LONDON BOROUGH OF EALING

SAFER EALING PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

SANIKA BATHAK AGED 62

UMLAWFULLY KILLED IN NOVEMBER 2020
IN EALING

REVIEW PANEL CHAIR AND AUTHOR
BILL GRIFFITHS CBE BEM QPM

26 OCTOBER 2022

Safer Ealing Partnership - Domestic Violence Homicide Review Panel
Sanika Bathak aged 62, killed in Ealing in November 2020

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INTRODUCTION

1. Just before 17:00 on an afternoon late in November 2020, police were called by Rishi Bathak to a terraced house in the London Borough of Ealing (LBE) where he believed his wife, Sanika Bathak aged 62, had been murdered. He also noticed his son Priyan Bathak aged 31, who lived with his parents and had long standing issues with his mental wellbeing, was absent. Despite the best efforts of police and paramedics, Sanika was beyond saving and her life was pronounced extinct at 17:22hrs by the attending doctor. In December 2021, Priyan pleaded not guilty to murder, but guilty to manslaughter, on the grounds of diminished responsibility and was detained under the Mental Health Act (MHA) 1983.

2. This report of a domestic homicide review examines agency responses and support given to Sanika and Priyan Bathak prior to the homicide. 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.

3. The key purpose for undertaking the review is to enable lessons to be learned from homicides where a person is killed because of domestic violence. 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.

4. One of the operating principles for the review has been to be guided by humanity, compassion and empathy, with the 'voice' of Sanika Bathak at the heart of the process. Through the Chair, the Panel have offered Sanika's family their heartfelt condolences upon their loss.

TIMESCALES

5. Upon the report of the homicide the Chair of the Safer Ealing Partnership (SEP) requested partners to secure all records of contact with the parties to support the commissioning of a Domestic Homicide Review (DHR). The review began with a Panel meeting in April 2021 when Terms of Reference (ToR - Appendix 1) were agreed and Chronology reports commissioned from all identifiable public and voluntary bodies that may have had contact with Sanika and Priyan Bathak to be returned by 12 May. The next meeting was set for 26 May for the purpose of reviewing the chronologies and commissioning of Individual Management Reviews (IMR).

6. At this meeting, it was established that Ealing Recovery Team West (ERTW), West London NHS Trust (WLNT) had completed a Level 2 Homicide Review and it was felt this would serve as their IMR in the first instance. The DHR process was then paused pending the criminal trial which concluded in December 2021. There was then a delay in facilitating a meeting between the Chair and Rishi Bathak which took place in February 2022. A first

draft of the narrative was reviewed and discussed at the third Panel meeting on 30 March and a second draft at the fourth meeting on 1 June. A fourth draft reflecting that discussion was provided to Rishi Bathak for review and comment, supported by his caseworker from the Victim Support Homicide Service, in a meeting at his home with the Chair on 12 August. Feedback from Mr Bathak was considered in version 5 at the Panel meeting on 31 August 2022. Version 6 was circulated to Panel members for final comments in advance of the SEP meeting on 26 October 2022. Subject to approval, version 7 has been anonymised using pseudonyms suggested by Mr Bathak. With the assistance of hos advocate, he was provided with this version 8 and confirmed that he is satisfied that publication should not lead directly to his family being identified.

CONFIDENTIALITY

7. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.

8. 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. First names will be used for family members below and are also listed in the glossary at the end of the report:

    Sanika Bathak, deceased, aged 62 at the time of the homicide
    Priyan Bathak, her son and the perpetrator, aged 31
    Rishi Bathak, her husband and father of her sons, aged 66
    Nitesh Bathak, their eldest son does not feature in the events subject of this report.

9. The Government Protective Marking Scheme (GPMS) was adopted throughout with a rating of ‘'Official-Sensitive' for shared material. Either secure networks were in place (gsi, pnn) and adopted (cjsm) or papers shared with password protection. A copy of chronologies and IMRs was provided to all Panel members for review and discussion.

TERMS OF REFERENCE

10. Following discussion of a draft in the first Panel meeting, the ToR were issued on the same day with a chronology template for completion by agencies reporting contact with those involved. The ToR set out the methodology for the review, the operating principles and the wider Government definition of domestic abuse, including controlling and coercive behaviour and may be seen in full in appendix 1. The main lines of inquiry were:
    1. Scope of review agreed from January 2008 (when Priyan's mental health problems were first identified for treatment) to date of homicide with any earlier event of significance to be included
    2. To manage interface with parallel investigations. The Chair set up liaison with the police investigation team and monitored progress through to conclusion. There has been a Mental Health Incident Review (MHIR) that has been shared with the Panel. The Inquest has been opened and adjourned pending the criminal process.
    3. Identify relevant equality and diversity considerations, including Adult Safeguarding issues (see paragraph 22)

4. Establish whether family, friends or colleagues want to participate in the review. If so, to ascertain whether they were aware of any abusive behaviour to the victim prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware if any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it (see paragraphs 15-16)
5. Take account of previous lessons learned in LB Ealing
6. Identify how people in the LB of Ealing gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague.

West London NHS Trust Review Terms of Reference

7. To establish the sequence of events as far as the Trust was involved, leading up to the alleged homicide incident in November 2020
8. To review the patients' mental and physical health care plans/risk assessments and risk management plan to establish whether they met the patient's overall needs
9. To review all care delivery, identify any gaps and consider whether this was consistent with evidence based guidelines and agreed clinical practice
10. To establish whether there was effective and appropriate communication and liaison between the patients' family and all agencies involved in the patient's care to meet their needs
11. To review the partnership arrangements in place and liaison between the local health services, local authority, and any other providers involved in the patients' care
12. To review all prescribed treatment and consider whether these were consistent with evidence based guidelines and agreed clinical practice
13. To consider whether abuse and or neglect was a factor in the death/injury, including where procedures may have failed and the case gives rise to serious concerns about the way in which local professionals and/or services worked together to safeguard adults at risk. To include if a MARAC referral was considered
14. To establish whether required policies and procedures were in place and whether they were followed
15. To highlight and learn from any positive practice
16. To identify the root causes and contributory factors of the incident and provide recommendations for the development of improvement actions to minimise the risk of recurrence and improve the quality and safety of care provided across the West London Trust and external agencies if appropriate
17. Investigate any other matters arising during the course of the investigation which, in the opinion of the panel, are relevant to the occurrence of the incident or might prevent a recurrence. To include if COVID-19 made a difference in the care provision

Family concerns raised with the Chair

18. The family are concerned about the efficacy of mental health treatment and management that was provided to Priyan since he became unwell in 2009, in particularly, the reduction in care provision and supervision/visits by Health Care Professionals in the period of the Covid pandemic in 2020 with a lack of awareness and assessment of the disproportionate impact on Priyan's mental health.

METHODOLOGY

11. Under s9 Domestic Violence, Crime and Victims Act 2004, a Domestic Homicide Review was commissioned by Ealing SEP and, in April 2021, Bill Griffiths CBE BEM QPM was appointed Independent Chair of the DHR Panel and report author. Tony Hester supported him throughout in the role of process manager and Secretary to the Panel.

12. This review was commissioned under Home Office Guidance issued in December 2016. Attention was paid to the cross-government definition of domestic violence and abuse and is included in the Terms of Reference (appendix 1).

13. The following policies and initiatives have also been scrutinised and considered:
    - HM Government strategy for Ending Violence against Women and Girls 2016-2020
    - Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews published by the Home Office December 2016
    - Domestic Homicide Reviews: Key Findings from analysis of domestic homicide reviews published by Home Office December 2016
    - Ealing Council website and related services

14. In addition, prior DHR reports were studied for any parallel lessons or repeat lessons to be learned and none were identified.

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

15. On appointment, the Chair arranged to meet Rishi Bathak, arranged by the Family Liaison Officer via Teams, and the Home Office leaflet for families was provided in advance. The advocacy section was highlighted and contact made with an advocate from Victim Support Homicide Service already supporting the family. Due to the Covid Pandemic and the judicial hearing process, it was not possible to meet face-to-face until February 2022 when the Chair met with Rishi at his home.

16. Due to his diagnosed mental condition, the establishment where Priyan Bathak is being held is not appropriate to be visited, nor him to be interviewed.

CONTRIBUTORS TO THE REVIEW

17. This review report is an anthology of information and facts from the organisations represented on the Panel, some of which were potential support agencies for Sansa and Priyan Bathak. The Panel were satisfied as to the independence of the Panel members and IMR authors. Reports were provided by:

    Metropolitan Police Service, Individual Management Review
    West London NHS Trust, Ealing Recovery Team West, Level 2 Homicide Review

North West London Integrated Care Board (ICB), Elm Trees Surgery, Individual Management Review of services provided to both Sanika and Priyan Bathak.

18. Ealing Adult Social Care (ASC), the London Ambulance Service (LAS) and local hospital records were checked. All contacts were through mental health incidents reported on, or referred by, other agencies within the narrative below, and no additional learning or relevance to system improvement was identified.

THE REVIEW PANEL MEMBERS

19. *Table 1 – Review Panel Members*

Name	Agency/Role
Joyce Parker	LB Ealing Safer Communities
David MacSweeney	West London Integrated Care System
Katherine Aston	Designated Professional Safeguarding Adults West London Integrated Care System
Holly Thomas	West London NHS Trust
Len Ramchelawon	Patient Safety Advisor, West London NHS Trust
Craig Ballantyne	Ealing Recovery Team West – Team Manager WLNT
Melisa Ellison	Ealing Mental Health – Service Manager WLNT
Karen Brown	Safeguarding Adults Ealing ASC
Sophie Shah	Ealing Adult Safeguarding
Hannana Siddiqui	Southall Black Sisters

Tracey Harrington	CEO CAPE Mental Health
Justin Armstrong	MPS Serious Crime Review Group
Bill Griffiths	Independent Chair and Author of report
Tony Hester	Independent Manager and Panel Secretary

AUTHOR OF THE OVERVIEW REPORT

20. In April 2021, Bill Griffiths CBE BEM QPM was appointed Independent Chair of the DHR 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 Ealing and no involvement in policing since retirement from service in 2010. Since 2013, Bill and Tony have jointly been involved in more than twenty DHRs.

PARALLEL REVIEWS

21. The Criminal Investigation concluded in December 2021. An Inquest was opened and adjourned by the Coroner pending the conclusion of criminal proceedings, then closed following the plea of guilty to manslaughter with diminished responsibility. West London NHS Trust have conducted a Level 2 Homicide Review by the Ealing Recovery Team West (ERTW).

EQUALITY AND DIVERSITY

22. Consideration has been given to the nine protected characteristics under the Equality Act in evaluating the various services provided:
    Age – Sanika was 62 and Priyan was 31 at the time of the homicide. Obviously, the difference is due to their mother/son relationship and is relevant
    Disability - Priyan was an adult with care and supports needs due to his mental health diagnosis
    Gender reassignment – not applicable
    Marriage and civil partnership – not applicable
    Pregnancy and maternity – not applicable
    Race – Both are British South Asian

Sex – Sanika was female and Priyan male. Their relationship was familial[1]
Religion or belief – the family were practicing the Hindu faith
Sexual orientation – not applicable.
Evidence of differential service or 'conscious/unconscious bias' from any public body for anyone subject of this report will be kept under review. There is no direct information available regarding how Sanika perceived services, nonetheless, the views of Rishi have been incorporated.

DISSEMINATION

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

Name	Agency	Position/ Title
Tony Clemence	London Borough of Ealing	Chief Executive
Ayesha Raza	London Borough of Ealing	Councillor for Community Safety; lead on domestic abuse
Mark Wiltshire	London Borough of Ealing	Director, Community Safety Service
Jess Murray	London Borough of Ealing	Head of Community Safety Service
Joyce Parker	London Borough of Ealing	Strategic Lead for Violence Against Women and Girls
Kerry Stevens	London Borough of Ealing	Head of Adult Social Care
Judith Finlay	London Borough of Ealing	Executive Director Social Services
Derek Tracy	West London Mental Health NHS Trust	Medical Director
Siobhan Appleton	NHS North West London NHS Trust	Assistant Director of Safeguarding
Sue Sheldon	NHS North West London NHS Trust	Assistant Director of Safeguarding
Jennifer Roye	NHS North West London NHS Trust	Director of Nursing
Charlie Sheldon	NHS North West London NHS Trust	Chief Nurse
Awaits	North West London Integrated Care Board	Head of Ealing, Harrow and Hillingdon
Awaits	NHS England	Patient Safety Projects Manager (London Region)
Sean Wilson	Metropolitan Police	Ealing Borough and West Area Commander
Justin Armstrong	Metropolitan Police	Review Officer Specialist Crime Review Group
Caroline Birkett	Victim Support London	Head of Service
Bill Griffiths	Independent Chair	Independent Chair/Author of the Domestic Homicide Review

[1] 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

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)

24. Sanika Bathak lived with her husband and Priyan, one of her two sons, in a terraced house in Ealing. She was of South Asian heritage and a devout Hindu. She had worked locally as a hospital administrator to a surgical ward for many years and had taken early retirement to help her husband Rishi Bathak care for their youngest son, Priyan. During her career, she often involved herself in organising social events and was incredibly well liked and respected by her peers, and all those she worked with. Sanika was also involved with a variety of charities, frequently raising money for local NHS trusts, many Hindu temples and local churches, through sponsored walks.

25. According to her clinical notes, Sanika had an established diagnosis of recurrent depression since March 1993. She reported high levels of stress and anxiety due to Priyan's mental health condition. From October 2001 to the time of her death, her prescribed medication was 30mg daily of clomipramine. It is felt that inclusion of this personal clinical information is relevant to the review.

26. Priyan Bathak had suffered with mental illness from the age of 17 when he was attending college. He has never worked but was financially independent, being in receipt of Personal Independence Payment, Universal Credit and an additional disability allowance paid direct to his bank. He lived with his parents who were jointly his carers. He was an outpatient of WLNT at the time of the homicide.

Priyan's Psychiatric diagnosis

27. Priyan is described in clinical notes as being a happy young child who engaged well with his peers at primary school. At secondary school he is reported to have become quieter and then increasingly aggressive at the time of his GCSEs. It was at this time that his parents first sought help from their GP and also consulted private practice. After school Priyan gained entry to a College in London to read Politics. There is no history of alcohol or drug use.

28. Priyan has a case note diagnosis of paranoid schizophrenia. When acutely unwell his illness is characterised by agitation, distractibility, labile mood, formal thought disorder and somatic, visual and auditory perceptual disturbances. There is a history of behavioural disturbance in the home with destruction of property and aggression towards his family,

apparently in response to psychotic symptoms. Priyan's illness has been considered to be treatment resistant and he was treated with clozapine.

29. Rishi's perspective on Priyan's illness was that it was like living in a micro-climate. When Priyan was well, it was fair and calm. He maintained personal hygiene and dressed smartly. He ate vegetarian food in the Hindu tradition. He was kind and caring, for example, to his mother and paternal grandmother. He had studied Human Rights at college and believed passionately in equality and fairness.

30. When Priyan was unwell, however, the 'climate' was dark and stormy. He was manic and responding to imagined voices; he neglected himself and dressed scruffily. He would leave the house in order to buy burgers and other non-vegetarian food. He was overtly and aggressively racist, even challenging his own parents why they were in this country and that they should leave. Rishi believes that the racism Priyan experienced at school is a trigger for his paranoid schizophrenia, manifest in an aggressive form of racism when he is unwell. Rishi provided another example. After discharge from the Lakeside MH Unit in 2016, Priyan was 'housed' in a care in the community hostel. On one occasion he was openly racist to an African-Caribbean nurse, for which he was removed from the hostel.

31. At the time of the homicide, Priyan was managed as a non-CPA (Care Programme Approach) patient, being reviewed primarily via the outpatient clinic by a consultant psychiatrist. Reflecting his diagnosis and treatment resistance and relatively low level of functioning he was assessed as being in cluster 13, which meant his mental health condition was at the serious end and his care should have been given priority by services.

Timeline of what was known to agencies[2]

32. The narrative below serves as a timeline and relevant dates are underlined to assist the reader to track the passage of time and also to highlight when significant events occurred.

<u>2006</u>

33. Priyan first presented at his GP surgery in November 2006, aged 17, complaining of sleeping problems which were attributed to bullying and teasing at school[3]; also a difficult relationship with his mother and brother. This resulted in a private referral to a psychiatrist who advised that Priyan should have some counselling sessions, of which he attended about three. The GP recorded that Sanika reported that the psychiatrist did not give any medication and thus asked for the NHS referral leading to referral to Child and Adolescent Mental Health Services (CAMHS) in 2007. The appointment with CAMHS was cancelled due to Priyan being on holiday and his mother making the decision that the family no longer required this service. Priyan was discharged from CAMHS early in 2007.

[2] With some context provided by Rishi Bathak
[3] Rishi informed the Chair that this abuse at a private school was racist in content

2008

34. In April, Priyan alleged to his GP that his brother had been abusing him emotionally and physically for three years. His brother moved out of the family home and it is reported that an uncle supported Priyan in returning to university to address the bullying. Details of 'Safe Counselling' were given to Priyan so that he could self-refer if he chose to.

2009

35. In May, Rishi called police after Priyan became verbally aggressive towards him. Priyan had returned from college, and was upset. His father had no way to control him so called police to give him words of advice, which they did. It was noted that Priyan was "edgy" and his father stated he may have had some kind of undiagnosed mental health issues. The officers completed a CRIS (Crime Reporting Information System) report, and a book 124D (a booklet specifically designed for recording details of domestic abuse, with statements, injury forms, and a mandatory risk assessment completion). No offences were alleged or apparent so this report was screened to the Community Safety Unit[4] (CSU), the risk assessed as 'Standard'[5], and recorded as a Non Crime Book Domestic (NCBD).

36. The IMR author has commented that this was an appropriate response for 2009, and the recording at that time should be seen as good practice. The sharing of information with partners of concerns regarding vulnerable adults via the MERLIN[6] ACN (Adult Coming to Notice) system did not come into place until 2013.

37. There were many subsequent calls for police assistance to the home with similar context and the IMR author has added for the avoidance of doubt information about the limitations on police powers under the MHA, s136, viz:

> *If a person appears to a constable to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of others, remove the person to a place of safety, or if the person is already at a place of safety, keep the person at that place or remove the person to another place of safety. Prior to the enactment of the Policing and Crime Act 2017, a constable only had power to enact s136 if a person is "found" in a "public place". It follows there was no power of arrest when on private property.*

38. Since the 2017 legislation, the MPS has designed a 'Mental Health Toolkit' available online to all officers and each Basic Command Unit (BCU) has a dedicated Mental Health Liaison Officer (MHLO) who reports into the Central MPS Mental Health Team, who review and revise central policy, as well as monitoring local MH engagement initiatives. Given the

[4] Formed by specially trained officers
[5] From a choice of Standard, Medium and High
[6] The MPS form for sharing instances of vulnerable children, adults and missing persons with partner agencies

nature of this toolkit and support structure no recommendation is made regarding central policy within the MPS IMR.

39. In June, Priyan was home from university for the holidays, and playing chess with Sanika, when they had an argument. This became heated so Sanika called the police to intervene. Both parents stated that Priyan needed to seek medical help, but were unable to elaborate further as to why. The officers attending correctly recorded all details on the CRIS and completed a 124D booklet. No offences were alleged or apparent so this report was screened to the CSU, risk assessed as 'Standard', and recorded as a NCBD. Intelligence checks identified and linked the May incident.

40. In August, Priyan was referred to the Ealing Crisis Home Treatment Team (CHTT) after presenting to the accident and emergency department with features of a paranoid psychotic illness. In September, information was shared with the GP surgery that Priyan had been reviewed at home by the locum psychiatrist and his care coordinator. He was reported to be complying with all his medication since discharge, however his parents were concerned that this medication was making him drowsy and a follow-up review was agreed.

41. Priyan remained in contact with WLNT from that point, initially under the Early Intervention in Psychosis Service (EIPS) and then Ealing Recovery Team West (ERTW). There have been nine admissions to hospital with the majority of these being under the MHA. The most recent admission was between mid-May and mid-December 2019 under Section 3 MHA.

2010

42. In June, Priyan had an argument with Sanika regarding an old school shirt he did not want placed in his drawer because it reminded him of the bullying he had suffered there. Things had become so heated that Rishi intervened, upon which Priyan punched him three times in the face. Police were called and, on the facts given plus his continuing aggression, they arrested Priyan for assault. His parents pointed out that he had mental health issues, but were unaware of the details, other than his medication had recently been reduced. They expressed the view that he was not getting appropriate treatment at Ealing Hospital.

43. The officers recorded that Priyan would benefit from seeing a Forensic Medical Examiner (FME, an 'on call' doctor) who attended and certified Priyan was fit to be detained and interviewed. Contact was made with his mental health worker who offered to conduct a family visit. His parents called while Priyan was in custody to state they did not wish to press charges against him. Priyan had already been interviewed and admitted the assault. He was issued with an adult caution and released from custody. Some Panel members felt that the police should have considered a referral to the local MARAC (Multi Agency Risk Assessment Conference) at this point and that this was a missed opportunity for safeguarding. The IMR author has acknowledged the point, however, guidance at the time required there to be more than four incidents of abuse in 12 months to trigger such a referral.

2011

44. After the first hospital admission in 2009 Priyan was referred to Ealing EIPS. He was treated initially with oral antipsychotic medication, olanzapine up to 20mg. In June, the GP Practice held a further mental health review with the EIS. The following month, Priyan presented at the GP surgery following a fight with an injury to his right hand and was referred to the fracture clinic at Northwick Park Hospital. It is not recorded who the fight was with.

45. In October, the care coordinator contacted the GP surgery by telephone to request a dietician referral as Priyan had reported having a poor appetite and had a recorded BMI of 16.1, which meant he was significantly underweight. It was agreed that he should see the GP in person to discuss this. A referral to the dietician was made two months later in December. Rishi later reported difficulties in getting Priyan to appointments as they were unable to force him if he refused to attend.

46. From November, in view of side effects, modest response and concerns about compliance he was started on injections of risperidone. It was noted that his family were very concerned about side effects of medication which they reported frequently to the EIPS staff and Rishi in particular appeared ambivalent about treatment. At an early stage the risk of violence was identified, with Sanika considered to be at particular risk.

47. Priyan remained symptomatic with a complex delusional system. In December a nurse from the North London College where Priyan was studying called the GP surgery to report Priyan had slapped an unknown (to him) student in the library at because of "coughing". The nurse was advised that he was under the mental health team and was due a review the following week and to speak or write directly to the psychiatrist so that they could review his medication. Information was shared by the EIS.

2012

48. In March, Priyan was referred by the GP to the urology team for investigation into physical symptoms which he believed were related to his medication and, for this reason, he had stopped them. He was referred for cognitive behavioural therapy (CBT) but only attended four of these sessions. A later appointment with the urologist felt his symptoms were due to a physical cause and advised that Priyan should be prescribed sustanon (hormone) injections.

49. In May, a multidisciplinary team (MDT) meeting was requested by the care coordinator, attended by herself, the GP, the psychiatrist, Priyan and his parents as he was not happy with his care. In this meeting the psychiatrist informed the MDT that Priyan had hit his mother and the student at university and that she had wanted to section him; however, the second assessor objected on the grounds that Priyan had stated he would engage in the treatment; which he did not do. She advised that Priyan's mental health was deteriorating

as he was not taking his medication. It was thought that the hormone injections could improve his physical symptoms, but there was also a possibility that they may not.

50. Rishi made his view known that the prescribed medication had adverse side effects, also that Priyan was sensitive to noise disturbance which caused him to become irritated. During the meeting, it was noted that Priyan interrupted his father when he was speaking and disagreed with what he was saying. He went on to state that his relationship with his parents had improved and he wanted to be discharged from mental health services. When this was challenged with evidence, further anger ensued.

51. The plan going forward from late May was for Priyan to see the GP on a monthly basis for six months for a report on his mental health state, any increase in A & E, Urgent Care Centre (UCC) or private hospital, doctor visits, or any incidents at home or outside, or any non-attendant appointments. If there were any concerns, then the GP would contact the psychiatrist. Priyan continued to point out that he was okay and did not want any medication. He was advised that if his mental health once again deteriorated, then medication would again need to be considered and possible sectioning under the Mental Health Act.

52. In early July, Rishi called police alleging Priyan has assaulted his mother. On arrival no allegations of assault were made by either parent and no injuries were apparent on them. Sanika described an argument in the bathroom that had become heated. Both parents emphasised that Priyan's mental health was deteriorating, and he had refused to take his medication. Priyan agreed to go in police transport to Ealing Hospital for an assessment. The officers completed a CRIS report and Book 124D which was referred to the CSU who noted the risk as 'Standard'. While the use of police transport in this way was not authorised unless under the MHA, the IMR author has pointed out that it was a pragmatic and caring approach to remove him from a tense situation, and an attempt to seek professional help for him. The care coordinator informed the GP practice. The GP IMR author has queried whether there was a missed opportunity to refer Sanika to an Independent Domestic Abuse Advocate (IDVA)[7] or, indeed, the MARAC (see below).

53. A few days later, officers were called to a verbal argument between Priyan and Rishi, regarding his aggressive nature and not seeking appropriate medical help for his mental health condition. Sanika stated she did not want Priyan in the house, and the officers conveyed him to the home of another family member. This was another example of pragmatic informal support to the family. The CRIS report was noted in the CSU and linked to previous incidents. The Officer in the Case (OiC) provided a referral letter to the parents. It is recorded that the incidents would be raised with the local MARAC officer. There is no electronic trace of it being received so it must be assumed that it was not in fact sent as shown on the record. It has been suggested that the referral should also have been sent to local adult safeguarding, however, this incident predates the introduction of referral of MERLIN reports to Adult Safeguarding.

[7] Referral to a specialist black and minority women's organisation based IDVA may have particularly benefitted Sanika

54. About a week after that, a MDT meeting was held at the GP surgery. Priyan was complaining of urinary symptoms and constipation and asked for laxatives. His vegetarian diet was lacking in fruit and his oral intake was poor. He was assessed by the psychiatrist who was clear his mental state had deteriorated since he had been reviewed and there had been violent outbursts at home. Section 2 of Mental Health Act was completed and Priyan was sent to Ealing hospital A & E for further assessment and management of both his physical and mental health problems.

55. Priyan was voluntarily admitted to Mary Seacol Ward at John Connelly Hospital. It appears that his physical health needs were not attended to. In late August, staff reported him missing from the ward. Priyan had not been seen on the ward since breakfast. The Doctor pointed out that, if Priyan did not receive his medicine soon his condition would deteriorate and he could become a risk to himself. This was assessed as a 'medium' risk which meant that enquiries were mainly computer and phone based. Eventually, the family's more proactive approach identified Priyan's whereabouts (he had been sleeping rough) in early September and he was returned to hospital.

56. The first trial of clozapine had started in July but was complicated by the development of a tachycardia at low doses. Rishi accused services of trying to kill his son by giving him clozapine and at one stage threatened to take the Trust to court. This problematic initiation as an in-patient was continued at home supported by the Ealing Crisis Resolution Home Treatment Team (CHTT) but clozapine was ultimately discontinued after he absconded from the ward.

57. Priyan was followed up by the EIPS and treated with oral aripiprazole, compliance was described as erratic. In October, the GP was informed that Priyan had been admitted under the MHA S2 following assessment by the CRHTT at his home following concerns about risk of aggression towards family, self-neglect, also about patient and family disengagement with services and patient's non-compliance with medication. It is unclear when he was discharged.

58. In late November, Rishi informed the GP that he had called the LAS the previous evening when Priyan was agitated but he had refused to be examined. Rishi said that Priyan had stopped taking medication and his eating had improved and he asked for a check on his physical health. He was also concerned he had not been seen by EIS for three weeks. The GP advised that when Priyan experienced side effects from his medication, he would then stop it, resulting in deterioration of his mental health. When there was professional intervention, Priyan would then restart his medication to prevent him from being sectioned.

59. Later that day, Priyan attended the practice alone. The consultation was difficult, in that he would not disclose why he was there and declined a physical examination. He was calm and well-presented with no signs of aggression or suicide ideation. He asked for information "pertaining to prejudice and moral information". He also asked for information about domestic violence organisations but, when given this claimed he had not requested it. The GP then contacted Rishi who informed him that Priyan's diet was slightly improved

but that his behaviour is variable on a daily basis. He could be physically aggressive and they had a low threshold for calling for help. Rishi felt that Priyan had been improving so may not believe he needed his medication. The GP outlined the roles of the medication and MDT approach to manage Priyan's symptoms.

60. In late December, Rishi called police to his son "causing problems". Priyan had been sectioned in October, but discharged to live back at the home. He was now pouring water onto the floor, and spitting. Sanika and Rishi informed officers that they were unaware of when he was taking medication, but a community nurse had been attending to assist in his treatment. Officers spoke to Priyan who seemed confused but not aggressive, and concluded that no offences had taken place. It was left that Sanika and Rishi would contact the community nurse for assistance. The officers completed appropriate records that were reviewed within the CSU, risk assessed as "standard" and closed with no further action.

2013

61. In January, Priyan was admitted to hospital after threats made against his father and possible use of a weapon and detained under s3 MHA. He required treatment on the Psychiatric Intensive Care Unit (PICU). During this admission his father's application for discharge was blocked with a barring order. In mid-January, staff at Mary Seacole ward reported Priyan missing, having not returned from lunch. It was noticed that there had been no contact with the parents and a telephone call established that Priyan returned home. Officers attended, detained him under s136 MHA and conveyed him back to the ward. He attempted to escape near the ward but was prevented and successfully handed into medical care.

62. Priyan was then started on depot antipsychotic medication, zuclopenthixol decanoate with the dose increased up to 600mg two-weekly. In March, Priyan was seen by the GP sixteen days after being discharged and was having injections very two weeks. Priyan was complaining of inability to sleep and headaches. Rishi was present during the consultation and requested that the GP take over his medication monitoring, however, was advised that this should be managed by the psychiatrist. A request was made to the psychiatrist to forward information in relation to what they would like the GP to monitor and who to refer to.

63. He was eventually discharged in May, subject to the CPA and on a s17 MHA Community Treatment Order (CTO). Care was transferred to the ERTW.

64. Priyan was then seen at regular intervals by a consultant psychiatrist in ERTW. Subsequent reviews noted some negative symptoms and persistent voices. The CTO was not renewed in October as he was adherent to the treatment plan. Through 2014 the dose of medication was gradually reduced at the request of Priyan. He attended a review with the GP in September and reported to feel well with the reduction of his medication, however constipation was still an issue. By January 2015 it was felt appropriate to downgrade his care to standard (non-CPA); by this time, he was on zuclopenthixol decanoate 200mg two-weekly.

2015

65. In April, Priyan was described as well but he stated he would only continue the injection for one year more. The consultant negotiated a continuation of this as she clearly felt it was in his best interests. The dose was further decreased due to complaints of sexual side effects. Reviews noted some negative symptoms but little else and there had been no serious incidents. Priyan was considering a return to college

2016

66. In January, Priyan requested a switch back to oral medication and after consideration of options, started olanzapine 5mg. He attended a GP review with his parents and declined psychometric testing that had previous been suggested. At the second review he attended with his father and stated that he did not want to commence another medication as he had read it may cause diabetes. He also did not want to continue with the injection as he was still having problems with constipation. The long acting injection was stopped and he was commenced on an alternative medication. He later changed his mind and asked to revert to the depot injection.

67. By May there were early signs of a decline in his mental health and in July the police were called to the home after he became distressed and locked himself in the conservatory. Also in May, Priyan attended a GP review with his parents, appearing dishevelled and having lost weight. Despite his father stating he seemed much better, his mother reported that he was occasionally verbally abusive. It was reported in the previous four months he had only taken his medication when he felt it was necessary.

68. In late May, Rishi called police because Priyan was being verbally abusive to his parents. He was allowed to take his medication when he wished but, when he omitted to do so, he became erratic and abusive. They asked officers to speak to Priyan regarding this abuse of his parents which was completed. Officers noted that the parents were Priyan's primary carers, and completed a MERLIN for sharing with partners. The report was assessed by the Ealing Public Protection Desk (PPD) as 'Green'[8], research was conducted and the report passed to Adult Social Care (ASC) with the comment: *Subject may benefit from an mental health assessment, review of his medication, and possibly placing subject in supported housing where he may get necessary help and support*.

69. In early July, Priyan called police saying he had injured himself banging his head against the wall. He added he had not taken his medication and images from the TV were upsetting him. The call handler transferred the matter to be dealt with by the London Ambulance Service (LAS) as there was no allegation of crime.

[8] From a choice of Blue, Green, Amber, Red

70. A few days later, a neighbour called police to a male acting suspiciously outside the Bathak family home. On arrival the officers established that this had been Priyan who was observed wiping his hands on the front door. He explained he had been painting inside but the paint had gone through the paper and showed them the inside of the house He added that he was attending the Limes centre for his mental health issues and been diagnosed with schizophrenia. He complained he was bothered by mosquitos, however, the officers noted no insects present in the house. They completed a MERLIN report which was assessed by the Ealing PPD as 'Green', completed research and passed it to ASC with the comment that: *the subject would benefit from regular contact from the home treatment team, also that he does not appear to have medication for his mental health*.

71. About ten days after that, Rishi called police as he was struggling to calm Priyan down after a mental health episode where he was shouting as he had seen something that had disturbed him on the television. On their arrival, Rishi told officers that he believed Priyan was autistic but this was undiagnosed. In addition he had not taken his schizophrenia medication, clozapine. Priyan calmed down when speaking to the officers, took his medication, and they left informing his father that they would complete a MERLIN for the attention of partners. The report was assessed by the Multi Agency Safeguarding Hub (MASH) supervisor as 'Green' and passed to adult social care noting: *There have been similar calls to the subject's home address recently and it would appear that the family require professional assistance*.

72. When Priyan was seen by clinicians in August. he had clear psychotic symptoms and was referred to the CRHTT for care coordination under the CPA.

73. Priyan called police near the end of August to allege an assault by his brother. On arrival, Priyan was incoherent and was talking about other random subjects. They managed to ascertain from his parents that the family had been in a restaurant in Leicester, and his brother had escorted him out because Priyan was talking very loudly about inappropriate subjects, which upset other families. Priyan's father had called the local mental health team who had attended prior to the police. The MERLIN report was passed to ASC for help/support consideration.

74. In early November, the LAS asked for police assistance to the home where they were about to attend where Priyan apparently was trashing the house during a mental health episode. The parents had locked themselves in the bathroom. On arrival police spoke to Priyan who was confused and had a mark on his forehead where he had banged it on a wall. When the paramedics arrived they requested that he go with them for a mental health assessment which he agreed to.

75. Police and LAS staff left him in the care of security staff in Accident and Emergency (A&E). Police then received a follow up call from A&E staff saying that Priyan had left before being assessed. He was found at a nearby bus stop wearing no trousers and being in public place, was detained under s136 MHA. He was transferred to the Lakeside Mental Health Unit (MHU) at West Middlesex hospital where they waited for a further hour for

arrangements to be made for assessment. A MERLIN was subsequently recorded, assessed by the MASH and graded as Level 4 'Red' (highest) and passed to ASC.

76. Rishi reported Priyan missing from home leave in late November. He had gone out at 22:00 the evening before and not returned home. Officers found Priyan outside Hounslow underground station. He was very confused and wanted to go back to the Lakeside unit, which the officers facilitated. Later that day Priyan's father called police to state he was back at Lakeside MH ward safe and well. Officers recorded their actions correctly on a MERLIN report.

77. The next day, Priyan accused another patient of the Lakeside MH unit of forced oral rape. Police attended the unit, and found it impossible to secure a coherent account from Priyan. They did manage to ascertain between him and staff members that the suspect was a male patient of similar age. Priyan's initial account swayed between performing the act consensually (describing it as *"passionate"*) and being forced to do it. The OiC decided in the initial review that a CRIS report for rape should be created for investigation as on the 'balance of probabilities' an offence may have occurred. The OiC also decided to instruct officers not to arrest the suspect at that time, although a rationale for this decision is not recorded.

78. Priyan provided forensic swabs as well as the clothing he was wearing at the time. He made it clear that he did not want to support a prosecution. The suspect was isolated in another ward after starting a fire. Priyan was provided with specialist Sexual Offences Investigation Techniques (SOIT) officer for support through the investigation. The OiC directed full intelligence checks which were carried out and informed background to both Parties. Information was received from staff that the suspect alleged that Priyan and he had been watching porn before the incident was reported.

79. Enquiries with staff revealed that Priyan had been *"chaotic and confrontational"* that day, saying: *"I am God why do you not listen to me"*. The investigation explored corroborative evidence, however, there was no CCTV or witnesses identified through extensive efforts. The SOIT officer attempted to engage with Priyan but noted: *"He didn't want to provide me with a statement because he didn't want to get the other party in trouble"*.

80. The OiC kept the investigation open for 10 months, concentrating on witness statements from medical staff and being guided by their professional opinion. However it was decided after consultation with the mental health team that Priyan was not well enough for a Visual Recorded Interview (VRI), and the suspect was deemed unfit for interview or detention. The matter was reviewed by supervisors and subsequently closed, with a full letter of explanation for the decision provided to Priyan.

81. The IMR author has commented that the issue of 'informed consent' is key and the OiC decision to create a CRIS and pursue all possible enquiries was correct. The suspect was not well enough to be detained or interviewed at any stage and Priyan was clear he did not want to support a prosecution. There was insufficient evidence to justify a file to the Crown

Prosecution Service (CPS) for consideration. The Standard Operating Procedures (SOP) for rape investigations have been comprehensively updated within the MPS Public Protection Improvement Plan 2018 and the IMR makes no recommendation regarding this incident. Some Panel members noted that there was no onward referral to adult safeguarding. The reason that this did not happen was that Priyan was in the residential care of mental health services.

82. Priyan was restarted on oral olanzapine and then injections of zuclopenthixol decanoate. After 4 weeks he was discharged to be followed up by the Ealing Crisis Assessment and Treatment Team (ECATT).

83. In late December, Priyan called police to say he had cut his wrists. On arrival this was not the case, he was clearly in need of help, and was taken by ambulance to A&E for an assessment. Officers completed a MERLIN report, and within the text the officer questioned the suitability of his placement with his parents.

2017

84. Early in January, Priyan called police to state he was suffering with his mental health and headaches. This was passed to the LAS. Rishi then cancelled the request, saying Priyan had retired to bed.

85. Clinical notes for January 2017 showed some improvement but Priyan remained symptomatic with pressured speech and grandiose thoughts. A referral to the treatment resistant psychosis service (Mott House) was considered. ECATT noted continued aggression and potential risk to parents.

86. Early in February, Priyan called police to state he had cut his wrists. On arrival this was not the case. Rishi said that he was happy to take Priyan to the hospital, as this was all he wanted, and why he had called police. The attending officers completed a MERLIN report which was sent to ASC.

87. By March, Priyan appeared more settled to clinicians and plans were made to transfer care back to ERTW.

88. In mid-April, Priyan called police saying he had run away from home as he wanted to return to the MH hospital, and that he had tried to kill himself earlier. He was traced by officers back at home, noted as having no injuries, and refused the assistance of the LAS. Priyan said he had concerns for whom would care for him once his parents had passed away. His parents said that they would take him to the hospital for an assessment. Later that day Rishi called police to report Priyan had left the house once more and they were concerned for him. Priyan was found in the back of an ambulance by Hounslow East London Transport station. He said he just wanted to return to Lakeside MH unit, which the LAS crew agreed they could assist with. Two separate MERLINs which were assessed and shared with partners. The second MERLIN noted that on the day of his two-weekly injection (that day), his behaviour was often erratic.

89. At some point in early May, Priyan attended Ealing Hospital Emergency Department (ED) following an attempt to set fire to himself with a lighter apparently in response to voices. He was discharged home with ECATT follow-up; the zuclopenthixol decanoate was increased to 600mg two-weekly.

90. Priyan next called police a few days later saying he wanted to kill himself and was being harassed by voices in his head. On arrival Priyan explained that ex-school friends had the power of X-men and were targeting his brain. He had tried to burn his own leg with a lighter, but just succeeded in damaging his trousers. The LAS arrived and Priyan wanted to go to Ealing Hospital for a MH assessment with them, which they did. The reporting officer's MERLIN was assessed at 'Amber' and passed by the MASH to ASC. It concludes:

    My opinion is that subject's health is only going to continue deteriorating and his parents are both struggling with his needs. At this time subject believes he is being harassed and the voices are telling him to kill himself. Subject is capable of harming himself. My obvious concern is that left alone its plausible subject may use the same or other methods to harm himself which could also lead to inadvertently harm others (parents).

91. In mid-May, Priyan called police claiming that Japanese people had broken into his house and had taken property. On police arrival, this was discovered not to be the case as his parents had been in all day with him**.** Officers completed a MERLIN report assessed at 'Green' and sent to ASC.

92. About a week after that, Priyan attended the police station with his father to report that his ex-school friends were harassing him using some form of X-men like power. Rishi offered to take him to hospital for an assessment. The station officer completed a MERLIN report assessed at 'Green' and sent it to ASC.

93. The next day, Priyan attended the Ealing ED. He described hearing voices telling him to kill himself and a sensation of being poked in the stomach. On the day before he had jumped off a bridge into water below hoping to kill himself. He was admitted, initially informally, but later detained under s3 MHA. After admission Priyan was treated with zuclopenthixol decanoate and then oral risperidone. Progress was slow with continued psychotic symptoms and an episode of self-harm while on leave.

94. In mid-June, Priyan called police and alleged he was being harassed by three males from school and he had been raped by one of them. On arrival he described that the harassment was psychic not physical. Rishi set out Priyan's MH history, saying he was under the care of Charing Cross Hospital and had been treated for his condition since 2009.

95. A few days later, the London Fire and Rescue Service called police to the family home where they had extinguished a fire. Officers attended and then visited New Ealing Hospital (NEH) where Priyan was being treated for smoke inhalation.

96. Due to some water damage at the home pending repair to make it habitable, the family had been living with Nitesh. On this day, Priyan had been dropped home for the day as he did not wish to attend a family wedding. Priyan's account was that the fire started when he did some ironing. This did not fit the fire investigation evidence that identified two seats of fire. It also transpired that Priyan had presented at Charing Cross hospital the day before when experiencing a MH Crisis but he was not admitted. The Psychiatric Liaison Officer at the hospital opined that Priyan should not be left alone as he did not have the capacity to carry out everyday tasks. The family did not want to support any form of prosecution, and no further action was taken.

97. The OiC for the fire investigation has been interviewed and he felt that it was a clear safeguarding issue rather than one for a criminal justice outcome. He clearly records how supportive Rishi was of how the police were treating his son. The OiC concluded that Priyan's MH issues required the intervention of NHS professionals, and that the options available within the criminal justice system did not suit those complex needs. He took into account the relatively minor damage caused, Rishi's wishes, Priyan's MH illness and that he was receiving treatment, and decided that it was not in the public interest to proceed with further investigation. A referral to forensic psychiatric services and/or disposal under ss37/41 MHA, would be a matter for NHS professionals to assess and they did not come to the conclusion that it was appropriate.

98. Near the end of June, Hammersmith and Fulham MH Unit reported Priyan missing. The initial call handler designated this a 'High Risk' Missing Person, and police attended the unit to investigate. However this assessment was downgraded by the local duty inspector as a voluntary patient 'absent' from a hospital. Apart from an address check, no further enquiries were made. The IMR author identified that this decision was at odds with the intelligence available, not least the arson incident only five days before. The inspector concerned has since retired and is not available for interview.

99. The 'Absent' category had been available since 2014 and downgrading from 'high risk' was within the authority of the rank held. One consequence of the decision was that no MERLIN report was filed and relevant partners were not aware Priyan was missing, moreover, no effort was made to locate and safeguard him. The 'Absent' category was removed in 2020 and a MERLIN referral is now required in all missing person cases, therefore, no recommendation has been made.

100. In late September, Priyan attended the police station with his parents. He declared that he was hearing voices telling him they wanted to kill him. They informed the officer of Priyan's MH history and the fact that he would be seeing his psychiatrist the next in order to adjust his medication. They added that they had brought him to the station at his request which had calmed him down. They left the station together. A MERLIN was completed and shared as an open case.

101. Later in September, while still an in-patient, Priyan went on a period of extended leave to India with his family. On return medication was switched to oral olanzapine 20mg and after periods of extended leave he was discharged from in-patient services in mid-November.

102. In late November, Rishi attended the police station to report Priyan missing. He had left home at 04:30 stating that he was leaving to live on the streets. Officers found Priyan on Hounslow High Street at 08:30 with Rishi who had just come across him. He was cold so was provided with a blanket; he did not appear unwell or a danger to himself, and was left in the care of his father who stated he would take him to hospital the next day regarding medication. A MERLIN was completed for the missing person, and a separate one for sharing with Social care as open case, risk assessed as 'medium'.

2018

103. When seen by ERTW in March, Priyan was noted to be constantly murmuring to himself with very little spontaneous speech. It was felt he still experienced voices but these appeared less prominent. Medication was gradually reduced to 12.5mg nocte. Between March and May 2019 there were two further face to face contacts and three missed appointments with the care co-ordinator. He did not attend his clinic appointment in July.

104. Rishi attended the police station in late September to report Priyan missing from the home at 13:30. By 15:00 this was cancelled because he had returned after a *"longer than usual walk"*. The officer assigned the missing person investigation has no recollection but his note shows that he spoke to a family member who stated that Priyan had just been out for an elongated walk and was safe and well, however, was unable to engage in a telephone debrief as he was incoherent and not making much sense. He assumed a MERLIN report would be completed by the missing persons unit but this did not happen because the initial investigation was not brought to their notice.

105. EWRT had no contact with Priyan between early November and the medical review following the incident below when Priyan attended the Emergency Department.

2019

106. In early May[9], officers were called to Priyan smashing up the house, with his parents locked in the bathroom fearing for their safety. On arrival they noted lots of smashed glass on the floor, some drops of blood, and smashed cups and saucers. His parents stated he had a similar episode the previous day and his medication needed altering once more. They gave the officers a full history of his MH issues, and medication taken. LAS paramedics arrived and Priyan was accompanied to Ealing hospital for a MH assessment. A MERLIN was completed, risk assessed as 'Green' and shared as an open case.

[9] Last police contact with family prior to homicide

107. The officer has reviewed notes of the incident. Had Priyan behaved in that way in a public place, she would have exercised her powers under s136 MHA and detained him. The accompanied transfer to hospital was a pragmatic way to achieve the goal of a place of safety for him. It was not appropriate to complete a CRIS report because she doubted that Priyan had the capacity to form intent and his parents did not wish to support an investigation.

108. During May, Priyan presented to Ealing ED twice in two weeks with prominent psychotic symptoms which led him to throw cups and glasses at home. ECATT input was unable to contain the episode and for the latter part of May, Priyan was admitted to the Hammersmith and Fulham MHU, initially under s2 MHA, later s3 MHA. Priyan was initially treated with oral aripiprazole but there was little response at the maximum dose. After further discussions with his family, who were initially reluctant, Priyan was commenced on clozapine from 15 July. There were some problems with his compliance with blood sampling and a slow dose titration was performed in view of previous side effects. By mid-October, on a clozapine dose of 350mg/day Priyan displayed more spontaneity and was able to focus better appearing less distracted by psychotic experiences. Tachycardia was treated effectively with bisoprolol.

109. During October, Priyan was an in-patient on Avonmore Ward WLNT, detained under s3 MHA. He attended the clozapine clinic then join the walking group. OT (Occupational Therapy) staff reported that Priyan was responding to unseen stimuli. At a visit by his mother two days later, he was restless and was pacing up and down. He was not engaging well with staff. The next day, he was assessed by a doctor regarding his capacity to consent to treatment and he was deemed able to consent to treatment.

110. During a ward round attended by Rishi, in-patient rehabilitation was discussed as an option for Priyan. Risk to self, risk to others and from others were deemed low. Feedback from the ward staff was that Priyan was engaging well in the creative writing group and walking group, although he continued to respond to unseen stimuli. Ward staff said that they did not have contact with Care Coordinator (CC), and Rishi said that he had also lost contact with Priyan's CC. Later in the month and into November, Priyan was granted short periods of home leave with his family under s17 MHA.

111. At the November Ward Round Priyan's CC was present. Rishi reported that the s17 leave home had been going well. Priyan's clozapine remained at 400mg a day. He said that he was enjoying activities on the ward such as art and creative writing. The discharge plan was to go home soon and the ward was aiming for him to be discharged before the end of the month. Priyan then reported chest pains and his heart rate was high (a side effect of clozapine) but an ECG was normal. Rishi felt the clozapine dose was too high and the plan was to reduce the dosage.

112. At the ward round in December, staff expressed suspicion that Priyan might be concealing his medication. His Clozapine was changed to the oral dispersal version. His blood results showed he had high liver function levels. Everyone in the ward round acknowledged that Priyan's mental state was deteriorating. Rishi said he was very concerned about the

tachycardia and wanted Priyan taken off clozapine while Priyan wanted to remain on the drug. The consultant decided to keep him on clozapine. Subsequent ward rounds noted that Priyan's mental state was deteriorating. He appeared more agitated and was talking with an aggressive tone, responding to hallucinations and making hand gestures.

113. By mid-December at the discharge ward round, Priyan had improved further on a clozapine dose of 400mg/day. He demonstrated better rapport and spontaneity. His mood was described as euthymic and congruent. He was still responding to auditory and visual hallucinations but able to distract himself and focus. He had an improved understanding of his illness and the need for medication. The risk of harm to self or others appeared low. After periods of extended leave, he was discharged home to be followed up by ERTW, subject to the CPA.

114. Priyan was followed up by the clozapine clinic, initially in Hammersmith and Fulham and then in Ealing. He attended all two-weekly appointments between December 2019 and July 2020, when the appointments became four-weekly. Routine clozapine monitoring tests were all satisfactory. The GP would be asked to stop one of Priyan's repeat prescription items from January.

2020

115. Priyan and Rishi met with the care coordinator early in January. They discussed activities in the community through Community Activities Project Ealing (CAPE) and the Solace Centre. The Care Coordinator also provided a brochure for the Recovery College. Rishi mentioned that Priyan liked art and wanted to know more about group offers. In February, Priyan applied to have the medication that was stopped in December to be re-instated. An appointment was made for review by the clinical pharmacist but Priyan did not attend.

116. In April, early in the Covid-19 pandemic, Priyan was "regraded to the Red team" which reflects the top priority within a Red/Amber/Green assessment of risk by ERTW. Nonetheless, the management team at that time felt that he did not need care coordination as he was being seen by the clozapine clinic who would review him. Priyan was also to have a 3 to 6 monthly review with the psychiatrist. This assumption was wrong. The clozapine clinic only monitor for side effects by monitoring blood and not the overall wellbeing of the patient.

117. However, this was not the reason for no follow up with care coordination. The problem for the team during the pandemic was that most community resources closed due to COVID. It resulted in scarce services being available for people in the community. In Priyan's case, the impact was that care-coordination was not provided[10].

[10] Since the pandemic, WLNT have introduced a new role within OT of 'Link Worker' with the specific role to meet the service user and find activities in the community, then support them to engage with identified services

118. In early June, Priyan had a scheduled telephone review with his consultant psychiatrist, who also spoke to his father who reported that Priyan was suffering from hearing voices. It was noted that Priyan disagreed with a diagnosis of schizophrenia and considered his main difficulties to be anxiety and depression. He denied experiencing psychotic symptoms in the past. Despite this he agreed to continue with antipsychotic medication (clozapine). The outpatient doctor did not elicit any overt psychotic symptoms nor any thoughts of harm to self or to others.

119. Details of this review were passed on to the GP Practice in July and an ECG was completed. The Practice Nurse undertook a telephone review for Priyan's mental health and Rishi questioned why it was not being carried out by the GP. A face-to-face appointment instead was made for two days later, but neither Priyan nor Rishi attended.

120. Between early June and early November there were eight further routine contacts where Priyan attended with the clozapine clinic. His blood results were all 'green', meaning the clozapine level had been checked and was at a therapeutic level, indicating Priyan had been compliant with his clozapine treatment. There were no further contacts with ERTW until the team were alerted to the report of the homicide.

121. Rishi informed the Chair that, prior to 2016, a psychiatrist would see Priyan face-to-face on a monthly basis. This was changed to three-monthly reviews, then six-monthly. He accepts that the Covid pandemic was a significant limiting factor for clinicians to make personal assessments, but he feels that Priyan was almost 'abandoned' by his support system. The care coordinator made no effort to speak to him from January 2020 and the single psychiatrist telephone call with Rishi and Priyan in June did not properly take account of the hearing of voices. Too much reliance was placed on the blood screening results. ERTW should have a more effective system for prioritising its services, otherwise being 'regraded to the Red team' is meaningless.

The day of the homicide

122. One morning in late November, Priyan had been in and out of the house, popping to the shops to get a magazine and buying and buying biscuits to take to his paternal grandmother because he did not understand the lockdown rules or 'bubbles'. Using his micro-climate analogy, Rishi assessed that Priyan was in 'fair and calm' mode that morning.

123. CCTV the police have obtained from neighbouring houses shows Priyan last returned to the house just after 13:45. Rishi thought his son was not back from visiting his grandmother and went upstairs for a nap at about 14:00. He left Sanika on the sofa in the front living room of the house. Neighbours heard noises, including a woman's screaming "No" and then go silent, followed by a swooshing sound likened to the sound of a whip followed by a thump. CCTV showed Priyan leaving the house at about 15:00.

124. Rishi woke from his nap and then scrolled through his phone for about 30 minutes before going downstairs. When he reached the living room and looked through the doors, he

found his wife, lying in a pool of blood on the floor with horrific injuries to her head and face. He called the emergency services just before 17:00. Police attended, and found the victim unresponsive, with very significant injuries to her face. Despite efforts to resuscitate Sanika by police and paramedics, it quickly became apparent they would be futile and her life was pronounced extinct at 17:22.

125. Priyan was arrested the next day in a nearby retail park. In interview, said that he had a cricket bat in his hands in the garden when he heard voices taunting him. He went into the lounge and hit his Mother several times with the bat. He panicked and left the scene. Forensic evidence provided clear links from him to the homicide scene. A Forensic Pathologist examined Sanika and found multiple lacerations to the scalp and facial soft tissues with severe underlying bony injuries to all the facial bones. He concluded Sanika had died from traumatic head and facial injury. The CPS subsequently authorised the charge of murder.

Psychiatric assessment to inform the Court

126. In April 2021, Priyan was assessed by Doctors instructed on behalf of both the prosecution and the defence. They have had access to all his medical records and both have had the opportunity to interview and assess him. Priyan was assessed to suffer from treatment-resistant paranoid schizophrenia which manifests as persecutory delusions and auditory hallucinations. His medical records show that he becomes distressed, angry and agitated by his symptoms.

127. Priyan's illness was both very disabling and treatment resistant and had not been symptom free for at least 10 years. He suffered from persecutory delusions that he was being followed, experienced auditory hallucinations, was chaotic, paced the ward having angry sounding conversations with himself and making aggressive gestures. He had been prescribed the gold-standard medication for treatment resistant psychotic illness.

128. Assessed again in July, Priyan remained in the acute stage of psychosis, and was severely distracted and thought disordered. He continued to experience very frequent auditory and visual hallucinations and has very limited insight into his symptomology. It was also concluded that his illness has failed to respond to different antipsychotic medications meaning he continues to suffer from a range of psychotic symptoms. He was ordered to be detained under the provisions of the MHA.

ANALYSIS

129. The WLNT MHIR Panel set out their findings and analysis as 'Care Delivery Problems' and 'Service Delivery Problems' with contributory factors:
Care Delivery Problem 1: There was a cumulative underestimation of the level of risk presented by Priyan and a lack of a cohesive formulation of the risk in the clinical record.
Patient factors

Priyan was chronically symptomatic with positive psychotic symptoms which increased the level of risk. There was only a partial response to medication including clozapine. There was a history of assaultive and abusive behaviour to family and others.

Task factors

The risk assessment failed to capture a longitudinal view of risk and did not contain a clear formulation of the risk presented. When the Clinical Risk Policy and documentation changed in September 2019 some historical information remained in the "old" risk assessment and was not carried forward into the new document. The relationship of the fire at home in May/June 2017 to Priyan's illness did not appear to have been investigated thoroughly; this and the cumulative less serious risk events could have prompted a referral to MARAC or for a forensic assessment.

Individual staff factor The care co-ordinator had no face to face contacts with Priyan and his family after November 2018 and there were no home visits after the discharge in December 2019. It was felt that this did not facilitate an understanding of the patient's mental state and any additional risk related information.

Team, and organisational and management factors

With the change in organisation of the service during the COVID pandemic there was a loss of continuity of care and reliance on the clozapine clinic rather than the care coordinator for contacts. This reduced the likelihood of detecting any escalation in the level of risk presented.

130. *Care Delivery Problem 2: There was limited involvement of the community team in planning discharge from hospital in December 2019. The inpatient care plan was not updated to make it relevant to community care.*

Task factors

Priyan's care plan had not been updated following his discharge from the ward in December 2019. The current care plan was not adapted to reflect his care in the community. The 'crisis, relapse and contingency plan' was also out of date, as it was last updated in December 2017. Rio records should be updated as required to reflect changes to the care plan with Priyan's full involvement.

Individual staff factor

The Care Coordinator did not attend the discharge CPA meeting on the ward and therefore did not contribute to the planning of a collaborative care plan for Priyan in the community. Priyan's wishes to continue with art therapy in the community were not followed up.

Organisational and management factors

The care plan policy that requires a three day follow up from the Care Coordinator (or in their absence another team member) was breached. No attempt was made to contact Priyan for three weeks following his discharge. The organisation should have a system in place that informs management if this breach is about to happen.

131. *Service Delivery Problem 1: There was a high level of variability in understanding the change of care system in March 2020, which took place in the context of the Covid-19 pandemic. The change from care co-ordination and Care Programme Approach led to a loss of continuity of care, decreased frequency of contacts and over reliance on the clozapine clinic.*

Team Factors

When changes were made to the way in which care was delivered at the start of the COVID pandemic, the changes were not communicated clearly to staff and relatives. This led to a degree of confusion about the changes that were adopted.

Organisational and management factors

At the start of the COVID pandemic, changes were made to the way in which care was provided to many patients. The aim was to reduce the frequency of face to face or remote contact with a designated staff member.

Urgent changes which took place in respect of the need to re-organise care due to COVID, effectively stopped the CPA approach being followed.

The clozapine clinic was not aware of its extended role in monitoring patients due to changes brought about by the COVID Pandemic. No routine changes were made to the monitoring offered as the communication had not included the clozapine clinic.

132. *Service Delivery Problem 2: There was a failure to respond to the level of risk presented by involving MARAC or consideration making a referral to forensic services.*

Patient factors

The family reported some incidents, in particular during the first few years of contact with services but appear to have habituated to less serious events. This meant that there were fewer alerts over time, leading to a false impression of decreased or static risk.

Task factors

As noted in Care Delivery Problem 1 above, the risk assessment failed to capture a longitudinal view of risk and did not contain a clear formulation of the risk presented. In particular, the relationship of the fire at home in May/June 2017 to Priyan's illness did not appear to have been investigated thoroughly; this and the cumulative less serious risk events could have prompted a referral to MARAC or for a forensic assessment**.**

Organisational and management factors

The impression was formed that there is a systemic underuse of MARAC by adult mental health services. There is some reluctance to refer to local forensic services due to a perceived high threshold for their involvement.

133. The MHIR Panel concluded that the Root Cause of incident was that the patient was experiencing psychotic symptoms which led him to attack his mother. The DHR Panel have had full access to the MHIR report and, following discussion, concur with the findings and analysis therein, which are adopted to fulfill the purpose of the DHR.

CONCLUSIONS AND LESSONS LEARNED AND GOOD PRACTICE

134. The MPS IMR author concluded that the Bathak family regularly sought support and assistance from the police in times of crisis, and indeed when they sought support with Priyan's behaviour. It is the view of the IMR author that this Service was sensitive, appropriate, and focussed on the wishes on Sanika, Rishi, and Priyan. In addition, information was appropriately passed to the partnership, often with additional comments from the reviewing unit to highlight the issues this family faced.

135. Post introduction of the MERLIN vulnerable adult coming to notice function in 2013, officers completed reports in all but one interaction with Priyan. There is a clear commitment from the officers and the reviewing units, firstly in the Ealing PPD, and latterly the MASH, to highlight concerns not only of that moment but combined with intelligence from the past.

136. Officers treated Priyan as someone needing intervention from partners rather than the tradition criminal justice route, and in doing so they were supporting the wishes of his increasingly desperate parents.

137. Recent structural changes in the MPS with the formation of Borough Command Unit (BCU) public protection hubs, as well as improvements in policy surrounding rape investigation have negated the need for any police recommendations for this review.

138. The GP IMR author has highlighted that Priyan had been suffering from mental health problems since the age of 17 and how extraordinarily difficult it must have been for the family to manage, especially as there was tension within the family unit between the parents and their sons. Whilst Priyan was in receipt of mental health services, he regularly disengaged and stopped his medication due to reasons pertaining to either feeling better, or the medication impacting on his physical health. Priyan was given support by the community health professionals and his care coordinator.

139. What is unclear from that review is what support was given to his parents during this very difficult and challenging period. Alongside her son's mental health problems, Sanika was also struggling with stress related problems; citing stress at work and family bereavement and a fire in the family home, which resulted them being temporarily rehoused in December 2018.

140. The main lesson learned is that correspondence from mental health to the GPs should have been submitted in a timely manner. There were occasions identified in the chronology when the GP was not aware of the care and treatment received by Priyan from secondary care, until the patient or his representative would inform them.

141. In addition, agencies should implement the 'Think Whole Family' Approach when working with individuals, taking into account how this is impacting on immediate family members and offer support, where possible. There should also be a challenge to the 'professional optimism' (or 'wishful thinking') displayed when discharging Priyan from secondary care after being assured by him and his father that he would comply, despite clear historical evidence to contradict this opinion.

142. In terms of good practice, the GP was supportive to both Priyan and Sanika. When required, referrals were made to secondary care to further help the individuals with their mental health and physical needs. There is evidence contained within the chronology records that the practice were proactive in working with secondary care to manage Priyan's mental health and physical needs.

143. The MHIR Panel concluded that:

- Priyan has a diagnosis of paranoid schizophrenia which has been resistant to treatment and he has remained symptomatic despite treatment with clozapine. There is a history of behavioural disturbance and assaultive behaviour associated with psychotic symptoms. This was not captured in a clear formulation of risk and did not lead to referral to MARAC or a forensic referral.
- Following discharge from hospital in December 2019 Priyan was subject to CPA but there was relatively little contact with services. Following service changes made in the contact of the COVID pandemic he remained in contact with the clozapine clinic but there were no contacts with ERTW apart from a single outpatient appointment before the index event in November 2020.
- The panel have highlighted two care delivery problems and two service delivery problems.

144. The MHIR Panel also reviewed their ToR for this section for the lessons learned:

1. *To establish the sequence of events as far as the Trust was involved, leading up to the alleged homicide incident in November 2020*
   Fully included in the Brief Facts section above.

2. *To review the patients' mental and physical health care plans/risk assessments and risk management plan to establish whether they met the patient's overall needs*
   <u>Mental and Physical Healthcare Plan – C2 Care Programme Approach and Care Planning Policy</u>
   - There was no representation by the Recovery Team at the Discharge CPA meeting from the ward in December 2019. The three day follow up was breached by the Care Coordinator and the first contact with the patient after discharge was made in January 2020. The meeting with the care coordinator, patient and father in January was in line with the C2 policy. The meeting did involve the father and patient in discussions around care planning and risk assessment but unfortunately the plan was not reflected in the care plan document. The community care plan was last updated in December 2017. There was no carers care plan or recovery care plan. At the discharge CPA in December 2019 the patient identified art therapy as beneficial and the patient wanted to continue with art therapy in the community but this was not followed through.
   - In addition to the care plan being out of date the 'crisis, relapse and contingency plan' was also out of date, last updated in December 2017. Records should be updated as required to reflect changes to the care plan with the patient's full involvement. The role of the care coordinator includes working collaboratively with individuals and their carers to produce a care plan, together with carrying out a comprehensive needs assessment, covering both health and social care needs. The patient did not receive good quality care planning or coordination in the community.

- By March 2020 the patient appeared to have come off CPA and care coordination although this was not clearly explained to the patient and his family. Supporting someone within CPA is a clinical judgement and when an individual is taken off CPA this should be done with care and diligence. Prior to the Covid pandemic a patient with complex needs should remain on CPA and if they have had an admission into hospital under the MHA in the last 6 months, the patient should not be removed from CPA.
- When a patient is taken off CPA to non CPA care they should be reviewed regularly by a lead professional. The lead professional must consider if support within CPA is more appropriate. The patient's cluster was 13 indicating he had an ongoing or recurrent psychosis with high symptoms and disability. The patient's care would have been best placed under CPA. The lead professional did review the patient in June 2020, in accordance with C2 the lead professional did reference a care plan in his progress notes. The lead professional planned for a named worker to sign post the patient to recovery orientated activities and groups in the community to address further recovery, but this did not happen

<u>Risk assessment / management</u>

- At an early stage of Priyan's contact with services, the risk of violence, in particular to his mother was noted. While there was some police involvement, the family chose not to press charges. There were a number of episodes indicating an enhanced level of risk, notably a minor assault on another student in 2011, threats against his father, an assault on his mother in January 2013 and the setting of a fire in May/June 2017. There were a number of reports of other episodes of verbal abuse to which the family appear to have habituated.
- While many of these episodes were described in the progress notes the cumulative risk was not fully captured by the risk assessment and did not lead to a referral to external agencies.
- The risk assessment document completed on the ward in September 2019 contained some historical information which highlighted risks presented by Priyan towards his parents. In October 2019 an updated Trust risk assessment process and documents were introduced (Policy C27). The updated process prompts and facilitates a formulation of risk and is intended to be used to record static risk factors which change slowly over time and separates out the timeline of key risk events. Key information about Priyan was not carried forward or entered into this new documentation, though the "old" risk assessment remained available to view.
- The latest RiO risk assessment document before the index incident was dated mid-December 2019 just before Priyan's discharge from the inpatient service. The risk assessment did not contain a clear formulation of his risk but rather contained a short repetitive listing of recent events on the ward.
- This risk assessment documented that at the time Priyan was on home leave. Entries relating to previous dates did not identify any thoughts of self-harm or suicide. In relation to risk to others an entry noted that Mr A was reported to be "accusing staff and speaking aggressively to staff when he spoke about another patient". There were no subsequent updates to the risk assessment by Recovery Team staff.

- The crisis, relapse and contingency plan was last updated by the ERTW care co-ordinator in mid-December 2017. This had clearly been copied from previous plans dating back to May 2014. In general, it remained relevant to Priyan's needs but referred to seeking medical input from the Early Intervention in Psychosis Service.

3. *To review all care delivery, identify any gaps and consider whether this was consistent with evidence based guidelines and agreed clinical practice*
   - There was a long history of low level aggression to family members and others in the context of Priyan's psychosis. When arson was reported in relation to the family home in 2017 an opportunity for a more detailed risk assessment and management plan by seeking an opinion from the Forensic services was missed.
   - The ongoing risk presented by Priyan, with a high likelihood of relapse with poor compliance with medication was underappreciated by the community team. There were long gaps when there was no contact with the patient leading to an incident report being generated in 2019 about the lack of clinical contact. This is a failure of care delivery.
   - There was a lack of joint working between the ward and the community team. The care coordinator only visited the patient once in the seven months of his last admission.
   - The discharge planning meeting took place without community input. This was a failure of agreed clinical practice and discharge planning.
   - Following discharge in December 2019 there was only one face to face contact with the care coordinator over a three-month period even before the COVID pandemic. This was not consistent with agreed clinical practice and was a failure in care delivery. The CPA policy would indicate that this type of patient should be seen weekly by the care coordinator for six weeks and then monthly. This could have happened before COVID changes.
   - From April 2020 until the incident took place the teams were responding to an unprecedented crisis with the COVID global pandemic. This led to a number of changes in how the team managed their caseload and a new way of risk rating the patients. Priyan was no longer care coordinated. Attempts to communicate the changes clearly to all staff were unsuccessful.

4. *To establish whether there was effective and appropriate communication and liaison between the patients' family and all agencies involved in the patient's care to meet their needs*
   - Between August 2009 and December 2012 Priyan was under the care of the Early Intervention in Psychosis Service (EIP) and there was regular, appropriate contact with his family. Priyan's father in particular took an active interest in his care. He appeared to have some ambivalence about Priyan taking antipsychotic medication and frequently would report back any problems with side effects of medication to which EIS responded. The first trial of clozapine was ended in part because of the family's concern about side effects. From May 2013 Priyan was followed up by Ealing Recovery Team West (ERTW). Priyan's father was generally positive about

contact with services during this period until Priyan became more consistently unwell from 2015 onwards. He felt that more frequent home visits would have provided a more accurate picture of his son's illness. Prior to the last admission in May 2019 there was a period of seven months with no contact between Priyan and his family and ERTW.

- During the last inpatient admission, the family and treating team were in frequent contact. A member of the family, usually Priyan's father, was present at most ward rounds and this facilitated joint working, for example to plan home leave in the period leading up to discharge in December 2019.
- Following discharge in December 2019 the frequency of contacts with community services was relatively low with one face to face contact with the care co-ordinator in January and two phone calls with no reply. As noted above, in April 2020 Priyan was "regraded to the Red team" in ERTW. This meant that care-co-ordination no longer occurred, and follow-up was to be arranged on a team basis. In practice this defaulted to the clozapine clinics in Hammersmith and Fulham and then Ealing. These appointments were also attended by his family and although contacts were brief they allowed an opportunity to raise concerns. Priyan's father was involved in the last medical review by telephone in June 2020.

5. *To review the partnership arrangements in place and liaison between the local health services, local authority, and any other providers involved in the patients' care.*
   No issue identified.

6. *To review all prescribed treatment and consider whether these were consistent with evidence based guidelines and agreed clinical practice*
   - Priyan's medical treatment was in line with NICE guidance and in particular there was evidence throughout that he and his family were involved in decisions about the choice of medications prescribed. When adherence to oral medication was incomplete, long acting injections were prescribed. After trials of two different classes of antipsychotics clozapine was considered. The first trial of clozapine in July 2012 ended early due to development of tachycardia and poor adherence to treatment. The second trial started during the last inpatient admission in 2019. All expected monitoring of clozapine was in place, including an estimation of the plasma level on 9 September 2020 which was 0.42mg/l (target level is usually at least 0.35mg/l).
   - In the guideline 'Psychosis and Schizophrenia in adults: prevention and management' the National Institute of Health & Care Excellence (NICE). NICE recommends patients with schizophrenia are offered a family intervention and individual cognitive behavioural therapy (CBT), delivered as described in the guideline. The panel found no evidence these were offered in the records or in the interviews with staff members and meetings. Family intervention is particularly important when patients are residing with their family members and/or there has been violence within family.

7. *To consider whether abuse and or neglect was a factor in the death/injury, including where procedures may have failed and the case gives rise to serious concerns about the way in which local professionals and/or services worked together to safeguard adults at risk. To include if a MARAC referral was considered*
   The panel did not consider that abuse or neglect were factors in the incident.

8. *To establish whether required policies and procedures were in place and whether they were followed*
   CPA Policy C2
   Dealt with under item 2
   Mental Health Clinical Risk Policy C27
   - The updated Policy C27 was introduced in late September 2019 and ratified on 7 October 2019. Policy C27 states that risk should be reassessed at various time points including when granting leave or discharging from a section, community follow up within three days of discharge from inpatient care and before deciding about moving a service user to or from CPA.
   - The updated process prompts and facilitates a formulation of risk and is intended to be used to record static risk factors which change slowly over time and separates out the timeline of key risk events.
   - The latest RiO risk assessment document before the index incident was dated mid-December 2019 just before Priyan's discharge from the inpatient service. Key historical information was not carried forward or entered into this new documentation, though the "old" risk assessment remained available to view. The risk assessment did not contain a clear formulation of Priyan's risk but rather contained a short repetitive listing of recent events on the ward
   - There were no subsequent updates to the risk assessment by Recovery Team staff. The panel understand that risk was considered in April 2020 when the service changes were made and Priyan was no longer subject to CPA and care coordination, though there was no formal documentation of this.
   - The crisis, relapse and contingency plan was last updated by the ERTW care coordinator in mid-December 2017. This had clearly been copied from previous plans dating back to May 2014. In general, it remained relevant to Priyan's needs but referred to seeking medical input from the Early Intervention Service.

9. *To highlight and learn from any positive practice*
   - S17 leave home was used regularly whilst Priyan was an inpatient. This gave him and his parents the opportunity to see how he was managing at home and in the community. This was noted as good practice as the ward designed a care plan that gradually exposed Priyan back into the community.
   - Despite the additional pressures of the COVID pandemic the clozapine clinic continued to function and became the main provision of clinical support for many recovery team patients. The panel was confident that the level of expertise in the clozapine clinic was such that a deterioration in the mental state of Priyan would

have triggered decisive action and the community team would have been contacted immediately.

10. *To identify the root causes and contributory factors of the incident and provide recommendations for the development of improvement actions to minimise the risk of recurrence and improve the quality and safety of care provided across the West London Trust and external agencies if appropriate*
    Dealt with under Analysis section above

11. *Investigate any other matters arising during the course of the investigation which, in the opinion of the panel, are relevant to the occurrence of the incident or might prevent a recurrence. To include if COVID-19 made a difference in the care provision*
    - With the onset of the COVID pandemic the service was forced to consider different models of care due to rapid changes in staff availability through isolation, sickness, shielding, and redeployment to other areas. There was also a priority to minimise face to face contact while maintaining a system which highlighted those with more complex needs. These were pragmatic changes made during and in response to the COVID pandemic.
    - The panel understands that the way in which teams work together is currently under review as part of the community service redesign

145. The full ToR included the family concerns raised with the DHR Chair about the efficacy of mental health treatment and management that was provided to Priyan since he became unwell in 2009, in particularly, the reduction in care provision and supervision/visits by Health Care Professionals in the period of the Covid pandemic in 2020 with a lack of awareness and assessment of the disproportionate impact on Priyan's mental health. It is felt the MHIR report findings, conclusions and lessons learned have comprehensively addressed those concerns. Mr Bathak agrees with this assertion.

146. The DHR Panel queried whether the family had been offered a carer's assessment with respect to Sanika and Rishi of Priyan remaining in the family home or made any referral to the Local Authority for Care Act Assessment or Carers assessment, which are statutory responsibilities of the Local Authority. Records have been checked from October 2019 when Priyan was last discharged from hospital with Clozapine medication and there is no trace on Local Authority or Trust records of an assessment being offered or undertaken.

147. Since this case WLNT has made improvements to its system for supporting carers. They have created a Triangle of Care (Trust strategy) forum for all staff to attend. The Trust support the local Ealing Carer's support group and there is a Trust wide Carer Council which any carer in Ealing can attend. This is to get feedback on services and to help them design new services. The Service Line also created a standardised supervision template for staff where the Triangle of Care is included to ensure it forms part of supervision discussions. The Local Authority has also recruited a new Carer Assessor who will be conducting carers assessments. Ealing Southall Mental Health Integrated Network Team

(MINT - formerly Ealing Recovery Team West) has also now added a new standing section for Triangle of Care in their weekly clinical meetings.

RECOMMENDATIONS

148. The MHIR has highlighted two care delivery problems and two service delivery problems, leading to seven recommendations. These are set out below and again in the Action Plan at appendix 2 that shows action taken and progress to date. The Panel have considered other learning points arising from the Police and General Practice IMRs, including from their own discussions, to ensure they are incorporated within the wider recommendations from the MHIR, viz:

    Referrals to MARAC/IDVA and/or forensic referrals – recommendation 7 below
    'Think Whole Family' approach and carer's assessments – recommendation 5 (b)
    Improved communication of decisions by Secondary Care relevant to Primary Care – recommendation 4 (b).

149. *Care Delivery Problem 1: There was a cumulative underestimation of the level of risk presented by Priyan and a lack of a cohesive formulation of the risk in the clinical record.*
    Recommendation 1
    Staff should ensure that they use clinical formulation through supervision and training.

150. *Care Delivery Problem 2: There was limited involvement of the community team in planning discharge from hospital in December 2019. The inpatient care plan was not updated to make it relevant to community care.*
    Recommendation 2
    The care coordinator must be present at the s117 discharge planning meeting, which should also be attended by the Local Authority as they have shared responsibility. The care plan must be updated on discharge to reflect the patients' needs in the community.

151. *Service Delivery Problem 1: There was a high level of variability in understanding the change of care system in March 2020, which took place in the context of the Covid-19 pandemic. The change from care co-ordination and Care Programme Approach led to a loss of continuity of care, decreased frequency of contacts and over reliance on the clozapine clinic.*
    Recommendation 3
    All teams should ensure there is a process to review all patients who have had CPA removed due to COVID and reinstate the CPA if this is required.
    Recommendation 4
    a) When major changes are made to how a service is delivered, a clear process of communication needs to be adopted.
    b) This includes providing verbal and written information to staff, patients, carers and community partners, such as General Practice.
    c) Team managers needs to ensure that all staff have regular supervision which allows complex cases to be identified and reviewed as required.
    Recommendation 5

a) Changes to how care is delivered should be dealt with by adapting the CPA plan and incorporating the required changes in the plan, rather than removing the CPA.
b) The CPA process should be used to discuss the changes with the patient, GP and family ('Think Whole Family' approach) to ensure that adequate support mechanisms are in place.
c) A copy of the amended CPA outlining the changes can be send to the patient, family and GP as required, to support communication.

Recommendation 6

a) Clozapine clinic staff should be involved in decision making about their service.
b) A named member of the clozapine clinic staff could be linked in with each community team to facilitate communication about service changes and individual patients.
c) Clozapine clinic staff linked to a particular team should be considered to be additional members of that community team and in this way be included in important team communications/ attend team meetings monthly.

152. *Service Delivery Problem 2: There was a failure to respond to the level of risk presented by involving MARAC or consideration of making a referral to forensic services*

Recommendation 7

a) The panel recommends that the service raises awareness of the importance of MARAC referrals where a patient has allegedly harmed a family member
b) For appropriate representatives and local and forensic services to meet and agree how a timely informal opinion can be obtained.

Author

Bill Griffiths CBE BEM QPM

26 October 2022

Glossary

ACN	Adult Coming to Notice
ASC	Adult Social Care
BCU	Basic Command Unit
CAMHS	Children and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CPA	Care Programme Approach
CHTT	Crisis Home Treatment Team
CRIS	Crime Reporting Information System
CSP	Community Safety Partnership
CSU	Community Safety Unit
DHR	Domestic Homicide Review
EIPS	Early Intervention in Psychosis Service
ERTW	Ealing Recovery Team West
GP	General Medical Practitioner
IMR	Individual Management Review
HTT	Home Treatment Team
LAS	London Ambulance Service NHS Foundation Trust
LBE	London Borough of Ealing
MASH	Multi Agency Safeguarding Hub
MARAC	Multi Agency Risk Assessment Conference
MHU	Mental Health Unit
MHLO	Mental Health Liaison Officer
MHA	Mental Health Act 1983
MHIR	Mental Health Incident Review
MINT	Mental Health Integrated Network Team
MPS	Metropolitan Police Service
NCBD	Non Crime Book Domestic
NHS	National Health Service
PICU	Psychiatric Intensive Care Unit
PPD	Public Protection Desk
SEP	Safer Ealing Partnership
SOIT	Sexual Offences Investigation Techniques
ToR	Terms of Reference
WLNT	West London NHS Trust

Name references used

Sanika Bathak, deceased
Priyan Bathak, her son and perpetrator
Rishi Bathak, her husband and father of her sons
Nitesh Bathak, their eldest son does not feature in the events subject of this report.

Safer Ealing Partnership - Domestic Violence Homicide Review Panel
Sanika Bathak aged 62, killed in Ealing in November 2020

Appendix 1

Context of review

At about 17:00 in late November 2020, while at his home in **Ealing**, **Rishi Bathak** discovered his wife, **Sanika Bathak** aged 62 suffering from serious head injuries. Paramedics were called but she was beyond saving. Their son, **Priyan Bathak** aged 31, was subsequently arrested and charged with her murder. He is in custody pending a psychiatric assessment. A Mental Health Incident Review (MHIR) by West London Mental Health NHS Trust is in progress.

Under s9(1) Domestic Violence, Crime and Victims, Act 2004, the Ealing Community Safety Partnership have appointed Bill Griffiths CBE BEM QPM as independent chair of a Domestic Homicide Review (DHR), supported by Tony Hester who will manage the process.

Purpose of review

1. Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.

2. Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence, including its impact on children in the home.

3. Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.

4. Apply these lessons to service responses including changes to policies and procedures as appropriate; and

5. Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

6. Highlight any fast track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life

Terms of Reference for Review

1. To identify the best method for obtaining and analysing relevant information, and over what period prior to the death to understand the most important issues to address in this review and ensure the learning from this specific death and surrounding circumstances is understood and systemic changes implemented. Whilst checking records, any other significant events or individuals that may help the review by providing information will be identified [Note: At the first Panel meeting on 7 April 2021, January 2008 (year when Priyan Bathak's mental health problems were first identified for treatment) and late November 2020 (date of death), together with any prior relevant events].

2. To identify the agencies and professionals that should constitute this Panel and those that should submit chronologies and Individual Management Reviews (IMR) and agree a timescale for completion [The current membership would continue with the addition of an advisor from CAPE]

3. To understand and comply with the requirements of the criminal investigation, any misconduct investigation and the Inquest processes and identify any disclosure issues and how they shall be addressed, including arising from the publication of a report from this Panel [The criminal investigation is ongoing. The Coroner has opened and adjourned the Inquest]

4. To identify any relevant equality and diversity considerations arising from this case and, if so, what specialist advice or assistance may be required [There are nine protected characteristics. Sanika is female and Priyan male; both are Hindu of South Asian heritage. Priyan was an adult with care and support needs]

5. To identify whether the victims or perpetrator were subject to a Multi-Agency Risk Assessment Conference (MARAC) and whether perpetrator was subject to Multi-Agency Public Protection Arrangements (MAPPA) or a Domestic Violence Perpetrator Programme (DVPP) and, if so, identify the terms of a Memorandum of Understanding with respect to disclosure of the minutes of meetings [Not known to MARAC]

6. To determine whether this case meets the criteria for a Serious Case Review, as defined in Working Together to Safeguard the Child 2018, if so, how it could be best managed within this review [No children involved]

7. To determine whether this case meets the criteria for an Adult Case Review, within the provisions of s44 Care Act 2014, if so, how it could be best managed within this review and whether either victim or perpetrator(s) were 'an adult with care and support needs' [Priyan was an adult with care and support needs under the Care Act. Given this review and the one conducted by West London MHT, a Safeguarding Adult Review may not be required but this will be kept under review]

8. To establish whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim or the children she was looking after, prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware if any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it [The family are supported by an advocate from the Victim Support Homicide Service and the Chair has held one virtual meeting]

9. To identify how the review should take account of previous lessons learned in the LB Ealing area and from relevant agencies and professionals working in other Local Authority areas [Links to an ongoing DHR has been provided and along with prior published reviews will be researched for parallel or repeat lessons]

10. To identify how people in the LB Ealing gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague [Research will be undertaken on the information provided]

11. To keep these terms of reference under review to take advantage of any, as yet unidentified, sources of information or relevant individuals or organisations

Key issues for the DHR

West London MH Trust Review Terms of Reference

1. To establish the sequence of events as far as the Trust was involved, leading up to the alleged homicide incident in late November 2020
2. To review the patients' mental and physical health care plans/risk assessments and risk management plan to establish whether they met the patient's overall needs
3. To review all care delivery, identify any gaps and consider whether this was consistent with evidence based guidelines and agreed clinical practice
4. To establish whether there was effective and appropriate communication and liaison between the patients' family and all agencies involved in the patient's care to meet their needs
5. To review the partnership arrangements in place and liaison between the local health services, local authority, and any other providers involved in the patients' care
6. To review all prescribed treatment and consider whether these were consistent with evidence based guidelines and agreed clinical practice
7. To consider whether abuse and or neglect was a factor in the death/injury, including where procedures may have failed and the case gives rise to serious concerns about the way in which local professionals and/or services worked together to safeguard adults at risk. To include if a MARAC referral was considered
8. To establish whether required policies and procedures were in place and whether they were followed
9. To highlight and learn from any positive practice
10. To identify the root causes and contributory factors of the incident and provide recommendations for the development of improvement actions to minimise the risk of recurrence and improve the quality and safety of care provided across the West London Trust and external agencies if appropriate
11. Investigate any other matters arising during the course of the investigation which, in the opinion of the panel, are relevant to the occurrence of the incident or might prevent a recurrence. To include if COVID-19 made a difference in the care provision

Family concerns raised with DHR Chair

12. The family are concerned about the efficacy of mental health treatment and management that was provided to Priyan since he became unwell in 2009, in particularly, the reduction in care provision and supervision/visits by Health Care Professionals in the period of the Covid pandemic in 2020 with a lack of awareness and assessment of the disproportionate impact on Priyan's mental health.

Panel considerations

1. Could improvement in any of the following have led to a different outcome for Sanika Bathak, considering:
   a) Communication and information sharing between services with regard to the safeguarding of adults and children
   b) Communication within services
   c) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services

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

a) Professional standards
b) Domestic abuse policy, procedures and protocols

3. The response of the relevant agencies to any referrals from January 2008 relating to Sanika Bathak and Priyan Bathak. It will seek to understand what decisions were taken and what actions were or were not carried out, or not, and establish the reasons. In particular, the following areas will be explored:
   a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with Sanika Bathak and Priyan Bathak
   b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
   c) Whether appropriate services were offered/provided, and/or relevant enquiries made in the light of any assessments made.
   d) The quality of any risk assessments undertaken by each agency in respect of Sanika Bathak and Priyan Bathak

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

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

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

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

8. Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

Operating Principles

a. The aim of this review is to identify and learn lessons as well as identify good practice so that future safeguarding services improve their systems and practice for increased safety of potential and actual victims of domestic abuse (as defined by the Government in 2015 – see below)

b. The aim is not to apportion blame to individuals or organisations, rather, it is to use the study of this case to provide a window on the system

c. A forensic and non-judgmental appraisal of the system will aid understanding of what happened, the context and contributory factors and what lessons may be learned

d. The review findings will be independent, objective, insightful and based on evidence while avoiding 'hindsight bias' and 'outcome bias' as influences

e. The review will be guided by humanity, compassion and empathy with Sanika Bathak's 'voice' at the heart of the process.

f. It will take account of the protected characteristics listed in the Equality Act 2010

g. All material will be handled within Government Security Classifications at 'Official - Sensitive' level

Definition of Domestic Abuse

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Appendix 2

ACTION PLAN

Care Delivery Problem 1: There was a cumulative underestimation of the level of risk presented by Priyan and a lack of a cohesive formulation of the risk in the clinical record.						
Recommendation	**Scope of recommendation**	**Action to take**	**Lead Agency**	**Key Milestones Achieved in enacting recommendations**	**Target Date**	**Date of completion and outcome**
1 Staff should ensure that they use clinical formulation through supervision and training	WLNT	**1.1** For staff to receive training on formulation and for complex cases to be discussed in the MDT meeting and also within supervision	WLNT	**1.1** Following the incident Ealing Southall MINT contributed to the creating of the new risk assessment formulation. The team manager took part in delivering the training to Ealing Southall MINT and also other teams within the trust. **1.2** Ability to monitor staff training through our mandatory training report. The format is designed for Ealing Southall MINT but is able to be produced for all teams. This is audited monthly in our Clinical	April 2021	**1.1** New risk formulation training has been completed and delivered to all staff **1.2** All staff were retrained with the new risk assessment training. CIG scorecard shows teams remain 100% compliant with completion of assessments

				Improvement Group (CIG) meeting **1.3** Expansion of MDT meetings the team holds, including an MDT meting for each Primary Care Network (PCN). Each PCN has a lead practitioner such as a nurse/OT/Social worker. There is also a Consultant Psychiatrist for each PCN and they attend the meetings. A new template has been created for these meetings and will be stored on the G drive and reviewed weekly by the MDT and SMT **1.4** Creation of a standardised Supervision template that covers the core risk areas.		**1.3** The PCN meeting are now running and taking place weekly There is one meeting for the North Southall PCN and the South Southall PCN. Other services within the trust are able to attend these meetings. This includes the Clozapine Clinic team and General Practitioners (GP) **1.4** There is now a standardized template that is used for the service line. This means that all teams, not just Southall MINT, have to use this template. This covers

						core risk areas. Supervision is also uploaded to our internal intranet. This is so the Trust can pull repots on the team to ensure that supervision is taking place **Completed between April 2021 and September 2022**
Care Delivery Problem 2: There was limited involvement of the community team in planning discharge from hospital in December 2019. The inpatient care plan was not updated to make it relevant to community care.						
2 The care coordinator must be present at the s117 discharge planning meeting, which should also be attended by the Local Authority as they have shared	WLNT	**2.1** For staff to be reminded through the CIG meeting	WLNT	**2.1** Two changes have been made since the homicide. A rapid discharge team has been developed, led by a group of social workers. When a patient is admitted to hospital the rapid discharge team are notified and the patient allocated to a social	April 2021	**2.1** A Rapid Discharge Team has been developed. The team consists of social workers. When a patient is admitted to hospital the rapid discharge team are notified and the

responsibility. The care plan must be updated on discharge to reflect the patients' needs in the community.				worker for review. They will explore section 117 care needs and ensure presence at the ward rounds and discharge meeting		patient is allocated to a social worker. They will then be part of the inpatient team that attend ward rounds and assess the patient's community needs and develop a care plan. This includes any section 117 aftercare needs. Examples of aftercare needs are packages of care or If the patient would benefit from supported accommodation. Even with this in place staff from the community mental health team were also reminded that care coordinators should still attend the discharge CPA meeting. This was discussed and highlighted in the April 2021 CIG meeting .

						Completed April 2021
Service Delivery Problem 1: There was a high level of variability in understanding the change of care system in March 2020, which took place in the context of the Covid-19 pandemic. The change from care co-ordination and Care Programme Approach led to a loss of continuity of care, decreased frequency of contacts and over reliance on the clozapine clinic.						
3 All teams should ensure there is a process to review all patients who have had CPA removed due to COVID and reinstate the CPA if this is required	WLNT .	**3.1** The team's whole caseload will be reviewed to ensure that they are on the correct level of care, such as CPA, and that there is an active intervention planned	WLNT	**3.1** Every patient under the team will have a review of their needs and what level of care they may need under MINT. This will be tracked and monitored through an operational report that can be identified from the patient electronic record System (RiO). Progress will also be tracked by the transformation team within WLNT at a weekly meeting held by the transformation team	April 2021	**3.1 Completed March 2021**
4 a) When major changes are made to how a		**4.1** To ensure clear communication is available		**4.1 (a)** Since the homicide the Trust have updated their website for the public and		**4.1 (a)** Please see the updated WLNT website using the link

service is delivered, a clear process of communication needs to be adopted. b) This includes providing verbal and written information to staff, patients, carers and community partners, such as General Practice c) Team managers needs to ensure that all staff have regular supervision which allows complex cases to be identified and reviewed as required.		to the public, carers and their family **4.2** The team managers will ensure they inform the service manager of any potential service delivery changes. No service delivery changes will be made until this has been sighed off by the service manager, associate director and the clinical director **4.3** Team managers will ensure that all staff have regular supervision which		stakeholders to see changes made. This includes a video to help the public understand what is trying to be achieved **4.1 (b)** A MINT Operational Policy will have been created and signed off and shared with all staff **4.2** Monthly meetings have been set up where the Senior Management Team (SMT) in the trust review planned changes. The changes have to be agreed by the SMT and signed off by the Clinical Director and the Associate Director of the service line **4.3** The WLNT intranet provides access to a monthly report. The team will need to		below: https://www.westlondon.nhs.uk/min **4.1 (b)** A MINT Operational Policy has now been signed off by senior management and shared with staff **4.2** There is now an Operational SMT Meeting that currently takes place on the first Friday of every month. Changes to services must be submitted for approval. These meetings are minuted and are stored for evidence **4.3** Progress is tracked through the monthly CIG meeting.

		allows cases to be identified and reviewed as required		ensure that all staff have supervision		The report for August 2022 shows that staff are having monthly supervision. **4.1 – 4.3 Completed September 2022**
5 a) Changes to how care is delivered should be dealt with by adapting the CPA plan and incorporating the required changes in the plan, rather than removing the CPA. b) The CPA process should be used to discuss the changes with the patient, GP and family ('Think		**5.1** Staff will be reminded of the CPA policy. This highlights that changes in care planning should happen through the CPA processes such as MDT discussions and reviews (evidence to be from discussion in CIG and minutes) **5.2** CPA meetings should include key people involved in the individual's care such as the client, carer's, GP, psychiatrist and other organisations such as Adult Social Care. The discussion should influence the care		**5.1** For the CPA policy to be discussed and provided in the CIG meeting. This should also be discussed in supervision **5.2** CPA policy to be discussed in the CIG meeting. It falls under the section of patients where patients that are overdue a CPA are discussed. Staff will also be advised to take overdue CPA's reviews to the		**5.1, 5.2, 5.3** The CPA is now embedded in the supervision template for discussion. There is also a section to prompt the supervisee to check that the CPA policy is being adhered to. The trust did not feel that there had been a significant discussion in the CIG meeting after the incident. Therefore, the learning was shared again in the September 2022 CIG

Whole Family' approach) to ensure that adequate support mechanisms are in place. c) A copy of the amended CPA outlining the changes can be send to the patient, family and GP as required, to support communication.		plan/pathway (to be evidenced by CIG discussion and minutes) **5.3** All decision making and reasoning should be captured within the CPA documentation. This should then be distributed to all the key people in the individual's care and logged on Rio. Evidence: Discussion at CIG and minutes		Multidisciplinary Review Meeting **5.3** Evidence revealed and confirmed in minutes of CIG meetings		**5.1 – 5.3 Completed September 2022**
6 a) Clozapine clinic staff should be involved in decision making about their service. b) A named member of the clozapine clinic		**6.1** Community teams will liaise with their local clozapine clinic team. Members of the clozapine clinic will be invited to key MDT meetings and CPA meetings when they take place. Clozapine clinics will be included and updated in		**6.1** Poster with contact details, put up in areas detailing the following: The manager of each clozapine clinic, their email address and their phone number. The clozapine clinic in Ealing now has the Microsoft Teams invite for the morning MDT		**6.1** The clozapine Clinic Poster has now been shared with all MINT teams across the trust. Evidence confirmed of email communication from the clozapine clinic of how the service also

staff could be linked in with each community team to facilitate communication about service changes and individual patients. c) Clozapine clinic staff linked to a particular team should be considered to be additional members of that community team and in this way be included in important team communications/ attend team meetings monthly		any service delivery changes that might be happening within the team		Zoning Meeting which takes place daily. This is a risk mitigation meeting where the MDT discusses patients that are in a crisis or at risk of going into a crisis.		escalate concerns they may have regarding patients **Completed September 2022**

Service Delivery Problem 2: There was a failure to respond to the level of risk presented by involving MARAC or consideration making a referral to forensic services						
7 a) The panel recommends that the service raises awareness of the importance of MARAC referrals where a patient has allegedly harmed a family member. b) For appropriate representatives and local and forensic services to meet and agree how a timely informal opinion can be obtained.	WLNT	**7.1** Team managers will ensure that their teams are aware of safeguarding mechanism's regarding domestic violence. This includes raising safeguarding alerts and using other safety panel's such as the Multi-Agency Risk Assessment Conference (MARAC) **7.2** When a client has a significant risk history towards others a professional meeting will be held between the forensic services to discuss risk management strategies	WLNT	**7.1** The trusts internal domestic abuse coordinator held a training session for the whole team that included follow up documentation. An up to date notice board on safeguarding is available with signposting to information about WLNT shared drive on Safeguarding **7.2** WLNT has reviewed its operational procedures for the Specialist Community Forensic Team (SCFT). The policy now states that they can offer joint working with "secondary mental health services/other services taking the lead role (short term involvement, usually in	June 2021	**7.1 & 7.2** Evidence from email that shows the training that was delivered. The training covered MARAC, Independent Domestic Violence Advocacy service and how to make a referral There is also evidence of Ealing Southall MINT engaging with the service and organising a consultation with the forensic team **Completed September 2022**

				support & consultation)" They can also support mental health teams with risk assessments for patients that pose a high risk to others. The SCFT team have to respond to referrals within 3 days. All referrals are screened weekly by SCFT panel and allocated to the correct SCFT hub for assessment, supporting the work of MINT escalating cases to SCFT who review the case on RiO, offering advice and guidance to MINT		