SAFER MERTON

COMMUNITY SAFETY PARTNERSHIP
FOR THE
LONDON BOROUGH OF MERTON

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

ADELA AGED 63

KILLED IN MERTON IN JULY 2017

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

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

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INTRODUCTION

1. In July 2017, the body of Adela aged 63 was discovered in the rear garden of a terraced house in the London Borough of Merton (LBM) where she lived with her daughter, Catia, granddaughter Daniela and grandson Bartak aged 20. She had died from multiple stab wounds and blunt trauma. Her pet dog and cat had also been killed and mutilated. Bartak was arrested and charged with killing Adela and, in August 2018, he was detained indefinitely under sections 37 and 41 of the Mental Health Act (MHA) 1983.

2. This report of a domestic homicide review (DHR) examines agency responses and support given to Adela and her family in the period from October 2016 when Bartak was first diagnosed with paranoid schizophrenia and July 2017 when he killed his grandmother and her pets. Any relevant fact from their earlier lives will be included in background information.

3. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

4. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed because of domestic violence, in this case by a close family member. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

5. One of the operating principles for the review has been to be guided by humanity, compassion and empathy, with the voices of Adela, Bartak and their family at the heart of the process. Heartfelt condolences were offered by the Chair on behalf of the Panel at the first opportunity he had to meet with Catia and Daniela at a Pre-Inquest Review held by the Assistant Coroner for Inner West London in August 2019.

TIMESCALES

6. The review began with a Panel meeting on 6 December 2018 when Terms of Reference (ToR) were discussed and Chronology reports commissioned from all identifiable public and voluntary bodies that may have had contact with Adela and Bartak A joint Mental Health Investigation Report (MHIR) had already been commissioned by South London and Maudsley (SLaM) NHS Foundation Trust and South West London and St George's (SWL&StG) Mental Health NHS Trust and the view taken by Merton Community Safety Partnership that this would embrace the DHR requirement. However, it was subsequently established that there had been relevant contact with the Metropolitan Police which accounts for the 18-month delay in commissioning a DHR and forming the Panel. There also had been a delay due to the *sub judice* aspect of the criminal investigation and hearing that resulted in Bartak being 'sectioned'. Although at that point 'work in progress', a draft

copy of the MHIR was shared with DHR Panel members for the second meeting and progress of the action plan made a standing item at subsequent meetings.

7. The second meeting on 22 January 2019 also reviewed chronologies tendered by the Metropolitan Police Service (MPS) and London Ambulance Service (LAS) and Individual Management Reviews (IMR) were commissioned from those agencies. There were no other agencies or voluntary bodies, including Clinical Commissioning Groups, that had contact with Adela and Bartak. A third meeting set for March was postponed to 15 May 2019 due to discussions regarding the Inquest. At this meeting the IMRs received from the MPS and LAS were reviewed, then the focus was on managing a joint DHR/MHIR review and contact with the family where Polish translation would be needed.

8. The fourth meeting was set for early July but the Assistant Coroner had notified a Pre-Inquest Review (PIR) for 6 August 2019 which the Chair would be attending as an 'Interested Person' (IP), so the DHR process was paused until the Inquest had concluded.

9. At the PIR, the Assistant Coroner announced there would be a 'Jamieson[1] Inquest' with full disclosure to IPs. A second PIR was held on 11 December 2019 and the Assistant Coroner listed the witnesses to be called to a hearing in April 2020. This aspiration was impacted by the March Covid Pandemic and the hearing was not held until February 2021 via video conferencing.

10. At the conclusion of the Inquest, the Chair sought the Assistant Coroner's permission to speak to the family with the support of the translator to agree a process whereby they could speak him about what had emerged from the Inquest and to comment on a draft of the overview report. This arrangement proved difficult to implement due to the availability of the translator. Meanwhile, a second draft was prepared and discussed by the Panel on 29 July 2021. The translation challenge continued and the Chair prepared a 3rd version reflecting the Panel discussion and it was sent to a different Polish translator who was needed for the written version.

11. The Polish version was made available to the family for comment but Catia had returned to Poland for a period. Upon her return, a third Polish translator supported a virtual meeting with the Chair on 28 October 2021 on which Catia provided feedback. The Chair also assisted her with signposting legal advice via the local Citizens Advice Bureau. A 4th version was circulated to Panel members for comment in January 2022 in advance of the fifth version being presented to the CSP on 9 February 2022. As a result of discussion, further recommendations were added to this, the final and anonymised, version.

CONFIDENTIALITY

12. The findings of each IMR are confidential. Information is generally available only to participating officers/professionals and their line managers, save in this case that all such information was disclosed to IPs, including the family.

[1] 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')

13. For ease of reference, all terms suitable for acronym will appear once in full and there is also a glossary at the end of the report. The four family members involved in this tragedy will be referred by first name throughout. They declined to suggest pseudonyms and these were chosen by the author from a random alphabetical list of Polish names.

14. The Government Protective Marking Scheme (GPMS) was adopted with a rating of ''Official-Sensitive' for shared material. Either secure networks were in place (nhs.net, pnn) and adopted (cjsm) or papers shared with password protection. Electronic copies of the MHIR, the chronologies and IMRs were provided to all Panel members for review and discussion.

TERMS OF REFERENCE

15. 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 late 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 early October 2016 to early 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 (MPS)
        b. The London Ambulance Service (LAS)

INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

16. The first PIR in August 2018 was the first opportunity for the Chair to meet the family and this was in company with a family liaison representative from SWL&StG who had also been delayed in meeting due to the criminal proceedings. They were assisted by a Polish translator. The Chair provided a Polish version of the Home Office DHR leaflet for families

and highlighted the advocacy section as well as the opportunity to address the DHR Panel if they wished.

17. The family had seen the ToR for the MHIR concerning care provision by SLaM and SWL&StG during the handover of Bartak's support between May and July 2017 and he asked them to reflect on any additional concerns for inclusion in the ToR for the DHR. They raised the lack of response to Daniela's calls to police and ambulance for assistance in late June 2017 (ToR 9). The Chair met with the family for the second time with the translator at the second PIR and no additional concerns were raised.

18. Covid restrictions meant that all subsequent contact was through video conferencing, including the final meeting in October 2021 when the ToR were examined in detail and Catia's concerns reflected in the narrative that follows.

19. Despite the question being asked of professionals and the family, there were no other sources of information available to the review, such as from friends and work colleagues identified by the family or from agencies.

CONTRIBUTORS TO THE REVIEW

20. This review report is an anthology of information and facts from the organisations represented on the Panel listed below, some of which were potential support agencies for Adela and Bartak. Each agency was asked for a chronology of contact. The joint NHS MHIR was already in progress with their analysis of what happened, identification of any lessons to be learned, as well as good practice, with recommendations for improvements to the system for safeguarding. The joint MHIR was managed by a panel of expert investigators with independent chair and membership. IMRs are conducted by a senior manager not connected with the events. The Panel were satisfied as to the independence of the Panel members and IMR authors:

The local Clinical Commissioning Group
South London and Maudsley Trust NHS Foundation Trust (joint MHIR)
South West London and St George's Mental Health NHS Trust (joint MHIR)
NHS England Safety Manager for Mental Health
London Borough of Merton Adult Social Care (ASC)
Metropolitan Police Service (provided IMR)
Victim Support London (specialist adviser)
*London Ambulance Service also provided an IMR

THE REVIEW PANEL MEMBERS

21. Table 1 – Review Panel members

Name	Agency/Role
At time of report - Neil Thurlow	London Borough (LB) of Merton, Head of Community Safety

Currently Alun Goode	
At time of report - Temitayo Oketunji Currently - Zoe Gallen	LB Merton Domestic Abuse & VAWG Lead
Gemma Blunt then Anna Reeves	LB Merton Safeguarding Adults
Anna Reeves	General Manager Community and Complex Care Croydon
Alena Buttivant	NHSE Patient Safety Manager for Mental Health
Abigail Fox-Jaeger	South London and Maudsley Trust Investigation Facilitator
Ryan Taylor	South West London and St George's Mental Health Trust, Assistant Director Governance and Risk
Jennifer Lewis-Anthony	South West London and St George's Mental Health Trust
Marino Latour	Designated Safeguarding Adults Lead Merton & Wandsworth CCGs
Kate Frail	Victim Support London
Janice Cawley	MPS Specialist Crime Review Group and IMR author
Rachel Samuel then Andrew Wadey	MPS South West Basic Command Unit, Safeguarding Lead
Bill Griffiths	Independent Chair and Author of report
Tony Hester	Independent Manager and Panel Secretary

AUTHOR OF THE OVERVIEW REPORT

22. Under s9 Domestic Violence, Crime and Victims Act 2004, a Domestic Violence Homicide Review (DVHR) was commissioned by Merton Community Safety Partnership and, in October 2018, Bill Griffiths CBE BEM QPM was appointed Independent Chair of the DVHR Panel and report author. Tony Hester supported him throughout in the role of process manager and Secretary to the Panel. Bill Griffiths is a former police officer who has had no operational involvement in LB Merton and no involvement in policing since retirement from service in 2010. Tony Hester has a similar background, having retired in 2007 and is also independent. Since 2013, Bill and Tony have jointly been involved in more than twenty DHRs.

PARALLEL REVIEWS

23. When the DHR Panel was convened in December 2018, the criminal process had already concluded. A joint MHIR by the two NHS Trusts involved with Bartak had been commissioned and was incorporated into the DHR. A 'Jamieson Inquest' was declared by the Coroner and this eventually was heard via video conferencing between 24 and 26 February 2021.

EQUALITY AND DIVERSITY

24. Consideration has been given to the nine protected characteristics under the Equality Act in evaluating the various services provided:
    Age – Adela was 63 and her grandson was 20 but the difference between their ages does not appear to have been a relevant factor
    Disability – Bartak had been diagnosed with paranoid schizophrenia and would be considered an adult with care and support needs under the Care Act
    Gender reassignment – neither party had been, nor were known to be considering, gender reassignment
    Marriage and civil partnership – It is understood that Adela had been married and divorced. Bartak was not married or in a civil partnership
    Pregnancy and maternity – not applicable
    Race – Both are Polish, White Eastern European
    Sex – Adela was female and Bartak is male. Women's Aid state: "*domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family*".[2] Safe Lives report that victims aged 61 and over are much more likely to experience abuse from an adult family member than those 60 and under[3]
    Religion or belief - is not known but not believed to be actively pursued by either party or is a factor for consideration
    Sexual orientation – the sexual orientation for each is believed to have been heterosexual.

25. There is evidence that the family not having English as their first language led to a differential service or 'conscious/unconscious bias' when there was not an interpreter or translator available. Not having translation available meant it was very difficult for them to

[2] Women's Aid: Domestic Abuse is a Gendered Crime, n.d.
[3] Safe Lives 2016

follow complex medical guidance and this will be examined in the narrative and analysis sections of the report.

DISSEMINATION

26. The intended recipients of copies of this report, once approved by the Home Office Quality Assurance Panel, are listed in table 2 below:

Name	Agency	Position/ Title
Hanna Doody	LB Merton	Chief Executive
Was Cllr Agatha Akyigyina Now – Cllr Elanor Stringer	LB Merton	Councillor for Community Safety; lead on domestic abuse
At time of report – Neil Thurlow Currently – Alun Goode	LB Merton	Head of Community Safety
Lorraine Henry	LB Merton	Safeguarding Adults Board
Dagmar Zeuner	LB Merton	Director of Public Health
Ryan Taylor	South West London and St George Hospital NHS Trust	Assistant Director Governance and Risk
Jennifer Lewis-Anthony	South West London and St George Hospital NHS Trust	Associate Directorate of Mental Health Social Work
Abigail Fox-Jaeger	South London and Maudsley NHS Foundation Trust	Trust Investigation Facilitator
Marino Latour	Merton and Wandsworth CCG	Designated Safeguarding Adults Lead
Alena Buttivant	NHS England	Patient Safety Manager for Mental Health
Rachel Nicholas	Victim Support London	Operations Manager
Elisabeth Chappel	Metropolitan Police Service	South West BOCU Commander
Janice Cawley	Metropolitan Police Service	Detective Sergeant Specialist Crime Review Group
Bill Griffiths	Independent Chair	Independent Chair/Author of the Domestic Homicide Review
Tony Hester	Director Sancus Solutions Ltd	Independent Administrator and Panel Secretary
Quality Assurance Panel	Home Office	-
Sir Mark Rowley	Metropolitan Police Service	Commissioner
Sophie Linden	Mayor's Office for Crime and Policing	Deputy Mayor
Baljit Ubhey	Crown Prosecution Service	London Chief Crown Prosecutor

BACKGROUND INFORMATION (THE FACTS)

27. 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.

28. Catia subsequently became aware through Adela that, in late 2014 or early 2015, Bartak's behaviour began to change and he broke off all contact with his friends. He began to watch a lot of video content on the internet and Catia said he paid to speak to some of the content providers. Catia added that he would share links to the websites with Adela which annoyed her and she felt this content had a negative effect on him. Although both Adela and Catia were concerned about the change in Bartak's behaviour they agreed they could not force him to be assessed by a doctor.

29. In 2016 Bartak returned to the UK accompanied by Adela. Catia has explained she did not want Adela to remain in Poland on her own when the rest of the family were in England. Adela and Bartak moved in with Catia and Daniela at an address in Streatham, LB Lambeth then, in May 2017, the family relocated to rent a terraced house in LB Merton.

30. During 2016, Bartak's mental health deteriorated significantly. He smoked cannabis regularly, a habit he had experimented with when aged 14. As the result of an incident in October 2016, Bartak was sectioned under the Mental Health Act and admitted to the South London and Maudsley (SLaM) Hospital. Whilst an in-patient his behaviour was violent and aggressive towards staff. He eventually improved when prescribed with the anti-psychotic drug Clozapine.

31. Bartak was discharged from hospital in early May to be monitored by Community Mental Health Services in Merton but this was actually undertaken by the SLaM Lambeth Care Coordinator pending the handover. Bartak was non-compliant with his medication regimen and, following further deterioration in his mental health, the Merton Community Team referred him for assessment to section him under the Mental Health Act again. The date for the assessment was set for mid-July, too late for the fatal incident.

Timeline of relevant events and reported contact with agencies[4]

Phase 1 - while Bartak was an in-patient at SLaM October 2016 to May 2017

32. In late October 2016, police were called by a security officer at a block of flats in Pimlico, City of Westminster who alleged that Bartak had followed a member of the public saying he believed he was Jesus. The concern was for his mental health or that he may be under the influence of drink or drugs. When the officers attending attempted to speak to Bartak he acted in a strange manner but would not respond to them. As no criminal offences were alleged or apparent he was advised to go on his way.

[4] Sources: Joint MHIR, MPS and LAS IMRs, Coroner's Inquest

33. Bartak was then observed to stand in the way of oncoming traffic in the middle of a busy road. When he was directed to return to the pavement, he ran into the path of moving vehicles. The officers detained him for his own safety at which point he became violent and aggressive, head-butting one of them. The officers were concerned for his well-being and decided to detain him under Section 136 of the Mental Health Act.

34. Bartak was conveyed[5] for assessment to the nearby Gordon Hospital, an acute adult mental health facility, but because there was suspicion he may have taken drugs, staff said he would have to be medically cleared first. The officers conveyed Bartak to St Thomas' hospital where he was admitted for tests before returning to the Gordon Hospital. Officers noted that, although conscious, he was totally unresponsive. The officers completed an intelligent report on the CRIMINT[6] system and a MERLIN[7] Adult Coming to Notice (ACN) report. This was shared with Adult Social Care in Lambeth.

35. Following a MHA assessment at Gordon Hospital Bartak was placed under section 2 of the MHA for a period of assessment. When it was confirmed that he lived in the SLaM catchment area, Bartak was transferred to a SLaM Triage Ward and then to a male acute mental health ward at Lambeth Hospital. He was then moved 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.

36. Bartak did not respond as expected to treatment and so required a further period of detention in hospital under section 3 of the MHA. The record of the section 3 assessment notes that he was "clearly unwell and has no insight into his condition". As Bartak's behaviour continued to deteriorate he required enhanced observations by two nurses (known as 2:1 nursing). At the beginning of December 2016, he was referred to a Psychiatric Intensive Care Unit [PICU] due to:

    Harm to others
    Intimidating, threatening, confrontational, both physically and verbally abusive towards staff, refusing to be 'timed out'
    Sexually disinhibited behaviours, and
    …kicked the door off the chill out room

    He was transferred to the PICU at Bethlem Royal Hospital [BRH] in Beckenham, LB Bromley and remained there for five weeks.

37. In mid-January 2017 police were contacted by staff at the BRH while Bartak was detained under section. Bartak had been assaulted by another patient but there were no visible injuries. The report was accepted by telephone because it was added that neither of the parties involved were available to speak to a police officer. The matter was closed with no further action as it was deemed that neither party "had capacity" and both were receiving treatment for mental health conditions.

[5] This was a pragmatic solution but the IMR author has noted, contrary to College of Policing guidance
[6] The police intelligence database
[7] The police system for sharing information about vulnerable people with partner safeguarding agencies

38. Two days later, Bartak was transferred to an acute male mental health ward, Aubrey Lewis ward 3 (AL3), at the Maudsley Hospital in Lambeth. His presentation was reported as "challenging" but his behaviour less aggressive. He continued to cause concern because he did not respond as well as expected to antipsychotic medication. There was also evidence that he was able to gain access to cannabis while on AL3 ward and it had a detrimental effect on his mental state. Furthermore, there were episodes when his compliance with medication was questionable as it was suspected that he avoided swallowing tablets on occasions.

39. The AL3 discharge record, written in May 2017, summarised the efforts made on that ward to stabilise Bartak's mental state using antipsychotic medication. He was prescribed Olanzapine up to 20mg, but it failed to fully treat his symptoms, as he still exhibited bizarre beliefs, for example, that his mother was Cleopatra. He was then given a full trial of another antipsychotic medication, Risperidone. This did not result in any great improvement in his mental state

40. Because trials of two antipsychotic [neuroleptic] medications demonstrated little improvement to Bartak's mental state, the ward team initiated Clozapine, an antipsychotic neuroleptic medication which is reserved for use in treatment resistant psychosis. This medication requires very careful monitoring; including weekly blood tests for the first 18 weeks, as there can be serious side effects.

41. In mid-March 2017, Bartak was given the initial dose which was then gradually increased up to a therapeutic level. It is reported that he responded to an extent. Delusions were less intrusive, although they did not entirely disappear, during the six weeks that he was treated with Clozapine on AL3. As Bartak appeared more settled, plans began to be made for his discharge back to his family home. He was granted a period of section 17 MHA home leave with input from the Lambeth Home Treatment Team (LHTT). They arranged for Bartak to have the necessary blood test to monitor the effects of clozapine and visited him at home on a daily basis.

42. Bartak's trial period of leave went well and the ward team were preparing to discharge him to the joint care of LHTT and the LEO community team (Lambeth Early Onset Service) when Bartak informed them that his family were preparing to move house. It emerged that due to some difficulties that the family were experiencing with the landlord of their rented accommodation, they had decided to move to another property two and a half miles away, in Merton. This put them outside the catchment area for the LHTT but the LEO community team stated that they would provide care coordination and medical reviews when necessary until Bartak could be referred, and eventually transferred, to an equivalent team that covered Merton. This team was the Merton EIS (Early Intervention Service) team.

Phase 2 - while Bartak was under community care early May 2017 to early July 2017[8]

43. Bartak was discharged from AL3 as planned in early May following a ward round. His care coordinator was on leave at the time but a colleague attended from the LEO community team. Bartak was also discharged from Lambeth HTT on the same day as he and his family had by then moved out of the area. He was provided with a further seven days' supply of Clozapine liquid on discharge which was given to his family to administer. He was scheduled to have a blood test [week 9 of 18] in mid-May 2017 at the Clozapine Clinic at Lambeth Hospital.

44. Both Catia and Daniela worked in the same restaurant business and would often be required to work late shifts. Bartak's care day-to-day fell to Adela because he lacked motivation to care for himself. She would prepare his meals and ensure he bathed and changed his clothes regularly. This became a source of friction between them.

45. Whilst waiting for seven day follow-up Bartak was placed in the Red Zone[9] by the LEO community team. He did not present to the Clozapine Clinic at Lambeth Hospital as planned for mid-May or attend the LEO community team base in Kennington for his pre-planned seven day follow up appointment four days later.

46. A home visit took place in mid-May by the LEO community team when the care coordinator saw Bartak and his mother at their new home in Merton. All appeared to be well and Bartak said he was taking his medication as prescribed, although he said it was making him drowsy. During the visit he showed what remained of his medication to the care coordinator. At this stage Bartak was five days overdue for the Clozapine monitoring blood test and should have had no medication left had he been taking it as prescribed.

47. The home visit was discussed by LEO community MDT (Multidisciplinary Team) the next day and it was agreed that Bartak no longer needed to be in the Red Zone. It was acknowledged that the blood tests were due and a medical review by a core trainee psychiatrist was arranged to take the necessary blood tests and prescribe medication. The LEO care coordinator and the core trainee doctor visited Bartak the day after that. Blood tests were taken for a full blood count and for Clozapine levels. Bartak was prescribed a 28 days' supply of Clozapine liquid on an FP10 prescription[10]. The local NHS providers only dispense Clozapine via hospital pharmacies. No community pharmacies in the area would be able to dispense Clozapine from an FP10 prescription.

48. During the next two weeks, the LEO care coordinator made several attempts to establish how to refer Bartak to the appropriate South West London and St Georges Hospital (SWL&StG) community team. It appears that there was some unclear information about which service Bartak would come under. The LEO care coordinator was advised to and completed a referral to the 'Sutton-Uplift' service and then he was told that Bartak came under a different catchment area. He was finally given details of Merton EIS duty contact in mid-May. He was told that they had no record of Bartak and the team leader would need to

[8] To assist the reader some dates/times are underlined to show a new incident/event
[9] Meaning the highest level of supervision by the team
[10] A prescription that can be issued by a GP, nurse, pharmacist prescriber, supplementary provider or a hospital doctor

discuss the referral. The care coordinator left his contact details and asked for a call back. He continued to follow up over the next week.

49. Three days later, the LEO care coordinator had contact with Daniela and made a visit the following day. At that visit, Bartak told him that he continued to take his medication as prescribed and had no psychotic symptoms. His family did not report any concerns about him, however, it was reported that his benefits had been suspended and his sick certificate had lapsed, so there were some concerns about welfare arrangements. Bartak was asked to attend the LEO community team base to resolve these issues (and he agreed to do so) but he did not attend. Blood tests for Clozapine monitoring were due in the following two weeks but did not take place.

50. In early June, the LEO care coordinator got through to Merton EIS and arranged to fax a referral through to them. It is understood that the referral was not assessed as a priority and a CPA (National Care Programme Approach) transfer was to be arranged in due course. The referral information was received by Merton EIS four days later and uploaded onto RiO (the electronic patient record system) the next day.

51. That day, the LEO care coordinator visited Bartak at home to assist him in re-applying for benefits. It is recorded that he "presented as stable in his mental state" however Bartak's mother mentioned that he had been using cannabis recently. Cannabis had been previously identified as a potential trigger for psychosis.

52. Blood tests for Clozapine monitoring were due on two and nine days later but did not take place. Had the FP10 prescription been dispensed Bartak would have run out of that supply of medication in mid-June. It is not documented that this was highlighted within the LEO community team.

53. Later in June, the LEO care coordinator received a telephone call from Daniela describing the family's concerns that Bartak was relapsing and was being hostile to his mother. He was also angry with Adela because she was trying to persuade him to have a bath. Daniela stated that it seemed he was not taking his medication as prescribed. The LEO care coordinator made contact with Merton EIS that day and it was confirmed that the LEO referral had been accepted but Bartak's case had not yet been allocated to a care coordinator at Merton EIS or that a handover had been arranged. The LEO care coordinator provided advice to the family to contact the emergency services if they had concerns overnight and a home visit by the LEO care coordinator was arranged for the following day.

54. At about 19:10 on that day a call to the Merton address was received at the MPS emergency contact centre and logged on the CAD (Computer Aided Dispatch) system. The record does not show the caller's name but notes that she told the call handler that her brother was not taking his medication. She said that sometimes he was aggressive and at other times normal. She had spoken to her doctor and he 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 (London Ambulance Service) or her doctor again.

55. The caller is now known to be Bartak's sister, Daniela and the IMR author has examined a transcript of the conversation. The caller identified herself as Daniela (full name given). Although she did not explicitly state that Bartak was acting aggressively at the time of the call she did refer to her brother making threats to kill the dog. The police operator suggested that her brother's aggression toward the dog could be due to his illness. Having established that Daniela was asking for police to attend to make Bartak take his medication, the operator asked Daniela what she felt they could do as they would be unable to force Bartak to take his medication. Police officers do not have such powers and his was in line with extant policy. The call concluded with the suggestion that Daniela revert to her doctor for advice.

56. It is unclear why the police operator did not record the name of the caller on the CAD system and they did not ask for any further information about the person the caller was referring to. There is no note about his medical condition, the nature of his aggression or any potential risk he could pose to himself or others. It does not appear consideration was given to tasking a unit to complete a welfare check which should then have led to the completion of a MERLIN ACN report. The CAD operator has been asked to comment on the record of the call and the actual transcript but was unable to recall anything due to the passage of time and the volume of calls handled within each shift.

57. Since this call in 2017, the MPS have introduced the THRIVE+[11] risk assessment tool and have provided refresher training based on this model to all MPS Operations Command and Control (MetCC) staff. The IMR author has recommended that the police operator who dealt with the call from Daniela is debriefed to remind them of the importance of recording accurate details regarding the caller and their concerns fully on the CAD system. The MetCC Senior Leadership Team (SLT) should also confirm that training on the use of THRIVE+ has been provided to this operator and this has been completed.

58. Five minutes after the call to police (19:15) the LAS Emergency Operations Centre (EOC) received a call from Daniela. It is recorded that a 21 year old male (Bartak) was not taking his medication, could be violent and was threatening to kill the caller's dog. The caller was reported to be "scared". An ambulance was not dispatched until 19:50, with no reason for delay noted, however, it appears from the police record that a decision was taken not to attend without police alongside.

59. This supposition arises from the police CAD which, initiated by a different operator at 19:25, logs a request from the LAS requesting assistance to deal with a 21 year old male at the Merton address who had a psychotic illness and could pose a significant risk of danger to himself or others. The CAD noted that he was not taking his medication. It was further reported that he was threatening to kill the dog. The CAD record notes that there were no police units available to be assigned at that time. The incident report was broadcast for any available unit to attend at 19:30 hours and 19:55 hours. At 20:00 hours the LAS informed the MPS that they will not attend without police as the patient was violent and had threatened to kill the dog. An entry at 20:10 recorded the assignations and call signs of all

[11] Threat; Harm; Risk; Investigation; Vulnerability; Engagement + Prevention/Intervention

the police units on duty that evening to show none were available. At 20:55, the CAD notes that the LAS reported they were in attendance and no longer required police assistance at the scene.

60. Meanwhile, the LAS record shows that the ambulance dispatched at 19:50 arrived at 20:08. Notes from the paramedics at the scene show that a family member called because Bartak had not been taking his medication and was growing more aggressive. The family had growing concerns over his unpredictability as he had been violent in the past. Bartak was not registered with a doctor.

61. When seen he was on a computer and did not engage with them. On examination Bartak refused for any clinical observations to be undertaken, denied having declining mental health issues and had capacity to make decisions. Bartak looked physically well with good skin colour. He was refusing to engage but presenting with various threatening body language and being evasive. When answering ambulance staffs questions, Bartak was presenting them with intense and threatening gazes directed at each member of staff in turn.

62. The staff documented concerns for Bartak's welfare but he denied anything is wrong and stated: “I am fine”. Bartak also denied stopping his medication. The ambulance staff contacted a nurse from the Mental Health Team at Leo Ward, SLaM, who was going to speak to a senior nurse and ring back Bartak’s family with advice on how best to proceed. It is recorded that the nurse was aware of the full situation and had access to a full history of Bartak’s mental health.

63. Bartak was left on scene in the care of his family with the advice to wait for the phone call from Leo Ward, to avoid antagonising Bartak and if they felt threatened to ring the police and exit the house/area. They should ring for an ambulance in a medical emergency or if Bartak’s mental health deteriorates. The IMR author has concluded that LAS actions that evening were in line with their clinical guidelines.

64. The LEO care coordinator attended as planned the next day. He found Bartak asleep in his bedroom. His grandmother was in the house with him and said that he was “doing well”. The care coordinator followed up the home visit with a call to Daniela. She described the events of the previous evening and said that his mental state was rapidly fluctuating and he had said that his family were “evil” and that “he can see the devil…”.

65. Bartak was placed back in the Red Zone by the LEO community team and the LEO care coordinator visited him at home again the following day. It became clear to the LEO care coordinator during this visit 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…”.

66. The LEO care coordinator responded to the risks that Bartak presented. With the assistance of the link nurse from Merton EIS, a joint visit with Merton HTT was arranged for the next day. An assessment was undertaken by the Merton HTT consultant psychiatrist.

This was her first day working with the Merton HTT, although she had worked with the HTT in an adjacent borough for some time. Her understanding of the purpose of the home visit on that day was to assess Bartak with a view to "Clozapine re-titration"[12].

67. On assessment, the consultant psychiatrist identified that Bartak was not taking Clozapine as prescribed. Her impression was that he required admission and was not suitable for home treatment because he lacked capacity. She found him to be visibly unwell, expressing delusional beliefs and exhibiting risky behaviour to his family, for example, throwing a pillow at his mother and threatening to kill the family dog. As Bartak did not have the capacity to consent to an informal admission, it was noted a MHA assessment would be required. His family were advised to give no further doses of Clozapine.

68. The records show that there was some miscommunication about whether or not a first recommendation for admission under section 2 of the MHA was completed by the Merton HTT consultant psychiatrist. She informed reviewers and the Coroner that she had indicated that she was willing to provide one if required.

69. Both the Merton HTT consultant psychiatrist and a member of the LEO community team referred Bartak to the Merton AMHP (Approved Mental Health Professional) service for assessment under the Mental Health Act, with a view to admission to hospital, on this Friday. It is recorded that the LEO referral was accepted by the AMHP Administrator and it is documented on RiO "Client is Lambeth Authority in between transfer to EIS. Lambeth is the responsible authority. Paperwork completed and e-mailed to Duty AMHP".

70. According to the AMHP Lead for the Merton Services, IT issues on that day resulted in all of the referrals in the 'AMHP Inbox' being deleted from the system. Ultimately these issues were found to have resulted not from information technology issues but from human error. The AMHP Lead told investigators that there was a failsafe system for telephone follow-up by the administrator once a referral had been e-mailed. However, this did not appear to have happened in this instance and such a system was not described in the account given by the manager of that service. Consequently, the referral was not handed on to the Out of Hours AMHP Service and so no assessment for Bartak was arranged over this weekend in late June.

71. Reviewers were told that, on the Monday, the contents of the 'AMHP Inbox' was partially restored but Bartak's referral remained lost and so his referral was unknown to the AMHP Lead. However, it so happens that the Merton AMHP service was co-located with the Merton HTT. The AMHP Lead was then made aware of the referral by a colleague in HTT and eventually the referral was retrieved on the system in the middle of the week.

72. On the following Thursday, the AMHP Lead contacted the LEO care coordinator and informed him that the MHA assessment would probably take place in the latter part of the following week. In the meantime, the AMHP lead informed the LEO care coordinator that the LEO community team would be responsible for supporting Bartak and his family. The plan was documented in the notes as follows:

[12] 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

Plan – agreed with CC [Care Coordinator]

- *CC/AMHP desk to Contact family to check wellbeing and to re-assure support being arranged*
- *If MHA assessment is still needed - consider Least Restrictive option*
- *Obtain s135(1) warrant / police /ambulance /s12 approved Dr*
- *Inform LEO CC to be part of MHA ax [assessment]*
- *Refer to Emergency Duty Team to alert them should patient require assessment over the weekend.*

73. The LEO care coordinator maintained contact with the family during this period. When he called Daniela that evening she reported that Bartak was: “doing fine” and "keeping to himself".

74. On the next day, the LEO community team reviewed the progress of the MHA assessment and the transfer of Bartak's care to Merton EIS. They agreed that the LEO care coordinator should continue to support the family. The LEO care coordinator was contacted by Merton AMHP service to confirm that no assessment would take place over the weekend: “they have a lot of assessments this week” and would “be in touch next week”.

75. The AMHP Lead told the reviewers that, on the following Tuesday, he left a message for Bartak’s mother, Catia, asking her to contact him. On Thursday, he said that he left several further messages on her mobile phone and planned to contact the LEO care coordinator if there was no response. He said he also intended to make an “unannounced home visit” but had “not got round to doing so” due to the high activity at the time and because the level of risk was not clear to him at the time.

76. On the next Thursday, the LEO care coordinator contacted Daniela by phone. She raised some concerns about her brother’s behaviour deteriorating but she did not feel that he needed to be in hospital. Crisis and contingency plans were discussed with her by the LEO care coordinator as well as the importance of an MHA assessment. The LEO care coordinator agreed to visit the family the following day. Before the LEO care coordinator left home for that visit, the LEO Team received a phone call from police to inform them of the fatal incident.

The Fatal Incident in early July 2017

77. Near to midnight on that day, police received several calls requesting attendance to the family home in Merton. The callers had heard screams and one reported seeing a trail of blood leading from the house to the garden. When police arrived at the scene they observed this trail which led them to Adela in the rear garden. She had sustained catastrophic head injuries and some mutilation. The family pet dog and cat were positioned beside her; both had been killed, their heads mutilated.

78. Catia and Daniela were present, having just arrived at the scene. They had both been at work that afternoon and evening. Catia had last spoken to her mother at around 15:45 hours to enquire after Bartak. Adela told her that Bartak had thrown her out of his room when she had tried to speak to him. After finishing work, Catia had attempted to contact

her mother by phone to arrange to meet her and Daniela locally as they did most evenings. When there was no response, they decided to return home and found the scene as described above just prior to the police arrival.

79. Catia relayed to the officers the family concerns about Bartak's mental health and behaviour in the weeks prior to the homicide. He had made threats to kill the dog, saying that a demon had possessed it. He told the family he was not an ordinary man and that only he could save humans. She explained that they sought help from police and the LAS [three weeks earlier in June] but that they had refused to attend. They had subsequently called a number of hospitals and, although the family were visited by a mental health professional, they were advised there were no beds available. She added that they queried how they could manage Bartak's medication if he was uncooperative and they told her he would have to return to the hospital.

80. Bartak was not present at the scene. He was subsequently located in a nearby park, arrested by police and taken into custody. He was examined by Forensic Medical Examiner (FME) who determined he was not fit for interview. A mental health assessment was conducted and a recommendation made for Bartak to be detained under Section 3 of the Mental Health Act. It was noted that he was confused, distracted, delusional and paranoid.

81. In notes from the MH assessment, Bartak is recorded as saying he could: "feel angels and demons all around". He added that he felt angels within himself and felt demons in other people.

82. A post mortem examination was conducted and the cause of Adela's death recorded as: 'multiple incised wounds to the throat and associated complications'. Adela's head injuries were inflicted after the wound to her throat which would likely have proved fatal. Rib fractures found were sustained after her circulation had stopped as there was no associated bruising. It was also noted it was likely her eyes were removed prior to infliction of the head injuries as they were intact.

83. In July 2018, Bartak appeared at the Central Criminal Court and pleaded guilty to manslaughter on the grounds of diminished responsibility. A section 37 hospital order with a section 41 restriction under the Mental Health Act was imposed for Bartak to be detained indefinitely.

ANALYSIS

National Health Service perspective

84. The main factor that increased the potential risks Bartak presented to members of his family with was the deterioration in his mental state. While he was an inpatient, it took a considerable amount of time to establish him on a medication regime that improved his mental state. Nevertheless, compliance remained an issue in the context of his lack of insight into his illness.

85. After he was discharged, simultaneously from AL3 ward and the LHTT, his medication monitoring and management became inconsistent with safe practice, as described in the Maudsley Prescribing Guidelines 12th Edition, the main source of guidance available to clinical services at the time.

86. By June 2017, it was recognised that Bartak's mental state had deteriorated and he was no longer taking medication as prescribed. It was agreed, following assessment, that admission was required and he would need assessment for admission under the MHA as he did not have the capacity to agree to an informal admission. The factors that contributed to the failure to arrange that assessment as a priority resulted in his risks escalating with no plan in place to mitigate them.

87. A number of 'areas of concern' were identified in the MHIR:
    1. 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 AL3
    2. Clozapine monitoring and management by LEO Community Team was not in line with Maudsley Guidelines, 12th edition
    3. There was no agreed plan about how the transfer from LEO Community Team to Merton EIS would take place
    4. 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
    5. 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
    6. 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
    7. Although they made a number of requests, the reviewers were not provided with a copy of the referral made to the Merton AMHP service on in late June 2017 or evidence that it was permanently deleted.

88. The reviewers also recorded 'Notable Practice':
    The named link person or interim care coordinator in Merton EIS was active in liaising with the LEO care coordinator, helped to facilitate the Merton HTT review and tried to expedite the transfer of Bartak to Merton local services. The reviewers found that she went beyond what was required of her to try to assist.

Metropolitan Police Service perspective

89. The MPS had no previous contact with Adela and limited contact with Bartak. When he was first encountered in October 2016 his mental health presentation was recognised and professionally managed whereby he was taken to a place of safety, assessed and sectioned under the MHA. The incident was properly recorded on MERLIN and shared with partners. The report in January 2017 that he was a victim of crime in the mental health setting was noted but no further action was required.

90. 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 Chief Inspector from the MPS Operations Command and Control unit acknowledged this shortcoming at the Inquest and pointed to the THRIVE+ revised risk assessment tool training as the systemic remedial action taken.

91. This officer had also conducted analysis and provided evidence of the police deployments and availability that evening when the subsequent request for assistance by the LAS was received. He confirmed that there were no police officers available to support LAS staff due to exceptional demand that evening. In the event paramedics did attend to assess Bartak's needs and cancelled the request for police assistance.

92. Even if officers had been available to attend that evening, 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. In the absence of either, they would need to be in possession of a warrant granted by a Magistrate under the Mental Health Act.

Family perspective

93. Catia was provided with a Polish translation of a near-final version of the overview report and, with the support of a Polish translator, discussed the content with the Chair at their video conference in October 2021. The Chair invited feedback on the accuracy of the narrative and the interpretation in the analysis, with particular reference to the ToR for the review. She had no observations other that to reiterate her anger and disappointment at the failures in service that have been highlighted. She pointed out that her days consist of visiting her mother's grave and then travelling to visit her son who is detained a short distance away.

SUMMARY AND CONCLUSIONS

94. What follows is the summary and conclusions arrived at by the MHIR Investigation Team in June 2018. These findings were closely monitored by the Chair as clinicians provided their evidence to the Inquest in February 2021 and no new findings emerged.

95. In summary, Bartak is a young man who had no reported history of mental health problems until October 2016 when he presented with psychotic symptoms and was admitted to hospital. The admission that followed was unusually long as the antipsychotic medication prescribed had limited effect. He was referred to the LEO community team in Lambeth and allocated a care coordinator who would support him and his family once he left hospital.

96. In March 2017, Bartak was prescribed Clozapine and appeared to respond as there was some improvement to his presentation. After a short period, plans were made for trial home leave supported by the LHTT with a view to discharge. At this time, his family announced their intention to move to a flat in Merton, in the London Borough of Merton and under the catchment area of SWL&StG's mental health services. Plans for home treatment to follow him up for a short time after his discharge were changed as he was no longer under the LHTT.

97. As Bartak and his family moved to Merton the plan was for him to be provided with 7-day follow up by the LEO Community Team before his care was transferred to Merton EIS team. He was also scheduled to attend the Clozapine Clinic at Lambeth Hospital where his blood tests would be taken then medication prescribed and dispensed following on from a 'green' blood test result. Bartak did not attend the planned appointment and a home visit was arranged by the LEO care coordinator with a junior doctor with little community experience who were not aware of the wider medication management limitations involved when administering and prescribing Clozapine. As a result, the signs that Bartak was not taking his medication as prescribed were missed. In addition, he was supplied with a prescription that did not meet the monitoring requirements (a FP10 for 4 weeks supply when he required weekly monitoring) and which would not have been accepted in a general community pharmacy.

98. The LEO care coordinator encountered unexpected difficulties when he tried to arrange Bartak's transfer to the Merton EIS team and it became evident that the transfer would take longer than had been anticipated, although no arrangement for transfer had been agreed at the time of the incident beyond a notional CPA transfer meeting. Care coordination by the Lambeth service became a challenge and was complicated by a lack of familiarity with the Merton service framework, which appears to have been difficult to navigate.

99. After the home visit in mid-May 2017, there was a reliance on Bartak's family to contact the LEO care coordinator if and when they had any concerns about his presentation. When they did so, in mid-June 2017, there was a prompt response and the LEO care coordinator was able to mobilise the Merton HTT to carry out an assessment the following day.

100. What became clear to the Merton HTT consultant psychiatrist when she carried out the review in June 2017 was that Bartak was not taking his medication as prescribed. She told

the family to stop giving it to him with immediate effect but no alternative was discussed or prescribed. The Merton HTT consultant psychiatrist decided that as Bartak required formal inpatient admission for Clozapine re-titration, this excluded him from further support from their service.

101. A referral was made to the Merton AMHP team by the LEO duty worker on that day. Although the reviewers have not had sight of this referral, the AMHP lead reported to them that it did not assist his awareness of the risks that Bartak presented with. Nevertheless, the review team believe that there were unreasonable delays in arranging the MHA assessment which resulted from human error and inadequate systems.

102. In conclusion, the reviewers found a range of care and service delivery problems resulting from systems and human error across both SLaM and SWL&StG. At least two of these problems contributed to the incident:
    1. Bartak was not taking medication safely; he was not having regular blood tests as required when taking clozapine and he was not prescribed medication correctly
    2. When his mental state deteriorated to the extent that he required assessment for admission under the MHA, little action was taken to arrange the assessment.

    In the absence of any medication or an inpatient admission, Bartak's mental state continued to deteriorate and, in the view of the review team, this undoubtedly contributed to the fatal incident.

THE INQUEST

103. The Coroner for Inner West London held a 'Jamieson Inquest' over three days in February 2021 via video conferencing and called the relevant witnesses that had been interviewed in the course of the joint MHIR and a senior officer from the MetCall Command. The family were present throughout, were supported by a Polish translator and were able to ask questions. The Chair was present and received disclosure of documents as an 'Interested Person'.

104. The Coroner concluded that Adela died as a result of multiple incised wounds to the throat with associated complications and was found dead in the garden of her home address. She had been the victim of a sustained and brutal fatal attack. The perpetrator was known to mental health services and awaited a Mental Health Act assessment due to a relapse in his mental state. Adela was unlawfully killed.

105. So far as point 9 in the ToR regarding the actions of the MPS and LAS on the evening in late June 2017 is concerned, the Coroner accepted that, notwithstanding the acknowledged poor quality of the police call handler's response to Daniela's call for assistance, it had been verified there were no officers available that evening to be deployed; also that the paramedics had followed clinical guidelines in their attendance and had cancelled their call for police back-up.

106. With respect to the evidence heard regarding the management of Bartak's mental health while he was under community care between May and July 2017, the Coroner cited a number of care and service delivery problems:

- Bartak was at a disadvantage with a diagnosis of treatment resistant schizophrenia
- It necessitated the use of clozapine, a difficult drug to manage; its toxic to therapeutic ratio is not good and even on clozapine, with some improvement, there was an ongoing reluctance by him to take his medication with a persistent lack of insight into his mental health
- There appears to be some lack of contingency planning about those risks at the point of discharge. He was someone who was likely to be non-compliant with medication and therefore relapse
- He was discharged to the LEO Early Intervention Service but with the family responsible for administering the medicine. It was made clear that this was a difficult and complex responsibility to put the family in. The family were not completely understanding about the medication, its risks and the monitoring requirement
- English was not their first language and there was over-reliance on Bartak's sister, who was only a young person herself, to translate what were complex medical issues
- This was then complicated by the family moving out of the LEO catchment area
- The transfer from the LEO team to the Merton Early Intervention Service was protracted, which meant that Bartak's care coordinator was having to work out of his Borough which made it more difficult to visit and engage with the family, given an existing high caseload within the LEO team
- A local team such as the Merton EIS may have been able to provide more time, more crisis planning, proper risk assessment, contingency planning and increased support when signs of relapse showed. This lack of transfer also impacted on the ease of arranging a Mental Health Act assessment
- When he was obviously relapsing and had stopped his medication there was a lack of intensive support and crisis planning. The Home Treatment Team did not take him on or indeed provide additional support for a family who were in a time of crisis. There was insufficient planning and risk assessment and limited contact with the family after the date in June when it was decided that a MHA assessment was required. This was a period of time in which one might expect a family, and certainly a patient, would need very much increased levels of support
- There was clearly a lack of knowledge within the LEO team about clozapine, its prescribing and its monitoring. It seems at no point did the team realise he had not had a working prescription of clozapine since his discharge in early May
- This is all compounded by delay in arranging of the MHA assessment, which is multi-factorial, mainly through over-reliance on IT, with an IT glitch, and the lack of a local team.

107. The Trusts had recognised all of these matters and the Coroner summed up her findings on the joint SLaM and SWLStG review, drawing five themes from the MHIR action plan:
    1. Clozapine prescribing and management
    2. The family being required to administer the medications, a difficult and complex requirement, without any understanding
    3. The delay in transfer between the Lambeth LEO Team and the Merton EIS
    4. The AMHP system found to some extent to be fragmented and unstructured
    5. The lack of HTT follow-up for patients awaiting a MHA assessment.

108. The Trust provided the Coroner with an updated Action Plan which is shown in full in appendix 1 attached, having been updated by the Trusts for this review.

LESSONS LEARNED AND RECOMMENDATIONS

Learning Point 1

109. A range of factors contributed to the lack of plans to manage and monitor medication and his expected lack of concordance principally that he was prescribed an unusual preparation not frequently encountered in the community and was not fully established on that medication. This information was not fully handed over or documented in the patient notes by the inpatient ward.

110. Had Bartak attended the Lambeth Clozapine Clinic as planned there may have been an opportunity to respond to these uncommon circumstances. In the event, because he moved out of area, this task was allocated to a junior doctor and a Locum care coordinator. These junior clinicians had little experience of managing clozapine in the community and were not adequately trained to understand the complexities of prescribing and monitoring liquid clozapine in the community.

111. Procedures for clozapine monitoring and management are described in the Maudsley Prescribing Guidelines but this is not operational guidance and is not widely available to nonmedical clinical staff. There is currently no SlaM policy or protocol that provides guidance to all staff on the monitoring and management of clozapine in its different preparations or outlines operational responsibilities of different services e.g. pharmacy; responsible clinicians; inpatient wards; community teams; clozapine clinics.

Recommendation 1

112. 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:
    - Titration protocols
    - Registration with ZTAS or DMS[13]
    - Prescribing pathways for inpatient and community settings including the monitoring requirements and action to be taken where a red/amber/green result
    - A robust system for overseeing pathology testing and to generate an alert when a patient has missed a monitoring blood test
    - Guidance on side effects and the risks associated with non-concordance with medication as prescribed
    - How to discuss risks with patients their families and carers, especially where English is not their first language
    - Training Needs Analysis for different staff groups involved.

Learning Point 2

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

113. The SLaM clinical teams relied on the family to administer and monitor medication. Based on the information available to this review it is unlikely that the family fully understood the potential hazards if Bartak did not take the medication as prescribed. Support for the family did not appear consistent with the key principles of the Carers' Charter:
    1. Your essential role and expertise is to prioritise, respect and encourage
    2. You are given the information and advice that you need to help you provide care
    3. You are involved in the planning and agreement of the care plan for the person whom you are supporting
    4. Your individual needs as a carer are prioritised, responded to and reflected in the Care Plan
    5. Your receive appropriate help and support when you need it
    6. You are actively involved in the planning, development and evaluation of services
    7. You are aware of the roles and responsibilities that exist within the care partnership

    Given the length of Bartak's admission (October 2019 to May 2017) and a that care coordinator was allocated in November 2016, there were missed opportunities to offer a carer's needs assessment to Catia while he was an inpatient.

Recommendation 2.1

114. 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.

Recommendation 2.2

115. 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.

Learning Point 3

116. There were no agreed plans or timescales for Bartak to be transferred from LEO community team to Merton EI.

Recommendation 3

117. 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.

Learning Point 4

118. The systems in use by the Merton AMHP service at the time were fragmented, unstructured and lacked any senior oversight.

Recommendation 4

119. 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.

Learning Point 5

120. The Merton HTT did not follow up patients who are awaiting MHA assessment this appears to be the point at which home treatment would be essential

Recommendation 5

121. SWL&StG review the Merton HTT pathway to ensure that support is offered to patients awaiting a Mental Health Act assessment.

122. The format of the Action Plan in appendix 1 is retained in that of its original in the MHIR, together with updates provided to the Coroner, because there are no recommendations from other agencies. It has been further updated by the Trusts for this review.

Learning Point 6

123. At the CSP presentation on 9 February 2022, the Partnership discussed the impact on the family of English not being their first language and there was over-reliance by agencies on Bartak's sister, who was only a young person herself, to translate what were complex medical issues (highlighted in the MHIR - paragraph 106, point 5, above). This is closely aligned to a lack of professional curiosity being displayed in order to properly understand their situation. As a result, two recommendations have been added to the Action Plan.

Recommendation 6.1

124. 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.

Recommendation 6.2

125. 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.

Author

Bill Griffiths CBE BEM QPM

25 October 2022

Glossary

AL3	Aubrey Lewis Ward 3
AMHP	Approved Mental Health Professional
ASC	Adult Social Care
CCG	Clinical Commissioning Group
cjsm	Criminal Justice Secure eMail
DA	Domestic Abuse
DHR	Domestic Homicide Review
DVHR	Domestic Violence Homicide Review
EIS	Early Intervention Service
EOC	Emergency Operations Centre (for LAS)
gsi	Government Secure Internet
IMR	Individual Management Review
HTT	Home Treatment Team
IP	Interested Person
LAS	London Ambulance Service
LB	London Borough
LBM	London Borough of Merton
LEO	Lambeth Early Onset
LHTT	Lambeth Home Treatment Team
MARAC	Multi Agency Risk Assessment Conference
MetCC	MPS Operations Command and Control
MHA	Mental Health Act 1983
MHIR	Mental Health Investigation Report
MPS	Metropolitan Police Service
NHS	National Health Service
PICU	Psychiatric Intensive Care Unit
PIR	Pre-Inquest Review
pnn	Police National Network
RiO	NHS electronic patient record
SLaM	South London and Maudsley NHS Foundation Trust
SWL&StG	South West London and St George's Mental Health NHS Trust
ToR	Terms of Reference

Name references used

Adela	Victim
Bartak	Perpetrator and grandson of victim
Catia	Daughter of victim and mother of perpetrator
Daniela	Granddaughter of victim and sister of perpetrator

Appendix 1

JOINT SLaM AND SWL&StG

ACTION PLAN

Lesson learnt	Recommendations	Action	Status[14]
A range of factors contributed to the lack of plans to manage and monitor medication and his expected lack of concordance principally that he was prescribed an unusual preparation not frequently encountered in the community and was not fully established on that medication. This information was not fully handed over or documented in the patient notes by the inpatient ward. Had Bartak attended the Lambeth Clozapine Clinic as planned there may have been an opportunity to respond to these uncommon circumstances. In the event, because he moved out of area, this task was allocated to a junior doctor and a Locum care	**1.1** The SLaM Clinical Policy Working Group to commission a discrete policy on clozapine monitoring, management and prescribing that will help inform local protocols and best practice in both inpatient and community settings. It should include the requirement for an alert to be raised on ePJS that a patient is on weekly/monthly monitoring and their log number and which company is responsible for monitoring	Commissioning of discrete policy on clozapine from SLaM Clinical Policy Working Group Due by 20/03/20	Fully implemented Completed 18/12/19
	1.2 A Blue Light Bulletin – Importance of raising a medication alert on ePJS when a patient is registered with ZTAS or DSM.		

[14] Embedded updated policy documents provided by the Trusts removed prior to preparation of anonymised version

coordinator. These junior clinicians had little experience of managing clozapine in the community and were not adequately trained to understand the complexities of prescribing and monitoring liquid clozapine in the community.			
The SLaM clinical teams relied on the family to administer and monitor medication. Based on the information available to this review it is unlikely that the family fully understood the potential hazards if Bartak did not take the medication as prescribed.	**2** Where there is a reliance on a family to administer medication and monitor compliance, they must be properly equipped to do so. For example, they must be provided with information about the possible risks, in their first language if required. There should be documented records of any pharmaco-educational discussions with them.	SLaM LEO Operational Policy to be updated to provide care coordinators with guidance on working with family and carers	Fully implemented Completed 15/02/21 Simon Darnley will provide further detail to Toby de Mellow of progress in implementation, and audit
There were no agreed plans or timescales for Bartak to be transferred from LEO community team to Merton EI.	**4** SWL&StG and SLaM EI services develop guidance for referrers on what they can expect when transferring in and out of their respective boroughs.	SWLStG and SLaM have jointly, with other London MH Trusts, developed a pan-London standard for transfers between EIS and other community teams. This covers principles, timescale and processes for transfer, with a requirement that the period from referral to completion of handover takes no longer than six weeks. While the death of Ms IK took place within six	Approved and promulgated by NHS England January 2021 Start date to be set by NHS England (likely to be no later than 1st April) SWLStG has already circulated the agreement to community teams and instructed them to begin operating in accordance with it.

		weeks of referral, the communication, engagement and planning required by the standard would have prevented gaps in care during the process of handover from LEO to Merton EIS. In addition, SLaM has also updated its discharge and transfer policy.	Issues requiring escalation under the agreement will be audited by SWLStG in summer 2021 and communicated to NHSE via the UEC Board.
The systems in use by the Merton AMHP service at the time were fragmented, unstructured and lacked any senior oversight.	**5** There is an evaluation of the revised 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) oversight of case progression at a senior level;	LB Merton to review the operation of its AMHP service in conjunction with SWLStG	The review took place in summer 2019. The updated operational policy below was adopted and subsequently revised further. This provides a robust referral system (section 7), clarification of responsibility for risk management (7.3), and oversight of case progression by the AMHP lead (7.7, 7.9). LB Merton keeps this service under review; Associate Director Jennifer Lewis-Anthony has provided evidence of the system operating correctly, and an audit from Q1 2020 showing how delays are monitored:
The Merton HTT did not follow up patients who are awaiting MHA assessment this appears to	**6** There is a review of the Merton HTT pathway to ensure support	SWLStG to review all borough pathways and change policy to ensure that all patients awaiting	SWLStG adopted a revised Bed Management Policy (below) in May 2019. This provides for the

be the point at which home treatment would be essential	is offered to patients awaiting Mental Health Act assessment.	admission or MHA assessment are monitored and supported throughout	active monitoring and management of patients awaiting admission via MHA assessment (or otherwise), and clarifies responsibilities for this process (section 12, and appendix 8 showing details of how this works in practice). Any delays in MHA assessments or admissions are reviewed weekly by the Director of Nursing & Quality at the Quality Matters meeting. This has demonstrated that the above process has worked safely and reliably since instituted in summer 2019.
There was an impact on the family of English not being their first language that resulted in an over-reliance by agencies on the sister, who was only a young person herself, to translate what were complex medical issues. This is closely aligned to a lack of professional curiosity being displayed in order to properly understand their situation.	**6.1** All agencies working with victim and survivors of domestic abuse should ensure they understand what is being said and if necessary arrange independent (not using family members) translation services. This will ensure the victim/survivors have the best knowledge available that they understand.	The Community Safety Partnership will provide training to all agencies working with victim and survivors of domestic abuse to ensure that independent (not using family members) translation services are highlighted and offered to victims and survivors so they can express what is happening to them and for agencies to understand what support an agency can give.	Some of this has already been incorporated into current training but this will be further highlighted in future training happening in 2022
	6.2		

	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.	The Community Safety Partnership will provide training to all agencies so they understand how professional curiosity is important when working with victims and survivors. This could be while using the DASH risk assessment or when assessing cases and don't have all the answers.	Some of this has already been incorporated into current training but this will be further highlighted in future training happening in 2022