SAFER MERTON

COMMUNITY SAFETY PARTNERSHIP FOR THE LONDON BOROUGH OF MERTON

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

ADELA AGED 63

KILLED IN MERTON IN JULY 2017

REVIEW PANEL CHAIR AND AUTHOR
BILL GRIFFITHS CBE BEM QPM
25th October 2022

SAFER MERTON - Domestic Violence Homicide Review Panel
'Adela' aged 63, killed in Merton in July 2017

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The Review Process

1. This summary outlines the process initiated by the Chair of the Safer Merton Partnership to commission a Domestic Homicide Review (DHR) Panel established under s9 Domestic Violence, Crime and Victims Act 2004 independently chaired by Bill Griffiths CBE BEM QPM, to review the homicide in Merton of 'Adela'[1] aged 63, caused by multiple wounds in July 2017, that had been inflicted by her grandson Bartak aged 20, who is detained indefinitely under sections 37 and 41 of the Mental Health Act (MHA) 1983.

2. The process began in December 2018 with a meeting of all agencies that potentially had contact with those involved prior to the death of Adela. Due to the Coroner's decision to hold a 'Jamieson[2] Inquest' that was then delayed because of Covid-19 until February 2021, the process was paused and then proceeded with virtual meetings. A further delay was due to meeting the family to discuss a Polish translation of the overview. The process ended when the Safer Merton Partnership Board approved a final version of the overview report at a meeting in February 2022.

Contributors to the review

3. Agency representatives on the Panel and participating in the review were:
   Marino Latour: the local Clinical Commissioning Group
   Abigail Fox-Jaeger: South London and Maudsley (SLaM) NHS Foundation Trust (joint Mental Health Investigation Report (MHIR))
   Ryan Taylor and Jennifer Lewis-Anthony: South West London and St George's (SWL&StG) Mental Health NHS Trust (joint MHIR)
   Alena Buttivant: NHS England Safety Manager for Mental Health
   Anna Reeves and Anna Reeves: London Borough of Merton Adult Social Care (ASC)
   Zoe Gallen: LB Merton Domestic Abuse and VAWG Lead
   Andrew Wadey and Janice Cawley: Metropolitan Police Service (MPS) (provided IMR)
   Kate Frail: Victim Support London (specialist adviser)
   *London Ambulance Service (LAS) also provided an IMR.

4. The Chair met with Catia (daughter of Adela and mother of Bartak) and Daniela (granddaughter of Adela and sister of Bartak), supported by a Polish translator, at the first Pre Inquest Hearing in August 2018 and incorporated their concerns in the Terms of Reference for the review (point 9).

Author of the overview report

5. Bill Griffiths is the author of the overview report. He is a former police officer who has had no operational involvement in LB Merton. He has been appointed as the independent Chair of the DHR Panel having had no involvement in policing since retirement from service in 2010.. Since 2013, he has been involved in more than twenty DHRs. The Panel were satisfied as to the independence of the Panel members and IMR authors.

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[1] Not her real name and randomly chosen. All other names are pseudonyms
[2] An Inquest where the Coroner will consider whether a lack of care or common law neglect has led to the cause of the death of the deceased (Source: Crown Prosecution Service website cps.gov.uk under 'Inquests')

Terms of Reference (ToR) for the review

6. When the DHR Panel was formed, ToR 1-8 listed below for the MHIR had already been set. These were later adopted for the DHR with the addition of the actions of the MPS and LAS in response to emergency calls from the family in June 2017 at point 9.
    1. Establish the facts i.e. what happened to whom, when, where. Review and comment on care and treatment provided to the patient by all services involved for period October 2016 to July 2017
    2. Review the transition between services/organisations including:
        a) Arrangement in place at discharge from the inpatient ward to the community including the period of care under the Home Treatment Team
        b) Transfer arrangements from SLaM to SWL&StG
    3. Consider any barriers to the transfer of the patient
    4. Consider any barriers to engagement including English as a second language for the family and how such issues were addressed by services
    5. Review the appropriateness of risk assessment and management plans
    6. Consider how the patient's family were involved in his care; supported by services and how risks to carers, as family members, was assessed
    7. Review how concerns about the deterioration of the patient's mental state were managed during the transition from SLaM to SWL&StG, including:
        a) The review by home treatment and the decision to decline the referral
        b) How the referral for MHA assessment was managed
    8. Review and comment upon the interface between partner agencies in health and social care
    9. Review and assess the efficacy of the response to emergency calls made by family during an evening in late June 2017 by:
        a) The Metropolitan Police Service
        b) The London Ambulance Service

Summary Chronology

7. Adela's daughter, Catia, initially settled in England in 2010 and was followed in 2011 by her children, Daniela and Bartak, who came to live with her. She is estranged from their father who also lives in London. The children enrolled in school but, in 2013, Bartak returned to Poland to live with Adela, his grandmother, and continue his education. They had a very strong relationship and Bartak "adored his grandmother". Bartak was also a kind and protective elder brother to his sister, Daniela.

8. In 2016 Bartak returned to the UK accompanied by Adela. They moved in with Catia and Daniela at a rented house in LB Lambeth. Shortly after that, Bartak's mental health deteriorated significantly. He smoked cannabis regularly, a habit he had experimented with when aged 14. He subsequently became mentally unwell and there are two phases relevant to this review.

9. <u>Bartak was an in-patient at SLaM October 2016 to May 2017</u>
    a) How Bartak became 'sectioned' and his treatment while in hospital:
    b) Late October 2016, police in Westminster called to Bartak following a member of the public saying he was Jesus, then observed to stand in the way of oncoming traffic in the middle of a busy road. Detained for his own safety, he became violent and aggressive, head-butting

one of the officers. Concerned for his well-being, they detained him under Section 136 of the MHA.

c) Following a MHA assessment at Gordon Hospital, was Bartak placed under s2 of the MHA for a period of assessment. When confirmed he lived in the SLaM catchment area, Bartak triage transferred him on to the dedicated early onset psychosis ward (LEO - Lambeth Early Onset Unit) and allocated a care coordinator, based in the LEO community team, in early November 2016.
d) January 2017, Bartak was transferred to the acute MH ward, at Maudsley Hospital in Lambeth. Presentation was reported as "challenging". Concern continued because he did not respond as well as expected to antipsychotic medication. Also evidence that he was able to gain access to cannabis while on the ward with detrimental effect on his mental state.
e) Trials of two antipsychotic medications demonstrated little improvement and the ward team initiated Clozapine, an antipsychotic neuroleptic medication reserved for use in treatment resistant psychosis. This requires careful monitoring; weekly blood tests for 18 weeks, due to serious side effects.
f) Mid-March, given initial dose, gradually increased to a therapeutic level. Bartak appeared more settled, plans began for his discharge home. Granted a period of section 17 MHA home leave with input from the Lambeth Home Treatment Team (LHTT), arrangement for necessary blood test monitoring with daily home visits.
g) When preparing discharge to the joint care of LHTT and the LEO community team in May 2017, the family relocated to a rented terraced house in LB Merton, about two miles away and outside the catchment area for the LHTT. The LEO team undertook provision of care coordination and medical reviews until Bartak could be referred/transferred, to an equivalent team for Merton - the Merton EIS (Early Intervention Service).

10. <u>Bartak was under community care early May 2017 to early July 2017</u>
    a) The sequence of events between his discharge from hospital care and the killing of Adela:
    b) Bartak discharged from Lambeth HTT on the same day in early May that he and his family moved home. Provided with seven days' supply of Clozapine liquid given to his family to administer. Scheduled to have a blood test [week 9 of 18] in mid-May 2017 at the Clozapine Clinic at Lambeth Hospital – did not attend (DNA).
    c) Both Catia and Daniela worked in the same restaurant business and would often be required to work late shifts. His day-to-day care fell to Adela because he lacked motivation. She prepared his meals and monitored his hygiene which became a source of friction between them.
    d) Mid-May - home visit by LEO team noted Bartak five days overdue for Clozapine blood test yet showed some unused medication, Care coordinator and trainee psychiatrist attended next day for blood test and prescribed 28 days supply of Clozapine, however, format could not be dispensed by community pharmacy, only by the hospital.
    e) Next two weeks - several attempts by LEO care coordinator to establish how to refer Bartak to the SWL&StG community team. There was unclear information about which service for Bartak but Merton EIS contacted in mid-May. Bartak told coordinator benefits suspended and sick certificate lapsed. DNA follow up meeting or for blood tests.
    f) Early June - coordinator agreed FAX referral to Merton EIS. Not assessed as a priority. Bartak seemed stable on coordinator visit but Casia referred to recent access by Bartak to cannabis (previously identified as a potential trigger for psychosis). Due blood tests did not take place and, if dispensed, the 28-day prescribed Clozapine would have run out.

g) Late June – coordinator received call from Daniela describing the family's concerns that Bartak relapsing and hostile to Casia, plus angry with Adela because she told him to bathe. He was not taking his medication as prescribed. Coordinator contact with Merton EIS confirmed acceptance of case but not yet allocated or handover arranged. Coordinator advised family to contact the emergency services if concerns overnight. Home visit arranged by coordinator.

h) That evening Daniela called MPS emergency contact centre regarding Bartak not taking medicine. Sometimes he was aggressive and at other times normal. Her doctor had told her to call the police. The call handler did not feel this was a matter for police and advised her to call the LAS or her doctor again. This call has been listened to. The police operator did not record the name of the caller, did not ask for any further information, did not note his medical condition, the nature of his aggression, any potential risk and did not consider tasking a unit to complete a welfare check

i) Five minutes later, Daniela called the LAS with a similar account and the LAS asked for police backup. However, by this time there were no police units available to be deployed and the LAS attended about one hour after the first call to police. Bartak did not engage with the paramedics, declined clinical observations and denied MH issues. When answering questions, Bartak presented intense and threatening gazes directed at each in turn. The staff contacted the LEO team who was aware of and had access to Bartak's clinical history and undertook to speak to a senior nurse and call back with advice to the family. Bartak was left in the care of his family pending contact with advice to call police if felt threatened.

j) The LEO coordinator attended the next day and noted that Bartak's mental state had deteriorated substantially and that he had not been taking his medication as prescribed. He was threatening members of the family. Both his sister and mother were concerned about him living with his grandmother because, according to the notes, "He has targeted her on a few occasions stating that she was evil…".

k) The day after that the LEO coordinator attended with the Merton HTT consultant psychiatrist. This was her first day working with the Merton HTT, and her understanding of the purpose of the home visit was to assess Bartak with a view to "Clozapine re-titration"[3]. She assessed that he required admission and lacked capacity and a MHA assessment would be required. She found him to be visibly unwell, expressing delusional beliefs and exhibiting risky behaviour to his family and their dog.

l) Due to human error that included misunderstanding of the IT system, this referral was not handed to the out of hours AMHP (Approved Mental Health Professional) service over the weekend. Once picked up, the AMHP left a message for Catia to contact him and, when there was no response, planned an 'unannounced visit'. Meanwhile, the LEO coordinator spoke to Daniela by phone. She raised concerns about her brother's behaviour deteriorating but did not feel that he needed to be in hospital. Crisis and contingency plans were discussed as well as the importance of an MHA assessment. The LEO care coordinator agreed to visit the family the following day.

m) That evening, police were called to the family home to find that Adela had been murdered by multiple incised wounds and the mutilated remains of the family dog and cat were nearby. When detained, the MH assessment recorded Bartak as saying he could: "feel

[3] Titration is the procedure for introducing a new drug in small doses with gradual increases over time. Re-titration refers to starting again when a drug has not been taken for 48 hours

angels and demons all around". He added that he felt angels within himself and felt demons in other people.

Key issues arising, conclusions and lessons to be learned from the review

11. A number of 'areas of concern' were identified in the MHIR:
    a) There were no plans to address the risks associated with Bartak's lack of understanding about how important it was to take medication at the point of discharge from SLaM
    b) Clozapine monitoring and management by LEO Community Team was not in line with Maudsley Guidelines, 12th edition
    c) There was no agreed plan about how the transfer from LEO Community Team to Merton EIS would take place
    d) The Mental Health Act assessment was requested in late June 2017 and yet no clear actions had been taken to make arrangements by early July, almost two weeks later
    e) There was no oversight of the case by the Merton HTT, that may have included consideration of commencing an alternative medication, or clear contingency plan agreed by the clinical teams while the MHA assessment was being arranged
    f) There was little evidence that any work was done with the family by the LEO community team while Bartak was an inpatient. It is recorded that someone from the team, including the allocated LEO care coordinator, was present at ward rounds on only four occasions from November 2016 to May 2017. There is no record of any other visits
    g) Although they made a number of requests, the reviewers were not provided with a copy of the referral made to the Merton AMHP service in June 2017 or evidence that it was permanently deleted.

12. When Daniela sought police emergency assistance in late June 2017 with concerns for Bartak's deteriorating mental health, the potential risk he posed to himself and his family was not adequately probed or recognised. A revised risk assessment tool has been implemented. Analysis has been conducted to confirm there were no police officers available to support LAS staff due to exceptional demand that evening. Even if available to attend, their powers would have been limited when on private premises to making an arrest if a crime had been committed or acting to prevent an immediate threat of violence. The Coroner concluded that police and ambulances responses in late June were appropriate in the operating context of that evening.

13. She summed up her findings on the joint SLaM and SWLStG review, drawing five themes from the MHIR action plan:
    a) Clozapine prescribing and management
    b) The family being required to administer the medications, a difficult and complex requirement, without any understanding
    c) The delay in transfer between the Lambeth LEO Team and the Merton EIS
    d) The AMHP system found to some extent to be fragmented and unstructured
    e) The lack of HTT follow-up for patients awaiting a MHA assessment.

Recommendations from the review

14. All of the recommendations from the review arise from these themes and have been debated and agreed by the Panel. They are listed in the Action Plan as an appendix to the overview report:
    1. The SLaM Clinical Policy Working Group commission a discrete Trust-wide policy on clozapine monitoring, management and prescribing. This will help inform local protocols and best practice in both inpatient and community settings. It should include the following based on the learning from this incident:
        a) Titration protocols
        b) Registration with ZTAS or DMS[4]
        c) Prescribing pathways for inpatient and community settings including the monitoring requirements and action to be taken where a red/amber/green result
        d) A robust system for overseeing pathology testing and to generate an alert when a patient has missed a monitoring blood test
        e) Guidance on side effects and the risks associated with non-concordance with medication as prescribed
        f) How to discuss risks with patients their families and carers, especially where English is not their first language
        g) Training Needs Analysis for different staff groups involved.
    2. The LEO Operational Policy should be updated to provide guidance to care coordinators working with families and carers. How they can access needs assessment/support from Trust services and/or be signposted to the local authority for a carer's assessment under the Care Act 2014. This should include guidance on sharing care plans and emergency contact information with the family, with the patient's permission.
    3. Where it is likely that a family member will administer medication and monitor compliance an assessment should be prioritised and any gaps in understanding about the medication and its risks, resulting from language/educational differences, should be identified and responded to, to ensure that the individual is properly equipped and supported to undertake this task. For example, they must be provided with information about the possible risks associate with the medication, in their first language if required or an interpreter engaged to help explain the risks and benefits to them. There should be documented records of any education discussions with them with regard to pharmacology. This guidance should form part of the policy reviewed and updated in Recommendation 1.
    4. SWL&StG and SLaM early intervention services to develop guidance for referrers on what they can expect when transferring in and out of their respective boroughs. This guidance could form the basis for pan-London agreements on standards for transfers.
    5. There is an evaluation undertaken by SWL&StG of the revised Merton AMHP system now in place to ensure there is:
        a) a robust and transparent system for taking referrals and communicating with the referrer agreeing crisis/contingency plans as required
        b) a clear framework for the AMHP service to collate and evaluate risks which will assist with prioritising assessments
        c) a process for escalation for all assessments that are delayed by more than 24 hours
        d) oversight of case progression at a senior level.

[4] Both are companies contracted to the NHS to report blood test results for clozapine patients

6. SWL&StG review the Merton HTT pathway to ensure that support is offered to patients awaiting a Mental Health Act assessment.
7. All agencies working with victim and survivors of domestic abuse should ensure they understand what is being said and if necessary arrange translation services. This will ensure the victim/survivors have the best knowledge available that they understand.
8. All agencies working with victims and survivors of domestic abuse should demonstrate professional curiosity in order to understand what is happening for the victim/survivor to offer the best support and service.

W Griffiths CBE BEM QPM
Chair and Author of the Domestic Homicide Review 25 October 2022