Domestic Homicide Review
Executive Summary

Review into the death of Hassan in January 2019

Review Panel Chair and Report Author:
Mark Wolski

Report Complete: August 2022

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1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by the Community Safety Partnership, (Keeping Bristol Safe Partnership) and Domestic Homicide Review panel in reviewing the circumstances of the homicide of Hassan who lodged with the perpetrator Omar. Both were local residents.

1.2 The following pseudonyms have been in used in this review to protect their identities. The pseudonyms were chosen by the panel.

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

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
Hassan	Victim - Lodger	[redacted]	Black African
Omar	Perpetrator - Tenant	[redacted]	Black African

1.4 The criminal trial concluded on the 20th August 2020 when Omar was convicted of manslaughter, sentenced to life imprisonment and recommended to serve a minimum of 2 years.

1.5 The Keeping Bristol Safe Partnership reviewed the circumstances against the criteria set out in the Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews and the chair of the CSP determined that a DHR should be undertaken. The chair ratified the decision and the Home Office was notified on 19th March 2019.

1.6 Agencies that potentially had contact with Hassan and Omar prior to the point of death were contacted and asked to confirm whether they had involvement with them.

2. CONTRIBUTORS TO THE REVIEW

2.1 Agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all the organisations and agencies that had contact with Hassan and Omar.

2.2 The following agencies who had contact and their contributions are shown below.

Agency	Nature of the contribution
Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG) on behalf of GP practice	IMR and Chronology
Avon and Wiltshire Mental Health Partnership NHS Trust	IMR and Chronology
Bristol City Council Housing and Landlord Services (BCC H&LS)	IMR and Chronology
Avon and Somerset Constabulary	IMR and Chronology
South Western Ambulance Service NHS Foundation Trust (SWASFT)	Concise Investigation Report
University Hospitals Bristol and Weston NHS Foundation Trust	Chronology
Children's Social Care	Factual Report

2.3 IMRs and factual reports were completed by authors who were independent of any prior involvement with Hassan and Omar.

2.4 The authors and panel members assisted the panel further, with a number of one-to-one meetings and answering follow up questions as necessary.

3. THE REVIEW PANEL MEMBERS

3.1 The review panel members included the following agency representatives.

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

3.2 The review panel met on six occasions.

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

4. AUTHOR OF THE OVERVIEW REPORT

4.1 The Chair of the Review was Mark Wolski. Mark has completed his Home Office approved Training and has attended training by Advocacy After Fatal Domestic Abuse. He completed 30 years-service with the Metropolitan Police Service retiring at the rank of Superintendent. During his service he gained experience leading the response to Domestic Abuse, Public Protection and Safeguarding.

4.2 Mark has no connection with Bristol or any agencies involved in this case.

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 The primary aim of the DHR was defined as examining how effectively Bristol's statutory agencies and Non-Government Organisations worked together in their dealings with Hassan and Omar.

5.2 The purpose of the review is specific in relation to patterns of Domestic Abuse and/or Coercive Control, and will:

- Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.
- Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Contribute to the Prevention of Homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Highlight any fast-track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life

5.3 Case specific lines of enquiry included the following

Term 1 - Family awareness of abuse and barriers to reporting

- Whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim, prior to the homicide (any disclosure, not time limited).
- In relation to the family members, whether they were aware of any abuse and of any barriers experienced in reporting abuse? Or best practice that facilitated reporting it?

Term 2 – Interagency Communication

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

- Communication and information sharing between services with regard to the safeguarding of adults
- Communication within services

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

Term 3 – Standards and Policy:

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

- Professional standards
- Domestic abuse policy, procedures and protocols

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

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

- Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with victim or perpetrator.
- Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
- Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made.
- The quality of any risk assessments undertaken by each agency in respect of Hassan, children or perpetrators.

Term 5 - Thresholds

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

Term 6 – Cultural Sensitivity

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

Term 7 – Escalation

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

Term 8 – Training and Awareness issues

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

5.4 The timeframe for this DHR was agreed as from 5 years prior until his death in January 2019.

6. SUMMARY CHRONOLOGY

6.1 Regretfully little is known about Hassan or his family. He arrived in the UK from Holland in 2014, lodging with Omar, who was the registered tenant in accommodation provided by Bristol City Council Housing and Landlord Services. He had infrequent contact with agencies

and his immediate family are resident in Somalia and a local cousin with whom the police engaged, did not want to take part in the DHR process. Omar had lived in the UK since the 1990's, and was known to a number of health agencies and police.

Family Perspective (Omar)

6.2 Family describe Omar as a proud man, who found difficulty in managing his mental illness. He was known to have PTSD and other issues and to have regularly attended his GP and taken medication for his condition.

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

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

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

Community Perspective

6.6 Community representatives reflected upon a number of barriers to the Somali community accessing assistance regarding mental health, including the stigma associated with mental illness, a mistrust of the system exacerbated by a lack of cultural representation within the system. When asked about what may 'enable' local communities to seek help, they spoke about working with local 'grass root' organisations and mosques to whom individuals may first seek help.

GP and Avon & Wiltshire Mental Health Partnership Trust *(Omar)*

6.7 Omar had a number of challenges related to his mental health. He was diagnosed with post-traumatic stress disorder and prior to that period his illness had been described as agitated depression and depressive episodes. His illness was managed between his General Practitioner and specialist Mental Health practitioners of Avon and Wiltshire Mental Health Partnership Trust (AWP).

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

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

Housing *(Omar)*

6.10 Omar had lived in his council flat since November 1999. Housing records show that there was 'credible threat' marker on their system owing to a previous conviction for a violent offence. Their records also note that in 2010 he spent some time in hospital owing to his mental illness. In the summer of 2015, he gave permission for housing to speak to his cousin on his behalf. On exploration, this was an informal arrangement allowing the cousin to speak to housing about tenancy issues.

Avon and Somerset Police

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

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

- Three incidents involved Omar having disputes with a female he had a relationship with between January and September 2018.
- In December 2018, Omar came to notice of police suffering a mental health issue, whereby he was self-harming in the street with a knife. The matter was dealt with as a medical issue and the ambulance service attended
- One in January 2019 involved Omar being in dispute with a male he claimed owed him money and was threatening towards him.

6.13 The final incident, days before the homicide related to threats to harm another over an old debt. Whilst spoken to by police, the victim suggested that Omar had mental health problems, did not wish to pursue the allegation and the matter was dealt with informally.

South Western Ambulance Service

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

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

Criminal Trial

6.16 In the judges summing up when sentencing, reference is made to a conviction history including serious violence, and a history of mental illness. It was further noted that he had failed to take his medication, lived with the side effects of the medication he was taking, and was losing insight leading up to the homicide.

7. CONCLUSIONS AND KEY ISSUES ARISING FROM THE REVIEW

7.1 The panel has unfortunately been unable to gain an understanding of Hassan's life, as the chair has been unable to identify family or friends willing to speak to him or the panel. The chair has however been able to take into account the views of friends and family of the perpetrator Omar.

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

7.3 Omar is an older man who had experienced war in Somalia. Living in the UK he had a history of mental illness, post-traumatic stress disorder, and tardive dyskinesia (TD). In the two years before the homicide, TD developed as a side effect of his medication. The antipsychotic drugs became problematic, and his mental health deteriorated. Medication compliance became an issue and effected his behaviour. The judge, further commented on

this issue in summing up, highlighting the deterioration in his behaviour and how Omar lost insight into how unwell he had become. In such circumstances, there competing priorities, that of managing his mental illness versus the potential side effects of medication. It is therefore concluded that his mental illness was a pivotal factor in this homicide.

7.4 It is apparent that Omar found living with his mental illness and TD difficult, with a number of reports 6 months prior to the incident of deteriorating mental health coinciding with a period when he wasn't engaged with medical professionals. Incidents in December 2018 and January 2019 that may have indicated a deterioration in Omar's mental health were not alerted to his GP or AWP, nor was there a scheduled formal assessment of his mental health following an assessment of his health and changes in medication in the summer of 2018.

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

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

Mental Illness. Capability of Violence and Medication Compliance

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

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

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

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

Risk Assessment, Mental Illness and Capability of Violence

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

Feedback Loop and Information Sharing

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

Risk Assessment, Information Sharing and Decision Making

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

7.14 Police did not deploy to a call of self-harming in a public place in December 2018 and their own review highlighted opportunities for more effective decision making, through more robust procedural use of THRIVE (risk assessment model), but conversely reported on the concept of 'diagnostic overshadowing' as a potential explanation for not deploying resources, though there were multiple factors that should/could have resulted in deployment.

7.15 The panel learned of limitations in accessing medical information and expertise outside office hours that may have informed the decision to deploy. It also learned of a missed opportunity to search for information from police intelligence databases. Though it is not certain that 'knowable' information would have been found owing to the potential for misspelling of personal details, etc, it may have assisted decision making by both the police and SWASFT as to deployment and action. Therefore, the access to, and active seeking of more information is seen as an 'enabler' for effective decision making.

7.16 Nevertheless, the incident in December 2018 presented multiple risk factors that the panel agree merited closer consideration. There is precedent in national call-handling procedures for certain types of calls to the police to be subject to mandatory supervision and it seems there is an opportunity to enable the same approach for calls where all three risk factors shown below are present.

Alerting Agencies and Information Sharing

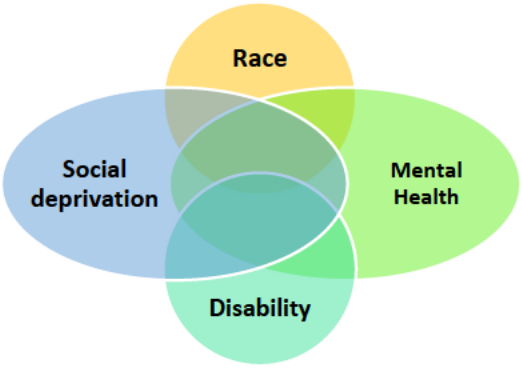
7.17 There was insufficient information available to the police or ambulance service at the time of incidents in the months prior to the homicide to merit a Safeguarding alert and from what the panel learned; it was unlikely that a threshold would have been reached. The panel explored why a GP referral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

Professional Curiosity

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

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

Equalities and Intersectionality



7.20 Hassan and Omar were Somali, living in a socially deprived area of Bristol area with a number of challenges.

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

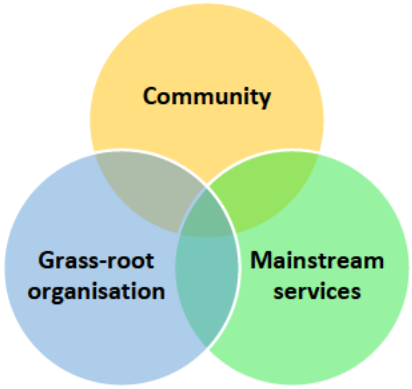
7.22 The review identified that the Somali community faced multiple challenges when dealing with mental illness, ranging from the specific needs of individuals who have experienced significant trauma, through to a range of barriers in addressing these needs. These included, stigma, isolation from the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

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

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

7.25 The comment within the RCA is further triangulated with (a) the information that there was a lack of Somali speaking talking therapies provision at Nilaari to whom Omar had been referred and (b) the findings within a publication 'IMPROVING MENTAL HEALTH SUPPORT FOR THE UK SOMALI COMMUNITY' [1] that found that 78% of respondents from the Somali community did feel that available services understood the Somali community. (c) the community perspective of multiple barriers facing members of the Somali community living with mental health challenges including; stigma, mistrust, the language used to describe mental illness and a lack of culturally representative professionals.

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



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

8. LESSONS LEARNED

The review identified a number of learning points that build upon agency IMRs. These have then been considered against a background of agency and policy developments that mitigate the need for a number of recommendations that may have otherwise arisen.

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

8.2 There is an opportunity to strengthen the overall approach to risk management by ensuring that factors such as medicine compliance and fluctuating insight are considered, particularly for patients who have shown the capability of extreme violence previously, and that working together risk assessments are scheduled in accordance with best practice.

[1] Source: Source: ATM-Improving-Mental-Health-Support-for-the-UK-Somali-Community.pdf (theatm.org) (Accessed Dec 2021)

8.3 The lack of engagement with agencies outside primary and secondary care, reveals an opportunity to close the feedback loop between those agencies and primary care.

8.4 The presence of multiple risk factors of 'self-harm, weapons and mental health' merits closer consideration for police attendance.

8.5 There is an opportunity to improve access to police intelligence and medical information to inform decisions to deploy and take action when handling emergency calls.

8.6 There are opportunities to use this review to show the need for improved professional curiosity in respect of Omar's mental health.

8.7 The overlaying of a number of social characteristics risked intersectionality, that is that various social characteristics contribute to systemic discrimination, and there remains a need to strengthen the links between the community, grass-roots organisations and mainstream services. Conversations with community groups and a review of local research, suggest there remain multiple barriers facing the Somali community in respect of mental illness.

9 GOOD PRACTICE

9.1 Bristol City Council Housing and Landlord Services

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

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

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

9.3 Avon and Wiltshire Mental Health Partnership NHS Trust

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

9.4 Avon and Somerset Police

- The use of Body Worn Video in practice is noted as good practice
- The introduction of a revised Welfare Policy to assist call handling is noted as a positive development

9.5 South Western Ambulance Service NHS Foundation Trust

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

9.6 Local Initiative

- The local initiative cited at 7.27 is acknowledged.

10. RECOMMENDATIONS

10.1 Local IMR Recommendations

10.1.1 Bristol City Council Housing and Landlord Services

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

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

- No recommendations

10.1.3 Avon and Wiltshire Mental Health Partnership NHS Trust

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

10.1.4 University Hospitals Bristol and Weston NHS Foundation Trust

- No recommendations

10.1.5 Bristol City Council Children and Family Services

- No recommendations

10.1.6 Avon and Somerset Police

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

10.1.7 South Western Ambulance Service NHS Foundation Trust

- No recommendations

10.2 Overview Report Recommendations

The following recommendations have been agreed by the panel.

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

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

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

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

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

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

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

APPENDIX A – LEARNING FROM DHR BRIEFING

1. Domestic Homicide Review

The Keeping Bristol Safe Partnership commissioned this DHR following the homicide of Hassan in January 2019.

2. Case Summary

Hassan was aged [redacted] at the time of his death. He was of Somali origins and came to the UK via Holland. He lived with Omar as a lodger in a two bedroomed flat who was aged [redacted] at the time of Hassan's death.
Omar had lived in the UK for over twenty years.

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

3. The Facts – an overview

The flat where they lived is in one of 34 wards in Bristol and the local ward profile shows a number of challenges such as; - higher levels of deprivation than other wards; - the third highest crime rate; - highest rate of overcrowded households ; - highest percentage of population belonging to a Black or Ethnic Minority group and with a higher rate of people having been born outside the UK, of which the Somali community is over three times higher than others. In addition, English is not the first language of 30% of this local population.
Regrettably, little is known about Hassan, save he worked as a cab driver.
Omar had previous convictions for acts of violence, was known to his GP and specialist mental health care professionals.
There had been recent contact with the authorities in the months leading up to the homicide.

- In January 2019, Omar was involved in a dispute with a male he claimed owed him money. It was suggested by the victim that Omar had mental health problems. The victim chose not to substantiate the allegation.
- In December 2018, Omar came to the notice of police suffering a mental health issue, whereby he was self-harming in the street with a knife. The matter was dealt with as a medical issue and the ambulance service attended.
- In May 2018, Omar was referred to AWP in respect of PTSD associated with his experience of war, a recent incident where he was a victim of crime, and an ongoing medical issue.
- Prior to this period, Omar had been in contact with his GP, and there had been unsubstantiated domestic incidents with a girlfriend.

In the judges summing up when sentencing, reference is made to a conviction history including serious violence, and a history of mental illness. It was further noted that he had failed to take his medication, lived with the side effects of medication he was taking, and was losing insight leading up to the homicide.

4. Learning Points

The intersection of mental illness, a capability of violence and medication compliance are three important markers in understanding this homicide. They provide an opportunity to understand why such events take place in the longer term and how to minimise the reoccurrence of similar events.
There is an opportunity to strengthen the overall approach to risk management by ensuring that factors such as medicine compliance and fluctuating insight are considered, particularly for patients who have shown the capability of extreme violence previously, and that working together risk assessments are scheduled in accordance with best practice.
The lack of engagement with agencies outside primary and secondary care, showed an opportunity to close the feedback loop between those agencies and primary care.
On calling the police and ambulance service, there were multiple risk factors present of 'self-harm, weapons and mental health' that merited closer consideration for police attendance. There is an opportunity to improve accessing police intelligence and medical information to inform decisions to deploy and take action in emergency call handling.
There were opportunities for improved professional curiosity in respect of Omar's mental health.
The overlaying of a number of social characteristics risked intersectionality, that is that various social characteristics contribute to systemic discrimination, and there remains a need to strengthen the links between the community, grass-roots organisations and mainstream services. Conversations with community groups and a review of local research, suggest there remain multiple barriers facing the Somali community in respect of mental illness.

5. Recommendations

Recommendation 1: Take steps to ensure that Nilaari and ROADS, with appropriate consent provide updates about patient referrals to primary care (GP) and referrer (if not GP).
Recommendation 2: Improve the protocols for risk assessment and management, ensuring that (a) medicine compliance is considered for patients with a history of violence, (b) that post transition assessments are scheduled/conducted for this cohort, (c) fluctuations in patient insight are considered and (d) that this is explicitly documented in the handover between AWP and GP.
Recommendation 3: Improve the understanding of the specific needs of the local Somali Community (SC) in respect of Mental Health that includes; - what enables/hinders the SC accessing support and that clearly identifies the gaps in provision.
Recommendation 4: That the learning from this review is shared through mandatory safeguarding training to encourage increased professional curiosity when presented with potential client welfare concerns.
Recommendation 5: Seek to ensure that staff are aware of how to access medical information out of hours.
Recommendation 6: Avon and Somerset Police to review call handling policy where there are multiple apparent risk factors and implement a systemic approach that mandates these calls being supervised.
Recommendation 7: Avon and Somerset Police to review their systems of call handling to ensure that intelligence checks are carried out and recorded within the call handling system.

6. Links and further information

To be inserted post publication.