

Newham Care Services Partnership

Overview Report: Domestic Abuse Related Death Review/ Domestic Homicide Review into the Death of

Shompa

Date of death April 2022

Note: Shompa is a pseudonym suggested by London Black Women's Project and used for the purposes of this Report.

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Author on behalf of Older Mind Matters Ltd:
Dr Susan M Benbow, MB, ChB, MSc, FRCPsych, PhD, GMC 2382872
Director of Older Mind Matters Ltd, Visiting Professor, University of Chester,
Systemic Psychotherapist

Pen portrait

Shompa was much-loved and her family have been devastated by the circumstances of her death We and they are therefore unable to include a pen portrait here.

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1. INTRODUCTION

1.1 Context

This report of a Domestic Abuse Related Death Review¹ (Domestic Homicide Review) examines agency responses and support given to Shompa², a resident of Newham, prior to the point of her death in 2022.

In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the death, 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.

Her grandson, Baseet³, was arrested for murder on a date in April 2022 after stabbing his grandmother, Shompa, at Address 1. Three other women were at the address at the time.

Baseet had a history of mental health service contact and was discharged from a Mental Health Hospital two days prior to the homicide. He was subsequently charged with murder.

Shompa was aged 80 at the time of her death and is of Bangladeshi heritage. Baseet was aged 33 at the time of the homicide and is British born of Bengali heritage.

The review covers agency involvement from 2012 until the date of death in 2022 and any additional relevant information or domestic incidents known to agencies prior to this timeframe.

The key purpose for undertaking Domestic Abuse Related Reviews is to enable lessons to be learned from deaths where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each domestic abuse related death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

The Panel and all those involved in this Review would like to acknowledge how distressing these events have been for the family and to send our sincere condolences. We would also like to thank all those

¹ The then Government announced in February 2024 that the name 'Domestic Homicide Reviews' would be changed to Domestic Abuse Related Death Reviews, so the latter term is used in this Report.

² Shompa is a pseudonym suggested by London Black Women's Project and used for the purposes of this Report

³ Baseet is a pseudonym suggested by London Black Women's Project and used for the purposes of this Report

who have contributed in any way to the review process for their time, patience, commitment and cooperation.

1.2 Timescales

This review began on 4 July 2022 and was concluded on 30 May 2025.

The target date for completion of the Review was 6 months from the date of commencement. However, the Review was paused on the advice of the Police after an initial Panel meeting in July 2022, pending court proceedings. Baseet was deemed unfit to stand trial and a trial of the facts took place. A jury returned a guilty verdict and Baseet was sentenced to a Section 37 Hospital Order with a section 41 restriction: any release would need the authority of the Home Secretary. The Review was then recommenced in 2023 with a panel meeting in August 2023. Further delay occurred in submission of some individual management reports and, at a late stage, it was identified that an additional independent management report should be requested, causing further delay in finalising the report.

1.3 Confidentiality

The detailed findings of this review are confidential and only available to participating officers/ professionals and their line managers. For this reason, the names of victim and alleged perpetrator have been anonymised. The Overview Report will be published after sharing it with the family, should they so wish.

2. TERMS OF REFERENCE

2.1 Legal context

The Domestic Violence, Crime and Victims Act 2004⁴ states that:

‘domestic homicide review’ means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

- (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*
- (b) a member of the same household as himself,*

held with a view to identifying the lessons to be learnt from the death.

The purpose of a Domestic Homicide Review is to:

- a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;*
- b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;*
- c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;*
- d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;*
- e) contribute to a better understanding of the nature of domestic violence and abuse; and*
- f) highlight good practice*

2.2 Principles of the Review

The principles of the Review will be:

⁴ See Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2016 at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

- a) To conduct the Review in line with guidance and according to best practice;
- b) To be objective, independent and evidence-based;
- c) Ask questions and analyse information relating to the case in order to learn lessons whilst not blaming individuals or organisations;
- d) To engage with family and friends (where relevant and whilst respecting their wishes);
- e) Respect equality and diversity;
- f) Conduct the review with openness and transparency whilst safeguarding confidential information as much as possible;
- g) Disseminate learning effectively.

2.3 Time period under review

The scoping period covered by the review in a detailed chronology was agreed as:

Start date – 2012 (this is when the background information available to the Panel starts)

End date – date of death

Any additional relevant information or domestic incidents prior to this timeframe were requested to be included in a separate summary.

2.4 Key Lines of Enquiry

The key lines of enquiry are outlined below and should be considered in the context of the general areas of consideration listed in the Domestic Homicide Review guidance.

1. What information did each agency hold about the relationship between victim and alleged perpetrator, indicators of domestic abuse, mental health issues and/ or alcohol/ substance-related issues and did this information inform risk assessment and practice?
2. Did each agency follow single and multi-agency policies and procedures (including Multi-Agency Risk Assessment Conference, MARAC)? Were there any gaps in policies or procedures?
3. What risk assessments were carried out in the case of victim and alleged perpetrator, and how was risk kept under review? Were risk levels appropriate and how was risk managed?
4. What did each agency do to safeguard any children exposed to domestic abuse?
5. What services did each agency offer, were they accessible, appropriate, 'fit for purpose' and sympathetic to the needs of those involved, and were there any barriers in an agency that might have stopped them from seeking help for domestic abuse?
6. How effective was each agency's supervision and management of practitioners involved with the response to needs of those involved and did managers have effective oversight and control of the case?

7. How effectively was information shared with partner agencies about domestic abuse, mental health issues, and alcohol/ substance use - did that information inform practice, and were there missed opportunities to share information?
8. Were agencies effective at holding the alleged perpetrator of domestic abuse accountable for his behaviour, and how was this addressed?
9. Were there missed opportunities to intervene in relation to the domestic abuse?
10. How did each agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to those involved, and how were the views of victim and alleged perpetrator ascertained and taken into account?
11. What knowledge or concerns did family, friends and/or employers have about domestic abuse and did they know what to do with it?
12. What consideration was given by agencies to the possible negative impact the COVID⁵ lockdown may have had on the relationship between those involved and did this inform practice? Did agency support change during the COVID lockdown, and, if so, what impact did this have on the support offered and received?
13. Were there issues in relation to capacity or resources in an agency that impacted on its ability to provide services to those involved, or on your agency's ability to work effectively with other agencies?
14. What learning has emerged for each agency?
15. Are there any examples of outstanding or innovative practice arising from this case?

⁵ COVID or COVID-19 stands for coronavirus disease of 2019.

3. METHODOLOGY

3.1 Initiating the Domestic Homicide Review

The Community Services Partnership was notified of the homicide by the Metropolitan Police but it has not proved possible to locate the date of that notification. The Chair of the Community Services Partnership consulted the Partnership Board to make a decision prior to April 2022, but unfortunately, the exact date and records of the Community Services Partnership consideration cannot be located. The Board is made up primarily of statutory partners including the Local Authority, Police, London Fire Brigade, Probation, National Health Service partners, and Children's and Young People's Services, but also includes other partners. The Board considered and agreed to this Domestic Homicide Review before notifying the Home Office of the decision to proceed with a Domestic Homicide review on 8 April 2022.

The following agencies were contacted to ask whether they knew the victim or alleged perpetrator:

- Adult Social Care
- Anti-Social Behaviour Team:
- Barts Health NHS Trust
- GP/Primary Care
- Housing
- London Ambulance Service
- Mental Health Services
- Metropolitan Police

Five agencies responded to confirm that they held records. These were:

- Adult Social Care (ASC)
- Anti-Social Behaviour (ASB) Team
- Housing
- Metropolitan Police
- Mental Health Services (East London NHS Foundation Trust)

There is no record of the agencies having been asked to secure records: requests made to agencies imply that they were asked to provide records related to their involvement with the victim or perpetrator.

3.2. Involvement of family, friends, and other relevant community members

The Care Services Partnership (CSP) initially wrote to inform the family of the review and the appointment of an independent chair. The Independent Chair then wrote to introduce herself to the family, and to offer them a phone conversation should they wish to ask any questions about the process. The letter also invited them to see and comment on the terms of reference for the review, and offered that they could meet the review panel as well as contribute to the review should they wish, and in whatever way they wished. This was done by letter to the lead family contact (who was acting as family contact for all matters pertaining to the homicide) and supported by the Family

Liaison Officer. The Home Office leaflet about Domestic Homicide Reviews was sent with both Care Services Partnership and Independent Chair's letters, together with details of links to the Home Office website and information about Advocacy After Fatal Domestic Abuse plus details of how to contact them. When the review was paused the family was informed of this, and, when it was re-started, they were again informed. The Panel was told on each occasion that the family was too distressed to be involved.

An updating letter was sent to the lead family contact in July 2024 informing them that the Review was still in progress. The letter offered to share a final draft of the report with the lead family contact and/or other family members, and invited any comments they or other family members would wish to make. It also offered to get the report translated into another language to make it more accessible if the family wished. The Independent Chair was later informed by the police officer liaising with the lead family contact that the lead family contact would like a copy of the final report, in English. He explained that the family still felt they were living in a nightmare, but that he would like a copy to hand should any family members change their mind in the future and decide they would like to read it.

With regard to involving the perpetrator, the Panel was informed by the forensic psychiatry service that the alleged perpetrator was too unwell to be contacted about possible involvement in the review process.

3.3. Contributors to the Review

The following organisations were asked to provide information and/or to contribute to developing learning and recommendations from this Domestic Abuse Related Death Review.

Individual Management Reviews and chronologies were requested from:

- Barts Health NHS Trust
- London Ambulance Service NHS Trust
- London Borough of Newham Safeguarding Governance Team and Mental Health Adult Social Care Service
- Mental Health – East London Foundation Trust
 - To include all relevant teams including learning disabilities (if relevant)
- NHS North East London (in respect of primary care services)
- The Metropolitan Police

A short report or further information was requested from:

- Anti-social Behaviour Unit
- Department of Work & Pensions
- London Black Women's Project

At a late stage in the review, it emerged that Barking, Havering and Redbridge University Hospitals NHS Trust had provided care for Shompa following the stroke and they were asked to provide an Individual Management Review.

In addition, the Home Office was contacted to ask whether Shompa was entitled to free NHS care.

Individual Management Reviews were provided as detailed in Table 1 below. Individual Management Review authors were all confirmed to be independent of involvement in this case.

Table 1: Individual Management Reviews by agency

Agency	Responsible for:	Referred to as:	Author (by role)	Quality assured by
Barts Health NHS Trust	Shompa could not be found on the system.			
Barking Havering and Redbridge University Hospitals Trust	Medical care for Baseet in 2021 and post-stroke care for Shompa	Acute Hospital Trust		Deputy Director Safeguarding and Named Midwife
East London NHS Foundation Trust	Mental health services (to include all relevant teams including learning disabilities)	Mental Health	Deputy Borough Director, Newham	Borough Director
London Ambulance Service NHS Trust	Provides ambulance services across London.	Ambulance service	Safeguarding Officer	Head of Safeguarding and Prevent
London Borough of Newham Safeguarding Governance Team and Mental Health Adult Social Care Service	Safeguarding and adult social care.	Adult Social Care	Service Manager Mental Health Adult Social Care	Head of Mental Health, Learning Disabilities and Safeguarding and Independent Living
Metropolitan Police	Responsible for policing across London.	Police	Review Officer Specialist Crime Review Group	Members of Senior Leadership Team; and by the Specialist Crime Review Group Senior Leadership Team.
NHS North East London (NEL ICB)	The Integrated Care Board for north east London. Responsible for planning and buying health services across	Primary Care	Named GP for Primary care, NEL ICB based in Newham	Associate Director for Safeguarding Adults North East London Integrated Care Board

Agency	Responsible for:	Referred to as:	Author (by role)	Quality assured by
	north east London.			
Probation service	Manages offenders throughout their time in the criminal justice system.	Probation	-	-
Short report or further information				
Anti Social Behaviour (ASB) London Borough of Newham	Tenant of registered housing providers report ASB to them	Anti Social Behaviour	ASB Coordinator (Team Leader) London Borough of Newham	n/a
Department for Work and Pensions (DWP)	Administers the State Pension and a range of working age, disability and ill health benefits.	DWP	DWP Customer Experience Directorate	n/a
London Black women's project	A specialist, women-only organisation dedicated to supporting Black, Asian and minoritised women.	London Black women's project	Senior Refuge Caseworker	n/a

Originally agencies were given a date of 28 June 2023 by which to submit Individual Management Reviews (IMRs), with the next panel meeting due on 5 July 2023, however, several agencies flagged up that this would not give them sufficient time to prepare reports, so the submission date was extended and the panel meeting deferred until 2 August 2023. Only two reviews were received by the date of the August panel meeting. The Serious Incident Report prepared by the Mental Health Trust was shared with the Chair in advance of that panel meeting.

Agencies were then given a revised date of 8 September 2023 by which to submit remaining Individual Management Reviews for a panel meeting booked to take place on 2 October 2023. Unfortunately, the reviews were not received in time for that meeting which was therefore cancelled and a new panel date set for 13 November 2023. Three further Individual Management Reviews were received in time for the November panel meeting (one on 10 November 2023), but one still remained outstanding on 13 November.

A further panel meeting was booked for 15 January 2024 but information was still outstanding so that meeting was deferred to February. Emails were then sent to the following agencies requesting missing/ additional information on 9 January 2024:

- Adult Social Care
- Anti-social Behaviour

- Barts Health NHS Trust
- GP/ Primary Care
- Housing/ Homelessness
- London Ambulance Service
- Mental Health
- Police

Responses were received from the following:

- Anti-social Behaviour
- Housing/ Homelessness
- London Ambulance Service
- Police

Adult Social Care informed the Chair/ Author that the information was being put together, and Barts Health NHS Trust replied that the victim had no records on the system.

That left the following requests for missing/ additional information outstanding:

- GP/ Primary Care
- Mental Health

It also became evident that although Probation was listed as contributing a Panel member no information had been received from them, so on Feb 14th the Author emailed them to request a short report with particular attention to whether the homicide victim was the grandmother that Baseet was required to live with (and why live with her rather than another family member) plus anything that might be known about his relationship with her and about his learning disability. In response to a follow up email on 5 March 2024 one of the two Probation contacts replied by email to advise that neither of the two contacts now sit on domestic homicide reviews for Newham, and to directly contact to the head of service for the unit. An email was sent to the address given for the head of service that same day.

Further emails were sent to the agencies that had not responded on 15 February 2024 with a final date of 26 February for receipt of missing information. Information was received by that date from:

- Adult Social Care
- Mental Health

With regard to the GP/ Primary Care, information was received on February 19 2024 and a further email was sent drawing particular attention to:

'The most important issue is this. I need your help please with tracking down Shompa's admission when she had her stroke. I hope that the GP records will have information about where she was admitted and treated as the hospitals contacted all say they can't trace any records. I am particularly interested in care arrangements on discharge, discharge address, any discussions with the family about her care (and who in the family it was discussed with), and how

much she was able to communicate regarding her needs, wishes etc. My background information about her is quite limited so anything you could add to that would be welcome.'

(It later emerged that at the time of the stroke Shompa was not registered with a GP practice and that her discharge letter was therefore not sent.)

At a late stage in the Review (April 2024) we learned that Shompa's stroke care had been at Barking, Havering and Redbridge University Hospitals NHS Trust and an Independent Management Review was requested. This raised the question of whether Shompa had been entitled to recourse to public funds/ free NHS care. As a result, further information was requested from the Acute Hospital Trust and the Home Office was also approached for information. These enquiries led to further delays in finalising the draft Report.

3.4 The Review Panel Members

Table 2 lists Review Panel members including their role, and the organisation they represented.

Review Panel members were all independent of involvement in the case.

Table 2: Domestic Homicide Review Panel membership

Agency	Name	Role/ job title
Barts Health NHS Trust	Clare Hughes	Head of Safeguarding
Change Grow Live (substance misuse services)	Sonia Mills Lauren Mulligan	Services Manager
Department for Work and Pensions	Laura Anderson	
East London NHS Foundation Trust (mental health services)	Fenno Outen	Deputy Borough Director, Newham
Hestia (domestic abuse support services)	Sharna Marshall Robi Bibi	
London Black women's project (representing VAWG and women from minoritised communities)	Ishrath (Tasnia) Jahan	Senior Refuge Caseworker
Adult/ Disability Services	Anna Mwiluki	Safeguarding Governance Team
Children's Social Care	Mahfuzul Khan	Head of Service, Children's MASH, EDT, NRPf and Families First Service

Agency	Name	Role/ job title
Domestic Abuse commissioner	Sharmeen Narayan	Domestic Abuse and Sexual Violence commissioner
Housing	Dawn Henry	Specialist Pathways Team Leader
Operations and Safeguarding	Emma Cockerell	Director of Operations and Safeguarding
Safeguarding	Wendie Hatt	Senior Safeguarding Governance Officer, Safeguarding Governance Team
Police - Family Liaison Officer	Elly Mitchell	Family Liaison Officer
Police - Specialist Crime Review Group	Sally Pattison	Met Police Review Officer
NHS North East London Clinical Commissioning Group	Sabeena Pheerunggee Emma Tukmachi	Named GP for Safeguarding Children & Adults
Nia (services to end violence against women and children)	J Woodward	
Probation Service	Olivia Brooks (initially but later informed she no longer sat on Newham DHRs)	Probation Officer
NHS England	Angela Middleton	Patient Safety Lead for Mental Health
Observer	Denice Sealy	

The Review Panel met on the following dates:

- 04 July 2022 online using Microsoft Teams
(The review was then paused)
- 02 August 2023 online using Microsoft Teams
- 02 October 2023 online meeting deferred because IMRs still awaited
- 13 November 2023 online using Microsoft Teams
- 15 January 2024 online meeting deferred as information still awaited
- 12 February 2024 online using Microsoft Teams
- 15 April 2024 online using Microsoft Teams

3.5. Author of the Overview Report

The Reviewer/ Author of this report is by professional background a psychiatrist and systemic psychotherapist specialising in work with older adults. She has broad clinical and multi-agency experience in the North West and West Midlands and undertook consultant roles in Manchester and then Wolverhampton until 2009 when she retired early from her NHS roles and started to develop a portfolio career in independent practice.

She has acted as Chair and/or Author, and expert medical adviser/ consultant to Domestic Homicide Reviews, Serious Case Reviews, Safeguarding Adult Reviews, and Local Case Reviews in the past on behalf of Older Mind Matters Ltd. She is a member of the AAFDA Network and in 2024 undertook the Certificate in Chairing a Domestic Homicide Review course.

She has no connections or ties of a personal or professional nature with the family, with the Community Safety Partnership, or with any other agency participating in this review. She has an ongoing interest in reviews involving older adults and has published, with colleagues, an analysis of domestic homicide reviews in England involving adults over 60 years of age in 2018 and a paper on adult family violence.

3.6 Parallel Reviews

Parallel investigations were:

- HM Coroner's investigation
- Mental Health Serious Incident review: this was conducted by the Trust providing Baseet with mental health services and the report was shared with the Domestic Homicide Review panel.
- The patient safety lead for Mental Health for NHS England, responsible for the commissioning of Independent Investigations following a Mental health-related homicide contacted the Independent Chair to say that NHS England were in the process of reviewing Shompa's case and she agreed to join the Domestic Homicide Review panel.

3.7 Equality and Diversity

Of the protected characteristics age, gender, disability and culture are potentially relevant and have been considered where appropriate during the review process. These characteristics are considered below.

Age and gender

Shompa was aged 80 at the time of her death. The Home Office 2021 document entitled Key findings from analysis of domestic homicide reviews:

October 2019 to September 2020⁶ found the average age of victims to domestic homicides to be 41 but notes that the oldest victim was aged 94: domestic homicide (like domestic abuse) can occur at any age. Bows (2019)⁷ found that around 1 in 4 domestic homicides involved older victims, and, unlike in younger age groups, older people are almost as likely to be killed by a partner as they are by a family member (most often an adult child). In the case that this review focuses on, a grandson killed his grandmother. The Home Office 2021 document included 2 cases of grandchildren killing a grandparent within a 12 month period. A report prepared for the Home Office entitled Domestic Homicide Reviews Quantitative Analysis of Domestic Homicide Reviews October 2020⁸ sets out information from 108 Domestic Homicide reviews that went through the Home Office's quality assurance process over a 12 month period up to the end of September 2021. The victims of domestic homicide were predominantly female (77%): domestic homicide is regarded as a 'gendered' crime. This series of reviews included three cases of grandparents killed by grandchildren (9% of reviews where the relationship between victim and perpetrator was familial). In younger age groups domestic homicide takes place most often in the context of an intimate partner relationship rather than a familial relationship. In older age groups a greater proportion of domestic homicides take place in the context of a familial (non-intimate partner) relationship⁹ (most often when an adult child kills a parent).

Disability

Public Health England looked at disability and domestic abuse and published a topic overview on this in 2015¹⁰. Although this document was published some time ago now the findings are still pertinent and fit with other findings. The overview notes that disabled people experience higher rates of domestic abuse than non-disabled people. The Figure that follows (Figure 1) is taken from a paper by Khalifeh and colleagues¹¹, and shows that people with a long-term illness (2.6 times more likely), and those with mobility problems (1.9 times more likely) are at increased risk of experiencing domestic abuse. Shompa was disabled as a consequence of a stroke which left her with mobility problems and in need of care. We are told that she had a dementia condition and this would be regarded as a mental illness: Khalifeh and colleagues found mental illness to increase the risk of experiencing domestic

⁶ See <https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews>

⁷ Hannah Bows, Domestic Homicide of Older People (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK, *The British Journal of Social Work*, Volume 49, Issue 5, July 2019, Pages 1234–1253, <https://doi.org/10.1093/bjsw/bcy108>

⁸ See [https://assets.publishing.service.gov.uk/media/64356534877741000c68d7d3/Annex A DHRs Review Report 2020-2021.pdf](https://assets.publishing.service.gov.uk/media/64356534877741000c68d7d3/Annex_A_DHRs_Review_Report_2020-2021.pdf)

⁹ See Domestic Homicide Project Spotlight Briefing 2: Older victims available at: <https://www.vkpp.org.uk/assets/Files/Older-Victims-Spotlight-Briefing-Feb-2022-AC.pdf>

¹⁰ C. Dockerty, J. Varney and R. Jay-Webster. Disability and domestic abuse Risk, impacts and response. 2015 Public Health England. See:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480942/Disability_and_domestic_abuse_topic_overview_FINAL.pdf

¹¹ Khalifeh H, Howard LM, Osborn D, Moran P, Johnson S. Violence against people with disability in England and Wales: findings from a national cross-sectional survey. *PLoS One*. 2013;8(2):e55952. doi: 10.1371/journal.pone.0055952.

abuse by 2.6 times. Thus, Shompa had vulnerabilities which could be regarded as increasing the risk to her.

Baseet had long-standing mental health problems and this could be seen as a vulnerability that increased the risk of him becoming a perpetrator of domestic abuse. The Home Office Key Findings 2021 document found that 31% of perpetrators in domestic homicides were identified as having mental health issues and 10% as having a psychotic illness.

Culture

The Home Office Key Findings publication 2021 reported that 8% of domestic homicide review victims in their series were of Asian/ Asian British ethnicity and 11% of perpetrators. The 2021 census¹² found that 9.3% of the population of England and Wales described themselves as Asian, Asian British or Asian Welsh. The population distribution across England and Wales varies geographically and is greater in some big cities. In the 2021 census, 42.2% of people in Newham identified their ethnic group within as Asian, Asian British or Asian Welsh category. Shompa was of Bangladeshi heritage and Baseet is British born of Bengali heritage. Shompa's preferred language and that of some members of her family is Bengali.

A recent publication by Chantler and colleagues¹³ notes how cultural aspects of shame, honour and gender can complicate help-seeking in relation to domestic abuse. These factors are highly relevant in reviews involving those from minoritised communities. In their study, Chantler and colleagues noted the inconsistency in use of professional interpreters and lack of female interpreters, and highlight how, when the views of victims of domestic abuse are not obtained directly, vulnerabilities may be unrecognised and people's voices may be absent from risk assessments. It is worth noting that similar considerations may be equally important in relation to help-seeking in relation to mental illness, dementia and some other disabilities.

This report considers how the intersecting protected characteristics of age, gender, ethnicity, culture (and language) might have influenced agency responses to Shompa and her family.

¹² See

<https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/bulletins/ethnicgroupenglandandwales/census2021#ethnic-groups-in-england-and-wales>

¹³ K. Chantler, K. Bracewell, V. Baker, K. Heyes, P. Traynor and M. Ward (2022)

An analysis of minoritisation in domestic homicide reviews in England and Wales
Critical Social Policy 43 (4): 602-625. DOI: 10.1177/02610183221133052

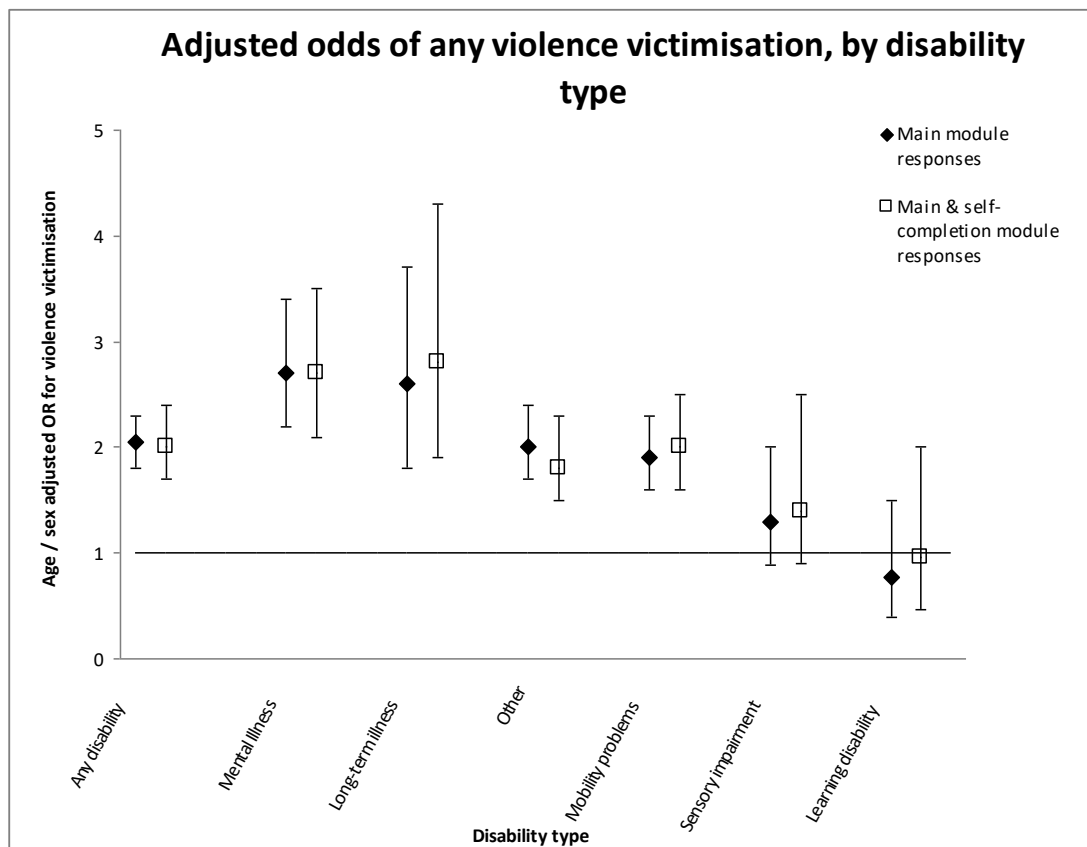


Figure 1: Figure showing adjusted odds of any violence victimisation, by disability subtype

from Khalifeh H, Howard LM, Osborn D, Moran P, Johnson S (2013) Violence against People with Disability in England and Wales: Findings from a National Cross-Sectional Survey. PLoS ONE 8(2): e55952.

<https://doi.org/10.1371/journal.pone.0055952> - taken from an open-access article distributed under the terms of the Creative Commons Attribution License permitting unrestricted use, distribution, and reproduction provided original author/ source are credited.

3.8. Dissemination

Agencies required to provide reports were responsible for producing internal recommendations to improve practice and for the implementation of the associated action plan template provided. Agencies were asked not to wait until the end of the review process to implement any learning identified. Agencies were also required to ensure staff who were involved in the review were made aware of any recommendations that arose from the Domestic Abuse Related Death Review.

Agencies were required to disseminate any learning specific to their organisation and the Community Safety Partnership to facilitate the dissemination of any broader multi-agency learning.

The original intention was that the final Report and Executive Summary would be disseminated to all involved agencies and also published on the Newham Council website after quality assurance by the Home Office. In addition to all involved agencies the Report will be shared with the Domestic Abuse Commissioner, the local Police Crime Commissioner and Shompa's family.

All recommendations will be addressed through the Care Services Partnership Domestic Homicide Review Recommendations Group which ensures that all recommendations and actions from Domestic Abuse Related Death Reviews are completed.

4. BACKGROUND INFORMATION (THE FACTS)

At the time of her death, Shompa was living in the London Borough of Newham with her adopted daughter, the adopted daughter's husband and their two adult children, Baseet and Baseet's sister. The adopted daughter's husband was not present in the home at the time of Shompa's death but another of Shompa's daughters was. We were told that Shompa moved between different family members' homes but that she had been at this address (referred to as Address 1) for at least three weeks. She was disabled and in need of care following a stroke in mid 2021. Baseet had a history of mental health service contact over many years and had been discharged from a Mental Health Hospital two days before Shompa's death.

On the morning of Shompa's death, family members at Address 1 heard screaming from downstairs. There were three women in the house in addition to Shompa and Baseet (Shompa's adopted daughter and granddaughter plus Shompa's Daughter 1). They came down to investigate and saw Baseet walking from the kitchen to the front door. Before leaving, he is reported to have said '(someone) told me to do it from Brick Lane. They murder people too.' Baseet then left the address and the family found Shompa injured on her bed.

Police were contacted by the London Ambulance Service to attend the scene, stating that an 80-year-old woman had been stabbed in the neck by her grandson and was not breathing. The Police were first to arrive, and were told at the door by a family member that Baseet had left prior to police arrival. Shompa had numerous stab wounds to the abdomen and no sign of breathing. The London Ambulance Service and Helicopter Emergency Medical Service arrived at the scene and took over cardiopulmonary resuscitation. They moved Shompa outside the address and did everything they could. The Helicopter Emergency Medical Service confirmed 18 stab wounds to the neck, upper part of the chest and abdomen. At 1040 hrs a doctor from the Helicopter Emergency Medical Service pronounced life extinct.

Whilst police were responding to the call, other officers stopped Baseet based on the description of the offender. He was arrested, taken into custody, interviewed, and subsequently charged with murder.

A forensic post-mortem was carried out. The worst injuries were to the chest, and inflicted with a severe level of force. Many of the injuries were capable of being fatal. The medical cause of death was given as stab wounds to the chest.

A criminal trial took place in March 2023 and the jury returned a verdict of guilty in relation to Baseet committing the act of killing Shompa. Baseet was sentenced to a Section 37 hospital order with a Section 41 restriction.

Figure 2 shows a partial family tree for Shompa. Members of the household are shaded in green and those family members indicated by diagonal stripes were at the address at the time of Shompa's death.

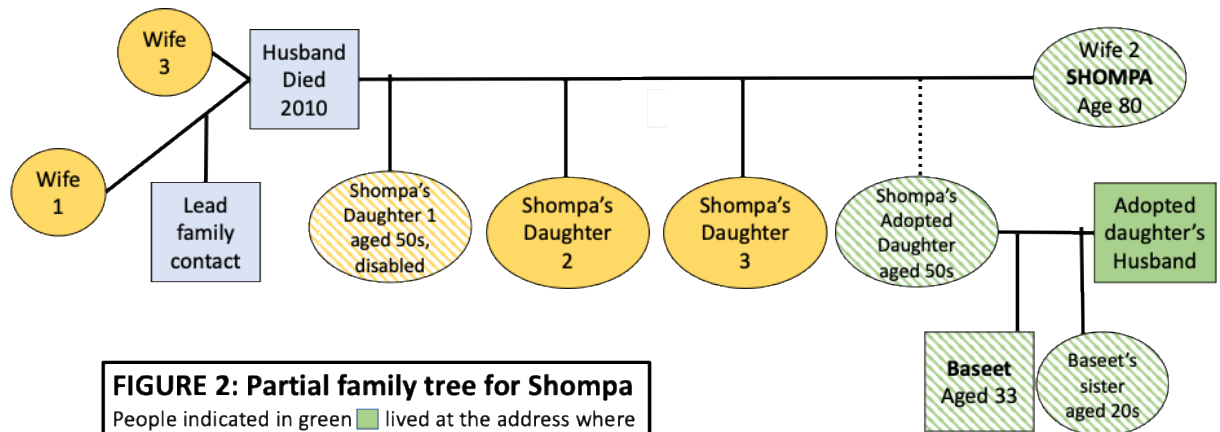


FIGURE 2: Partial family tree for Shompa
 People indicated in green lived at the address where the homicide took place (Address 1)
 People indicated by diagonal stripes were at Address 1 on the morning of Shompa's death

5. CHRONOLOGY

5.1 Background information

5.1.1 *Shompa*

The information available to the review about Shompa's background is very limited. What follows is drawn from agency records.

Shompa had three daughters and travelled to the UK from Bangladesh in 2009. Shompa was one of her husband's three wives and her husband travelled to the UK on a regular basis. However, visa restrictions meant that he could only bring one wife at a time. In 2009 Shompa travelled with her disabled daughter, Shompa's Daughter 1, to the UK to visit family (see Figure 1 for a partial family tree). Shompa's husband was due to join her a few months later but died suddenly in May 2010. Shompa decided to stay in the UK with her daughter, and we were told that the family believe she was given the right to remain in the UK but they were uncertain of the exact date. In Shompa's younger years, as far as the panel is aware, she was a housewife and did not work after arriving in the United Kingdom (UK).

We understand that Shompa was fit and well until 2021 when she suffered a stroke. She was admitted to Hospital 3 for treatment. However, she lost the use of the left side of her body and became incontinent. Following the stroke, Shompa is said to have experienced the onset of dementia which impacted her speech. She became frustrated when people couldn't understand her and she would screech to get people's attention.

Shompa had very few personal belongings. She stayed with various family members for varying lengths of time depending on what events were taking place in that particular household. It is said that Shompa was taken to Baseet's address around one and a half weeks before she was killed (but the mental health documentation records 'grandmother' living in the family home when Baseet was admitted to mental health care in March 2022). At the time of Shompa's death, Baseet and three women were present in the two-bedroomed house in addition to Shompa; her adopted daughter who is Baseet's mother; Shompa's Daughter 1 who is understood to have a disability; and Shompa's adopted daughter's daughter ie Shompa's adopted granddaughter who is Baseet's sister. Shompa slept on a mattress in the living room. Baseet's father had left to go to work.

Shompa was not related to Baseet although she was regarded as his grandmother. Baseet's mother was orphaned as a child in Bangladesh and Shompa looked after her from then on. All the extended family considered her to be part of the family.

5.1.2 Baseet

Similarly, information about Baseet's background is limited and the information below is taken from agency reports.

Baseet was born and raised in Newham. His parents were born in Bangladesh and the family are Muslim. Records indicate that he had a history of developmental delay as a child, possibly complicated by a road accident when he was aged 7, and he has been diagnosed and recorded as having a mild learning disability. He is also known to have asthma.

He attended mainstream schools and left school aged sixteen without any formal qualifications. He then went on to attend college for three years. He did not gain any further qualifications, and has never held employment. He first had contact with mental health services around age 20.

At the time of the homicide, Baseet was aged 34, in receipt of benefits, and living with his parents and younger sister in the two-bedroomed family home. He is single and has no children. His mother is Shompa's adopted daughter and his mother was regarded by agencies as Baseet's main carer. It appears that, at that time, the home was also accommodating his grandmother (also referred to as step-grandmother) and possibly an aunt. His father is a restaurant worker, and his mother is a home keeper. His mother's first language is Bengali and mental health staff use an interpreter when communicating with her directly.

Baseet smokes about twenty cigarettes a day; his use is said to increase when he is unwell. There appears to have been some brief historical concern for alcohol and cannabis use in 2020 but not more recently.

5.2 Combined narrative chronology

A combined narrative chronology follows below and the chronology is also included in tabular form in Appendix 1.

Contact/ information in this chronology relating to Shompa is highlighted in grey, thus.

5.2.1 Prior to the scoping period

2009: Baseet was referred to the Early Intervention in Psychosis team in relation to seeing ghosts, snakes and rats at home, and remained with that team for three years: his care was then transferred back to his GP. He was given diagnoses of depression and somatisation disorder, and reported pain, fatigue and weakness. At the time, he was not felt to have a psychotic disorder but he did not continue with prescribed medication.

2009: In 2009 Shompa travelled with her disabled daughter, Daughter 1, to the UK to visit family. Her husband was due to join her a few months later. The GP records give UK entry date as 4 September 2009.

May 2010: Shompa's husband died suddenly. She decided to stay in the UK with her daughter and the family believe she was given the right to remain, but they are uncertain of the exact date.

2010: Baseet was referred to Adult Social Care. The referral describes him as dependent on his mother and unable to be left alone. *'The referral indicates that his family reinforce the above behaviours and beliefs and recommended psychology/ family therapy alongside a functional assessment.'* At that point he was known to Learning Disability Psychiatry and had 'three sessions' in 2011. The nature of these three sessions is unclear.

20 October 2010: Baseet declined an Occupational Therapy assessment by Newham Learning Disability Team. His mother was noted to be his main carer.

15 November 2010: Baseet was discharged from care of the Early Intervention in Psychosis team. A letter on file (Adult Social Care) notes he was given *'reasonable presence'* in relation to his housing request. It is not clear what this means.

5.2.2 Scoping period starts in 2012 – 2012-2017 period of relative stability

4 April 2014: The Anti-Social Behaviour team received a report, likely to be from Baseet's father (name incorrectly spelled), at Address 1: *'Urgent noise. Loud music and shouting'*. The Anti-Social Behaviour team noted that an advisory letter was sent to the complainant requesting more information.

29 April 2014: The Anti-Social Behaviour team received a report from a Baseet's mother at Address 1: *'loud music, smoking weed, noise, blasting'*

music - goes on to early morning from (a neighbouring address given)'. The Anti-Social Behaviour team noted that an advisory letter was sent to the neighbouring address.

14 May 2014: The Anti-Social Behaviour team received a report from Baseet's father at Address 1: '*Customer reporting asb by youths hanging around the street on (street), customer says the youths are dealing drugs causing nuisance to the residents. Youths are described to be gang members, it is said that they are not only using drugs but also playing loud music and drinking, shouting and causing threatening behaviour to the others members of the residents.*' The Anti-Social Behaviour team noted that '*Safer Neighbourhood Team gather details with stops and liaise with us for action*'.

14 May 2014: The Anti-Social Behaviour team received an anonymous report as follows: '*The gentleman called to say that a group of 16 people between the age of 20 and 40 gathered in front of house (Address 1). The group are disturbing the peace of the caller and the neighbourhood as they are fighting, swearing and shouting. The caller wants the ASB team to come over to send them away.*' The Anti-Social Behaviour team noted that the police were already aware and that there were no details to update the complainant.

16 May 2014: The Anti-Social Behaviour team received a report from an occupant of Address 1 who wished to remain anonymous. No details of the complaint were recorded

18 May 2014: The Anti-Social Behaviour team received a report from Baseet's mother at Address 1: '*Urgent noise - loud music from (neighbouring address given). Caller also inf(orme)d that noise is also coming from door (a different neighbouring address given)*'. The Anti-Social Behaviour team noted that they spoke with the complainant on the phone for 35 mins, and the complainant said they did not want anyone coming to the property and would not let anyone in if they attended.

13 June 2014: The Anti-Social Behaviour team received a report from Baseet's mother at Address 1: '*Urgent noise - loud music & shouting from (neighbouring address given)*'. The Anti-Social Behaviour team noted that no visit was conducted initially, however, shortly afterwards officers visited the location and observed 15-20 males engaging in drug use. (Council officers would usually pass such information on to the police, however there is no record or evidence to suggest that happened on this occasion.)

30 August 2014: The Anti-Social Behaviour team received a report that was probably from Baseet's mother (name mis-spelled) at Address 1: '*urgent request loud music from (neighbouring address given)*'. The Anti-Social Behaviour team noted that the complainant did not want uniformed officers to visit the home address for safety reasons. An advisory letter was sent - advising the complainant that the team needed to witness the noise.

6 October 2014: Baseet saw his GP for an increase in his dose of duloxetine¹⁴ and complained that noisy neighbours were getting him down and that he was unable to sleep – noise day and night.

2014-2015: On 11 October 2014 Baseet was arrested in relation to possession of a knife and threatening others with it. Records say that he ran out into the street with a large knife and threatened others with it, and it was alleged that he stabbed a neighbour's door causing damage. His solicitor believed he was suffering from severe mental health issues, but a police doctor deemed him fit for interview.

He was charged with criminal damage, possession of a knife and a public order offence, and was remanded to prison for three months awaiting trial. At court on 22 January 2015, he pleaded guilty and received a 12-month custodial sentence, suspended for 11 months, with 12 months' supervision by probation. He was required to live with his grandmother for a short while, and it is believed that this may refer to Shompa. During the criminal justice process, he was referred to the Learning Disability team and remained open to them until March 2015. During this time, he reported auditory hallucinations and was diagnosed with depression, somatisation disorder, unspecified psychosis and mild learning disability. He was offered (and declined) psychology support. The consultant involved wrote letters of support to housing, the benefits agency and his GP.

Sometimes Baseet did not attend medical appointments and family attended instead. They reported he was too frightened to leave home. He was said to be scared that 'local boys' would harm him, or that they would get him into trouble and he would have to go back to prison.

10 September 2015: Baseet's GP saw his mother who described housing issues. Baseet was described as low in mood, not leaving the house and having difficulty engaging with the community mental health team.

24 September 2015: A mental health team attended Baseet's address. He complained about his immediate neighbours who, he said, were always complaining and conspiring against him. He said that, if nothing was done, he would consider arming himself with a knife and would not be responsible for his actions. When the mental health team left the address, a group of men were standing outside and were overheard to make a comment about staff leaving the property as though giving a surveillance commentary. Though staff were not threatened, they described the atmosphere as intimidating. It is unclear if police attended this incident, but an information report was created by the Safer Neighbourhood Team detailing the concerns of the mental health team.

24 to 28 Sept 2015: Open to the Crisis Team for 5 days following concerns reported by family: he accused his family of trying to get him rearrested, had been knocking on neighbours' doors and family were worried this would lead to a confrontation. Baseet did not like different people visiting daily, and

¹⁴ Duloxetine is a medication used for mental health reasons, primarily to treat major depressive disorder and generalised anxiety disorder.

declined to engage after 5 days. His care was transferred back to the Learning Disability Team.

25 September 2015: An ambulance was requested for Baseet following a report of an allergic reaction to medication (duloxetine) administered by a home treatment team. The ambulance staff documented that Baseet had psychosis and mild learning disability. Following assessment Baseet was conveyed to hospital, accompanied by his mother, and his care was handed over to hospital staff.

14 October 2015: Baseet's GP recorded an asthma check.

15 October 2015: An ambulance was requested for Baseet following a report that he was out of control, moving furniture, talking to himself, not eating/drinking, had vomited, was not taking his medication, and kept walking in and out of the house. On arrival ambulance staff found that Baseet's mother was chasing him down the road. They caught up and chatted with him. He was initially reluctant to talk and kept walking away, but eventually agreed to get into the ambulance. Following assessment, he was conveyed to hospital, accompanied by family, and care was handed over to the hospital staff.

16 October 2015: Baseet's mother and aunt took him to an Emergency Department following concerns of deteriorating mental state in the context of non-compliance with prescribed medication for 3 months. He was seen by the Psychiatric Liaison Service and referred for Mental Health Act assessment. He was noted to be irritable, agitated, confused, and talking *'to himself'*/responding. He had not been eating or drinking for two days; presented as persecuted; and felt unsafe. He believed that his family were imposters who were trying to poison him. He presented as angry and reported thoughts of hitting others. He was admitted to hospital under Section 2 of the Mental Health Act.¹⁵

Whilst on the ward, the Consultant wrote a letter to support an application for alternative accommodation due to ongoing locality antisocial behaviour and noise with related impact on Baseet's mental state and recovery. Baseet's medication was revised to mirtazapine¹⁶ and he was discharged to the care of a community mental health team with diagnoses of learning disability, somatisation disorder and unspecified non-organic psychosis.

12 Nov 2015: Baseet consulted his GP. He had been discharged from a psychiatric ward the previous day and wanted duloxetine changed to mirtazapine.

20 Nov 2015: Adult Social Care received a referral from a Centre for Mental Health to support Baseet around finances and housing. Contact was made with Baseet's father who said Baseet was *'unable to participate due to not understanding what was being asked.'* It was reported that the family was waiting for rehousing from the council, as the current area affected Baseet's

¹⁵ Section 2 of the Mental Health Act 1983 allows a person to be admitted to hospital for up to 28 days, for assessment. See <https://www.legislation.gov.uk/ukpga/1983/20/section/2> for more details.

¹⁶ Mirtazapine is an antidepressant drug, used primarily to treat depression.

mental health. He was said to be unable to go out without family support due to being unsafe on the streets, and that he had gone to prison for three months in October 2014 for carrying a knife. No social care needs were identified and the outcome was no further action.

Baseet was noted to be able to manage all his daily living skills with support from his family. A mental health team was noted to be supporting him as an out-patient with housing and benefits claims.

22 Nov 2015: An ambulance was requested to attend an unknown male aged 27 following a report that he had fallen downstairs and hurt his foot. The caller was advised to ring NHS 111. (This contact is thought to refer to Baseet.)

20 May 2016: The Anti-Social Behaviour team received a report from Baseet's mother at (Address 1): '*language line calling to report persons park up in vehicle outside (Address 1) and play music loudly. caller only speaks Bengali, unable to give details of vehicles. Passed to Noise team.*' The Anti-Social Behaviour team noted that the noise nuisance needed to be witnessed at the time.

23 May 2016: Baseet's sister called police as a group was causing a disturbance outside their address, drinking and smoking. She said that her brother had mental health problems and it was making him angry. An anti-social behaviour report was created and sent to the local Safer Neighbourhood Team who conducted extra patrols and spoke with the family regarding a possible harassment warning against neighbours. The family said they had felt victimised by the neighbours since 2014 when Baseet was arrested after having a knife and threatening neighbours. The family wished to remain anonymous when reporting incidents for fear of reprisals.

5 Aug 2016: Baseet's mother saw the GP without him and reported that he was getting more anxious and '*can get aggressive*'. They discussed benefits that might help.

18 Oct 2016: Baseet was seen by a nurse in primary care for an asthma review.

1 Nov 2016: Baseet's GP saw him in person for a mental health review and noted that he was spending all his time at home.

18 Nov 2016: Baseet was reviewed by a mental health doctor. There were no concerns but his medication was increased and the doctor provided a letter to support rehousing.

10 March 2017: Baseet's GP completed an unplanned admissions avoidance template.

14 March 2017: An ambulance attended Baseet at his home address following a report that he was experiencing chest pain, dizziness, and had a history of psychosis. Following assessment, he was conveyed to hospital, accompanied by his mother and care was handed over to hospital staff.

Whilst there, he was seen by a psychiatric liaison service and noted to be quiet and withdrawn.

14 March 2017: A Community Recovery Team was notified of the contact and asked to make follow up contact. Subsequently Baseet was reviewed on 10 April 2017, and it was found that his symptoms had worsened despite an increase in aripiprazole¹⁷ and mirtazapine dosage and so he was started on olanzapine¹⁸.

8 July 2017: The Anti-Social Behaviour team received a report from someone at Address 1 saying '*Males in two cars putting alcohol bottles outside number (of Address 1) and playing loud music*'. The Anti-Social Behaviour team noted that an advisory letter was sent to Address 1 requesting more detail.

8 July 2017: The Anti-Social Behaviour team received a report from someone at Address 1 saying '*Urgent noise - loud music. Caller confirmed that noise is coming from door no: (neighbouring address given). This is caller's second call today*'. The Anti-Social Behaviour team noted that noise was audible but not meeting threshold for Statutory Noise Nuisance. They visited that neighbouring address and advice was given. The music was turned off. There was a discrepancy on the house numbers and '*due to not being able to verify which address (the perpetrator) actually lives in*' a P6¹⁹ would not be sent out.

8 Sept 2017: Baseet's GP carried out a mental health review with both Baseet and his mother.

9 November 2017: Baseet was reviewed in a mental health outpatient clinic, and noted to have disabling symptoms. His diagnosis was revised to paranoid schizophrenia and major depressive episode. The doctor recommended considering clozapine²⁰ if there was no improvement by the next review. Baseet was offered and declined referral to recovery groups and for psychotherapy. The doctor completed another letter of support for housing.

5.2.3 2018 to date of Shompa's stroke in 2021 - contacts with services increase

2018

8 March 2018: Baseet's mother saw the GP with an interpreter, and it was noted that Baseet was on aripiprazole, and that mental health services were involved.

¹⁷ Aripiprazole is an anti-psychotic medication.

¹⁸ Olanzapine is an anti-psychotic medicine.

¹⁹ A P6 letter is a letter sent to the reported party advising that officers from the council have witnessed noise emanating from their address, and, although the noise did not reach the threshold for Statutory Noise Nuisance, the noise was audible and it is advisable that reasonable steps are taken to try and reduce noise levels.

²⁰ Clozapine is an anti-psychotic medicine, used to treat illnesses that have not responded well to other treatments.

26 April 2018: Baseet was reviewed in an outpatient clinic, and noted to have a complex presentation which likely included a component of affective psychosis in addition to obsessional traits and generalised anxiety arising in the context of borderline intellectual disability. There were concerns that a change in medication may have triggered his current (hypomanic) presentation.

3 May 2018: The GP reached out to psychiatry for further guidance and noted that a switch in medication from aripiprazole had brought on instability in mood and behaviour – his dose of olanzapine was increased.

4 May 2018: NHS 111 contacted by Baseet who reported he wanted a private space to use the toilet and appeared angry. The outcome was that Baseet terminated the call.

5 May 2018: An ambulance attended Baseet at his home following a report that he was experiencing difficulty in breathing, was not taking his medication, had psychosis, schizophrenia, and was angry and pacing. It was reported that new medication had started the previous day and was not helping. Baseet had seen a mental health team 1 week prior to this, and they suggested he should go to hospital if out of hours. Following assessment, Baseet was conveyed to hospital, accompanied by his mother, and his care was handed over to hospital staff.

5 May 2018: Attended Emergency Department and was seen by Psychiatric Liaison Service. Complained of generalised pain, presented some traits of an obsessive-compulsive disorder around toilets and showering. Had stopped taking medication. Family '*denied any risk of harm to themselves*'. Community Recovery Team North notified and requested to make follow up contact in community.

7 June 2018: Reviewed in outpatient clinic and given a diagnosis of schizoaffective disorder and mild learning disability. Mirtazapine increased and olanzapine reduced.

10 July 2018: Police called an ambulance to Baseet at his home address following a report that he believed someone was trying to kill him; he was angry and stressed, and getting worse; and the crew was told that he had history of paranoid schizophrenia. It was also reported that he had taken an overdose. Following assessment, he was conveyed to hospital, where care was handed over to hospital staff.

Police created a Vulnerable Adult MERLIN²¹ but it was not shared with partners due to resource issues.

²¹ MERLIN reports are safeguarding reports that share details about vulnerable people (children, disabled, mental health, etc.) who come into contact with police. These details can then be accessed by other police officers, and other agencies. MERLIN stands for MERLIN stands for Missing pERsons and other Linked Indices and the system is only used by the Metropolitan Police Service.

10 July 2018: Subsequently Baseet was referred for a Mental Health Act assessment after taking an overdose of promethazine²² tablets. He had declined informal admission and appeared to have limited insight. He was detained on Section 2 of the Mental Health Act.

11 July 2018: Baseet was admitted to a mental health bed on Section 2 of the Mental Health Act²³. After 7 days (on 17 July) he was discharged from the Section 2. On 20 July he was discharged from in-patient mental health care after having leave the previous day (19 July).

30 Aug 2018: Baseet declined to attend a mental health outpatient appointment. His mother attended with an interpreter. She reported that he was preoccupied with contamination and ran water taps for a long time. The doctor wrote letters of support for his mother to the water company and housing.

1 Nov 2018: An ambulance attended Baseet at his home address following a report that he was very agitated, possibly intoxicated, and not sleeping. It was further reported that he had a history of schizophrenia. His family was concerned that he had been throwing things around and then gone out for 4-5 hours. Following assessment, he was conveyed to hospital, accompanied by his mother, and care was handed over to hospital staff.

2 Nov 2018: Baseet was referred for a Mental Health Act assessment following reports by his family of 2 weeks deterioration of mental state. No violence was reported but he was described as irritable. The outcome was an admission to mental health care under Section 2 of the Mental Health Act²⁴. The Approved Mental Health Professional recommended a social care needs assessment, and a carers assessment for his mother. He was discharged from hospital after 9 days (on 13 Nov) to the care of a Community Recovery Team.

14 Nov 2018: Baseet had been seen by a community team following discharge from mental health care but they did not engage with him and he declined support. His mother was noted to be his main carer, overwhelmed and struggling to cope. She was dealing with medication, prompts for personal care, meal preparation, and prompts for eating owing to his lack of motivation. She was noted to be in need of emotional and practical support (in Bengali).

2019

²² Promethazine is an anti-histamine drug used to treat a variety of conditions.

²³ ²³ Section 2 of the Mental Health Act 1983 allows a person to be admitted to hospital for up to 28 days, for assessment. See <https://www.legislation.gov.uk/ukpga/1983/20/section/2> for more details.

²⁴ ²⁴ Section 2 of the Mental Health Act 1983 allows a person to be admitted to hospital for up to 28 days, for assessment. See <https://www.legislation.gov.uk/ukpga/1983/20/section/2> for more details.

11 Jan 2019: Adult Social Care sent a letter in English to Baseet's carer after efforts to phone were unsuccessful: a response was requested within 14 days.

20 Jan 2019: Baseet was stopped and searched by police: he told officers he was just relaxing, but was sweating and shaking and, when asked if he had a knife, he said he did and then that he did not. He was searched and nothing was found. No further action was taken.

25 Jan-25 July 2019: Police received multiple calls over this period regarding anti-social behaviour outside the address and in the area. Actions of police included patrols in the area and increased focus on stop and search some of which led to arrests. The family was encouraged to make a diary of what they were experiencing so it could also be reported to the council. Door to door enquiries were also carried out by the Safer Neighbourhood Team including leaflet drops.

30 June 2019: The Anti-Social Behaviour team received a report from Baseet's sister at Address 1: '*Urgent noise - Loud music from (neighbouring address given)*'. The Anti-Social Behaviour team noted that advisory letters were sent to both addresses.

25 July 2019: An ambulance attended Baseet at his home following a report that he was angry; violent; trying to leave the house but being restrained by his mother and aunt; had psychosis and had not been taking medication. Due to the nature of the call police were requested to attend and later cancelled the ambulance request.

Police created a vulnerable adult MERLIN for Baseet but this does not appear to have been shared with Adult Social Services.

23 Aug 2019: An ambulance attended Baseet at his home following a report that his mental health was deteriorating; he was verbally aggressive, had twice put cleaning products in his family's food; had not eaten or slept for couple of days; was not taking his medication and had a history of schizophrenia. Following assessment, Baseet was conveyed to hospital, accompanied by his mother, where his care was handed over to hospital staff.

24 Aug 2019: Baseet's sister informed the crisis team that he had thrown Mum's phone at her in an attempt to hurt her, and was pushing Dad around in an attempt to hurt him. A police officer reported that they had said that he wasn't being aggressive - '*clear contradictory information*' being given. (The GP independent management review notes this was not coded by clinical coders as Domestic Violence but should have been.)

An ambulance was requested by police to attend Baseet at his home. On arrival Baseet's family informed the ambulance staff that police had taken him to hospital.

Police officers created a vulnerable adult MERLIN and this was shared with Adult Social Care.

Family were recorded as '*possibly minimising concerns*' upon police arrival according to the mental health Serious Incident Review report. Baseet was

assessed and voluntarily admitted to hospital for 10 days. Medication reviewed and blister pack recommended to support compliance.

27 Aug 2019: Adult Social Care received the MERLIN. The report stated that Baseet was willing to go to hospital voluntarily to be assessed. He had accused the family of not giving him any food and had poured a named disinfectant/ cleaning product into the food. His sister reported that Baseet had thrown a phone at his mother, pushed his father, and touched her a sexually inappropriate manner - the family had locked themselves in a different room to call the police.

4 Sept 2019: Discharged from in-patient mental health care.

8 Oct 2019: An ambulance attended Baseet following a report that he had taken the wrong medication. He was angry, did not feel well and was hallucinating. It was further reported that he had psychosis, schizophrenia, asthma, depression and anxiety, and felt unable to stay in the house with his family. The family stated that Baseet had taken double his medication – he said not. Following assessment, Baseet was conveyed to hospital, where care was handed over to hospital staff. The GP was informed that there was no self-harm intent and that Baseet had been discharged to the Rapid Assessment Interface and Discharge Service.

9 Oct 2019: Next day an ambulance attended Baseet following a report that he had taken an overdose the previous day and had left hospital without being seen. He had slept all night and was refusing to take his medication, unable to relax and breathing fast. Following assessment, he was conveyed to hospital, and handed over to hospital staff.

10 Oct 2019: Baseet's father called police to report him missing. Baseet had attended hospital with his mother after not taking his medication, but walked out and did not return home. Police did not attend the incident - Baseet had attended hospital voluntarily and there were no immediate concerns for his welfare. Baseet's father called back later to say he had returned home.

25 Oct 2019: Baseet's mother attended a mental health review with the GP without her son – a review home visit was arranged.

28 Oct 2019: An ambulance attended Baseet following a report that he was hearing voices and having family issues. Following telephone assessment, it was deemed not a medical emergency and he was referred to NHS 111.

28 Oct 2019: An ambulance was requested by police to attend Baseet following a report that he had not taken his medication, was becoming aggressive, and had a history of schizophrenia. It was reported that he was upset as he no longer wanted to live with family because he heard voices every time, but his family wanted to stay with him to support him. He had new medication prescribed on 18 October which he was up to date with and took regularly – the family felt he appeared more settled with new medication.

Following assessment, Baseet declined to go to hospital or an alternative pathway. He was deemed to have capacity to decide and was left at home with his family.

The family told Police that Baseet had been agitated all evening, brought on by him not taking his medication and neighbours playing loud music and setting off fireworks.

Police created a MERLIN report which was shared with Adult Social Care, and contacted a mental health crisis line who confirmed Baseet was on a home treatment plan and they had scheduled a follow up appointment with him. Police MERLIN report information (as noted by Adult Social Care) was as follows: Baseet called police from home stating he felt like hurting his family. On police attendance, he appeared calm, stated he didn't feel suicidal or want to hurt his family, but that he wanted out of the house and help with housing.

5 Nov 2019: Baseet's sister called police due to anti-social behaviour saying that youths were targeting houses with fireworks. She said around 30-40 people were being verbally aggressive and blocking the road. Baseet ran out of the house because he could not stand the noise. Police did not attend – it was bonfire night and there were insufficient officers.

6 Nov 2019: An ambulance was requested to attend Baseet following a report that he was having mental health problems. Following telephone assessment, he was referred to 111. An ambulance then attended Baseet noting a report that he was hearing voices and had mental health issues, ongoing for a number of years.

Following assessment, Baseet declined to go to hospital. Ambulance staff made him an appointment with a mental health team for the next day which he agreed to attend. He was left at home in his mother's care.

12 Nov 2019: Information from Police MERLIN report: Baseet called police on 6 Nov stating he wanted to harm someone. Due to lack of resources Police attended on 8 Nov. Baseet apologised for calling the police, stating that when he doesn't take his medication, he calls the police and ambulance when he does not require it. His father stated that he has taken his medication and is better but that his behaviour changes when he doesn't take it. Outcome: suggestion for the mental health team to consider a Section 135 warrant²⁵ as Baseet will refuse treatment.

19 Nov 2019: His parents attended the surgery for Baseet's GP mental health review. They reported that he seemed stable and liked quiet places. They said they had spoken to housing many times.

29 Nov 2019: Baseet was seen on a GP home visit. His parents reported that his mental health was pretty stable. Gangs make a noise and drink outside the house – the family have to call the police. Mother rarely goes out. Father works part time in a restaurant. Daughter lives with them, works afternoons at school and helps the family with cooking and cleaning. Baseet rarely goes

²⁵ Section 135 allows the police to enter a person's home and take a person to (or keep them at) a place of safety so that a mental health assessment can be done. The police must have a warrant from a magistrate's court that allows them access.

out, and doesn't like television. He smokes too much, and spends a lot of time sleeping. No drugs or alcohol. Baseet came down to talk to the GP who noted blunt affect, poverty of speech and thought, apathy and anhedonia. Vaccines were given and an asthma review completed.

2020

11 Jan 2020: Police were called to the address due to anti-social behaviour: drug dealing outside the address. An Anti-Social Behaviour report was created and sent to the Safer Neighbourhood Team.

25 Feb 2020: GP mental health review was carried out (not in person). The notes reviewed and compliance with medication checked.

25 March 2020: Family contacted Mental Health Crisis Line - Baseet had stopped taking medication; was verbally aggressive and violent, breaking furniture and items at home. Family advised to contact police and Community Recovery Team North.

On the same date an ambulance was requested by police to attend Baseet following a report he was having a '*mental health episode*'. Police later cancelled the request as Baseet's father was taking him to hospital.

26 March 2020: Police MERLIN report: police were called by Baseet's sister worried about her brother's welfare as he was throwing stuff around his room and not taking medication. When officers arrived, he was calm and collected but stated he wanted to be re-housed. After a long conversation police were satisfied that there were no immediate concerns. 30 minutes later the family called again, and reported that '*behaviour*' continued. The outcome was that he was taken to hospital by his father with police accompaniment. He was seen by a Crisis Team for mental state assessment and 'reported difficult family dynamics': he wanted to be re-housed and had an appointment with the Homeless Prevention Advice services scheduled for 28 May.

5 Apr 2020: An ambulance attended Baseet following a report that he had a fever, could not relax, and had leg pain. Following telephone assessment, he was referred to NHS 111.

6 Apr 2020: An ambulance attended Baseet following report of pain in his body and feeling dizzy. Following telephone assessment, he was referred to NHS 111.

On the same date (6 Apr 2020) Baseet's father contacted a mental health crisis line concerned about deterioration: Baseet was agitated and pacing, with increased energy. Information was forwarded to a community team for follow up.

7 Apr 2020: The GP reviewed Baseet's mental health with his father.

14 May 2020: Baseet did not attend a mental health outpatient appointment. A doctor spoke with his family who '*denied any concerns for mental state or risk*' at the time.

18 May 2020: An ambulance attended Baseet after his sister contacted police and said that Baseet was holding a knife and threatening to harm himself and others: he had not taken his medication, was going crazy, was trying to run out of the house, shaking a lot and drinking lots of caffeine. Due to the nature of the call the police were also asked to attend and were on scene on ambulance arrival.

Baseet had said that he was having a mental health breakdown and wanted to stab himself and others. Police were informed that he was smoking outside and had a knife. On police arrival Baseet ran at the officers and was 'red dot challenged' with a Taser: he then complied, was handcuffed and searched but no knife was found. He was detained under section 136²⁶ of the Mental Health Act and taken to hospital. He said he still wanted to kill people and that he had been going to meetings where they were telling him to stab people and kill them. Baseet also mentioned a yellow and silver kitchen knife in his mother's kitchen which he had planned to take to stab people with. A MERLIN was created and shared with adult social services.

He was admitted to a Centre for Mental Health under a Section 2 of the Mental Health Act²⁷.

19 May 2020: Baseet called police from a Centre for Mental Health to say he was not being allowed out of the Centre - he wanted officers to come and get him. Police tried to call back but could not get through. No further action was taken.

20 May 2020: Baseet called police from a Centre for Mental Health again to say he was not allowed out of the mental health centre and nothing was happening with regards to treatment. Also told the operator that the nurses were trying to strangle him. No further action taken and police did not attend as he was in a place of safety.

3 June 2020: Baseet was referred to a mental health access and assessment team during hospital admission at a Centre for Mental Health. Care Act assessment was completed on 3 June and he met the eligibility threshold for support under the Care Act in the following domains: developing and maintaining relationships; making use of the community, and accessing and engaging in work, training, education or volunteering. Recommendations were made for a care package of outreach support totalling 5 hours per week, to support him to identify and attend activities outside the home, to explore volunteer work and to attend appointments. Risk assessment indicated aggression towards family, isolation, and self-harm.

8 June 2020: Baseet spent 20 days on Section 2. On discharge from Section and ward, he was referred to local authority to request follow up by social worker with consideration of a Support Worker for 'community support'.

²⁶ Section 136 of the Mental Health Act gives police emergency powers if they think someone in a public place has a mental disorder and needs immediate help.

²⁷ Section 2 of the Mental Health Act 1983 allows a person to be admitted to hospital for up to 28 days, for assessment. See <https://www.legislation.gov.uk/ukpga/1983/20/section/2> for more details.

Early July 2020 (date not identified): Assessment carried out by 'Three C's'²⁸ to explain the type of support they could offer Baseet to reduce isolation and provide structure. He declined the support, stating he wanted his physical aches and pains to be reduced and that this is what prevents him going out. He also stated he thought a move from the family home would be beneficial as aspects of his relationship with his parents impact his mental health. Following this, the allocated social worker phoned his father who stated the family would continue to support him. An email was sent to his consultant psychiatrist; he was referred to a Supported Employment Team and his case was closed to the mental health access and assessment team. It is not clear what happened with referral to the Supported Employment Team.

22 July 2020: A pharmacist reviewed Baseet as he was on the serious mental illness register and on a GP practice register for quarterly reviews (however it appears that reviews did not take place consistently).

1 Oct 2020: An ambulance was requested by police to attend Baseet following a report that he was having mental health issues and throwing boiling water at his family. It was also reported that an ambulance was needed for a female who had been scalded, living at same address. Following assessment, a woman's burns were dressed and she was left at home in the care of family with advice to ring back if the burns worsened.

Baseet was arrested for actual bodily harm. Officers were concerned for his mental health as he was more worried about the fact his mother would not let him have any cigarettes than the incident. He was bailed for the offence and given conditions not to contact the family or attend the home address. The officer involved made numerous attempts to obtain a statement but ultimately Baseet's sister and mother did not want to support a prosecution, as they were worried about Baseet's mental health and believed he was unable to look after himself. They wanted him back in the family home. There was no other evidence to support a prosecution. Multi-Agency Risk Assessment Conference (MARAC) referrals were recorded by the police as having been made²⁹, and a MERLIN was created and shared with Adult Social Care. The MERLIN report was received by Adult Social Care on 2 October and noted that police were called by Baseet's sister for a domestic violence incident – Baseet had thrown boiling water on his mother after an argument about cigarettes.

2 Oct 2020: Baseet was diverted from police custody to hospital under Section 2 of the Mental Health Act³⁰. He reported that his family were not his family, that they were paid to make him take tablets, and that he will stab them. He presented as guarded, thought disordered, floridly psychotic, and with homicidal thoughts. Police completed a safeguarding referral. During

²⁸ Three Cs stands for 'Control and Choice in the Community'. This involves providing Community Support, Supported Living, and Social Inclusion and Day Services for people with learning disabilities, autism and/or mental health challenges.

²⁹ See further information about this MARAC referral in Analysis page 47 – this referral could not be traced.

³⁰ Section 2 of the Mental Health Act 1983 allows a person to be admitted to hospital for up to 28 days, for assessment. See <https://www.legislation.gov.uk/ukpga/1983/20/section/2> for more details.

admission, Baseet required transfer to Psychiatric Intensive Care Unit after he assaulted a patient. He was discharged from Section 2 and from the ward after 25 days, and referred for supported living but declined this; his family wanted him to return to living with the family.

2 Oct 2020: An ambulance attended a woman at Baseet's address following a report that a woman had been burnt the previous day and was in extreme pain with blisters on her skin which had peeled off, and that she was unable to get dressings off. It was reported that Baseet had poured hot water on her following a mental health episode. Following assessment, she was conveyed to hospital and her care handed over to hospital staff.

27 Oct 2020: Baseet was made an informal patient with plan to remain on the ward until appropriate discharge destination identified. He then left the ward and returned to the family home at 3pm. Baseet's father stated that Baseet would not be returning to the ward.

28 Oct 2020: Baseet was discharged from the ward in his absence.

2021

22 Jan 2021: An ambulance was requested and attended Baseet following a report that he was being verbally aggressive, hallucinating and had a history of mental health problems. It was documented that Baseet was scared his behaviour was escalating and that previously he had poured water over his mother: he also requested police attendance. Baseet reported that he felt he was unable to stay in the house with his family. Family stated that Baseet had taken double his medication: Baseet denied this.

He was referred for a clinical ring back. Following an enhanced telephone assessment, it was deemed that an ambulance was needed. On arrival of the ambulance staff, they documented that Baseet was not on scene. He was wandering around Newham. An area search was completed but Baseet was not found. Ambulance staff left the scene advising the family to ring back if they were further concerned when Baseet returned.

23 Jan 2021: Baseet's father reported to police that he had gone missing in the early hours but he returned 25 minutes later when police attended.

23 Jan 2021: An ambulance later attended Baseet following a report that he was anxious and depressed - his father was on scene. Following assessment, he declined to go to hospital, was deemed to have the capacity to decide, and was left at home in his family's care.

23 Jan 2021: Subsequently an ambulance attended Baseet following a report that his heart was beating fast and he felt uncomfortable and frightened. The crew noted he had earlier declined to be conveyed to hospital but on this occasion, ambulance staff felt he did not have capacity to make this decision and requested police to assist in his best interests. Police asked Baseet to go to the ambulance and he complied. He was conveyed to hospital 2, where care was handed over to hospital staff.

Police completed a MERLIN and shared it with Adult Social Care.

24 Jan 2021: In the Emergency Department his mother filled staff in with some of Baseet's history and reported that he had not slept for a week, his hallucinations/ delusions had worsened and he believed he would be killed. He was '*violent to family members.*' He was referred to liaison psychiatry who discussed giving him intramuscular lorazepam and contacting them when 'medically clear'. The medical plan was recorded as intravenous antibiotics and fluids.

25 Jan 2021: Baseet was noted to have high inflammatory markers and was suspicious when a doctor tried to see and examine him. That same day a Learning Disabilities Nurse visited but was unable to assess him (he was asleep) and contacted the Newham Learning Disabilities team. The notes suggested he had a learning difficulty rather than a learning disability. A Charge Nurse completed a Deprivation of Liberty Safeguards (DoLS) Form and assessed him as not having capacity to agree to close observation; remaining on the ward; low rise bed; sedation; and 1:1 security.

25 Jan 2021: Adult Social Care subsequently received a DoLS Form 1 from Hospital 2 requesting standard authorisation and urgent authorisation. The purpose of the standard authorisation stated help with personal care, mobility, intra-venous medication. Behaviour issues were specified as distress, aggression, wandering and communication issues related to learning disabilities. He was deemed not to have capacity to agree to close observation, being kept on ward, sedation, low rise bed and 1:1 security. Risks without the deprivation of liberty authorisation included aggression to others causing hostile response, self-neglect, vulnerable, falling and inadequate nutrition. The outcome was that Baseet was discharged on 28 January 2021 before the DoLS process could be completed. There is no further information on the Adult Social Care system regarding the nature of the hospitalisation or further outcomes.

26 Jan 2021: The medical registrar discussed Baseet's care with an on-call consultant psychiatrist who suggested community follow-up if his psychiatric symptoms did not change. The registrar tried to call the family but did not get through.

27 Jan 2021: Baseet told the psychiatric liaison team that his parents did not want him home – no reason was given.

28 Jan 2021: The psychiatric liaison team recommended home treatment team review after discharge. The discharge summary said that Baseet was treated for an infection with antibiotics and improved clinically.

7 Feb 2021: An ambulance attended Baseet following a report that he was generally unwell. He was referred for a clinical ring back. Following an enhanced telephone assessment via his father, advice was that he was to attend an Urgent Care Centre, but the family insisted an ambulance attend. An ambulance subsequently attended Baseet and, following assessment, he was conveyed to hospital, where care was handed over to hospital staff.

29 March 2021: The community team discharged Baseet from their care back to GP following a period of non-engagement.

14 Apr 2021: The ambulance service received a call regarding Baseet – it was reported that the GP was not helping but an ambulance was not required. Baseet was advised to call 111.

14 Apr 2021: A call was received by the ambulance service giving Baseet's address details. The caller requested to speak to a Bengali doctor. They were advised they could talk to the call handler via an interpreter. This was declined – the caller said they would call back later.

14 Apr 2021: A call was received by the ambulance service: the male caller was initially reluctant to give any details. They asked for housing assistance and wanted to speak to a lady doctor. They then reported a headache. Clinical ring back was needed. A further call was later received cancelling the ambulance request as Baseet was feeling better.

11 May 2021: An ambulance was requested to attend Baseet following a report that he was having mental health problems, had stopped taking medication and was throwing stuff around – it was referred for a clinical call back. Following enhanced telephone assessment, it was deemed an ambulance was needed. Following assessment, Baseet was conveyed to hospital, where care was handed over to hospital staff.

12 May 2021: Baseet was referred for a Mental Health Act assessment. He had been taken to hospital via ambulance for physical health issues, and cleared of any physical health concerns but there were concerns over his mental state. He did not demonstrate any insight, and the impression was that his mental state was relapsing. He stated that he wants his own home and support with this, as there were too many people in the house. The outcome was an admission to mental health in-patient care that same day under Section 2 of the Mental Health Act³¹. The Approved Mental Health Professional recommended social care needs assessment.

20 May 2021: GP spoke with Baseet's mother and sister. They were concerned that he did not take medications and therefore relapsed. He was currently an in-patient. They were asked to wait and see what plans were made on discharge.

22 May 2021: Baseet called police whilst an in-patient at a mental health centre and said that his bank card had been stolen. Police attended next day and Baseet said that he called police because they would not let him smoke on the ward and his card was not stolen. No further action was taken.

³¹ Section 2 of the Mental Health Act 1983 allows a person to be admitted to hospital for up to 28 days, for assessment. See <https://www.legislation.gov.uk/ukpga/1983/20/section/2> for more details.

8 June 2021: When Section 2 was expiring, he was regraded to Section 3 of the Mental Health Act after Mental Health Act assessment³² on 8 June 2021. The assessment found that he was still lacking insight and appeared pre-occupied with housing, wanting independent accommodation. Because of concerns for erratic compliance with oral medication, he was prescribed depot medication³³.

9 June 2021: Baseet failed to return from Section 17 authorised unescorted leave on 9 June. His s2 leave arrangements were 30 minutes unescorted leave twice per day and this is believed to have continued when the Section was regraded to Section 3.

11 June 2021: the in-patient mental health ward reported to police that Baseet was absent without leave.

5.2.4 From the date of Shompa's stroke to her death in April 2022

11 June 2021: An ambulance attended Shompa following a report that she had fallen off the bed, had slurred speech and numbness to left side of body. Her granddaughter was on scene. Shompa was assessed as FAST+ (Face, Arms, and Speech Test positive)³⁴ suggesting that she had had a stroke, and was conveyed to Hospital 3, where care was handed over to hospital staff. In the Emergency Department staff recorded that her family had noted complete left-sided weakness. Her son assisted with translation but his name was not documented in the notes. In the Stroke Unit Shompa was seen by occupational therapy who called her 'next of kin' (noted to be a granddaughter) to request consent to carry out assessment in Shompa's best interests due to 'the language barrier'.

11 June 2021: Baseet was reported missing from an in-patient ward at a Centre for Mental Health while on un-escorted leave. He had returned home. His father said he would return Baseet to hospital that morning, but Baseet did not return. The mental health facility said they did not need further police involvement as they knew his whereabouts.

15 June 2021: An alert was added to Shompa's hospital records by the Overseas Department stating that Shompa was **not entitled to free NHS treatment** and that appointments should not be booked.

16 June 2021: Notes added to the hospital electronic system stated that Shompa was a Bangladeshi national who entered the UK in 2009 as a visitor. Her son (name given, and the person noted on the electronic records as her

³² Section 3 of the Mental Health Act 1983 allows a person to be detained in hospital for treatment and care for up to 6 months. See

<https://www.legislation.gov.uk/ukpga/1983/20/section/3> for more details.

³³ Depot medication is given by injection and released slowly.

³⁴ The FAST test looks for the common symptoms of a stroke. For further information see <https://www.nhs.uk/conditions/stroke/symptoms/>

next of kin) had said that her passport was lost/ missing, she had no family in her homeland, and the son was aware that her care was chargeable.

16 June 2021: An ambulance was requested to attend Baseet following a report that he was refusing to take medication and was aggressive: he was on leave from a mental health ward at the time and still under Section 3 of the Mental Health Act³⁵. He did not want to return to the ward.

17 June 2021: Police were called by Baseet's father who said Baseet was detained under Section 3 and had absconded the Centre for Mental Health a week ago. The family had asked the Centre to take him back but they would not collect him. His mental health had deteriorated. Police attended the address and took Baseet back to in-patient mental health care. He was described as having been found at his parents' home looking 'emaciated and scruffy'. Police completed a MERLIN and this was shared with social services.

18 June 2021: Baseet was now back on the ward: a risk assessment recorded that he destroyed Trust property, slapped staff and voiced sexually inappropriate words towards staff. His risk history was noted to include '*aggression towards family*'.

18 June 2021: Shompa was still on the stroke unit and noted to be crying during a ward round. The plan was to refer her to 'neuro psych' but there was no further record relating to a neuro psych referral and no exploration of the reason for her crying was noted. Later she was seen by occupational therapy using an interpreter via video link and was tearful throughout assessment. It was noted that she was confirmed as an overseas patient, and could not return to her next-of-kin's property: she was now homeless. Safeguarding was not considered.

22 June 2021: Shompa was seen by speech and language therapy with her 'next of kin' (said to be youngest daughter and son) who said they would manage her care at home. A new wheelchair was provided.

23 June 2021: Shompa was again seen by speech and language therapy using her son for support and translation. It was noted that her 'next of kin' (name not recorded) said she was emotional as they had not seen one another for a few years until this week.

Later that same day she was seen on the ward by physiotherapy and occupational therapy and her son (name given) translated. He reported that Shompa would be going to live with another son (name given) and the address was said to be in the front of the file but no alternative address was documented.

Later that afternoon her son agreed to take her home in the family car and was given some training. The team advised that it would be beneficial for Shompa to have private physiotherapy if possible and he was given a list of

³⁵ Section 17 of the Mental Health Act (1983) gives the responsible clinician of a patient detained under the Mental Health Act the power to grant that patient leave from the hospital.

equipment to purchase for her. There is no evidence that interpreting services were accessed to obtain Shompa's views and wishes.

The discharge summary gave the primary diagnosis as right middle cerebral artery and posterior cerebral artery stroke. The discharge address did not indicate a different address from admission and the plan was given as:

1. Stroke follow up
2. 24 hour tape and echocardiogram as an outpatient (this was cancelled on 25 June as she was housebound with no further follow up noted)
3. Aspirin initially then clopidogrel
4. Continue the statin
5. Continue pregabalin for 1 month then GP to review

However, it was known that Shompa had no registered GP at that time, and we were told that the discharge summary was not sent.

24 June 2021: Baseet was referred for a Care Act assessment by a Centre for Mental Health on 23 May for possible exploration of supported accommodation. The referral stated that he informed the Ward that he was in receipt of Employment and Support Allowance³⁶ (ESA) managed by the family, and it was unclear whether he could access it, stating 'they spend my money'. A request was made to further explore this.

The Care Act assessment was not completed as Baseet was discharged back to the family home. Social Workers' notes state the family did not wish to pursue supported accommodation and instead were satisfied that Baseet was started on depot treatment. Notes also stated that he was care coordinated and working with the family for extra support. The case was then closed.

4 July 2021: Police were called to the Centre for Mental Health by staff, who alleged Baseet had touched a female nurse's bottom over her clothing whilst she was completing her tasks. He had been following her into other patients' rooms, watching her whilst treating other patients, and making sexual remarks, causing her distress. This was the second time it had happened and she did not want him arrested. Due to concerns about Baseet's mental capacity, it was agreed that matter would be dealt with internally and action would be taken to safeguard the victim and Baseet. Police officers spoke with Baseet but he had been sedated and did not speak with clarity. Police officers created a MERLIN and this was shared with Adult Social Care. No formal capacity assessment was recorded. It was agreed that Baseet or the nurse would transfer to another ward.

6 July 2021: Police Merlin report: Police called to ward at Centre for Mental Health by female nurse stating sexual assault - Baseet touched her bottom. Nurse stated this was the second time this has happened, did not want to progress the investigation, but wanted to report it. Outcome: To safeguard the nurse either Baseet or nurse was to move to another ward.

³⁶ Employment and Support Allowance is a benefit that people who have a disability or health condition that affects how much they can work can claim. See <https://www.gov.uk/employment-support-allowance>

29 July 2021: Baseet was discharged from in-patient mental health care to the care of the Community Recovery Team North. By this time his grandmother was back at Address 1 being cared for by family.

30 July 2021: A contact form was created by Newham's Access Team following a referral dated 28 July 2021 (received on 29 July 2021) from a GP practice giving the following information: Shompa had a stroke one month previously and right sided weakness. Her family was not coping with her support needs – she had difficulties mobilising and managing continence as she was unable to get to the toilet. She was living at Address 1 (the address where she later died). On that same date the GP practice was emailed by the Access Team to advise that Shompa's family had declined support for her and that her son said they were happy to continue caring for her and would contact if support was needed in future.

5 Aug 2021: Mental health and asthma reviews were carried out for Baseet by his GP on a home visit but no learning disability review took place. The GP offered blood testing when required for Baseet's medication. The family painted a picture of a man who didn't like talking to people because of mental health issues. Most consults were done on his behalf - by either his sibling or parents - although he had been seen for a home visit in August 2021 and November 2019. He didn't like attending surgery to have blood tests so reasonable adjustments were made to do them in the community.

16 Aug 2021: An ambulance attended Shompa at her home (Address 1) following a report that she had a swollen left hand, painful and slightly numb. There was no answer at the door on ambulance arrival. On call back, the Ambulance Service was told an ambulance was not needed and Shompa would see the GP.

1 Sept 2021: Police contacted the surgery – Baseet was admitted for his mental health in June 2021 and stabilised on depot medication.

7 Sept 2021: An ambulance was requested to attend Baseet following a report of headache. Enhanced assessment was attempted but Baseet declined to talk. His mother reported he had been pacing all day but was not aggressive. The call was later cancelled, as Baseet was reportedly feeling better.

21 September 2021: The Anti-Social Behaviour team received a report from a resident of (the street of Address 1) saying '*Outside (Address 1) in the car park, a BMW which belongs to a resident is smashed in the front end of the car and the car alarm keeps going off all day and night witch (sic) keeps the young children up. This has been going on for over a month now and is becoming a massive problem as the owner leaves the car here 24/7 and works in the day so is not here to turn the alarm off*'. The Anti-Social Behaviour team noted that an advisory letter was sent to (Address 1) to disable the car alarm.

23 Oct 2021: A welfare check was conducted at Baseet's address by a detective who was investigating the assault on his mother. A MERLIN was created and shared with adult social services.

2022

2 Feb 2022: Baseet's sister called the GP practice concerned about her brother, stating that he lacked insight, was paranoid, had trashed his room, and was not compliant with medications after his depot appointment was changed (he did not like change). The GP signposted her to the crisis team (Baseet's father had called them twice already). Advice was given about contacting police and ambulance if fearful.

4 March 2022: An ambulance attended Baseet at his home following a report that he was having a mental health crisis and had stopped taking medication. He had smashed his bedroom wall with a hammer and removed plaster stating he was making room for his wife despite being single. Following assessment, he declined to go to hospital. It was deemed that he did not have decisional capacity, and discussions took place with the mental health team. It was deemed that he needed to be taken to hospital and that police should be called to assist. Police assisted and he was transported to a Centre for Mental Health under the Mental Capacity Act³⁷. He went willingly. Police created a MERLIN and shared it with adult social services.

Mental Health Act assessment took place after Baseet was taken to the Centre for Mental Health by ambulance and police. The outcome was admission under Section 2 of the Mental Health Act³⁸.

19 March 2022: Baseet was reported missing to police by a Centre for Mental Health where he was an in-patient. He left the ward whilst on un-escorted leave and went to his home address. The Centre contacted him but he refused to return. There was no immediate risk, so the Centre was told that police would not attend and the mental health team should respond.

20 March 2022: Further call to police regarding Baseet being missing from the Centre for Mental Health. Baseet had not returned. Staff were concerned he would not take his medication and that his mental health might deteriorate. It was explained that this was not a police matter and should be dealt with by centre staff or the ambulance service.

21 March 2022: Police received a further call from a Registered Mental Health Nurse on a mental health ward regarding Baseet being missing from the ward: staff reported he had still not returned. The police recorded that mental health team staff did not want to attend Baseet's home address as Baseet was a risk to their safety. Baseet's father also called police and asked for assistance taking him back to the Centre. Police attended Baseet's home address and returned him to the centre. Whilst an in-patient, Baseet was absent without leave for 1 week, residing with family and refusing to return to ward. His family

³⁷ For Mental Capacity Act (2005) see <https://www.legislation.gov.uk/ukpga/2005/9/contents>

³⁸ Section 2 of the Mental Health Act 1983 allows a person to be admitted to hospital for up to 28 days, for assessment. See <https://www.legislation.gov.uk/ukpga/1983/20/section/2> for more details.

'denied' any concerns for Baseet during this time (according to mental health services) and said they were unable to convince him to return to ward.

Date shortly before Shompa's death: Baseet was discharged from the ward back to the care of a community team. Baseet's father agreed to his discharge to the family home and Baseet was keen to return to the family home: '*no evidence of risks to self or others upon discharge*' was recorded.

Date in April 2022: An ambulance attended Shompa at her home address (Address 1) following a report she had been stabbed in the neck and was not breathing. Shompa was recorded to have multiple stab wounds. The Helicopter Emergency Medical Service also attended. Shompa was pronounced life extinct by the Helicopter Emergency Medical Service doctor at 10:40 and left on the scene in Police care.

Whilst police were responding to the call to Shompa, other officers stopped Baseet based on a description of the offender. He was arrested and taken into custody where he was interviewed.

Date in April 2022: A forensic post mortem found that the worst of Shompa's injuries were through the chest cavity, and inflicted with a severe level of force. Many of the injuries were capable of being fatal.

Baseet was subsequently charged with murder.

29 March 2023: A criminal trial took place at the Central Criminal Court and the jury returned a verdict of guilty in relation to Baseet committing the act of killing Shompa. Baseet was sentenced to a Section 37 hospital order with a Section 41 restriction³⁹ (Only the Home Secretary has authority to release).

³⁹ A Section 37 of the Mental Health Act (1983) is called a 'hospital order' and means that a court has decided that instead of going to prison a person should be in hospital for treatment of a serious mental health problem. It is called a 'hospital order'. A Section 41 of the Mental Health Act is known as a 'restriction order' and is imposed by a court because of concern about public safety. See <https://www.legislation.gov.uk/ukpga/1983/20/section/37> and <https://www.legislation.gov.uk/ukpga/1983/20/section/41>.

6. OVERVIEW

This overview summarises what information was known to agencies and those involved with the family.

By the time of Shompa's death Baseet was well known to police, the ambulance service, his GP and mental health services. He had first become known to mental health services in 2010 when he was seen by the Early Intervention in Psychosis team and had been admitted to mental health care under the Mental Health Act twice in 2018 and once in each of 2020, 2021 and 2022. He had a pattern of not complying consistently with appointments or medications and of going absent from the ward whilst an in-patient. He lived with his family at Address 1.

The Anti-Social Behaviour team was contacted on a number of occasions due to loud noise, sometimes drug use or drug dealing, and on one occasion threatening behaviour, around Baseet's home address, although his family said they did not want to be visited for safety reasons.

The ambulance service and police were regularly called out to Baseet's home address, often because of concerns about his mental health and behaviours which could be aggressive. There was an incident when he sexually touched his sister (although police were unaware of this), and his mother was injured in a domestic incident when he threw boiling water on her. Police officers were very concerned about Baseet and 18 MERLINS were completed by Police between July 2018 and Shompa's death, though not all were shared.

Shompa was disabled following a stroke in June 2021 that occurred around the time that Baseet was also at Address 1 – he was absent without leave from a Centre for Mental Health where he was an in-patient detained under the Mental Health Act. Shompa was admitted to hospital and her discharge was arranged with the Lead Family Contact who did not live with her. Her hospital records stated erroneously that she was not entitled to free NHS treatment. After Shompa was discharged from hospital post-stroke, she was cared for by family members. She lived with Baseet and other family members at least some of the time. Adult Social Care contacted her family at the request of her GP who told them that the family was not coping with her support needs. The Access Team liaised with the Lead Family Contact, and informed the GP that the family declined support and said they were happy to continue caring for her and would get in touch if support was needed in future.

Two days after Baseet's discharge from the last mental health admission, ambulance and police were called to attend Shompa at Address 1 after receiving a report that she had been stabbed in the neck and was not breathing. Three women family members were present in the house with her at the time. The Helicopter Emergency Medical Service attended and she was pronounced dead at the scene. Baseet had left the house and was detained and arrested by other officers a short distance away. He was subsequently charged with her murder and found guilty of committing the act of killing Shompa at a later criminal trial of the facts.

7. ANALYSIS

7.1 Key lines of enquiry

The key lines of enquiry below (in italics, no bold) are numbered in line with the terms of reference and grouped thematically below. Key line of enquiry number 14 (*What learning has emerged for each agency?*) is addressed under 9. Lessons to be learnt, and key line of enquiry number 15 (*Are there any examples of outstanding or innovative practice arising from this case?*) are addressed under 7.4 Good practice.

7.1.1 Domestic abuse

1. *What information did each agency hold about the relationship between victim and alleged perpetrator, indicators of domestic abuse, mental health issues and/ or alcohol/ substance-related issues and did this information inform risk assessment and practice?*

Baseet is part of an extended and supportive family. In 2014 he received a suspended sentence and was required to live with his grandmother (believed to be Shompa). We understand that Shompa moved between different family members, at least in her later years, and that, after she had a stroke and became physically disabled, she was cared for by family members. This, however, might have meant that her address was uncertain and agency practitioners would not necessarily know where she was living at any one time. Thus, without checking out who would be in the home when Baseet was discharged from hospital in late March 2022, mental health staff were unaware that his grandmother, herself in need of considerable care and support in respect of activities of daily living, was living in the home to which he was discharged. The doctor who admitted Baseet to hospital on 5 March 2022 recorded in the social history that Baseet 'lives with mother, father, grandmother, sister and aunt in a house' - this information was therefore available to staff involved in discharge planning and arguably should have been taken into account.

There are references to Baseet's aggression towards family and domestically abusive behaviour from early in the scoping period:

5 August 2016: his mother told the GP that Baseet '*can get aggressive*'.

1 Nov 2018: an ambulance was called to the home and staff were told that Baseet '*had been throwing things around*'.

25 July 2019: an ambulance was called to the home and staff were told that Baseet '*was angry, violent, trying to leave the house but being restrained by his mother and aunt*'.

23 August 2019: an ambulance was called to the home and staff told that Baseet '*was verbally aggressive, (and) had twice put cleaning products in his family food*'.

24 August 2019: the crisis team was told that Baseet '*had thrown Mum's phone at her, in attempt to hurt her, and was pushing Dad around in attempt to hurt him*'. That same day police called an ambulance to Baseet who was reported to be '*very aggressive to his family*'.

27 August 2019: Adult Social Care was informed of the events of 23 and 24 August and also that he had '*touched his sister in a sexually inappropriate manner and the family had locked themselves in a different room to call the police*'. Similar information was given to mental health.

On 23 August 2019 Baseet put '*cleaning products*' into family food and on 24 August 2019 it is documented that Baseet attempted to hurt both his mother and father. It appears that he also sexually assaulted his sister. Family members were evidently afraid of him as they locked themselves in a room to call police. Police, ambulance service, mental health and Adult Social Care all became aware of these events (although the police were unaware of the sexual assault involving his sister, attempting to hurt his parents, and the cleaning products put in food). Baseet was an adult with care and support needs and this should have been referred for a safeguarding response. A domestic incident had taken place, agencies were aware, and yet this appears to have been a **missed opportunity** to trigger a multi-agency response.

Prior to this incident, reports refer to verbal (and possibly physical) aggression.

28 October 2019: an ambulance was requested by police as Baseet '*was becoming aggressive*' and it was reported that he no longer wanted to live with family.

October 2019: mental health report states that Baseet called police threatening to kill his family. The crisis team and local authority were notified of this by police.

In October 2019 there is the first documented threat to kill his family. Police, mental health and Adult Social Care were aware of this. There is reference to police notifying the local authority of 'safeguarding concerns' but there was no safeguarding response. This was **another missed opportunity**.

6 November 2019: Baseet called police saying he '*wanted to harm someone*'.

26 March 2020: police called - Baseet was '*chucking stuff around his room*'.

March 2020: crisis line contacted by family Baseet was '*verbally aggressive and violent, breaking furniture and items*'.

18 May 2020: ambulance called - Baseet was '*making threats to harm, himself or someone else*'. 'Had said he '*wanted to stab himself and others*'. After being detained '*he said he still wanted to kill people and had been going to meetings where they were telling him to stab people and kill them*'.

Adult Social Care records state that '*family reported he was threatening them with a knife*'. Mental health records record similar information.

Again, after repeated episodes of aggression and violence, in May 2020 there is a documented threat to family with a knife in the context of ongoing aggressive/ violent behaviour. By this stage there appears to be a pattern emerging of threats to family and/ or others with a knife by a mentally ill individual with care and support needs, and of **missed opportunities** to intervene.

3 June 2020: Adult Social Care records note that risk assessment '*indicates aggression towards family*'.

1 October 2020: ambulance requested by police - Baseet '*throwing boiling water at family*'. His mother was injured in this incident.

October 2020: Referring to mental health assessment of Baseet following the boiling water incident, it was noted by mental health that he had '*homicidal thoughts*'.

This was another clear domestic incident in which Baseet's mother (his main carer) was injured: a further **missed opportunity**. This incident was dealt with by the police Domestic Abuse unit and the officer involved says they made a referral to the Multi-Agency Risk Assessment Conference (known as the MARAC), however during the review process, the Panel was told that the referral could not be traced. HM Coroner's investigation had led to new information being found. It is clear now that a referral to the MARAC was indeed made by the police, but a decision was made to reject it for reasons that remain unclear. Baseet's case met the Domestic Abuse Multi-Agency Risk Assessment Conference threshold. The system in Newham has changed and now, in the event of a referral being rejected, the Coordinator goes back to a referring agency for more information in order to ascertain whether a MARAC referral meets the necessary threshold. Emails are sent to the referring agency to confirm the decision if a referral is rejected.

It is clear from the police individual management review that the police had real concerns for Baseet's mental health and the safeguarding of his family. The police officer in charge of the case relating to Baseet's arrest for Assault occasioning Actual Bodily Harm on his mother in the incident on 1 October 2020 contacted the mental health unit repeatedly to see what safeguarding measures were being put in place for the family when Baseet was discharged from in-patient mental health care. When informed that the community mental

health team was working with the family, the officer contacted the community team. The officer's line manager also emailed the police mental health team in an effort to escalate the matter and was contacted by the medical team in charge of Baseet's care who told them that a medical review would be arranged as soon as possible.

October 2020: mental health records record that Baseet reported '*he will stab them*' (ie family). (He reported that his family were not his family, that they were paid to make him take tablets, and that he will stab them.)

24 June 2021: Adult Social Care records note '*risk history includes aggression towards family*'.

2 February 2022: GP records note that Baseet '*had trashed his room*'.

4 March 2022: Adult Social Care records note Baseet '*had smashed his bedroom wall with a hammer*'.

21 March 2022: police recorded that Centre for Mental Health staff did not want to attend Baseet's home address whilst he was absent without leave as '*Baseet was a risk to their safety*'. The mental health report confirms this stating '*explained (to the police) about the current risks and how unsafe it was for staff to do that*' (referring to bringing Baseet back to hospital).

It appears that staff recognised the risk to their safety whilst family members did not. It also appears that, whilst concerned about their own safety, staff were less concerned about the safety of family members sharing the house with Baseet. It may have been that they were reassured by what the family told them, but the facts of incidents known to have taken place might have been expected to raise concerns for the family. Discussions regarding risk with family members appear to have focussed on Baseet's challenging behaviour and family members knowing where to get help in that context. Information received shows that family members were aware of how to access help and acted on this at various points in crises.

2 April 2022: Shompa stabbed at home address and Baseet subsequently arrested.

There were clear domestic incidents in August 2019 and October 2020 when family members were at risk or injured, together with a pattern of threats to kill, and ultimately Shompa, who was disabled following a stroke and being cared for by family, was stabbed at the family home and died. A safeguarding response or legal avenue could have been pursued at a number of points but was not, despite the fact that agencies in contact with the family were aware of what was happening. Why not?

It is likely that there were several factors in this:

- Sometimes domestic abuse is seen through the lens of intimate partner violence, and abuse by family members who are not intimate partners is not regarded in the same way either by agency practitioners or by families. Adult family violence⁴⁰ is a term sometimes used for domestic abuse by family members who are not intimate partners (e.g. between a son and his mother, sister or grandmother as in this case) but is part of the spectrum of domestic abuse and should be accorded the same priority.
- Baseet was regarded as mentally ill and his behaviour seen in that context, so a mental health response was seen as the avenue of choice.
- At various points the records note that the family '*denied*' risk to themselves. The Mental Health Trust refers to '*understatement and changeability of reporting*' and '*possibly minimising concerns*'. This use of language is unacceptable. There might have been a number of reasons why family continued to try to care for Baseet despite the risks to themselves and why they might have given different accounts to different people, including:
 - they may well have been afraid what might happen to him if they did not carry on caring
 - despite his actions and their fears, they did not believe he would harm a family member
 - at times he might have appeared to be ok
 - the GP individual management review notes that the family may have been fearful of criminal proceedings against him
 - they were trying to protect Baseet and to prevent him getting into trouble
- When services are under pressure and families say they want to carry on caring, the option of least resistance for practitioners might be to go along with what family want to do. Did anyone sit down with family members and talk frankly with them about the risks they were facing? How far were the women who (it appears) were doing most of the caring included in conversations about risk and about options for Baseet?
- The GP individual management review suggests that GPs may have been reassured that Baseet was under the care of psychiatry and being regularly assessed by mental health practitioners.
- The police individual management review notes that many of the calls attended by police may in future be attended by health care professionals under the Right Care Right Person⁴¹ initiative.

There might also have been questions about Baseet's finances. He was referred for a Care Act assessment by a Centre for Mental Health on 23 May 2021 for possible exploration of supported accommodation. The referral stated he informed the Ward that he was in receipt of Employment and Support Allowance, which was managed by the family, and it was unclear if

⁴⁰ Benbow, S.M., Bhattacharyya, S. and Kingston, P. (2023). Adult family violence coming out of the shadows, *The Journal of Adult Protection*, 25 (2): 91-99. <https://doi.org/10.1108/JAP-11-2022-0029>

⁴¹ See <https://www.gov.uk/government/publications/national-partnership-agreement-right-care-right-person/national-partnership-agreement-right-care-right-person-rcrp>

he could access it. In addition, he stated that *'they spend my money'*. We do not know whether Baseet had the mental capacity to manage his own finances and it is possible that family members thought him unable to manage his money - that might have been why they handled it on his behalf. However, this statement of Baseet's could have raised the question of financial abuse and that possibility was not picked up at the time.

8. *Were agencies effective at holding the alleged perpetrator of domestic abuse accountable for his behaviour, and how was this addressed?*

The individual management reports and collated chronology show that the alleged perpetrator of domestic abuse, namely Baseet, was not held accountable for his behaviour.

It seems likely that Baseet's behaviour was seen by other agencies as related to his mental health (which it probably was, if not wholly, at least in part), and that this meant that other agencies regarded mental health services as the primary/ responsible agency and expected mental health services to deal with it, rather than taking action themselves. It is also possible that mental health services shared this view. The officer working on the incident when Baseet's mother was injured in October 2021 stands out for persistence in following the incident up and taking their concerns further.

An additional complication is Baseet's mild learning disability and how that might have impacted on his behaviour.

9. *Were there missed opportunities to intervene in relation to the domestic abuse?*

Yes, as detailed above there were missed opportunities to intervene.

11. *What knowledge or concerns did family, friends and/or employers have about domestic abuse and did they know what to do with it?*

Although family members were aware of the domestic abuse it seems likely that they did not fully appreciate the risks they were running and what options there were for them as family and for Baseet. They prioritised him and his life as part of the family over their own safety and the safety of other family members. Yet families cannot be expected to have the understanding of risk that health and social care practitioners have, and what was seen as the family's *'denial'* (or perhaps *'minimising concerns'*) in relation to risk does not obviate the duty of professionals to assess risk and respond appropriately: the language used could be regarded as *'family-blaming'*.

In this context, it is of note that, when contacted about discharge planning on 24 March 2022 by a Registered Mental Nurse, Baseet's father asked if Baseet could be put on a Section 3 of the Mental Health Act - one has to wonder

why? This does not fit with the understanding that family were happy to have him home at this point.

Mental health staff had the impression that Baseet was doing well at home during the time that he was absent without leave, and that the main concern was non-compliance with medication. The medication compliance was thought to be resolved via an agreement for intra-muscular injection in the arm rather than buttock. His father agreed to the discharge plan in a telephone call with one of the doctors on the day that Baseet was discharged. Our understanding, however, is that the women in the family were those who were providing the main support to Baseet, as well as caring for Shompa, and their views were not sought prior to his discharge.

Key points relating to domestic abuse:

- Agencies involved with Baseet and his family were aware of domestic incidents and ongoing threats and aggression.
- It appears that this awareness did not influence practice.
- There were missed opportunities to intervene.
- It is likely that mental health services were regarded by other agencies (and possibly regarded themselves) as the agency with prime responsibility to intervene.
- Baseet was not held accountable for his behaviour, possibly for a number of reasons.
- It is likely that Baseet's family members were not fully aware of the risks to them and available options that might have benefitted Baseet's mental health.
- It appears that mental health staff did not involve family members in risk assessment.

7.1.2 Policies, practice and partnership working

2. *Did each agency follow single and multi-agency policies and procedures (including the Multi-Agency Risk Assessment Conference)? Were there any gaps in policies or procedures?*

3. *What risk assessments were carried out in the case of victim and alleged perpetrator, and how was risk kept under review? Were risk levels appropriate and how was risk managed?*

The Mental Health Trust notes that the Care Programme Approach policy was not followed: Baseet should have had an allocated care coordinator because of the complexity of his presentation. It appears that one was allocated in February 2022 but that, because Baseet was admitted soon after allocation, this did not impact on his care. At the time of his discharge, it appears that he had a temporary care coordinator, whom he did not recognise or remember when they made contact with him: his allocated care coordinator was said to be on sick leave and not due back for 2 months.

The documents appear to suggest that risk was assessed without capturing longitudinal information and that a Domestic Abuse, Stalking and Honour

Based Violence Risk assessment (DASH)⁴² might have been triggered by Baseet taking a hammer to damage the bedroom wall. The Specialty Doctor who carried out a medical assessment and completed a medical recommendation for Baseet's admission on a Section 2 of the Mental Health Act appears to have been able to access Baseet's '*extensive risk history, including being assaultive towards his family, throwing boiling water over his mother, and being sexually inappropriate ... fire risk and damage to property with secondary risks of harming others and himself*'. The Trust papers note that longitudinal understanding of risk is an area for development. Further, it appears that family members did not appreciate the risks that Baseet might pose to them, and were not involved in risk assessment. It is worthy of note that, when Baseet was absent without leave during his admission to in-patient care in March 2022, staff from the Centre for Mental Health did not want to attend his home address to try to return him to hospital, as they regarded Baseet as posing a risk to their safety.

The individual management review comments on the decision-making process when Baseet was discharged from services after declining support, referring to paragraphs concerning right to refuse care; stopping of services and individuals who are at risk to self or others. The Section referring to stopping services states that services cannot be stopped in the case of a person experiencing or at risk of abuse or neglect: whenever Baseet stopped taking medication he relapsed and was at risk of self-neglect, whilst the family were at the same time left vulnerable and at risk of abuse. The Section relating to individuals who are at risk to self or others states that residents with a history of significant violence when mentally unwell should not be closed '*unless there is an explicit care and support plan in place ... discussed and agreed at a multi-disciplinary meeting ...*' We were told that there is no record that this took place.

The incident when Baseet injured his mother by throwing boiling water at her was dealt with by the police Domestic Abuse unit, and the officer involved says they made a referral to the Multi-Agency Risk Assessment Conference (known as the MARAC), however that referral could not be traced and the incident was not considered at a MARAC. The Panel considered that Baseet's case met the Domestic Abuse Multi-Agency Risk Assessment Conference threshold on more than one occasion and there was the opportunity for several agencies to make a referral but it did not happen.

The MERLIN Application Standard Operating Procedures dated 06 January 2020 were kindly shared with the Author who wanted to understand how the system should work. A MERLIN is created when a safeguarding concern has been identified. There is reference in the Police Individual Management Report to Vulnerable Adult MERLINS being completed as follows:

- 10 July 2018 - MERLIN completed but not shared '*due to resourcing issues*'
- 25 July 2019 - MERLIN completed but not shared

⁴² DASH stands for the Domestic Abuse, Stalking and Honour Based Violence Risk assessment. For further information see

<https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf>

- 24 August 2019 - MERLIN completed and shared with Newham Adult Social Care
- 28 October 2019 - MERLIN completed and shared with Newham Adult Social Care
- 6 November 2019 - MERLIN completed and shared with Newham Adult Social Care
- 25 March 2020 - MERLIN completed and shared with Newham Adult Social Care
- 18 May 2020 - MERLIN completed and shared with Newham Adult Social Care
- 01 October 2020 - MERLIN completed and shared with Newham Adult Social Care
- 23 January 2021 - MERLIN completed and shared with Newham Adult Social Care
- 17 June 2021 - MERLIN completed and shared with Newham Adult Social Care
- 04 July 2021 - MERLIN completed and shared with Newham Adult Social Care
- 23 October 2021 - MERLIN completed and shared with Newham Adult Social Care
- 04 March 2022 - MERLIN completed and shared with Newham Adult Social Care

This number of MERLINS demonstrates the extent of police concern for Baseet, his family, and the wider public.

Table 3: Details of 13 MERLINS completed by police

Key: ASC = Adult Social Care
IMR = independent management report

Date of police incident/ completion & reference	Date received by Adult Social Care	What happened	Mental Health 'outcome' X=no, √=yes	So did action result?
10 July 2018 18PAC168528	Not shared	Completed but not shared 'due to resourcing issues'	X	No
25 July 2019 19PAC179209	Not shared	Completed but not shared	X	No
24 August 2019 19PAC202786	27 August 2019	Completed and shared with Newham Adult Social Care. Police	√	Baseet had gone to mental health hospital - deemed dealt with?

Date of police incident/ completion & reference	Date received by Adult Social Care	What happened	Mental Health 'outcome' X=no, ✓=yes	So did action result?
		took Baseet to hospital for assessment.		
28 October 2019 19PAC255930	29 October 2019	Completed and shared with Newham Adult Social Care	✓	MERLIN forwarded to Mental Health Assessment and Brief Treatment Team
06 November 2019 19PAC265159	12 November 2019	Completed and shared with Newham Adult Social Care	✓	MERLIN forwarded to Mental Health Assessment and Brief Treatment Team
25 March 2020 20PAC074279	26 March 2020	Completed and shared with Newham Adult Social Care	✓	Baseet taken to hospital by his father with police accompaniment. Seen by a Crisis Team for mental state assessment. Deemed dealt with?
18 May 2020 20PAC115457	Not listed in ASC IMR under MERLINS	Completed and shared with Newham Adult Social Care	✓	Baseet admitted to hospital on Section 2. Deemed dealt with?
01 October 2020 20PAC242106	02 October 2020	Completed and shared with Newham Adult Social Care	✓	Baseet arrested by police. ? diverted from custody in hospital, Section 2?
23 January 2021 21PAC018568	Not listed in ASC IMR under MERLINS	Completed and shared with Newham Adult Social Care	X	Admitted to in-patient physical health care. Deemed dealt with?
17 June 2021 21PAC157840	Not listed in ASC	Completed and shared	✓	Baseet had absconded from

Date of police incident/ completion & reference	Date received by Adult Social Care	What happened	Mental Health 'outcome' X=no, √=yes	So did action result?
	IMR under MERLINS	with Newham Adult Social Care		ward but was taken back by police - deemed dealt with?
04 July 2021 21PAC175629	06 July 2021	Completed and shared with Newham Adult Social Care	√	While Baseet an in-patient - sexual touching of nurse: either Baseet or nurse to move to another Ward. Deemed dealt with. BUT not linked with the previous incident when Baseet reportedly touched his sister in a sexually inappropriate manner.
23 October 2021 21PAC291497	Not listed in ASC IMR under MERLINS	Completed and shared with Newham Adult Social Care	X	No
04 March 2022 22PAC061147	Not listed in ASC IMR under MERLINS	Completed and shared with Newham Adult Social Care	√	Section 2 admission followed incident - deemed dealt with.

As the Author understands it, once a MERLIN has been completed it is automatically transferred to the borough-based Public Protection Desk which sits within a Multi-Agency Strategic Hub (known as a MASH). It is processed and undergoes an initial risk assessment. The relevant Standard Operating Procedures note that the process is not about creating a report for the sake of it. It appears that 13 MERLINS were completed and all but two were shared with Newham Adult Social Care. Furthermore, it appears that when Baseet was either seen by mental/ physical health services or arrested no further action resulted. This is interesting as it suggests that each incident is dealt

with separately without taking account of the broader context and history over time, and raises questions about whether that is appropriate. Alternatively (or in addition) it supports the hypothesis that mental health services were regarded as the agency that should be dealing with incidents involving risk and that once they were involved (in 9/13 cases: note that 2/13 were not shared) no further action was seen to be necessary. This meant that the broader risk context was not considered and longitudinal risk was not assessed.

The Ambulance Service confirmed that a safeguarding concern would be triggered by signs of abuse or neglect / self-neglect / any indication that the patient is an adult-at-risk. This may have been more complicated if clinicians were unaware of Shompa's presence in the home. Apart from Shompa and Baseet, none of the other adults in the family home appeared to have care or support needs, and therefore did not meet the threshold for a safeguarding referral. If clinicians deemed Baseet to have capacity and he declined a referral, the policy would be not to refer.

The Ambulance Service individual management report found that Baseet's social history was not explored on many occasions, suggesting that professional curiosity was not at play, and resulting in potentially missed opportunities to obtain additional information. Developments since this homicide involve teaching staff to explore social history and to use professional curiosity to gain a fuller picture. Had a fuller social history been obtained at the time, some of the triggers for a safeguarding concern might have been identified and could have led to a safeguarding referral. However, the independent management review author notes that a significant number of the calls were prior to both the introduction of the Level 3 Safeguarding Package and Electronic Patient Care Record (ePCR), both of which have contributed favourably to the quality of exploration and documentation of social history. These developments are to be welcomed.

The ambulance service independent management review author also notes that ambulance staff did not explore Baseet's mental health. On occasions he was not conveyed to hospital but was deemed to have capacity to make the decision not to go, and we understand that the service would expect staff to complete the London Ambulance Service capacity tool to aid their decision: is the patient able to communicate a decision effectively; can they have a rational conversation re pros and cons; do they understand the risks; can they retain information? The ambulance service notes that both the knowledge and documentation of decisions related to capacity have improved significantly since the introduction of the Level 3 Safeguarding package and the electronic Mental Capacity Assessment. In previous Safeguarding Adult Reviews, it had been noted that the old assessment tool was not fit for purpose. In addition, we understand that clinicians now have greater access to translator services via Trust iPads, enhancing communication when there is a language barrier. If a patient was declining to engage in meaningful conversation during the capacity assessment, they would be deemed to lack capacity.

4. *What did each agency do to safeguard any children exposed to domestic abuse?*

From information received there do not appear to have been any children in the household.

5. *What services did each agency offer, were they accessible, appropriate, 'fit for purpose' and sympathetic to the needs of those involved, and were there any barriers in an agency that might have stopped them from seeking help for domestic abuse?*

It appears that the agency response to Baseet's and the family's difficulties was regarded as primarily a mental health response: the family appear to have coped by calling ambulance and police services regularly.

The main barrier to multi-agency work with the family may therefore have been that the 'problem' was seen as Baseet's mental health so the expectation was that it should be dealt with by mental health services. This left the family in a position where they remained at risk and yet were probably not fully aware of the risks or of possible ways of managing risks. It may have meant that partner agencies saw intervention as the responsibility of mental health services and therefore did not consider ways that they would contribute to supporting the family, eg multi-agency meetings, raising a safeguarding concern. The result was that interventions offered to the family were limited by the lack of multi-agency support. Multi-agency working might have improved safety for family members by opening up a greater range of possible interventions. Discussions in Panel supported this, arguing that it appears that agencies were working in silos in relation to this family. The need for a lead professional in Adult Social Care cases was identified, in order to collate information and take an overview of risk. Contact with both people involved in relation to Adult Social Care was carried out by access teams and no one spoke directly with Shompa.

A further barrier appears to have been that the family was seen by agencies as reluctant to accept help. In paperwork seen during the review there were statements such as the family '*denied* any risk of harm to themselves' and that family members were possibly 'minimising' concerns. We were told that the use of 'denied' is shorthand. However, these comments appear to be potentially victim-blaming. It would be useful to know what choices/ help family members had been offered and why they chose not to take them up (if indeed they did choose not to take up support that was offered) - this is an area where the exercise of professional curiosity is important. There is no evidence that the family was offered support with domestic abuse or with regard to their safety. There was no holistic assessment of the home environment. The family could have been offered support from agencies which could support them in their mother tongue language, and which had a good understanding of cultural barriers and how domestic abuse manifests in communities. There is no reference to carer support in respect of Shompa or Baseet. Even when people decline support, it is good practice to show professional curiosity in order to understand why, to attend to concerns

wherever possible, to identify options that meet their needs, and, where possible, to follow up with them.

6. *How effective was each agency's supervision and management of practitioners involved with the response to needs of those involved and did managers have effective oversight and control of the case?*

Mental health staff have individual monthly supervision. Ongoing monitoring and decision-making around care planning, risk, any safeguarding elements are managed within regular team meetings. Teams also have safeguarding supervision on a group basis, not to replace day to day management, but to discuss individual cases for learning or for escalation purposes.

We know that the line manager of the police officer working the Assault occasioning Actual Bodily Harm case relating to the incident involving Baseet's mother on 1 October 2020 emailed the police mental health team in an effort to escalate concerns about Baseet and the safety of his family. This evidences effective supervision/ management in relation to police officers' involvement.

10. *How did each agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to those involved, and how were the views of victim and alleged perpetrator ascertained and taken into account?*

Accessing the views of victim and alleged perpetrator

Shompa was of Bangladeshi heritage and Baseet British born of Bengali heritage. The family is of Bangladeshi origin. Adult Social Care recorded Baseet's preferred language as Bangladeshi but noted that he could speak English. His mother is noted to speak Bengali and there are references to the need for an interpreter when speaking with her. The National Health Service has a legal responsibility to make sure that services provided are equally accessible to all service users from all communities. NHS guidance states that a professional interpreter should always be offered, in preference to using family or friends to interpret, where language is an issue in discussing health matters. Similarly, language issues should not disadvantage appropriate family members from involvement in a person's care.

The GP individual management review notes that Baseet's voice is 'rarely present' in the primary care notes. He was often represented by his parents or sibling in relation to accessing health care and sometimes family members attended without him for mental health reviews, although GPs completed mental health reviews with him in person on home visits in 2019 and 2021. We were told that it is good practice in primary care reviews to consult with the patient and not just the family.

The material shared by the Mental Health Trust notes that, during his final in-patient admission, communication was with Baseet's father, and that there was a plan to invite Baseet's mother with an interpreter to a ward round (on 17 March 2022 a doctor recorded '*invite mother to attend next week ward*

round'), but that this did not happen because Baseet went absent without leave. Yet it appears that Baseet's care and support was primarily provided by the women in the household who were not included in discussions about Baseet's ongoing treatment, risk assessment, or impending discharge. Was the fact that Baseet's mother was not included in discharge planning influenced by assumptions relating to culture and gender as well as by the barrier of language which meant that to engage with her would require an interpreter? Baseet's father is described as possibly assuming the main role in communication as '*the traditional head of the household.*' Was that the case, or did practitioners assume that he was '*the traditional head of the household*' because of the family culture? Perhaps there were other factors operating here. Is there sometimes tension between accepting what might be regarded as the 'cultural norm' and what would be accepted as good practice? In addition, is there pressure on families from some ethnic groups to care for their relatives because agencies are unable to consistently provide carers/support workers who speak their language and understand their culture?

This agency assumption of the family structure and culture might also be a factor in relation to housing. It is clear that his family wanted Baseet to remain at home but on a number of occasions he expressed a desire to live away from the family home (see further discussion under 3.3.1 housing issues). For example:

28 Oct 2019: It was reported that Baseet was upset as he no longer wanted to live with family ... but his family wanted to stay with him to support him.

Early July 2020: Baseet stated he thought a move from the family home would be beneficial.

2 Oct 2020: Baseet was referred for supported living but his family wanted him to return to living with the family.

12 May 2021: Baseet stated that he wanted his own home.

8 June 2021: Baseet was described as '*pre-occupied with housing, wanting independent accommodation*'. Although this is described as a preoccupation (with implications that it may have been a feature of his mental state), it may alternatively have been an expression of his wishes.

It is curious that Baseet's wishes were not clearly recorded or accessed and neither were Shompa's. Yet the wishes of the family (as expressed by 'the traditional head of the household') were clearly heard and recorded. Was this influenced by cultural expectations, ie that decisions were made by the head of the household and that those decisions should be privileged to the extent that other family members' wishes were not sought, not heard, or not respected? In any eventuality, it appears that the voices of Baseet and Shompa were not taken into account and that the women in the family were less involved in decisions despite being heavily involved in providing care.

This resonates with Chantler et al's findings in their paper⁴³ (see 3.7 Equality and Diversity for more information) regarding people's views not being accessed and professional interpreters being inconsistently employed.

Caring and carers

The fact that Shompa moved between different family homes attests to the family's commitment to care for her following the stroke. It must also, however, have complicated agency attempts to support the family and might have been a factor in deterring the family from accepting outside help. How do agencies accommodate support for people who move between addresses? Again, in relation to caring, most discussions were with Baseet's father and not with the women who were carrying out the work of caring for Baseet and Shompa.

Likewise, there is no doubt that the family was committed to supporting Baseet and keeping him at home, and they struggled to do so despite recurring and difficult challenges, calling on the police, ambulance service and mental health for support in crises.

Baseet was referred to Adult Social Care by a Centre for Mental Health for support around finances and housing in November 2015, and contact was made with his father. His father gave the impression of being the decision-maker and stated that Baseet was '*unable to participate due to not understanding what was being asked.*' The Adult Social Care independent management review notes that a Mental Capacity Assessment around support and treatment may have been beneficial in this instance and indeed it seems that a formal capacity assessment would have been indicated at that point. It is interesting that no one questioned Baseet's father's authority to make decisions on behalf of his son. Why not? How was that influenced by assumptions about culture and/ or learning disability? There is no evidence that agencies considered involving an independent advocate to support Baseet, despite his vulnerabilities.

Similarly, decisions were made on behalf of Shompa, apparently without her involvement. Her discharge from hospital following the stroke was negotiated with the Lead Family Contact and we are told that it is unclear from hospital records what address she was discharged to and who was to care for her. Did Shompa herself have capacity to express her wishes in respect of the discharge and care necessary? If not, then who had authority to make decisions on her behalf and how were her best interests taken into account? In July 2021 Shompa (at Address 1) was referred to Adult Social Care with information that the family was not coping with her support needs, that there were difficulties mobilising and managing continence as she was unable to get to the toilet. The Access Team advised the GP that her family had declined support for her, and that her son, the Lead Family Contact who did not live at Address 1, said the family was happy to continue caring for her and would contact if they needed support in future. There was no contact with Shompa, no consideration of her capacity to make support decisions for

⁴³ K. Chantler, K. Bracewell, V. Baker, K. Heyes, P. Traynor and M. Ward (2022) An analysis of minoritisation in domestic homicide reviews in England and Wales Critical Social Policy 43 (4): 602-625. DOI: 10.1177/02610183221133052

herself, and no consideration of whether the Lead Family Contact (or indeed any other member of the family) had authority to make decisions on her behalf. This is not to criticise the person concerned, who was likely doing their best on behalf of the family and acting in what were thought to be Shompa's best interests, but the Mental Capacity Act offers a legal framework for making decisions on behalf of people who lack capacity to make decisions for themselves, and it is good practice for it to be followed and that fact documented by health and social care practitioners.

The Panel noted that there needs to be more curiosity around people with mental health challenges and their carers, and more understanding of how difficult and challenging that caring role can be. The welfare of carers should be considered whether or not there is any risk to them.

7. How effectively was information shared with partner agencies about domestic abuse, mental health issues, and alcohol/ substance use - did that information inform practice, and were there missed opportunities to share information?

In terms of systems, it appears that there is limited technological sharing between Rio (the electronic record used by mental health) and Azeus (London Borough of Newham's social care record). Health Information Exchange is the interface and gives some limited information about, for example, social care contacts from within Rio. There is limited access by each to the other's system via small numbers of dual trained colleagues and remote provision.

There are shared meetings for both mental health and learning disability services to review ongoing safeguarding processes. In this case, however, no safeguarding process was triggered at any stage.

The police independent management review states that a Multi-Agency Risk Assessment Conference (MARAC) referral was made following the incident when Baseet's mother was injured in October 2020. However, on checking, it appears that the referral was not received and not considered. Indications⁴⁴ for referral to the MARAC are score on the Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment (DASH); professional judgement in conjunction with DASH score; and indicators of potential escalation.

The Multi-Agency Safeguarding Hub (MASH) collects incident reports from agencies and should connect them together for further management work as needed. It has emerged in this review that this doesn't always work perfectly (eg incomplete MERLIN sharing). It is a reactive process (reacting to an incident report) and the system is overburdened in terms of the volume of reports, which must make proactive work much more difficult. There is more

⁴⁴ Safelives (2018) Marac Referral Criteria: Definitions. Available at: <https://safelives.org.uk/practice-support/resources-marac-meetings/resources-people-referring>

information about MERLINS in Table 3 and the associated discussion. The fact that thirteen MERLINS were completed by police and this information did not inform practice with Baseet and his family suggests that there is a need for a mechanism to draw together the MERLINS and enable a broader understanding of what is happening in cases such as this.

Key points relating to policies, practice and partnership working

- It appears that the response to the family's difficulties was primarily regarded as the responsibility of mental health services and that this may have influenced the practice of other agencies in response to incidents of domestic abuse.
- As a result, there was a lack of information-sharing and partnership working with this family.
- There may sometimes be tension between accepting what might be regarded as the 'cultural norm' and what would be accepted as good practice.
- The Mental Health Trust Care Programme Approach policy was not followed and Baseet did not consistently have an allocated care coordinator.
- Longitudinal risk factors/ patterns of risk over time appear not to have been taken into account in risk assessment.
- It is good practice for practitioners to exercise professional curiosity in relation to family choices and avoid any suggestion of victim- or family-blaming.
- Baseet's and Shompa's voices were not heard or not sought in relation to their care and the views of family were privileged. No capacity assessments were carried out.
- Thirteen MERLINS were completed by police and all but two were shared with Newham Adult Social Care but little or no action resulted.⁴⁵

7.1.3 Systemic issues

12. What consideration was given by agencies to the possible negative impact the COVID lockdown may have had on the relationship between those involved and did this inform practice? Did agency support change during the COVID lockdown, and, if so, what impact did this have on the support offered and received?

It appears that regular appointments in primary care terminated during the pandemic and then restarted but less frequently, suggesting that the pandemic impacted on contact with the family.

It appears that there were no significant impacts on mental health care apart from visiting restrictions during Baseet's last admission. It is possible that these restrictions may have contributed in part to Baseet's absence from the ward without leave, but he had gone absent without leave on previous admissions.

⁴⁵ There is no recommendation made in this report regarding MERLINS as we were told that the Police are considering changes to the system.

Other agencies either continued their work during COVID lockdowns or were not involved with Baseet or Shompa.

13. *Were there issues in relation to capacity or resources in an agency that impacted on its ability to provide services to those involved, or on your agency's ability to work effectively with other agencies?*

The mental health Serious Incident Review report refers to 'a service affected by recruitment and retention difficulties, increased sickness and need for urgent annual leave, and who were also experiencing an increase in referrals and chronicity in a post-pandemic climate.' This suggests that that the service was under considerable pressure and that issues related to service capacity and resources impacted on the service to Baseet.

At least one of the MERLINS completed by police was not shared 'due to resourcing issues'.

Key points relating to systemic issues

- The COVID pandemic impacted on primary care contact with the family
- Service capacity/ resources are likely to have impacted on the mental health service contact with the family

7.2 Other issues raised by the Individual Management Reviews

7.2.1 Issues raised by Shompa's care post-stroke

Several important issues are raised by Shompa's care following the stroke in June 2021 after which she was admitted to a stroke unit. These are:

Eligibility for NHS care

The Trust providing care for Shompa following her stroke identified her as an overseas patient who was not entitled to NHS care on the basis of what they were told by a family member, who acted as her next of kin. The Trust did not check out her eligibility with the Home Office who informed this Review that Shompa **was** entitled to NHS care (and informed the Trust the same when they sought clarification during this review process).

The result was that the family was told they would need to seek private therapy following Shompa's discharge and they would need to buy any necessary aids. This is likely to have contributed to Shompa becoming more immobile after her discharge home and the family having difficulty in coping with her care. It may also have been a factor in their reluctance to accept support in her care.

Identification of next of kin and accessing Shompa's views

The terms of reference in point 10 asked how Shompa's views were ascertained and taken into account. The Acute Hospital Trust individual management review reveals that only on one occasion was it documented that an interpreter was used. All other times a family member translated.

Shompa reported, using the interpreter, that she was unable to return to the family home and that she was homeless, yet this did not trigger a safeguarding concern or risk assessment, nor was it followed up.

One of Shompa's children was recorded on her electronic record as her next of kin. There is no record that Shompa was asked who she regarded as her next of kin. It appears that different family members were regarded as next of kin on different occasions by different members of staff and the names of family members were not consistently noted. Good practice would have been to ask Shompa through an interpreter who she wished to act as her next of kin and to record the names of family members who were spoken with in order to avoid confusion. There is also uncertainty regarding the address to which Shompa was discharged and the discharge address of vulnerable patients is an important piece of information to record.

On one occasion a granddaughter was asked to consent to an assessment on Shompa's behalf in her '*best interest*' '*due to the language barrier*'. 'Best interest/s' is a term associated with the Mental Capacity Act 2005⁴⁶ when people are, or may be, unable to consent for themselves. The Mental Capacity Act Code of Practice⁴⁷ makes it clear that people should receive support to make decisions for themselves – a language barrier of itself does not mean that a person cannot consent, nor does it mean that someone else can consent on their behalf. Practice should be to involve an interpreter and ask the person to consent on their own behalf – only if they are then unable to consent would 'best interests' apply. One of the original principles of the Act is that:

'A person is not to be treated as unable to make a decision unless all practicable steps to help (them) to do so have been taken without success.'

Another concern relates to Shompa's evident distress and episodes of tearfulness. A referral was made to '*neuro psych*' but does not appear to have led to her being seen or assessed and was not followed up.

Not arranging for interpreting services to access her voice, not following up her distress, and accepting without question important information from family (however caring and well-intentioned) raises questions about possible discrimination due to race and/ or gender and/ or age or a combination of these.

7.2.2 Housing

The family was living in a London Borough of Newham owned property from 2013. They registered on the housing register to enable them to bid on other social housing properties in 2015: in part due to anti-social behaviour and with no mention of (possible) overcrowding. Housing has no record of supported

⁴⁶ See <https://www.legislation.gov.uk/ukpga/2005/9/contents>

⁴⁷ See <https://assets.publishing.service.gov.uk/media/5f6cc6138fa8f541f6763295/Mental-capacity-act-code-of-practice.pdf>

housing being requested for Baseet, however, there are numerous medical documents on file.

In December 2022 Baseet's sister provided medical documents to the lettings team with recommendations that the family be moved to a quieter area. They wanted to move together. In the emails the occupants of the household are listed as Baseet's sister, her parents and her brother Baseet.

A homelessness referral was received for Baseet from a Centre for Mental Health in 2020 stating that he could not return to the family home after his discharge from hospital. (It is noted that the homelessness prevention service only manages applications from those who are homeless and at no stage was Baseet homeless.) On further contact, Baseet's father said that he was not asking Baseet to leave and that his son could remain at the parental home. He said that he would contact the council if their circumstances changed. The application was then closed. We understand that there is no record of the housing adviser contacting Baseet to confirm that he wanted to stay in the parental home. At that time, in 2020, it was the height of the pandemic and the service was undergoing a significant restructure which had a huge impact on the service as a whole in terms of staffing and resources.

At the time of Shompa's death, it appears that the family was living in a two-bedroomed property. Shompa was sleeping on a mattress on the living room floor. There was a bed in the living room on which Baseet would sleep when he was bothered by noises outside his bedroom. We understand that otherwise he shared a bedroom with his father. His mother and sister shared the other bedroom, but we understand that some of the time an aunt was also at the house and it is not clear whether she stayed overnight and, if so, where she slept. Baseet was sensitive to noise and struggled to tolerate noise. The number of people in the house is unlikely to have been conducive to his mental health. In addition, his grandmother is described as having communication difficulties and sometimes shouting and screaming, which, a family member told police, 'irritated' Baseet.

In 2021 a specialist pathways team was created and revamped in May 2023. Specialist experienced housing advisers now work with specific cohorts that are most vulnerable in society. The team includes a specialist in Early interventions Hospital discharge (mental health) and a Domestic abuse coordinator.

We understand that the early intervention specialist works closely with mental health services and sits within Hospital 1 once a week, working with nurses and consultants to support those due to be discharged who are at risk of homelessness. In the last 6 months it is reported that there has been a marked change in the way that mental health teams and homelessness prevention service are able to support Newham residents who have experienced mental ill-health and are at risk of homelessness.

7.2.3 Anti-social behaviour

Anti-social behaviour records were examined for the previous 10 years and there were a number of contacts relating to the address where Baseet lived and the homicide occurred. These are included in the chronology. In summary there were:

- 8 contacts in 2014
- 1 contact in 2016
- 2 contacts in 2017
- 1 contact in 2019
- 1 contact in 2021

What appeared to happen recurrently was that a resident of Address 1 contacted to complain about loud noise, sometimes drug use or drug dealing, and on one occasion threatening behaviour. The complainants said that they did not want visits on two occasions and on one occasion said that this was for '*safety reasons*'.

In addition, police were contacted on the following dates:

- 23 May 2016
- Between 25 January and 25 July, 2019, the police received multiple calls regarding anti-social behaviour outside the address and in the area.
- 5 November 2019
- 11 January 2020

And when the family registered on the housing register to enable them to bid on other social housing properties this was recorded as being at least in part due to anti-social behaviour.

In her contact with the police in May 2016, Baseet's sister told them that her brother had mental health problems and the anti-social behaviour was making him angry. She also said that the family had felt '*victimised*' by neighbours since 2014 when Baseet was arrested after having a knife and threatening neighbours. It was noted in addition that Baseet's family wished to remain anonymous when reporting incidents for fear of reprisals.

We are told that, when an attending officer is called out to a property to assess noise levels, they will make a determination based on various factors as to whether or not, in their professional opinion the noise levels are excessive enough to be classed as Statutory Noise Nuisance, or not, which would determine the course of action taken by the officer.

It is not unusual for a resident to submit numerous complaints to the Council. The Council's powers and available interventions are limited until such time that Statutory Noise Nuisance is witnessed and evidenced. If the Council cannot prove that the noise is materially and substantially interfering with a person's use and enjoyment of their premises, then the Council cannot issue a legal abatement notice. In such situations, the approach would be to try to

amicably resolve the issue through communication, dialogue, advisory letters etc, whilst also trying to manage the expectations of the complainant. In the case of this family, it seems likely that they were afraid of the neighbours and that they didn't report all the anti-social behaviour that they were troubled by. It is also possible that, because of Baseet's response to noise, anti-social behaviour was a particular concern for them.

7.2.4 Learning Disability

Baseet was diagnosed with a mild learning disability and was under the care of learning disability services in around 2010.

The primary care independent management report notes that, although Baseet had a diagnosis of a learning disability, he did not receive an annual review which might have helped to identify reasonable adjustments that may have assisted him to access healthcare in a less restrictive manner.

The mental health Serious Incident Review report notes that an alert was added to Baseet's electronic record in 2015 stating that: '*This person has a learning disability, please consider making reasonable adjustments*'. The report notes that, despite this, some of those engaged in the review process reported that, although they were aware of some concerns regarding low IQ⁴⁸, they were not aware of his formal diagnosis of a mild learning disability.

There are two documents to mention here. Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition⁴⁹ was published in 2015, as was Building the right support⁵⁰: both were produced by NHS England, the Local Government Association and the Association of Directors of Adult Social Services. They were followed by actions to ensure that people with a learning disability are offered Annual Health Checks and Care and Treatment Reviews. Whenever a person with a diagnosed learning disability, is admitted to a mental health hospital they should have a Care and Treatment Review. The aim is to support the individual patient and their family to have a voice, to support the team around the individual, and to work with the individual and their family, in order to support effective discharge back into community. Unfortunately, Baseet's voice was rarely heard.

Key points raised by other issues:

Shompa's care after the stroke raises a number of areas where good practice is important but appears to have been lacking in this case:

- It is important to check out eligibility for free NHS care with the Home Office if there are questions about it.
- It is important to employ interpretation services if necessary to access the views of patients.

⁴⁸ A measure of a person's intelligence as measured on special tests.

⁴⁹ See <https://www.england.nhs.uk/wp-content/uploads/2015/10/service-model-291015.pdf>

⁵⁰ See <https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf>

- Patients views on their next of kin should be sought and the names and relationships of any relatives with whom their care is discussed should be clearly documented.
- Discharge addresses of vulnerable patients should be clearly documented in their records together with information about household composition.
- There is a risk of making assumptions about someone's wishes influenced by perceptions of their race and/ or gender and/ or age.

Housing:

- Baseet at times expressed a wish to move to live outside the parental home but despite that was repeatedly discharged back to his parents' home
- His family wanted him to stay at home and their view appears to have been privileged: it seems likely that they wanted to care for him and were concerned about his future should he not live within the family, but it is not clear whether there was ever a conversation about options for Baseet in respect of housing and support.
- The home appears to have been small for the number of people who were living there, although they may not all have been permanently resident at that address
- Housing officers were not involved in Baseet's management.

Anti-social behaviour:

- Anti-social behaviour in the locality impacted on Baseet's mental health and was an issue over an extended period of time
- Members of Baseet's family were intimidated by those perpetrating the anti-social behaviour - they feared reprisals.

Learning disability:

- Baseet's learning disability was not taken into account by services and taking it into account might have opened up possibilities that were not considered.

7.3 Good Practice

7.3.1 Persistence and dedication

The police were clearly concerned about Baseet and the risk he posed to the family and repeatedly supported the family when family members turned to them for help. In particular, the police officer in charge of the case relating to Baseet's arrest for Assault occasioning Actual Bodily Harm on his mother in the incident on 1 October 2020 showed persistence and dedication in following up the case and endeavouring to engage with the family.

8. CONCLUSIONS

Relating to domestic abuse

- Although agencies involved with Baseet and his family were aware of domestic incidents and ongoing threats and aggression there were missed opportunities for proactive intervention.

Relating to policies, practice and partnership working

- It appears that the response to the family's difficulties was primarily regarded as the responsibility of mental health services, that this may have influenced the practice of other agencies in response to incidents of domestic abuse, and that as a result there was a lack of information sharing and no coordinated multi-agency approach to supporting this family.
- Longitudinal risk factors/ patterns of risk over time appear not to have been taken into account in risk assessment.
- Family members do not appear to have been involved in risk assessment.
- It is good practice for practitioners to exercise professional curiosity in relation to family choices and avoid any suggestion of family-blaming.
- Thirteen MERLINS were completed by police and all but two were shared with Newham Adult Social Care but little or no action resulted⁵¹. It is arguable that the current system is not fit for purpose.
- The voices of Baseet and Shompa were largely absent in their contact with services.
- There may sometimes be tension between accepting what might be regarded as the 'cultural norm' and what would be accepted as good practice. It is good practice to ensure that family carers are included in discharge planning and treatment plans.

Systemic issues

- The lack of communication between agencies is a systemic issue.
- The COVID pandemic impacted on primary care contact with the family
- Capacity/ resources are likely to have impacted on mental health service contact with the family

Equality, diversity and inclusion issues

- Shompa was disadvantaged and her voice not accessed, most likely because of a combination of factors including her age, gender, disability post-stroke, ethnicity, need for an interpreter, and perhaps also because of assumptions about her cultural background and where the power was assumed to lie in her family. It appears that this

⁵¹ There is no recommendation made in this report regarding MERLINS as we were told that the Police are considering changes to the system.

combination of disadvantages led to her relatives' views being privileged by both health and social care.

- Shompa's views were not sought during her admission following the stroke or in relation to her need for care support following discharge.
- Shompa's eligibility for free NHS care was not established following the stroke and this may well have had long term impact of her health and welfare following discharge.
- Next of kin during Shompa's admission following stroke was not accurately recorded, her views were not sought, and different family members were treated as next of kin on different contacts with medical services.
- The experiences and views of those caring for Shompa and Baseet were not sought and this may well have been because of a combination of factors including gender, need for an interpreter, ethnicity and assumptions about culture.
- Baseet's learning disability was not taken into account by agencies working with him and taking account of it might have opened up other possibilities.
- Baseet at times expressed a wish to move to live outside the parental home but, despite that, was repeatedly discharged back to his parents' home and their expressed views were privileged over his.

Anti-social behaviour and its impact

- Anti-social behaviour in the locality impacted on Baseet's mental health and was an issue over an extended period of time
- Members of Baseet's family were intimidated by those perpetrating the anti-social behaviour - they feared reprisals.

9. LESSONS TO BE LEARNT

9.1 Lessons to be learnt taken from individual agency reports

The GP individual management review suggests:

- that abuse between family members as opposed to between intimate partners may be viewed differently.
- That a letter regarding a domestic incident was not coded as domestic abuse by a clinical coder and that all clinical coders should have safeguarding training (we were told that clinical coders all have level 1 safeguarding training but that further training is currently being discussed.)
- That it is important for GPs to recognise that contact with family is not a review of the patient.
- That housing pressures were not fully recognised.

The Mental Health Trust notes:

- The move away from the Care Programme Approach to all service users under secondary mental health care having a named worker
- The need to have a process to track S117 entitlement
- There is now a better system for flagging the need for Care and Treatment reviews for people with a learning disability
- The learning disability service is now managed under Newham Mental Health Directorate and it is hoped that this will enable more integrated working.

Adult Social Care notes:

- The Difficult or Non-Engagers Guidance is under review and relevant learning from this Domestic Homicide Review will be taken into consideration
- Shompa and Baseet were not linked on the Resident Recording System
- The impact that housing has on a person's mental health

Ambulance service notes:

- Recent service changes aiming to improve practice including mental health cars; increase in safeguarding team.

Acute Medical Trust

- Verbal confirmation of an individual's eligibility for free NHS care should not be accepted – only information supplied on the NHS Spine or from the Home Office.

9.2 Multi-agency lessons to be learnt

Relating to domestic abuse

- Violence/ abuse between family members who are not intimate partners (sometimes called adult family violence) may not be recognised as domestic abuse with the result that opportunities to intervene may be missed.
- Violence/ abuse seen as arising in the context of mental ill-health may be seen as the prime responsibility of mental health services and, as a result, those involved may miss out on partnership working.
- Risk assessment should take account of patterns of risk over time.

Relating to policies, practice and partnership working

- A coordinated multi-agency approach to supporting this family was absent
- It is important to always seek the views of service users and, if it is established on assessment that service users are unable to make necessary decisions at the necessary time, to follow the processes set out in the Mental Capacity Act (2005).
- There was no one person taking an overview of Baseet's illness, his care and its impacts on his family.
- When there is tension between accepting what might assumed to be the 'cultural norm' and what is accepted as good practice, it is important to ensure that good practice is followed, whilst being understanding of, and sympathetic to, possible cultural issues.

Relating to issues of equality, diversity and inclusion

- When someone is older, disabled and their first (or only) language is not English it is critically important that that everything possible is done to support them in being heard and their views taken into account in their care.

Relating to other issues

- Next of kin needs to be clearly identified and recorded, in line with a patient's wishes.
- Good practice in documentation involves recording discharge address, household composition, and the names and relationships of any family members involved in a patient's care.
- Taking account of Baseet's diagnosis of learning disability might have opened up other possibilities for intervention and support.
- Parents and their adult children for whom they care may have different perspectives and it is important to hear both perspectives rather than privileging one over the other.
- It is easy to under-estimate the impact of anti-social behaviour.

10. RECOMMENDATIONS

10.1 Single agency recommendations

Barking, Havering and Redbridge University Hospitals NHS Trust

Recommendation 1: The Trust to apologise formally to the family for the failure to check out Shompas eligibility for NHS care.

Recommendation 2: Where immigration status is in question, the patient's status must always be formally verified in writing with the Home Office.

Recommendation 3: All staff to complete safeguarding risk assessments when concerns or disclosures take place.

Recommendation 4: DASH assessments to be completed where there are concerns or disclosures about domestic abuse/ abuse within the family.

Recommendation 5: Ensure safeguarding training is updated to include the importance of risk assessing vulnerabilities/ risks within the household with respect to all family members.

Recommendation 6: Domestic abuse training to become mandatory for all frontline staff.

London Ambulance Service NHS Trust

None

London Borough of Newham Safeguarding Governance Team and Mental Health Adult Social Care Service

None

Mental Health – East London Foundation Trust

Actions were recommended in the SI report - no additional recommendations were made.

Recommendation 1: that the views, wishes and concerns of hands-on carers should always be sought and evidenced in the case-notes, particularly in respect of decisions around discharge. This might necessitate using interpreters or communication aids.

Recommendation 2: that the views, wishes and concerns of patients should always be sought and evidenced in the case-notes, particularly in respect of decisions around discharge. This might necessitate using interpreters or communication aids.

NHS North East London

Recommendation 1: To use this case as a case study in level 3 training.

Recommendation 2: To look at review templates and add a note to say that they should not be completed without the patient present.

The Metropolitan Police

None

10.2 Multi-agency recommendations

Relating to domestic abuse

Recommendation 1: Safeguarding and domestic abuse training to give appropriate emphasis to the fact that domestic abuse includes abuse between family members who are not intimate partners as well as abuse between intimate partners.

The aim of this recommendation is to ensure that violence between family members who are not intimate partners (which is sometimes called adult family violence) is recognised as domestic abuse, is risk-assessed, and that appropriate interventions are considered.

Recommendation 2: All agencies to use the Domestic Abuse, Stalking, Harassment and Honour based violence Assessment Tool (DASH).

The aim of this recommendation is to ensure that the DASH is embedded in practice across agencies.

Recommendation 3: All agencies to review how their risk assessments take account of longitudinal risk/ patterns of risk over time and to report back to the Care Services Partnership what changes need to be made and how to address longitudinal risk on an inter-agency level.

The aim of this recommendation is to ensure that risk events are not assessed individually without taking account of patterns over time.

Recommendations 4: All agencies to review whether practitioners consistently follow Multi-Agency Risk Assessment Conference (MARAC) processes and to ensure that practitioners are aware of the aims of, thresholds for, and process for referral to MARAC.

The aim of this recommendation is to ensure that the MARAC is used appropriately.

Recommendation 5: All disclosures of sexual abuse to be acted on and submitted to professional scrutiny: all agencies to ensure this is included in their policies and training, and that third party reporting is also included.

The aim of this recommendation is to ensure that all disclosures of sexual abuse are dealt with appropriately.

Relating to policies, practice and partnership working

Recommendation 6: When violence/ abuse is seen as related to mental ill-health it is important for all agencies to take a holistic view and to consider how partner agencies might be involved and might contribute to management.

The presence of mental ill-health, or even episodes of violence/abuse linked to mental ill-health should not preclude the need to take a holistic view of other potential factors in assessment and responses from partner agencies. The aim of this recommendation is to ensure that partner agencies contribute to care and support in complex cases.

Recommendation 7: All agencies to ensure that Mental Capacity Act training addresses the need to take learning disability and/or severe physical disabilities into account and the importance of speaking with service users and not speaking solely with family members.

The aim of this recommendation is to ensure that complex needs are taken into account and that people with complex needs are included in decision-making and their views sought.

Recommendation 8: All agencies to review domestic abuse policies and to put in place operational and strategic domestic abuse guidance for staff covering all forms of domestic abuse in a family setting.

The aim of this recommendation is to ensure that agency guidance encompasses all forms of domestic abuse in a family setting.

Recommendation 9, a and b:

Recommendation 9a: Newham Safety Partnership to ensure that the Domestic Homicide Review/ Domestic Abuse Related Death Review process includes the requirement that agencies secure their records when notified of a Review.

Recommendation 9b: Agencies to ensure that staff adhere to the requirement to secure records in relation to a pending Review.

The aim of these recommendations is to ensure that records are secured in line with existing national guidance.

Relating to equality, diversity and inclusion

Recommendation 10: All agencies to ensure that older people and people with disabilities are supported to participate in risk assessment and to express their views, concerns and wishes whatever their gender, age, cultural heritage or diagnosis. This might necessitate using interpreters or communication aids.

The aim of this recommendation is to ensure that people like Shompa are heard and respected and that the views of family members are not automatically privileged ahead of those of service users who may be less able to contribute to discussions.

Recommendation 11: All agencies to ensure that the views, concerns and wishes of hands-on family carers are sought irrespective of their gender and cultural heritage and without the views of other family members being privileged.

The aim of this recommendation is to ensure that assumptions are not made with respect to who speaks on behalf of other family members.

Recommendation 12: All agencies to evidence that they have accessed the views of all relevant family members, avoiding situations when men in a family feel they can speak for women and younger family members feel they can speak for older family members.

The aim of this recommendation is to avoid assumptions being made about where power lies in family, to ensure that quiet voices are heard, and to ensure a gender- and age-sensitive approach.

Recommendation 13: All agencies to ensure that equality, diversity and inclusion influence practice by involving all service users and family carers in decision-making, and ensuring that they understand agency processes including risk assessments, possible triggers, and options available to them. This might involve auditing the involvement of service users and family carers by preferred language, cultural background, and use of professional interpreters.

The aim of this recommendation is to embed good practice, to avoid cultural assumptions being made, and to recognise that inclusion is more important when there are language issues.

Additional Recommendations

Recommendation 14: To audit whether Annual Health Checks and Care and Treatment Reviews are taking place in accordance with guidance and, if they are not taking place regularly, to investigate how to improve their frequency.

The aim of this recommendation is to ensure that people who have a diagnosis of learning disability have needs related to learning disability taken into account.

Recommendation 15, a,b and c

Recommendation 15a: Senior staff signing off individual management reviews and similar documents to be sensitive to the use of language that is or could be seen as family-blaming, to ensure that it is removed from documents and reports, and that authors who use language that is or could be seen as family-blaming are required to reflect on their use of words and practise professional curiosity in relation to family members' experiences/ context.

Recommendation 15b: Practitioners to document that they have exercised professional curiosity when families say that they do not feel at risk despite evidence of behaviour and/or ideation that appears risky to others.

Recommendation 15c: Agencies to ensure that practitioners access training addressing unconscious bias; gender-based abuse; and avoiding victim-blaming practices and language.

The aim of these recommendations is to avoid victim-blaming practices and language; to eradicate statements such as the family '*denied* any risk of harm to themselves' and to encourage practitioners to exercise professional curiosity.

Recommendation 16: To allocate dedicated administrative support to Domestic Homicide Reviews.

The aim of this recommendation is to stream-line, and increase the efficiency of, the review process.

Recommendation 17: Newham Adult Social Care should review their MERLIN processes in light of the review and ensure that

Recommendation 17a: All MERLIN reports received are saved in one place in the case management system so all staff can access and view a full chronology of the reports received to inform decision making in domestic abuse cases

Recommendation 17b: All MERLIN reports are correctly assigned to the named individuals in the Merlin report

Recommendation 17c: The Safeguarding Adults Board takes responsibility for ensuring that this recommendation is evidenced and included in all operational procedures

Recommendation 17d: The Safeguarding Adult Board carries out audits every three months to ensure this recommendation has been completed and embedded.

The aim of these recommendations is to enable practitioners to view the MERLIN reports within a chronology) and attached to case files linked to the individual and wider family members, if they are known to adult social care, and to improve the response to MERLIN reports.

Recommendation 18: Adult Social Care to consider a quarterly review of MERLIN reports embedding professional curiosity to consider the impact of the contents of the report on other family members/older and vulnerable people within the home with a view to taking safeguarding action if required.

The aim of this recommendation is to improve the response to MERLIN reports.

APPENDIX 1: CHRONOLOGY IN TABLE FORMAT

Key to shading:

Learning disabilities

Mental health

Mention of knives

Risk to self-others

Safeguarding

Date	Agency	Shompa	Baseet
Pre-scoping period			
2009	Mental Health		Baseet referred to the Early Intervention in Psychosis team. Remained with them for three years before care was transferred back to GP; he was given diagnoses of depression and somatisation disorder.
2009	Various	Shompa came with her disabled daughter, Daughter 1, to the UK to visit family. Her husband was due to join her a few months later. GP records give UK entry date as 4 September 2009.	
2010	Adult Social Care		File records indicate Baseet first referred to Adult Social Care in 2010 by doctor from Community Team for People with Learning Disabilities: information indicates he had a history of developmental delay, possibly complicated by a road accident when aged 7. He had been known to a team called Early Intervention in Psychosis since 2009 in relation to seeing ghosts, snakes and rats at home. He also reported

Date	Agency	Shompa	Baseet
			pain, fatigue and weakness. He was not felt to have a psychotic disorder but he did not persist with prescribed medication. The referral describes him as dependent on his mother and unable to be left alone. <i>'The referral indicates that his family reinforce the above behaviours and beliefs and recommended psychology/ family therapy alongside a functional assessment.'</i> At that point he was known to Learning Disability Psychiatry and had <i>'three sessions'</i> in 2011.
20 Oct 2010	Adult Social Care		Learning Disability Team OT assessment. Mother noted as main carer and Baseet declined OT assessment.
15 Nov 2010	Adult Social Care		Discharge from the Early Intervention Team notes he was given <i>'reasonable presence'</i> in relation to his housing request.
Scoping period 2012-2022			
2014			
4 April 2014	Anti-social behaviour team		Report received likely to be from Baseet's father (name incorrectly spelled) at Address 1: 'Urgent noise. Loud music and shouting'. The Anti-Social Behaviour team noted that an advisory letter was sent to the complainant requesting more information.
29 April 2014	Anti-Social Behaviour team		Report received from Baseet's mother at Address 1: 'loud music, smoking weed, noise, blasting music - goes on to early morning from (a neighbouring address given)'. The Anti-Social Behaviour team noted that an advisory letter was sent to the neighbouring address.
14 May 2014	Anti-Social Behaviour team		Report received from Baseet's father at Address 1: 'Customer reporting asb by youths hanging around the street on (street), customer says the youths are dealing drugs causing nuisance to the residents. Youths are described to be gang members, it is said that they are not only using drugs but also playing loud music and drinking, shouting and causing threatening behaviour to the others members of the residents.' The Anti-Social Behaviour team noted that

Date	Agency	Shompa	Baseet
			'Safer Neighbourhood Team gather details with stops and liaise with us for action'.
14 May 2014	Anti-Social Behaviour team		Anonymous report received as follows: 'The gentleman called to say that a group of 16 people between the age of 20 and 40 gathered in front of house (Address 1). The group are disturbing the peace of the caller and the neighbourhood as they are fighting, swearing and shouting. The caller wants the ASB team to come over to send them away.' The Anti-Social Behaviour team noted that the police were already aware and that there were no details to update the complainant.
16 May 2014	Anti-Social Behaviour team		Report received from an occupant of Address 1 who wished to remain anonymous. No details of the complaint were recorded.
18 May 2014	Anti-Social Behaviour team		Report received from Baseet's mother at Address 1: 'Urgent noise - loud music from (neighbouring address given). Caller also inf(orme)d that noise is also coming from door (a different neighbouring address given)'. The Anti-Social Behaviour team noted that they spoke with the complainant on the phone for 35 mins, and the complainant said they did not want anyone coming to the property and would not let anyone in if they attended.
13 June 2014	Anti-Social Behaviour team		Report received from Baseet's mother at Address 1: 'Urgent noise - loud music & shouting from (neighbouring address given)'. The Anti-Social Behaviour team noted that no visit was conducted initially, however, shortly afterwards officers visited the location and observed 15-20 males engaging in drug use. (Council officers would usually pass such information on to the police, however there is no record or evidence to suggest that happened on this occasion.)

Date	Agency	Shompa	Baseet
30 August 2014	Anti-Social Behaviour team		Report that was probably from Baseet's mother (name mis-spelled) at Address 1 received as follows: 'urgent request loud music from (neighbouring address given)'. The Anti-Social Behaviour team noted that the complainant did not want uniformed officers to visit the home address for safety reasons. An advisory letter was sent - advising the complainant that they needed to witness the noise.
6 Oct 2014	GP		Seen by GP for increased dose of duloxetine, noisy neighbours getting him down. Can't sleep – noise day and night.
11 Oct 2014	Police		Baseet arrested after running out into the street with a large knife and threatening others with it. It is alleged that he stabbed a neighbour's door causing damage. His solicitor believed he was suffering from severe mental health issues, but police doctor deemed him fit for interview. Baseet was charged with criminal damage, possession of a knife and public order. Pleaded guilty at court and received a suspended sentence and supervision order.
2014	Mental Health		Arrested in relation to possession of a knife and threatening others with it. Remanded to prison for three months awaiting trial. Pled guilty to offences and received a 12-month custodial sentence, suspended for 11 months, with 12 months' supervision by Probation. Required to live with his Grandmother for a short while. During the criminal justice process, referred to the Learning Disability team and remained open to them until March 2015. During this time, he reported auditory hallucinations and was diagnosed with depression, somatisation disorder, unspecified psychosis and mild learning disability. Was offered and declined psychology support; the consultant wrote letters of support to housing, benefits agency and GP. Sometimes Baseet did not attend medical appointments and family attended

Date	Agency	Shompa	Baseet
			instead. They reported he was too frightened to leave home; he was scared that local boys would harm him, or that they would get him into trouble and he would have to go back to prison.
2015			
22 Jan 2015	GP		Fax received from HMP Pentonville. Arrested for significant offences - possession of a knife, waving at a stranger in a threatening manner, and put knife in neighbour's letter box.
10 Sept 2015	GP		Mother seen: Baseet low in mood, doesn't leave house. Issues with housing. Difficulties engaging with community mental health team.
24 Sept 2015	Police		Mental health team attended Baseet's address: he complained about his immediate neighbours who he said were always complaining and conspiring against him. He said if nothing was done he'd consider arming himself with a knife and wouldn't be responsible for his actions. When the mental health team left the address a group of males were standing outside and were overhead to make a comment about staff leaving the property as though giving a surveillance commentary. Though staff were not threatened, they described the atmosphere as intimidating. Unclear if police attended this incident but an information report was created by the Safer Neighbourhood Team detailing concerns of the mental health team.
Sept 2015	Mental health		Open to the Crisis Team for 5 days following concerns reported by family: he accused his family of trying to get him rearrested, had been knocking on neighbours' doors and family were worried this would lead to a confrontation. Baseet did not like different people visiting daily, and declined to engage after 5 days. Care transferred back to Learning Disability Team.

Date	Agency	Shompa	Baseet
25 Sept 2015	Ambulance Service		Ambulance requested for Baseet following report of allergic reaction to medication (duloxetine) administered by home treatment team. Documented that Baseet had psychosis and mild learning disability . Following assessment Baseet conveyed to Hospital, accompanied by his mother – care handed over to hospital staff.
14 Oct 2015	GP		Asthma check.
15 Oct 2015	Ambulance Service		Ambulance requested for Baseet following report that he was out of control, moving furniture, talking to himself, not eating/ drinking had vomited, not taking his medication and kept walking in and out of the house. On arrival Baseet's mother was chasing him down the road, ambulance staff caught up and chatted with him. He was initially reluctant to talk and kept walking away - eventually agreed to get into the ambulance. Following assessment Baseet conveyed to Hospital, accompanied by family – care handed over to the hospital staff.
16 Oct 2015	Mental health		Baseet's mother and aunt took him to Emergency Department following concerns of deteriorating mental state in the context of non-compliance with prescribed medication for 3 months. Seen by the Psychiatric Liaison Service and referred for Mental Health Act assessment. Noted to be irritable, agitated, confused, mute, talking 'to himself'/responding; had not been eating or drinking for two days; presented as persecuted; felt unsafe. Believed his family were imposters who were trying to poison him. Presented as angry and reported thoughts of hitting others. He was formally admitted to hospital under Section 2 of the Mental Health Act. Whilst on ward, the Consultant wrote a letter to support an application for alternative accommodation due to ongoing locality antisocial behaviour and noise, and its related impact on Baseet's mental state

Date	Agency	Shompa	Baseet
			and recovery. Medication revised to mirtazapine ⁵² and discharged to community mental health team with diagnoses of learning disability, somatisation disorder and unspecified non-organic psychosis.
12 Nov 2015	GP		Discharged from psychiatric ward yesterday. Wants to swap duloxetine ⁵³ to mirtazapine.
20 Nov 2015	Adult Social Care		Referral received from Centre for Mental Health for support around finances and housing. Contact made with father who said Baseet was 'unable to participate due to not understanding what was being asked.' Reports family waiting for rehousing from the council as the current area affects Baseet's mental health. Reports he is unable to go out without support of his family due to being unsafe on the streets and that he had gone to prison for three months in October 2014 for carrying a knife. Outcome: No social care needs identified, Mental Health team assisting with housing and benefits claims, no further action. Noted to be able to manage all his daily living skills with support from his family and input from GP and Mental Health team with housing transfer.
22 Nov 2015	Ambulance Service		Ambulance was requested to attend unknown male aged 27 at address 5 following a report that he had fallen downstairs and hurt his foot. Advised to ring NHS 111.
Nov 2015	Mental Health SRI		Baseet's mental health needs were met by community mental health team as outpatient.
2016			

⁵² Mirtazapine is an antidepressant drug, used primarily to treat depression.

⁵³ Duloxetine is used primarily to treat major depressive disorder and generalised anxiety disorder.

Date	Agency	Shompa	Baseet
20 May 2016	Anti-Social Behaviour team		Report received from Baseet's mother at Address 1: 'language line calling to report persons park up in vehicle outside (Address 1) and play music loudly. caller only speaks Bengali, unable to give details of vehicles. Passed to Noise team.' The Anti-Social Behaviour team noted that the noise nuisance needed to be witnessed at the time.
23 May 2016	Police		Baseet's sister called police as a group were causing a disturbance outside their address drinking and smoking. She said her brother had mental health problems and it was making him angry. Anti-social behaviour report was created and sent to the local Safer Neighbourhood Team who conducted extra patrols and spoke with family regarding the possible harassment warning against neighbours. Family said they had felt victimised by the neighbours since 2014 when Baseet was arrested after having a knife and threatening neighbours. Baseet's family wished to remain anonymous when reporting incidents for fear of reprisals.
5 Aug 2016	GP		Mum came without him - getting more anxious and can get aggressive. Discussed benefits that might help.
18 Oct 2016	GP		Seen by nurse for asthma review.
1 Nov 2016	GP		In person mental health review – spends all his time at home.
Nov 2016	Mental health		Little engagement with outpatient clinics. Reviewed in November. No concerns but his medication was increased and the doctor provided letter to support rehousing.
2017			
10 March 2017	GP		Unplanned admissions avoidance template completed.
14 March 2017	Ambulance Service		Ambulance attended Baseet at address 5 following a report he was experiencing chest pain, dizziness, and had a history of psychosis.

Date	Agency	Shompa	Baseet
			Following assessment, he was conveyed to Hospital, accompanied by his mother - care handed over to hospital staff
March 2017	Mental health		Attended Emergency Department reporting chest pain. Whilst there, was seen by Psychiatric Liaison Service and noted to be quiet and withdrawn. CRT North notified of the contact and requested to make follow up contact. Subsequently reviewed, symptoms had worsened despite increase in aripiprazole⁵⁴ and mirtazapine and so he was started on olanzapine⁵⁵.
8 July 2017	Anti-Social Behaviour team		Report received from someone at Address 1 saying 'Males in two cars putting alcohol bottles outside number (of Address 1) and playing loud music'. The Anti-Social Behaviour team noted that an advisory letter was sent to Address 1 requesting more detail.
8 July 2017	Anti-Social Behaviour team		Report received from someone at Address 1 saying 'Urgent noise - loud music. Caller confirmed that noise is coming from door no: (neighbouring address given). This is caller's second call today'. The Anti-Social Behaviour team noted that noise was audible but meeting threshold for Statutory Noise Nuisance. They visited that neighbouring address and advice was given. The music was turned off. There was a discrepancy on the house numbers and 'due to not being able to verify which address (the perpetrator) actually lives in' a P6 ⁵⁶ would not be sent out.
8 Sept 2017	GP		Mental health review with Baseet and his mother.

⁵⁴ Aripiprazole is an anti-psychotic medication.

⁵⁵ Olanzapine is an anti-psychotic medicine.

⁵⁶ A P6 letter is a letter sent to the reported party advising that officers from the council have witnessed noise emanating from their address, and, although the noise did not reach the threshold for Statutory Noise Nuisance, the noise was audible and therefore it is advisable that reasonable steps are taken to try and reduce noise levels.

Date	Agency	Shompa	Baseet
Sept 2017	Mental health		Reviewed in outpatient clinic. Noted to have disabling symptoms. Diagnosis revised to paranoid schizophrenia and major depressive episode. Doctor recommended considering clozapine ⁵⁷ if no improvement by next review. Was offered and declined referral to recovery groups and for psychotherapy. Doctor completed another letter of support for housing.
2018			
8 March 2018	GP		Mum came in with interpreter – on aripiprazole, psychiatry involved.
April 2018	Mental health		Reviewed in outpatient clinic. Complex presentation which likely included a component of affective psychosis in addition to obsessional traits and generalised anxiety arising in the context of borderline intellectual disability . Concerns that change to medication may have triggered current hypomanic presentation.
3 May 2018	GP		Switch from aripiprazole has brought on instability in mood and behaviour – olanzapine increased instead. GPs reached out to Psychiatry who provided further guidance
4 May 2018	Ambulance Service		NHS 111 contacted by Baseet who reported he wanted a private space to use the toilet – he appeared angry. Outcome - Baseet terminated the call.
5 May 2018	Ambulance Service		Ambulance attended Baseet at address 5 following a report that he was experiencing difficulty in breathing, was not taking his medication, had psychosis, schizophrenia, and was angry and pacing . It was reported new medication started the previous day not helping; and that he saw Mental Health team 1 week prior and they suggested to go to hospital if out of hours. Following assessment Baseet was

⁵⁷ Clozapine is an anti-psychotic medicine, used to treat illnesses that have not responded well to other treatments.

Date	Agency	Shompa	Baseet
			conveyed to Hospital, accompanied by his mother, where care handed over to hospital staff.
May 2018	Mental health		Attended Emergency Department and was seen by Psychiatric Liaison Service . Complained of generalised pain, presented some traits of an obsessive-compulsive disorder around toilets and showering. Had stopped taking medication. Family 'denied any risk of harm to themselves' . CRT North notified and requested to make follow up contact in community.
June 2018	Mental health		Reviewed in outpatient clinic and given a diagnosis of schizoaffective disorder and mild learning disability . Mirtazapine increased and olanzapine reduced.
10 July 2018	Ambulance Service and Police		Ambulance attended Baseet at address 5 following report that he believed someone was trying to kill him; he was angry and stressed, and getting worse; also that he had history of paranoid schizophrenia . Also reported that he had taken an overdose . Following assessment, he was conveyed to Hospital, where care handed over to hospital staff. Police created a Vulnerable Adult MERLIN but not shared with partners due to resource issues.
10 July 2018	Adult Social Care		Referred for a Mental Health Act Assessment after he attended Emergency Department following a large overdose of promethazine⁵⁸ tablets .
11 July 2018	Adult Social Care		Referred for Mental Health Act assessment following overdose promethazine tablets . Declined informal admission, home treatment team involvement and appeared to have limited insight. Outcome: Section 2 admission .

⁵⁸ Promethazine is an anti-histamine drug used to treat a variety of conditions.

Date	Agency	Shompa	Baseet
July 2018	Mental health		Took an overdose of promethazine. Family called ambulance and police were required to support attendance at Emergency Department. Assessed and detained under Section 2. Discharged from Section after 7 days, and from ward after 8 days.
Aug 2018	Mental health		Declined to attend an outpatient appointment. Mother attended with interpreter. She reported Baseet preoccupied with contamination and ran water taps for a long time. Doctor wrote letters of support for his mother to water board and housing.
1 Nov 2018	Ambulance Service		Ambulance attended Baseet at address 5 following a report that he was very agitated, possibly intoxicated, and not sleeping. Further reported that he had a history of schizophrenia. Family concerned that he had been throwing things around and then gone out for 4-5 hours. Following assessment, he was conveyed to Hospital, accompanied by his mother, where care handed over to hospital staff.
2 Nov 2018	Adult Social Care		Referred for Mental Health Act assessment following reports by family of 2 weeks deterioration of mental state . No violence reported but irritable. Outcome: Section 2 admission . Approved Mental Health Professional recommended social care needs assessment and carers assessment for his mother.
Nov 2018	Mental health		Family called for help after Baseet used alcohol; had not slept for some days; was throwing things around the house; had not taken his medication for 2 weeks. Admitted to hospital under Section 2. Discharged from hospital after 9 days to care of CRT North.
14 Nov 2018	Adult Social Care		Carer's Contact. Baseet had been seen by Home Treatment Team, following discharge, refusing to engage and declining support. FK noted to be main carer, overwhelmed and struggling to cope. She was dealing with medication, prompts for personal care, meal preparation, and prompts for eating owing to his lack of motivation.

Date	Agency	Shompa	Baseet
			She was noted to be in need of emotional and practical support (in Bangladeshi). Referral assigned to worker for a carer's assessment.
2019			
11 Jan 2019	Adult Social Care		Letter sent to contact Baseet's carer after efforts to phone were unsuccessful – response requested within 14 days (in English).
20 Jan 2019	Police		Baseet stopped and searched by police: he told officers he was just relaxing, but was sweating and shaking and when asked if he had a knife he said he did and then that he didn't. He was searched and nothing was found. No further action taken.
25 Jan – 25 July 2019	Police		Anti-social behaviour reported by family: Police received multiple calls over this period regarding anti-social behaviour outside the address and in the area. Actions of police included patrols in the area and increased focus on stop and search some of which led to arrests. Family encouraged to make a diary of what they were experiencing so it could also be reported to the council. Door to door enquiries also completed by Safer Neighbourhood Team including leaflet drops.
30 June 2019	Anti-Social Behaviour team		Report received from Baseet's sister at Address 1: 'Urgent noise - Loud music from (neighbouring address given)'. The Anti-Social Behaviour team noted that advisory letters were sent to both addresses.
25 July 2019	Ambulance Service and Police		An ambulance attended Baseet at address 5 following report that he was angry, violent, trying to leave the house but being restrained by his mother and aunt; had not been taking medication and had psychosis. Due to the nature of the call police were requested to attend - they later cancelled the ambulance request. Police created a vulnerable adult MERLIN for Baseet but this does not appear to have been shared with Adult Social Services.

Date	Agency	Shompa	Baseet
23 Aug 2019	Ambulance Service		Ambulance attended Baseet at address 5 following report that his mental health was deteriorating; he was verbally aggressive, had twice put cleaning products in his family food, had not eaten or slept for couple of days, was not taking his medication and had a history of schizophrenia. Following assessment Baseet conveyed to Hospital, accompanied by his mother, where care handed over to hospital staff.
24 August 2019	GP		Baseet's sister informed crisis team that he had thrown Mum's phone at her, in attempt to hurt her, and was pushing Dad around in attempt to hurt him. Police officer reported that they had said that he wasn't being aggressive – 'clear contradictory information being given'. (Note - not coded as Domestic Violence but should have been. Looks like it's been coded by clinical coders as exists in the text after a letter.)
24 Aug 2019	Ambulance Service and Police		Ambulance requested by police to attend Baseet at address 5 following report he was having a mental health breakdown, was not taking medication and was very aggressive to his family. On arrival Baseet's family informed ambulance staff that police had taken him to hospital. Police officers created a vulnerable adult MERLIN and this was shared with Adult Social Care.
27 Aug 2019	Adult Social Care		Police MERLIN report ⁵⁹ information: Baseet phoned his sister stating he was having a mental health crisis and she phoned police; he was 'apparently throwing things around the house.' He stated he was hearing voices and felt unsafe at home and trapped. Outcome: Report stated he was willing to go to hospital voluntarily to be assessed.

⁵⁹ Merlin reports are safeguarding reports that share details about vulnerable people (children, disabled, mental health, etc.) who come into contact with police.

The main purpose of merlin reports is to enable police and other agencies to effectively safeguard vulnerable members of the public.

Date	Agency	Shompa	Baseet
			Accused the family of not giving him any food then put (a named cleaning/ disinfectant product) into the food. Sister reported that Baseet had thrown a phone at his mother, pushed his father and touched his sister in a sexually inappropriate manner and family had locked themselves in a different room to call the police.
August 2019	Mental health		Family contacted Mental Health Crisis Line. Baseet had not been taking his medication; was verbally aggressive; had put dish soap in family food and in their beds. CRT North notified and requested to contact. Family called the Mental Health Crisis Line next day. Reported Baseet was smashing up the house; had sexually touched his sister; screams were heard and family locked themselves in room to keep safe. Police attended. Family were recorded as ' <i>possibly minimising concerns</i> ' upon police arrival. Baseet was assessed and voluntarily admitted to hospital for 10 days. Medication reviewed and blister pack recommended to support compliance.
8 Oct 2019	Ambulance Service		Ambulance attended Baseet following report he had taken the wrong medication; was angry, did not feel well and was hallucinating. Further reported that he had psychosis, schizophrenia, asthma, depression and anxiety, and felt unable to stay in the house with his family. Family stated Baseet had taken double his medication – he said not. Following assessment Baseet was conveyed to Hospital, where care handed over to hospital staff.
9 Oct 2019	GP		Seen in Emergency Department after taking double doses of medication – no self-harm intent and discharged to Rapid Assessment Interface and Discharge Service.
9 Oct 2019	Ambulance Service		Ambulance attended Baseet following report he had taken an overdose the previous day and had left hospital without being seen.

Date	Agency	Shompa	Baseet
			<p>Baseet had slept all night and was refusing to take his medication, unable to relax and breathing fast.</p> <p>Following assessment, he was conveyed to Hospital, and handed over to hospital staff.</p>
10 Oct 2019	Police		<p>Baseet's father called police to report him missing: Baseet attended hospital with his mother after not taking his medication but walked out, and did not return home. Police did not attend the incident - Baseet had attended hospital voluntarily and there were no immediate concerns for his welfare. Baseet's father called back later to say he had returned home.</p>
25 Oct 2019	GP		<p>Mum came on his behalf to mental health review – review home visit arranged.</p>
28 Oct 2019	Ambulance Service		<p>Ambulance attended Baseet following report he was hearing voices and having family issues. Following telephone assessment, it was deemed not a medical emergency and he was referred to NHS 111.</p>
28 Oct 2019	Ambulance Service & Police		<p>Ambulance requested by police to attend Baseet following report that he had not taken his medication, was becoming aggressive and had a history of schizophrenia: reported that he was upset as he no longer wanted to live with family because he heard voices every time, but his family want to stay with him to support him. He had new medication prescribed on 18 October which he was up to date with and took regularly - family felt he appeared more settled with new medication. Following assessment Baseet declined to go to Hospital or an alternative pathway. He was deemed to have capacity to decide and was left at home with his family.</p> <p>Family told Police that Baseet had been agitated all evening, brought on by him not taking his medication and neighbours playing loud music and setting off fireworks. Police also created a MERLIN report</p>

Date	Agency	Shompa	Baseet
			which was shared with Adult Social Care, and contacted Mental Health crisis line who confirmed Baseet was on the home treatment plan and they had scheduled a follow up appointment with him.
29 October 2019	Adult Social Care		Police MERLIN report information: Baseet called police from home stating he felt like hurting his family. On police attendance, appeared calm, stated he didn't feel suicidal or want to hurt his family but that he wanted out of the house and help with housing. Family reported he was agitated all night and that he had not been taking his medications. Outcome: Crisis line was called who confirmed he was under the care of the Home Treatment Team. Family advised to call police again if situation changed.
Oct 2019	Mental health		Accidentally took too much medication in effort to sleep. Family took him to Emergency Department where he was referred for Psychiatric Liaison Service, assessment but left before being seen. CRT North notified and requested to undertake urgent follow up. Later that month, Baseet called police threatening to kill his family. CRT North notified and police notified local authority of safeguarding concerns.
5 Nov 2019	Police		Baseet's sister called police due to anti-social behaviour saying that youths were targeting houses with fireworks. She said around 30-40 people were being verbally aggressive and blocking the road. Baseet ran out of the house because he could not stand the noise. Police did not attend – bonfire night and insufficient officers.
6 Nov 2019	Ambulance Service		Ambulance requested to attend Baseet following report he was having mental health problems. Following telephone assessment, he was referred to 111.
6 Nov 2019	Ambulance Service		Ambulance attended Baseet following report he was hearing voices and had mental health issues, ongoing for a number of years.

Date	Agency	Shompa	Baseet
			Following assessment Baseet declined to go to hospital. Ambulance staff made him an appointment with mental health team for next day which he agreed to attend. He was left at home in care of his mother.
12 Nov 2019	Adult Social Care		Police MERLIN report: Baseet called police on 6 Nov stating he wanted to harm someone. Due to lack of resources Police attended on 8 Nov. Baseet apologised for calling the police stating when he doesn't take his medication, he calls the police and ambulance when he does not require it. Father stated he has taken his medication and is better but that his behaviour changes when he doesn't take it. Outcome: Suggestion for the mental health team to consider a Section 135 warrant as Baseet will refuse treatment. Merlin forwarded to mental health team.
19 Nov 2019	GP		Parents come for his mental health review. Seems stable. He likes quiet places. They have spoken to housing so many times.
29 Nov 2019	GP		Baseet seen for a home visit, (parents reported that his mental health was pretty stable). Gangs make a noise and drink outside the house – family have to call the police. Mother rarely goes out, husband works part time in a restaurant. Daughter lives with them, works afternoons at school and helps them a lot with cooking and cleaning. Baseet rarely goes out, doesn't like television. Smokes too much, spends a lot of time sleeping. No drugs or alcohol. Baseet came down to talk to GP – blunt affect, poverty of speech and thought, apathy and anhedonia. Vaccines given and asthma review completed.
2020			
11 Jan 2020	Police		Police called due to anti-social behaviour: called regarding drug dealing outside the address, an Anti-Social Behaviour report was created and sent to Safer Neighbourhood Team.

Date	Agency	Shompa	Baset
25 Feb 2020	GP		Mental health review – not in person. Notes reviewed and electronic prescribing and medicines administration system checked: compliance with medication thought to be good.
25 March 2020	Ambulance Service & Police		Ambulance requested by police to attend Baset following report he was having a mental health episode . Police later cancelled the request as father taking him to hospital.
26 March 2020	Adult Social Care		Police Merlin report: police were called by sister worried about her brother's welfare as he was chucking stuff around his room and not taking medication. When officers arrived, he was calm and collected but stated he wanted to be re-housed. Long conversation - police satisfied there were no immediate concerns. 30 minutes later family called again, reported behaviour continued. Outcome: Taken to hospital by his father with police accompaniment. Further information in a contact form: Was seen by Crisis and Assessment Team for mental state assessment. He reported difficult family dynamics and wanted to be re-housed. He had an appointment with what is now the Homelessness Prevention and Advice Service scheduled for 28 May 2020.
March 2020	Mental health		Family contacted Mental Health Crisis Line - Baset had stopped taking medication; was verbally aggressive and violent, breaking furniture and items at home . Family advised to contact police and CRT North.
5 April 2020	Ambulance Service		Ambulance attended Baset following report he had a fever, could not relax, and leg pain. Following telephone assessment, he was referred to NHS 111.
6 April 2020	Ambulance Service		Ambulance attended Baset following report of pain in his body and dizzy. Following telephone assessment, he was referred to NHS 111.

Date	Agency	Shompa	Baseet
7 April 2020	GP		Mental health review by GP with Dad.
April 2020	Mental health		Father contacted Mental Health Crisis Line concerned for deterioration: Baseet agitated, pacing, with increased energy. Information forwarded to CRT North for follow up.
14 May 2020	Mental health		Did not attend outpatient appointment. Doctor spoke with family who 'denied any concerns for mental state or risk' at the time.
18 May 2020	Ambulance Service & Police		Ambulance attended Baseet following report he had not taken his medication, was going crazy, making threats to harm himself or someone else, trying to run out of the house, shaking a lot and drinking lots of caffeine. Due to nature of the call police also requested to attend and were on scene on ambulance arrival. Baseet had said that he was having a mental health breakdown and wanted to stab himself and others. Police were informed that he was smoking outside and had a knife. On police arrival Baseet ran at the officers and was 'red dot challenged' with Taser - he then complied, was handcuffed and searched; no knife found. He was detained under section 136 ⁶⁰ of the Mental Health Act. He said he still wanted to kill people and that he had been going to meetings where they were telling him to stab people and kill them. Baseet also mentioned a yellow and silver kitchen knife in his mother's kitchen which he had planned to take to stab people with. A MERLIN was created and shared with adult social services.
18 May 2020	Adult Social Care		Referred for Mental Health Act assessment after brought to hospital by police under Section 136 - police called by his sister who was concerned about him holding a knife intending to harm himself or others. Outcome: Section 2 Admission.

⁶⁰ Section 136 of the Mental Health Act gives police emergency powers if they think someone in a public place has a mental disorder and needs immediate help.

Date	Agency	Shompa	Baseet
18 May 2020	Adult Social Care		Admitted to Centre for Mental Health on following arrest by the police after family reported he was threatening them with a knife.
18 May 2020	Mental health		Sister contacted police and said Baseet holding a knife and threatening to harm himself and others. He was detained under Section 136. He reported being controlled by Brick Lane and said he wanted to stab others. Spent 20 days on Section 2. On discharge from Section and ward was referred to local authority to request follow up by social worker with consideration of a Support Worker for 'community support'.
19 May 2020	Police		Baseet called police from Centre for Mental Health to say he was not being allowed out of the mental health centre - wanted officers to come and get him. Police tried to call back but could not get through, no further action was taken.
20 May 2020	Police		Baseet called police from Centre for Mental Health again to say he was not allowed out of the mental health centre and nothing was happening with regards to treatment. Also told the operator the nurses were trying to strangle him. No further action taken and police did not attend as he was in a place of safety.
3 June 2020	Adult Social Care		Baseet referred to Mental Health Access and Assessment Team during hospital admission at Centre for Mental Health. Care Act assessment completed on 3 June when he met eligibility threshold for support under the Care Act in the following domains: Developing and maintaining relationships; Making use of the community, and accessing and engaging in work, training, education or volunteering. Recommendations made for care package of outreach support totalling 5 hours per week, to support him to identify and attend activities outside the home, to explore volunteer work and support to

Date	Agency	Shompa	Baseet
			attend appointments. Risk Assessment indicates aggression towards family, isolation, and self-harm.
'Early' July 2020	Adult Social Care		Assessment carried out by 'Three C's' to explain the type of support they could offer Baseet to reduce isolation and provide structure. He declined the support stating he wanted his physical aches and pains to be reduced and this is what prevents him going out. He also stated he thought a move from the family home would be beneficial as aspects of his relationship with his parents impact his mental health. Following this, allocated social worker phoned his father who stated the family would continue to support him, email sent to consultant psychiatrist to inform him, was referred to the Adult Social Care Supported Employment Team and case was closed to the Mental Health Access and Assessment Team. Unclear what happened with referral to Employment.
22 July 2020	GP		Pharmacist reviewed Baseet as he was on the serious mental illness register and on a practice register for quarterly reviews – at one point although this didn't appear to happen consistently.
1 Oct 2020	Ambulance Service & Police		Ambulance requested by police to attend Baseet following report that he was having mental health issues and throwing boiling water at family. Also reported that ambulance needed for a female who had been scalded living at same address. Following assessment female burns were dressed and she was left at home in care of family with advice to ring back if burns worsened. Baseet was arrested for actual bodily harm - officers were concerned for his mental health as he was more worried about the fact his mother would not let him have any cigarettes than the incident. Baseet was bailed for the offence and given conditions not to contact the family or attend the home address. The officer involved made

Date	Agency	Shompa	Baseet
			<p>numerous attempts to obtain a statement but ultimately Baseet's sister and mother did not want to support a prosecution, as they were worried for his mental health and believed he was unable to look after himself. They wanted him back in the family home. There was no other evidence to support a prosecution. MARAC referrals were made, and a MERLIN created and shared with Adult Social Care.</p>
2 Oct 2020	Ambulance Service		<p>Ambulance attended female at Baseet's address following report she had been burnt the previous day and was in extreme pain with blisters on skin which had peeled off, and she was unable to get dressings off. It was reported that Baseet had poured hot water on her following a mental health episode. Following assessment female was conveyed to Hospital and care handed over to hospital staff.</p>
2 Oct 2020	Adult Social Care		<p>Police MERLIN report: police called by sister for a domestic violence incident – Baseet had thrown boiling water on his mother after an argument about cigarettes. Outcome: Ambulance Service called as his mother sustained burn injuries. Baseet arrested.</p>
Oct 2020	Mental health		<p>Baseet poured boiling water over his mother. Subsequently arrested but then diverted from police custody to hospital under Section 2. He reported that his family were not his family, that they were paid to make him take tablets, that he will stab them. He presented as guarded, thought disordered, floridly psychotic and with homicidal thoughts. Police completed a safeguarding referral. During admission, Baseet required transfer to Psychiatric Intensive Care Unit after he assaulted a patient. Discharged from Section 2 and ward after 25 days. Referred for supported living but declined this opportunity; his family wanted him to return to living with the family.</p>
2021			

Date	Agency	Shompa	Baseet
22 Jan 2021	Ambulance Service		<p>22 January - An ambulance was requested and attended Baseet following a report he was being verbally aggressive, hallucinating and had a history of mental health problems. Documented that Baseet was scared his behaviour was escalating and that previously he had poured water over his mother, he also requested police attendance. Reported that Baseet felt he was unable to stay in the house with his family. Family stated that Baseet had taken double his medication, Baseet denied this.</p> <p>Referred for a clinical ring back, following an enhanced telephone assessment it was deemed that an ambulance was needed.</p> <p>On arrival of the ambulance staff, they documented that Baseet was not on scene, wandering around Newham, an area search was completed but Baseet was not found.</p> <p>Ambulance staff left the scene advising the family to ring back if they were further concerned when Baseet returned.</p>
23 Jan 2021	Police		<p>Baseet's father reported that he had gone missing in the early hours but he returned 25 minutes later when police attended.</p>
23 Jan 2021	Ambulance Service		<p>Ambulance attended Baseet following report he was anxious and depressed - his father was on scene. Following assessment, he declined to go to hospital and was deemed to have capacity to decide - was left at home in family's care.</p>
23 Jan 2021	Ambulance Service & Police		<p>Ambulance attended Baseet following report his heart was beating fast and he felt uncomfortable and frightened. Noted he had earlier declined to be conveyed to hospital but on this occasion, ambulance staff felt he did not have capacity to make this decision and requested police to assist in his best interests. Police asked Baseet to go to the ambulance and he complied. He was conveyed to Hospital 2, where care was handed over to hospital staff.</p>

Date	Agency	Shompa	Baseet
			Police completed a MERLIN and shared it with Adult Social Care. In the Emergency Department Baseet was seen by a triage nurse with palpitations, agitation, and confusion.
24 Jan 2021	Acute Hospital Trust		Mother told Emergency Department doctor that Baseet has not slept for 1 week. Hallucinations/delusions worse and believes he will be killed. He was violent to family members. He was referred to liaison psychiatry. Later plan to give intramuscular lorazepam discussed with liaison psychiatry. Also plan for intravenous antibiotics and intravenous fluids.
25 Jan 2021	Acute Hospital Trust		Baseet became suspicious of consultation with doctor in the Emergency Department; refused to answer doctor's questions and examination; had refused to provide urine sample. Blood test results showed Inflammatory markers high – unknown source. Later a learning disabilities nurse visited him on medical unit but he was asleep so nurse was unable to assess him. The nurse called Newham Learning Disabilities team and was advised he was not known. Notes suggested he had a learning difficulty not a learning disability. Nurse to return to reassess. Charge nurse completed Deprivation of Liberty Safeguards (DoLS). Baseet assessed as not having the capacity to agree to: <ul style="list-style-type: none"> • Close observation • Being kept on the ward • Low rise bed • Sedation • 1:1 security
25 Jan 2021	Adult Social Care		Deprivation of Liberty Safeguards Form 1 received from Hospital 2 requesting standard authorisation and urgent authorisation. Purpose

Date	Agency	Shompa	Baseet
			<p>of the standard authorisation states help with personal care, mobility, intra-venous medication. Behaviour issues specifically distress, aggression, wandering and communication issues related to learning disabilities. Deemed not to have capacity to agree to close observation, being kept on ward, sedation, low rise bed and 1:1 security. Risks without the deprivation of liberty included aggression to others causing hostile response, self-neglect, vulnerable, falling and inadequate nutrition. Outcome: discharged on 28 Jan 2021 before the DoLS process could take place. No further information on system regarding the nature of the hospitalisation or further outcomes.</p>
26 Jan 2021	Acute Hospital Trust		<p>Psychiatric consultant suggested to medical registrar that if no change in his psychiatric symptoms Baseet can be followed up in community. Plan was to call next of kin to update and if no further concerns for discharge home. Medical registrar attempted to call family on number provided without success. Liaison psychiatry asked to come back and review him.</p>
27 Jan 2021	Acute Hospital Trust		<p>Seen by psychiatric team. Baseet said his parents do not want him home but was unable to explain why. Reported he hears things but not telling him to harm himself or his parents. Said he had not had an altercation with his parents. Plan then was to speak with his father.</p>
28 Jan 2021	Acute Hospital Trust		<p>Liaison psychiatry discussed with discharge with ward doctor for Home Treatment Team to review. Medical team to liaise with father (new number provided) and arrange transport home.</p>

Date	Agency	Shompa	Baseet
			Discharge summary said he was treated for infection with antibiotics, improved clinically, was reviewed by psych team during admission, and psychiatry will review him in the community after discharge.
7 Feb 2021	Ambulance Service		Ambulance attended Baseet following a report he was generally unwell. He was referred for a clinical ring back. Following an enhanced telephone assessment via his father advice that he was to attend Urgent Care Centre, but family insisted an ambulance attend. Ambulance subsequently attended Baseet and, following assessment, he was conveyed to Hospital 1, where care was handed over to hospital staff.
April 2021	Mental health		CRT North discharged Baseet from their care, back to GP following period on non-engagement.
14 April 2021	Ambulance Service		Call was received regarding Baseet - reported that GP not helping but ambulance not required. Baseet advised to call 111.
14 April 2021	Ambulance Service		Call received giving Baseet's address details: person requested to speak to a Bengali doctor. Advised they could talk to the call handler via an interpreter. This was declined - caller said they would call back later.
14 April 2021	Ambulance Service		Call was received. Male caller initially reluctant to give any details - asked for housing assistance - wanted to speak to a lady doctor, then reported a headache. Clinical ring back needed. Further call later received cancelling ambulance request as Baseet feeling better.
11 May 2021	Ambulance Service		Ambulance requested to attend Baseet following report that he was having mental health problems , had stopped taking medication and was throwing stuff around. Referred for a clinical ring back. Following enhanced telephone assessment, it was deemed an ambulance needed. Following assessment Baseet was conveyed to Hospital 1, where care handed over to hospital staff.

Date	Agency	Shompa	Baseet
12 May 2021	Adult Social Care		Mental Health Act assessment - taken to hospital via ambulance for physical health issues, cleared of any physical health concerns but concerns over mental state. Did not demonstrate any insight, impression mental state relapsing , stated he wants his own home and support with this as there were too many people in the house. Outcome: Section 2 admission . Approved Mental Health Professional recommended social care needs assessment.
20 May 2021	GP		GP spoke to mum and sister – was discharged from Mental Health after relapse of psychosis – no follow up arranged. Concerned that he doesn't take medications and may relapse. Admitted again last Tuesday and is still an inpatient. Asked to wait and see what plans are on discharge.
22 May 2021	Police		Baseet called police from Mental Health Centre and said that his bank card had been stolen. Police attended next day and Baseet said that he called police because they would not let him smoke on the ward and his card was not stolen. No further action was taken.
May 2021	Mental health		Family reported concerns that Baseet unwell: had been throwing things in the bin; breaking things; was paranoid and looking through bags; had uncharacteristically been going out at night alone. Was assessed and admitted to hospital under Section 2. Whilst on ward, he sexually touched a nurse, became 'quite fixated', and followed her saying suggestive things. This necessitated transfer to another ward. In June and when Section was expiring, he was placed under Section 3. Because of concerns for erratic compliance with oral medication, was placed on depot medication ⁶¹ . Later discharged from ward into care of CRT North.

⁶¹ Depot medication is given by injection and released slowly.

Date	Agency	Shompa	Baseet
8 June 2021	Adult Social Care		Mental Health Act assessment regarding Section 3 admission following his Section 2 admission on 12 May. Still lacking insight and appeared pre-occupied with housing, wanting independent accommodation. Outcome: Section 3.
11 June 2021	Police		Baseet was reported missing from a ward at a Centre for Mental Health while on un-escorted leave. Had returned home – father said he would return Baseet to hospital that morning, but Baseet did not return. Police noted that the mental health facility said they did not need further police involvement as they knew his whereabouts.
11 June 2021	Ambulance Service	Ambulance attended Shompa following report that she had fallen off the bed, had slurred speech and numbness to left side of body. Granddaughter on scene. Following assessment Shompa was FAST+ (Face, Arms, and Speech Test) and was conveyed to Hospital 3, where care handed over to hospital staff.	
11 June 2021	Emergency Department	Family reported that Shompa had	

Date	Agency	Shompa	Baseet
		<p>complete left sided weakness.</p> <p>Later she was seen by the doctors and her son (name not recorded) used to translate '<i>due to language barrier</i>'. After a head scan, she was admitted to the stroke unit.</p> <p>Later that day on the stroke unit her 'next of kin' (a granddaughter) was called by occupational therapy for consent to assess her in her best interests '<i>due to the language barrier</i>'.</p>	
15 June 2021	Acute Hospital Trust	An alert was added to Shompa's hospital records by Overseas Department, stating that: this patient is not entitled to free NHS treatment: do not	

Date	Agency	Shompa	Baseet
		book any appointments.	
16 June 2021	Acute Hospital Trust	Notes added to electronic patient system, saying Shompa is Bangladeshi National, entered UK 2009 as a visitor. Son (name given, noted as next of kin on electronic record) stated her passport is lost/missing. Patient has no family in homeland. Son and daughters in the UK. He is aware patient is chargeable.	
16 June 2021	Ambulance Service		Ambulance was requested to attend Baseet following report that he was refusing to take medication and was aggressive: he had left a ward on unescorted leave and was under Section 3 of the Mental Health Act. He didn't want to return to the ward. Later update confirmed his father had spoken to police and Baseet had returned to hospital.
17 June 2021	Police		Police called by Baseet's father who said Baseet was detained under Section 3 MHA and had absconded the Mental Health Centre a week ago. They had asked the Centre to take him back but they could not

Date	Agency	Shompa	Baseet
			collect him. His mental health had deteriorated. Police attended the address and took Baseet back to the Centre. Police completed a MERLIN and this was shared with social services.
18 June 2021	Acute Hospital Trust	Shompa was noted to be crying during a ward round and the plan was to refer her to neuro psych (but there was no further documentation related to this referral.) Later that day occupational therapy saw her with an interpreter on video link. She was tearful throughout assessment. It was noted that she was confirmed an overseas patient; could not return to her next of kin's property and was homeless.	

Date	Agency	Shompa	Baseet
22 June 2021	Acute Hospital Trust	Speech and language therapy saw Shompa with her 'next of kin' – noted as youngest daughter and son. Family reported they felt they will manage looking after her at home better than in hospital. A new wheelchair was provided.	
23 June 2021	Acute Hospital Trust	Speech and language therapy saw Shompa again with her son (name not recorded) for support and translation. He reported she was emotional as they had not seen one another for a few years prior to this week. Later she was seen by physiotherapy and	

Date	Agency	Shompa	Baseet
		<p>occupational therapy with son (name given) who translated and said she would be going to live with another son. The new address was said to be at the front of the file but no alternative address was documented.</p> <p>In the late afternoon the same son agreed to take Shompa home in the family car and was given training. The team advised private physiotherapy and gave him a list of equipment to purchase.</p> <p>The discharge summary gave the primary diagnosis as right middle cerebral artery and posterior cerebral artery stroke.</p>	

Date	Agency	Shompa	Baseet
		<p>The discharge address did not indicate a different address from admission and the plan was given as:</p> <ul style="list-style-type: none"> • Stroke follow up • 24 hour tape & echo-cardiogram as an outpatient (cancelled on 25 June as she was housebound with no further follow up noted) • Aspirin initially then clopidogrel • Continue statin • Continue pregabalin for 1 month then GP to review (it was known that Shompa had no registered GP at that time). 	
24 June 2021	Adult Social Care		Referred for a Care Act assessment by Centre for Mental Health on 23 May for possible exploration of supported accommodation. Referral stated he informed the Ward that he is in receipt of ESA

Date	Agency	Shompa	Baseet
			<p>which is managed by the family and it was unclear if he could access it, stating '<i>they spend my money</i>', request made to further explore this. Attached risk assessment indicated he absconded from the Ward on 9 June 2021 and was brought back by police on 17 June 2021, having been found at his parents' home looking '<i>emaciated and scruffy</i>': also on 18 June 2021 he destroyed Trust property, slapped staff and voiced sexually inappropriate words towards staff. Risk history includes aggression towards family.</p> <p>Care Act assessment not completed as Baseet was discharged back to family home. Social Workers' notes state the family did not wish to pursue supported accommodation and instead were satisfied that Baseet was started on depot treatment. Notes also state he is Care Coordinated and working with the family for extra support. Case then closed.</p>
25 June 2021	Acute Hospital Trust	Referral for 24 hour tape was cancelled due to Shompa being housebound.	
4 July 2021	Police		<p>Police called to a Centre for Mental Health by staff, who alleged Baseet had touched a female nurse's bottom over her clothing whilst she was completing her tasks. He had been following her into other patients' rooms, watching her whilst treating other patients, and making sexual remarks, causing her distress. This was the second time it had happened and she did not want him arrested. Due to Baseet's mental capacity it was agreed that matter would be dealt with internally and action would be taken to safeguard the victim and Baseet. Officers spoke with Baseet but he had been sedated and did</p>

Date	Agency	Shompa	Baseet
			not speak with clarity. Officers created a MERLIN and this was shared with Adult Social Care.
6 July 2021	Adult Social Care		Police Merlin report: Police called to ward at a Centre for Mental Health by female nurse stating sexual assault - Baseet touched her bottom. Nurse stated this was the second time this has happened, did not want to progress the investigation, but wanted to report it. Outcome: To safeguard nurse either Baseet or nurse to move to another Ward.
30 July 2021	Adult Social Care	Contact form created by Newham's Access Team following referral dated 28 July 2021 (received 29 July 2021) from GP practice - Shompa had a stroke one month previously and right sided weakness. Family not coping with her support needs – difficulties mobilising and managing continence (unable to get to the toilet). Same date GP Practice emailed by Access Team to advise Shompa's	

Date	Agency	Shompa	Baseet
		family had declined support for her and her son said they were happy to continue care, would contact if support needed in future.	
5 Aug 2021	GP		<p>Mental health and asthma reviews were done by GP on home visit but no LD review? GP offered blood testing when required for Baseet's medication.</p> <p>Family painted a picture of a man who didn't like talking to people because of mental health issues. Most consults were done on his behalf - by either siblings or parents - although he was seen for home visit in August 2021 and November 2019. He didn't like attending surgery to have blood tests so reasonable adjustments made to do them in the community.</p>
16 Aug 2021	Ambulance Service	Ambulance attended Shompa at address 5 following report that she had a swollen left hand, painful and slightly numb. No answer at door on ambulance arrival. On call back told ambulance not needed – would see the GP.	

Date	Agency	Shompa	Baseet
1 Sept 2021	GP		Police contacted the surgery - was admitted for his mental health in June 2021 and stabilised on depot medication .
7 Sept 2021	Ambulance Service		Ambulance requested to attend Baseet following a report of headache. Enhanced assessment attempted but Baseet declined to talk. His mother reported he had been pacing all day but was not aggressive. Call later cancelled as Baseet reportedly feeling better.
21 Sept 2021	Anti-Social Behaviour team		Report received from a resident of (the street of Address 1) saying 'Outside (Address 1) in the car park, a BMW which belongs to a resident is smashed in the front end of the car and the car alarm keeps going off all day and night witch (sic) keeps the young children up. This has been going on for over a month now and is becoming a massive problem as the owner leaves the car here 24/7 and works in the day so is not here to turn the alarm off'. The Anti-Social Behaviour team noted that an advisory letter was sent to Address 1 to disable the car alarm.
23 Oct 2021	Police		Welfare check conducted at Subell's address by Detective who was investigating him for assault on his mother . A MERLIN was created and shared with adult social services.
2022			
2 Feb 2022	GP		Baseet's sister called the Practice concerned about her brother, stating that he lacked insight, is paranoid and has trashed his room , not compliant with medications after depot appointment changed - he doesn't like change. GP signposted to the crisis team – his father had called them twice already. Not clear what the outcome was. Advice given about police and ambulance if fearful.
4 March 2022	Ambulance Service & Police		Ambulance attended Baseet at address 5 following report that he was having a mental health crisis and had stopped taking medication. Following assessment, he declined to go to hospital. It was deemed

Date	Agency	Shompa	Baseet
			<p>he did not have decisional capacity, and discussions took place with the mental health team. It was deemed that he needed to be taken and that police should be called to assist. Police assisted and he was transported to Centre for Mental Health under the Mental Capacity Act. He went willingly.</p> <p>Police assisted taking Baseet to hospital: a MERLIN was created and shared with adult social services.</p>
4 March 2022	Adult Social Care		<p>Mental Health Act assessment after taken to Centre for Mental Health by ambulance and police: family had contacted ambulance service with concerns over his mental state. He had smashed his bedroom wall with a hammer and removed plaster stating he was making room for his wife despite being single. Outcome: Section 2 admission.</p>
19 March 2022	Police		<p>Baseet was reported missing from Centre for Mental Health: left Centre whilst he was on un-escorted leave and went to home address. Centre contacted him but he refused to return. There was no immediate risk, so the Centre was told that police would not attend - mental health team should respond.</p>
20 March 2022	Police		<p>Further call regarding Baseet being missing from the Mental Health Centre: Baseet had not returned; staff concerned he would not take his medication and mental health might deteriorate. Explained that this was not a police matter - should be dealt with by Centre staff or ambulance service.</p>
21 March 2022	Police		<p>Further call re Baseet being missing from Centre: Centre staff called police as Baseet still not returned. Staff at the Centre did not want to attend home address as Baseet was a risk to their safety. Baseet's father also called police and asked for assistance taking him back to the Centre. Police attended home address and returned him to Centre.</p>

Date	Agency	Shompa	Baseet
March 2022	Mental Health		On 4 March, family contacted ambulance and police with concerns for Baseet's behaviour. He had used hammer to try to break down wall in his bedroom. He said this was in preparation for his wife although there were no plans for marriage. He was assessed and admitted to hospital under Section 2 . Whilst on the ward, he was absent without leave for 1 week, residing with family and refusing to return to ward. Family ' <i>denied</i> ' any concerns for Baseet during his time and said they were unable to convince him to return to ward. Ward worked with police, who eventually returned Baseet to the ward to continue with planned period of assessment and treatment. On 31 March Baseet was discharged from ward back to care of CRT North. Baseet's father agreed to Baseet's return to family home and Baseet was said to be keen to return to home: ' <i>no evidence of risks to self or others upon discharge</i> '.
A date in March 2022	Police & Mental Health		Baseet left the Centre and was discharged to his home address.
A date in April 2022	Ambulance Service & Police	Ambulance attended Shompa at address 5 following report she had been stabbed in the neck and was not breathing. Shompa recorded to have multiple stab wounds. Helicopter Emergency Medical Service also attended. Shompa	Whilst police were responding to the call, other officers stopped Baseet based on description of the offender. He was arrested and taken into custody where he was interviewed.

Date	Agency	Shompa	Baseet
		was Pronounced Life Extinct by the Helicopter Emergency Medical Service doctor at 10:40 and left on scene in Police care.	
3 April 2022	Police	Forensic Post Mortem: the worst of Shompa's injuries were through the chest cavity, inflicted with a severe level of force. Many of the injuries were capable of being fatal.	Baseet was charged with murder.
29 March 2023	Police		Criminal trial at the Central Criminal Court: jury returned a verdict of guilty in relation to Baseet committing the act of killing Shompa. Baseet was sentenced to a Section 37 hospital order with a Section 41 restriction (Only the Home Secretary has authority to release).

APPENDIX 2: ACRONYMS/ ABBREVIATIONS USED IN THIS REPORT

As far as possible acronyms/ abbreviations are avoided in the text of this report for ease of reading but there is a list of acronyms that may appear in the Chronology Table below.

ASB/ asb	Anti-social behaviour
ASC	Adult Social Care
Azeus	London Borough of Newham's social care record
COVID/ COVID-19	Coronavirus disease of 2019
CRT	Community Recovery Team
CSP	Care Services Partnership
DASH	Domestic Abuse, Stalking and Honour Based Violence Risk assessment
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
EDT	Emergency Duty Team
ePCR	Electronic Patient Care Record
ESA	Employment and Support Allowance
FAST	Face, Arms, and Speech Test (for stroke symptoms)
GP	General Practitioner
HMP	His Majesty's Prison
IMR	Independent Management Review
LD	Learning disability
MARAC	Multi-agency Risk Assessment Conference
MASH	Multi-Agency Strategic Hub
MERLIN	Missing pERsons and other Linked Indices: a system used by the Metropolitan Police Service.
NHS	National Health Service
NRPF	No Recourse to Public Funds
OT	Occupational Therapist/ Occupational Therapy
Rio	The electronic record used by mental health
UK	United Kingdom
VAWG	Violence against women and girls

APPENDIX 3: BIBLIOGRAPHY

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