notes that clinical supervision (in particular regarding junior doctors undertaking outpatient clinics) was unstructured and not documented. It is acknowledged that access to the Responsible Consultant was available during these clinics but that advice was provided on an informal basis. Preparation prior to the clinics did not take place and regular case supervision was not provided.

Although there were other important aspects of care identified for improvement from the body of evidence, there was nothing to suggest that the offence incident could have been predicted or prevented. There was no significant evidence that Abdullah was a risk to himself or to others.

Several recommendations were made in the IMR and these are included at appendix B.

Metropolitan Police Service

Only one issue of significance was identified regarding actions taken as a consequence of Abdullah's calls on 16th October.

An appropriate response was raised by sending an email to the SNT requesting that an officer attend to 'ascertain Abdullah's health'. This would have provided an opportunity to review whether an offence had taken place, confirm whether or not there was credible evidence to justify not recording the allegation and to assess the full nature and circumstances of his calls to police. The CAD in relation to this incident was closed following the sending of an email to the SNT. There is no mention on the CAD as to whether the email was received, acted upon or supervised by the SNT sergeant. The CAD should not have been 'closed' until receipt of confirmation from the SNT that action had been taken. The closure of the CAD identifies a weakness in the audit trail of the MPS response.

The new and innovative computer system 'Airspace' has alleviated the weaknesses identified by providing a structured system for allocating, managing, risk assessing and supervising SNT actions.

Had a visit to Abdullah taken place, the outcome can only be speculated upon but it would have allowed police to consider his mental health and the voracity of the comments he had made concerning possible hacking of his Facebook and other computer accounts. A CRIMINT entry, as directed, may then have led to further police action or liaison with other agencies. Although the officer contacted Abdullah and left a message for him to contact police, ten days elapsed before the stabbings took place with no further contact made by the officer. The officer was the subject of a Misconduct Review and after consideration of the facts, was given words of advice by the Senior Leadership Team (SLT) at Waltham Forest Borough.

As such, there are no additional recommendations arising from this IMR.

Children's Social Care

The Waltham Forest Safeguarding Children Board has recently refreshed and re-published the Early Help and Threshold Criteria for Intervention. This document clearly articulates the staged model of intervention and provides guidance to practitioners on the nature of concerns about children, young people and families and the action they should take. Sitting alongside this, the Safeguarding Board have also published *Making a Good Referral & What Happens Next* to support practitioners across the partnership

The Independent Chair of the Safeguarding Children Board has also circulated guidance for staff in all partner agencies to remind them of who and how to escalate to if they make a referral for safeguarding concerns about children that they do not feel has been responded to appropriately.

As a consequence of the above actions, there are no additional recommendations for Children's Social Care.

The Panel also discussed in detail a number of other issues arising from the DHR. These included:

Overcrowding

The property in which all parties resided was owned by a private landlord and the fact that it was in multiple occupation was not known to LB Waltham Forest. Measures have been put in place to try and address the issue of rogue landlords including several prosecutions of landlords for failing to fulfil their statutory duties and serving over 150 statutory enforcement notices under the Housing Act. Since November 2013 the Council has been consulting on implementing a borough wide licensing scheme for all private rented accommodation which will enable the Council to identify and tackle rogue landlords who fail to manage their properties. If implemented the Licensing scheme will enable the Council to impose conditions for property management and will require landlords to ensure that their properties comply with health and safety standards. In light of these developments, the Panel made no further recommendations on this matter.

Immigration

Tekia and his family originated from Mauritius, a commonwealth country, so no visa was required for a stay in the UK of up to six months. This allowed the family to enter and subsequently become over-stayers. The Panel is aware that considerable changes have been made to the immigration system in recent months and as such makes no specific recommendations on this issue.

Safeguarding

As noted above, the North East London NHS Foundation Trust first made a referral to Children's Social Care in 2007 but understood the response to be that they were aware of the situation but were unable to intervene due to Tekia's immigration status. This belief is disputed by Children's Social Care who states that the immigration status would not have been a reason for not responding. Children's Social Care maintains that the referral did not include any safeguarding concerns and they interpreted the situation to be principally a housing issue. No further action was taken by CDAT until 2008 and again in 2009 although Children's Social Care have no record of having received any further referrals. Whilst it is acknowledged that at this time training on safeguarding might still have been in progress within the Trust, the DHR panel consider that the Trust's services accepted the Children and Family Service's decision too easily. The team should have been confident enough to put their concerns in writing to the manager and use the Trust's local Safeguarding team to gain advice and support. At this time, unknown to the service, Abdullah and his wife had been living with the family in a separate room for two years. This further would have raised concerns as Abdullah had a diagnosed mental illness and substance misuse habit.

It is unclear why health visitors did not raise concerns with Children's Social Care, whether as a safeguarding issue or as a 'children in need' concern. Nevertheless, comprehensive training and the introduction of a MASH (Multi-Agency Safeguarding Hub) since these events provided the Panel with reassurance that this situation would not recur.

EFFECTIVE PRACTICE

Referral to the Early Intervention of Psychosis Team (EIPT): Abdullah's first known contact with psychiatric services was in August 2007, when he was aged 34 years. Following the initial assessment of his mental state he was referred to the EIPT service for ongoing assessment and treatment of his psychosis. Although in the event he did not engage with the service this is

considered to have been an appropriate referral to have been made as the service would have been able to address both his mental health and social care needs.

Housing and support: Abdullah's over-riding need appeared to be in regard to suitable accommodation and the services did try to address this with him. Letters of support for his application for alternative housing were written promptly when requested.

Drug and Alcohol Services (CDAT): Tekia's first contact with Drug and Alcohol services was in 2005 and he remained with the service until his death in 2012. The staff built up a supportive relationship with Tekia over this period and at the time of his death he was actually decreasing his substance misuse.

CONCLUSIONS AND RECOMMENDATIONS FROM THE REVIEW

A number of procedural issues were identified throughout this DHR which have been subsequently addressed and practice is now much improved. After due consideration, the Panel concluded that even had expected practice been met at all stages, the eventual murder could not have been wither predicted or prevented. The Panel felt this would still have applied even if Abdullah had killed any of the other parties present on that day. There was no documented record anywhere of his previous violence to Adult 1 and there was no indication that Abdullah presented a threat to either himself or others.

The Panel wishes to extend its sincere condolences to Tekia's family and friends. May he rest in peace.

Appendix A: Acton plan (attached as separate file)

Appendix B: Action plan

Recommendation	Action taken to date	Further action required	Lead Person	By when	Progress/Evidence
It is recommended that the EIPT and CRT operational policy should state that a patient should not be discharged without some attempt to confirm the client's address and to visit the client at home. It is recommended that for Access Services and Community Clinics the discharge protocol should encourage workers to consider this.		Appropriate statements contained in the recommendation to be added to the CRT, EIP and Access/community clinics operational policies		31st July 2013	Completed Chase up if audit to see documentDA clarifiy if embeded
It is recommended that a reminder is sent to all doctors that it is the responsibility of the clinician initiating medication to ensure that it is adequately monitored and if there is evidence the GP is unwilling/unable to do this, it is the responsibility of the initiating doctor to do this.		E-mail to be sent by the CRD clinical lead to all Medical staff		31st July 2013	Completed – Lifeline what are the arrangements – learn the lessons learnt and shared – Stella Bailey to bring to her attention.
It is recommended that the Trust consider whether allocation to a particular cluster will determine if a client will be placed on CPA and include this in the clustering guidance. The Panel understands that additional training in this area is currently being designed and carried out.	New guidance has recently been formulated and distributed Dates for PBR training have been circulated to all clinical teams				Completed Training plan get evidence.

Recommendation	Action taken to date	Further action required	Lead Person	By when	Progress/Evidence
It is recommended that the Trust provides adequate training on the new risk policy including the production of a protocol for how a person's history is adequately incorporated in the assessment of risk.	A protocol for obtaining for the gathering of historical risk information has been formulated	Protocol to be distributed to services		30th June 2013	Completed Follow up
It is recommended that the Trust reviews its policy in regard to clinical records, and completion of these, following interventions that occur both just prior to or during weekends and other non - working days (e.g. bank holidays).		Policy to be reviewed and updated as required		31st July 2013	Completed – timely record keep – clarify if update and when.
It is recommended that the protocol for clinical supervision of junior and middle grade doctors is reviewed to ensure that a formal process takes place which is recorded and audited.		A protocol on the supervision of all Medical staff to be formulated and rolled out across services		31st December 2013	Completed – Policy has been reviews – audit

Recommendation	Action taken to date	Further action required	Lead Person	By when	Progress/Evidence
It is recommended that the details surrounding Mr AP's children are circulated throughout the Trust as an example of unacceptable risk and that the Trust's Safeguarding Training includes details of the appeal system that is in place to escalate cases that have been rejected. In addition, the Trust leads for Safeguarding should discuss with the local Authority whether information should be kept on the number of rejected referrals and that these become a standard item on the agenda for the Local Safeguarding Boards		Include slide on escalation process within NELFT Safeguarding Children Level 2 training. Provide service managers with their borough details of how to escalate in the event of continuing concerns and failure of social care to intervene. Process to be set up so Safeguarding teams notified by practitioners and provided with the NHS no of children for whom a multiagency referral has been made to children's social care Audit to be carried out to establish the numbers of referrals resulting in no further action		31st July 2013 31st July 2013 31st July 2013 31st August 2013	Completed Completed Completed Completed