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Together for a Safer Croydon

Domestic Homicide Review

Overview Report into the death of Rasika in June 2022

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Independent Chair and Author
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PS SAFEGUARDING LTD

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Preface

Only the independent author and review panel's names have been disclosed to ensure confidentiality; all other names are pseudonyms.

The author and review panel send their deepest condolences to all those impacted by Rasika's untimely passing and thank them for their involvement and support in this process.

The primary objective of a Domestic Homicide Review (DHR) is to permit the learning of lessons from the death of a person in a relationship where domestic abuse was known to have occurred. Professionals must understand what transpired in each instance for these lessons to be thoroughly and effectively assimilated and what must be altered most to reduce the likelihood of such tragedies.

The author thanks the panel and persons who submitted chronologies and materials for their time and cooperation.

1.1 Introduction

1.1.1 The report was written following the tragic death of Rasika in June 2022. South Area BCU referred Rasika to the Croydon Safety Community Partnership (CSP) on 30th June 2022. The case was discussed at a partnership meeting convened on 26th July 2022. The partnership panel found unanimously that the domestic homicide review criteria had been satisfied.

1.1.2 Adopted in 2011, Section 9(3) of the Domestic Violence, Crime, and Victims Act of 2004 added Domestic Homicide Reviews (DHRs). A DHR refers to an investigation into the circumstances surrounding the death of a 16-year-old or older individual that has or appears to have been caused by violence, abuse, or neglect.

1.1.3 The review was conducted following the Home Office's Multi-Agency Statutory Guidance for Domestic Homicide Reviews (updated in December 2016). [1]

1.1.4 Section 2 of the statutory guidance highlights circumstances which indicate a DHR:

(a) a person to whom he[2] 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,

Where the definition set out in a or b has been met, then a DHR should be undertaken.

1.1.5 Before her death in June 2022, Rasika was a Croydon resident. This review examines the agency's support and responses towards Rasika.

1.1.6 Besides considering agency involvement, the review will appraise the last year of Rasika's life (April 2021 – June 2022) to determine any relevant background or history of abuse before her death, whether community support was obtained and whether there were barriers to seeking community support. Taking an integrated approach, the review aims to find strategies for lowering the risk associated with such scenarios. The timeframe corresponded with Tharindu's (Rasika's grandson) contact with the police and his hospitalisation in a psychiatric intensive care unit (PICU).

1.1.7 This review does not replace the criminal or coroner's courts or resemble a disciplinary proceeding.

1.1.8 Rasika was discovered deceased by her daughter, Priya, at her home address. The perpetrator was Tharindu (Priya's son).

1.1.9 Tharindu, who has a history of mental illness, had been staying with his mother and older brother and sometimes with Rasika. According to the DHR Statutory Guidance

[1] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews
[2] Section 6 of the Interpretation Act 1978 - words importing the masculine gender includes the feminine

Paragraph 40q[3], the grandson would be considered an " adult at risk." In light of this, NHS England has been requested to contribute to the DHR report.

1.2 Case Summary

1.2.1 Pryia received a call from Tharindu's friend, who informed her that Tharindu had harmed his grandmother.

1.2.2 Pryia went to Rasika's house and discovered her in bed; she immediately began CPR and was joined by her son (not Tharindu) until the emergency services arrived.

1.2.3 Pryia provided the police with Tharindu's whereabouts after reporting that he had killed her mother.

1.2.4 Earlier that afternoon, Tharindu had instructed his mother against making her customary visit to the address. As he was going to sleep, the door would be locked. Pryia communicated with Rasika over the phone.

1.2.5 The police arrested Tharindu at the address provided by Pryia and placed him in custody. He was charged with manslaughter by diminished responsibility and pleaded guilty in July 2023.

1.3 Background Information about Rasika

1.3.1 The review contains few details about Rasika's background, and the family felt unable to contribute. The panel discovered that the agencies lacked information regarding Rasika. They corresponded with Rasika through her daughter Pryia and grandson Tharindu.

1.4 Timescales

1.4.1 Following the 2016 Multi-Agency Statutory Guidance for the Conduct of DHRs, Croydon CSP commissioned DHR in response to a decision to proceed with a review on 26th July 2022.

1.4.2 The Home Office Multi-Agency Statutory Guidance for the Conduct of DHRs specifies the review Chairs and Authors' requirements in sections 36 through 39. In this review, the responsibilities of the Chair and Author were merged.

1.4.3 The independent author for this DHR was commissioned on 5 December 2022. Croydon CSP approved the finalised report on 12th June 2024.

1.4.4 The first panel meeting was held on 6 July 2023.

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

1.4.5 A second-panel meeting reviewed agencies' detailed chronologies and determined that five reports would be required. Further panel meetings discussed the reports so the panel could pose questions and seek clarification as necessary.

1.4.5 The Home Office guidelines stipulate that reviews, including the overview report, should, whenever possible, be concluded within six months of notification.

1.4.6 Delays were caused partly by many unsuccessful endeavours to involve Adult Social Care and Housing. Senior directors were required to assist the partnership with engagement. However, housing did not engage.

1.4.7 The author tried to involve the family, but ultimately, through Victim Support, the family expressed their inability to participate.

1.5 Confidentiality

1.5.1 The review is confidential until the Home Office Quality Assurance Panel approves the release of the overview report. Only contributing officers/professionals and line managers have access to confidential information.

1.5.2 The review has been appropriately anonymised following the 2016 Home Office Domestic Statutory Guidance. The panel agreed to the pseudonyms, as the family felt unable to; only the author and review panel were identified. Additionally, the date of death has been removed to protect anonymity.

1.5.3 The following terms have been anonymised throughout this report to preserve the identities of the victim, her family, and the perpetrator.

- The victim: Rasika
- Daughter: Pryia
- Perpetrator: Tharindu

1.6 Terms of Reference

1.6.1 This review intends to identify the lessons learned from Rasika's tragic death and respond to those lessons to prevent deaths connected to domestic abuse and ensure that individuals and families are supported effectively.

1.6.2 The full terms of reference are included in Section 3.2. The panel accepted the terms of reference. Due to the absence of family, these were not disclosed beyond the panel.

1.6.3 On 29 April 2021, the Domestic Abuse Act was signed into law. The Act specifies the following legal definition of domestic abuse:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if:

(a) A and B are each aged 16 or over and are personally connected to each other, and

(b) the behaviour is abusive.
Behaviour is "abusive" if it consists of any of the following—
(a) physical or sexual abuse;
(b) violent or threatening behaviour;
(c) controlling or coercive behaviour;
(d) economic abuse;
(e) psychological, emotional, or other abuse; it does not matter whether the behaviour consists of a single incident or a course of conduct.
"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—
(a)acquire, use, or maintain money or other property, or
(b)obtain goods or services.
(5) For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

Two people are "personally connected" to each other if any of the following applies:

(a) they are, or have been, married to each other;
(b) they are, or have been, civil partners of each other;
(c) they have agreed to marry one another (whether or not the agreement has been terminated);
(d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);
(e) they are, or have been, in an intimate personal relationship with each other;
(f) they each have, or there has been a time when they each have had, a parental relationship concerning the same child;
(g) they are relatives.

1.7 Methodology

1.7.1 Home Office guidelines outline the procedure for performing a DHR.[4]

1.7.2 Before Rasika's death, she resided in Croydon; hence the review panel consisted of agencies from this area.

1.7.3 At the first review panel meeting on 6 July 2023, panellists shared their agency engagements for Rasika and Tharindu.

1.7.4 The review's approach was to request that agencies submit a chronology to determine which agency would be required to conduct an Independent Management Review (IMR) or summary report.

1.7.5 The panel agreed that IMRs would be provided by three agencies, with two agencies submitting summary reports due to their engagement and the remaining agencies submitting comprehensive chronologies (see 1.9.1).

1.7.6 The chronologies and report influenced the recommendations in this review.

1.7.7 The panel met a total of 5 times.

1.8 Involvement of Family and Friends

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

1.8.1 The author and panel acknowledged the vital role Rasika's family and friends could have in the review.

1.8.2 On 31 January 2023, the Croydon CSP notified Pryia about the review and provided contact details for the author.

1.8.3 No contact was received. The author contacted the family liaison officer on 3 October 2023, who agreed to speak with Pryia about the review. Priya felt unable to contribute to the review. She was offered the option to review the final report before submitting it to the Home Office and select the pseudonyms, which she declined.

1.8.4 Tharindu's brother and grandson of Rasika was also contacted; however, he expressed his inability to contribute and declined to review the draft report.

1.8.5 Neither Pryia nor Tharindu's brother provided the panel with the names of any other family members or friends, and the panel was unaware of other family and friends.

1.9 Contributors to the Review

1.9.1 The following agencies and their contributions to this review:

Agency and Profile	Contribution- Chronology/IMR/Summary/Other
Adult Social Care (ASC)	Chronology and IMR
Croydon Health Service (CHS) Two hospitals, Croydon University Hospital and Purley War Memorial Hospital, and dedicated community services	Chronology
GP Practice One– Rasika	Chronology and Short Report
GP Practice Two- Tharindu	Chronology
London Ambulance Service (LAS)	Chronology
Metropolitan Police Service (MPS)	Chronology and IMR
South London and Maudsley NHS Foundation Trust (SLaM) – Tharindu Mental Health Services	Chronology and IMR
St Georges University Hospitals NHS Foundation Trust	Short Report

1.10 The Review Panel Members

1.10.1 The independent review panel members:

Name	Role	Organisation
Alison Eley	Named Nurse for Safeguarding Children	South London and Maudsley NHS Trust (SLaM)
Alison Kennedy	Operations Manager	Croydon FJC (Domestic Abuse Agency)
Angie Middleton	Head of Investigations London	NHS England
Christobel Yeboah	Chief Vision Officer	ERSANA Community Interest Company, Specialist Panel Member

Ciara Goodwin	Domestic Abuse & Sexual Violence Coordinator	London Borough of Croydon
Estelene Klaasen	Designated Nurse Safeguarding Adults	South West Integrated Care Board (ICB) Croydon place
Clement Guerin	Head of Adult Safeguarding and Quality Assurance	London Borough of Croydon
Louise Emerson (RIP July 2023)	Croydon Safeguarding Children and Adults Lead	SLaM
Dr Marilia Calcia (commenced October 2023)	Consultant Psychiatrist	SLaM
Dr Shade Alu	Director of Safeguarding	Croydon Health Services NHS Trust
Detective Sergeant (DS) Viran Wilshire	DS	Metropolitan Police Service

1.11 Chair and Author of the Overview Report

1.11.1 Parminder Sahota is an independent reviewer who has worked in Safeguarding and Domestic Abuse for eleven years and obtained DHR Chair training in 2021 from Advocacy After Fatal Domestic Abuse. She has worked in the NHS for over 20 years as a Mental Health Nurse with a particular focus on crisis work and working with persons diagnosed with a personality disorder. She is currently employed as the Director of Safeguarding, Prevent, and the Domestic Abuse Lead for an NHS Trust.

1.11.2 Parminder Sahota had no contact with Rasika's family or friends and is independent of the participating agencies.

1.12 Parallel Reviews

1.12.1 The coroner confirmed that the case was not referred to them.

1.12.2 Tharindu entered a guilty plea in July 2023 to Manslaughter by diminished responsibility, which was accepted.

1.13 Equality, Diversity and Intersectionality

1.13.1 During the review process, the review author and panel reviewed all protected characteristics under the 2010 Equality Act.

1.13.2 Rasika was of Sri Lankan heritage and 89 at her death.

1.13.3 The characteristics relevant to this review are age, disability, sex, and race.

1.13.4 The Office of National Statistics[5] released data on domestic homicides.

[5] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2022#age

1.13.5 72.1% of domestic homicide victims were female, according to homicide data from March 2019 to March 2021. In 260 of the 269 female victims of domestic homicide, the suspect was male. 62.5% of male domestic homicides involved a male family member as the suspect.

1.13.6 In November 2020, the Local Government Association and the Association of Directors of Adult Social Services in England published a report[6] with the following:

- One thematic review collating evidence from a range of sources noted that domestic abuse of adults with care and support needs remains both under-recognised and under-reported" (page 99)
- "There were failures to consider the possibility of domestic abuse, [and] to recognise the impact of the abuse on all family members" (page 99)
- "Notably overlooked was domestic abuse in later life" (page 99)
- "Coercive and controlling behaviour in domestic abuse and sometimes in other relationships did not, in the SARs reviewed, always receive due attention in practice. Several reports noted a lack of understanding of coercive control and its role in the exploitation of people who have particular vulnerabilities" (page 100)
- "A thematic review of domestic abuse notes deficits in both knowledge and attitudes: approaches to the complexity of different communities were seen to be underdeveloped, with examples that practitioners had been ill-informed in their responses, and practitioners were reported to show reluctance to challenges issues of power and control in cases involving Black, Asian and ethnic minority groups, reducing these to 'cultural issues'. (page 103)
- "In a case of serious domestic abuse, the response to the risks the family faced was described as superficial and over-optimistic" (page 113)
- "In another case where past convictions and a pattern of escalating domestic abuse, violence and intimidation were evident, referral to MARAC was not made in a timely way, and when it was made, adult social care was not represented, a significant omission given there was an adult with care and support needs in the household" (page 140)
- "A major failing noted in many SARs was the absence of information-sharing. This was notable where agencies were working in silos. Still, it also featured in cases where some degree of coordination had been established or was expected … examples included police failure to make notifications to other agencies after noting on a home visit an individual's poor mental health presentation and aggression to his family; failure to share information from police adult-at-risk notifications beyond adult social care …. One SAR notes that two individuals receiving mental health services in a shared supported living context had separate support workers who did not share risk information, resulting in the absence of any strategy to manage the tensions between the two residents and eventually murder. Another notes that two men living together where one had disclosed domestic abuse, each had their own adult social care case worker but finds little evidence of joint working or communication" (page 140 – 142)

[6] https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019

1.13.7 A report commissioned by the Violence Reductions Unit of the Mayor of London and published by SCIE[7]; the following was reported:

- There were five female and four male victims, the majority of whom were aged over 65. The older age of the victims also meant that they experienced vulnerabilities such as chronic health problems;
- There were eight male perpetrators and one female, aged between 25 and 54;
- In six cases reviewed, there was a caring relationship between the victim and perpetrator.
- Five of the homicides were committed with knives or a bladed object;
- Nearly all the perpetrators in the cases of adult family violence we reviewed had serious mental health problems;
- A worsening of perpetrators' mental health problems; disengaging, or being discharged, from mental health services, or ceasing to take prescribed medication was a common feature;
- The cases of adult family violence often featured behaviours meeting the definition of domestic abuse. However, these were rarely recognised by practitioners as such.

1.13.8 According to Safe Lives[8], victims older than 61 are more likely than those younger than 60 to experience abuse from an adult family member or current intimate partner. Age UK[9] noted that one in every four domestic killings involves a victim over 60.

1.13.9 According to research conducted by Women's Aid[10], 94.3% of domestic abuse perpetrators are men. Refuge highlighted that the police receive a call about domestic abuse every 30 seconds, but only around a quarter of them are reported to the police.

1.13.10 The University of Warwick and Refuge[11] study presented extensive and substantial evidence on the incidence of suicidal ideation among victims of domestic abuse. They emphasised risk factors such as depression, psychological distress, despair, hopelessness, difficulties with drugs or alcohol, childlessness, and cumulative experiences of abuse, particularly sexual abuse.

1.13.11 As evidenced by the data[12], domestic abuse is a gendered crime; although men are abused, women are more likely to face recurrent and severe types of abuse.

1.13.12 The hospital team identified Rasika as requiring support for showering, mobilising with a stick, and using a wheelchair. According to the World Health Organization[13], 1 in 6 persons over 60 had experienced community-based abuse. This was partly due to the victim of abuse being dependent on others, having a disability,

[7] https://www.scie.org.uk/safeguarding/evidence/reviews-of-homicides-and-violent-incidents/
[8] Spotlight #1: Older people and domestic abuse | Safelives
[9] At least 200,000 older people experienced domestic abuse last year – but the experiences of over-75s are being entirely overlooked | Age UK | Media
[10] https://www.womensaid.org.uk/wp-content/uploads/2021/12/Domestic-Abuse-Report-2022-Early-Release.pdf
[11] https://nspa.org.uk/wp-content/uploads/2021/04/New-Suicide-Report2c-Refuge-and-University-of-Warwick.pdf
[12] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/domestic-abuse-is-a-gendered-crime/
[13] https://www.who.int/news-room/fact-sheets/detail/abuse-of-older-people

or experiencing poor mental health. Tharindu had a mental health diagnosis, engaged in substance misuse, and was financially dependent on his family. Tharindu had demanded money and threatened to harm Rasika, prompting a call to the police.

1.13.13 Pryia informed the hospital staff that she and Tharindu would care for Rasika. Tharindu had accompanied his grandmother to medical appointments, and Pryia had told the hospital staff that she and Tharindu would be caring for Rasika.

1.13.14 Rasika's vulnerability to abuse was enhanced due to her age, sex, lack of proficiency in English and dependency on others due to her poor physical health.

1.14 Dissemination

1.14.1 After the Home Office grants permission to publish, this report will be widely disseminated, including, but not limited to:

- Members of the Croydon Safety Community Partnership
- Agencies represented
- Domestic Abuse Commissioner
- NHS England
- A copy of the Summary report will also be published on the Croydon Safety Community Partnership webpage

2.1 The Facts

2.1.1 Rasika lived alone, although she had regular contact with her daughter Pryia, and her grandson Tharindu occasionally stayed with her and his mother.

2.1.2 In April 2021, Tharindu was formally detained in a Mental Health PICU. He presented with paranoia toward family members, and Pryia revealed he had placed a knife beneath his pillow and a baseball bat in his room as he felt unsafe. He was also known to have used cannabis. While in the unit, Tharindu was verbally and physically aggressive to staff. Tharindu was discharged in July 2021 and received mental health treatment by a Community Mental Health Team (CMHT) from July 2021 to June 2022.

2.1.3 Rasika was admitted to Croydon University Hospital in August 2021 for respiratory difficulties; she was discharged and advised of a daily showering assistance package. The care package was declined, as Pryia expressed her concern about COVID-19, stating that she and Tharindu would provide Rasika with support at home.

2.1.4 In August 2021, Pryia reported that Tharindu was consuming cannabis and showing signs of relapse of psychotic symptoms (persecutory beliefs). He had been disengaging from treatment, not answering phone calls or messages from the mental health team. SLaM spoke with Tharindu; he denied cannabis usage and presented as stable, with no paranoid thoughts noted or recorded.

2.1.5 Rasika was taken to St. Georges Hospital in September 2021 after intentionally overdosing on promethazine. She was assessed by the psychiatric liaison team and discharged with a letter sent to her GP.

2.1.6 Tharindu called 999 in December 2021 to report that his grandmother had fallen out of her wheelchair and sustained a head injury. He transported her to the hospital, she was assessed, treated, and discharged home.

2.1.7 Tharindu requested a decrease in his medication in December 2021 due to side effects (stiff tongue and weight gain, both of which are recognised side effects of the medication he was taking). He was assessed as stable, and his medication dose was reduced. There were concerns that he had not been taking medication consistently before that.

2.1.8 In March 2022, the police documented the first episode of domestic abuse involving Tharindu and Rasika. Tharindu was accused of threatening to hit Rasika in the face after he asked for money. Rasika did not wish to pursue police action. Hence, this case was closed.

2.1.9 In the same month, Tharindu and Pryia argued, and Pryia left the house to stay with her other son.

2.1.10 In May 2022, Tharindu was considered for a Mental Health Act Assessment[14] (MHAA) referral. He had expressed odd, suspicious beliefs, feared his family was plotting against him, recently got the locksmiths to change all the locks in his family home, and had fallen out with friends. Pryia reported to SLaM that Tharindu was arrested for possessing a knife on the train. SLaM assessed him; he denied any symptoms of psychosis or mood disorder; therefore, the consultant psychiatrist who assessed him did not make a recommendation for detention under the MHA. He asserted that he brought a knife to his grandmother's house to open packages. The mental health team concluded that he had a strained relationship with his mother, but that was not based on psychotic symptoms.

2.1.11 Rasika was discovered by her Priya with multiple stab wounds in June 2022, and Tharindu was charged with her murder.

2.2 Key Events from April 2021 to June 2022

Date	Rasika/ Tharindu	Contact	Agency
31.03.2021	Tharindu	During a home visit to Tharindu, he answered with a huge knife in his hand and stated he did not want any input from services before slamming the door shut.	SLaM
01.04.2021 – 29.05.2021	Tharindu	Tharindu came to notice on four occasions within this period for violent and abusive behaviour.	MPS

[14] https://www.nhs.uk/mental-health/social-care-and-your-rights/mental-health-and-the-law/mental-health-act/

06.04.2021		Priya called NHS 111. The GP record stated that NHS 111 referred Tharindu's mother to another agency due to Tharindu's aggression towards her. However, NHS 111 cannot locate any record of this.	GP Practice
12.04.2021	Tharindu	Priya advised SLaM Tharindu was unwell, and she agreed to facilitate entry for an MHAA to be carried out for Tharindu.	SLaM
	Tharindu	Family members expressed concern and anxiety that Tharindu would become angry with them if they allowed professionals in the home to do an MHAA. His records indicate that he had been ill since December 2020; he was paranoid/agitated and smoked cannabis. In addition, his family said he slept with a knife and a baseball bat because he felt unsafe. According to Priya, he is typically paranoid about his own family.	SLaM
13.04.2021	Tharindu	A PICU bed was agreed upon should Tharindu be detained. The Approved Mental Health Professional expressed concern that should an MHAA be performed in the family home, and Tharindu is not detained, he may pose a risk to his family. No evidence of safety advice was given to the family.	SLaM
16.04.2021	Tharindu	Tharindu was detained under Section 2 of the MHAA[15] and admitted to PICU.	SLaM
10.05.2021	Tharindu	A staff member was threatened with physical assault by Tharindu.	SLaM
11.05.2021	Tharindu	Tharindu was detained under Section 3 of the MHAA[16], and his family was invited to ward rounds with his consent.	SLaM
25.05.2021	Tharindu	Tharindu assaulted a staff member and was verbally hostile towards other staff members.	SLaM
08.06.2021 – 11.06.2021	Tharindu	The documentation indicated that Tharindu's mental state had significantly improved, and he was moved to an open ward from the PICU.	SLaM
12.06.2021 – 20.06.2021	Tharindu	At the family's request, Tharindu was granted leave to visit Rasika, who had recently suffered a stroke. The family reported no concerns and no evidence of paranoia towards the family.	SLaM
09.07.2021	Tharindu	Following home leave, Tharindu was discharged from the hospital. He received care from the Home Treatment Team[17] (HTT) until 19.07.2021, when his care was transferred to the CMHT. During his period under the HTT, he asked to reduce his medication dose due to concerns about weight gain.	SLaM
20.07.2021	Rasika	Rasika had taken promethazine (an antihistamine, however, used to aid sleep) for a few months since being bereaved, but the medication had run out. Promethazine was added to the repeat prescription.	GP Practice One
28.07.2021	Tharindu	Medication Requested – Tharindu	GP Practice Two
29.07.2021	Rasika	A phone call to Rasika revealed she did not understand English well and requested to talk with her grandson (not Tharindu). A call was made to the grandson, but there was no answer.	GP Practice One
12.08.2021 – 23.08.2021	Rasika	Rasika was admitted to Croydon University Hospital with breathing difficulties and chest pain. The hospital recommended a once-daily care package consisting of a shower, bed, and commode change. Pryia declined the care package because	CHS

[15] https://www.legislation.gov.uk/ukpga/1983/20/section/2
[16] https://www.legislation.gov.uk/ukpga/1983/20/section/3
[17] https://slam.nhs.uk/service-detail/service/home-treatment-croydon-56/

		she was concerned about COVID-19, and she and her son, Tharindu, would move in with Rasika to help her.	
20.08.2021	Rasika	Moorfields Eye Clinic, Croydon University Hospital, requested an assessment. Rasika was placed on a waiting list for a sensory impairment assessment under Section 2: Care Act 2014[18].	ASC
23.08.2021	Rasika	Certificate of visual impairment due to glaucoma received from Moorfields Eye Clinic.	ASC
	Tharindu	Pryia called to state that Tharindu was using cannabis again.	SLaM
26.08.2021	Rasika	Telephone call with Rasika. She consented to be included in the sight loss register and to receive an assessment to promote her residential independence. Following a heart attack, she had recently been discharged from the hospital and needed assistance with activities of daily living, such as dressing and preparing meals. As she declined the presence of carers, her family assisted her. Her grandson was living with her temporarily. Actions agreed upon: establishment of an on-site loss registry and referral to Croydon Vision for assistance in claiming Attendance Allowance; provision of travel concession application forms; placement on the waiting list to assess sensory impairment.	ASC
	Tharindu	Tharindu was called to discuss the significance of the medication. According to the records, Tharindu was polite and respectful on the phone.	SLaM
01.09.2021	Rasika	In addition to her sight loss registration card, Rasika received a letter informing her that she was placed on a waiting list for an assessment of sensory impairment and containing information and guidance regarding visual impairment.	ASC
02.09.2021 – 15.10.2021	Rasika	The cardiac team initiated contact to conduct an initial assessment. Given the language barrier, the grandson interpreted for Rasika. It was also noted that the grandson arranged medication for Rasika. Rasika was not brought to her appointment, and a phone call revealed that neither she nor Pryia were aware of the appointment.	CHS
09.09.2021	Rasika	A text message was sent to Rasika informing her that her request for promethazine was premature because she had been issued a 28-day prescription on 26 August 2021.	GP Practice One
10.09.2021	Rasika	Record of an overdose of promethazine. Rasika was transported by ambulance to St. George's Hospital.	LAS
13.09.2021	Tharindu	According to the record, Tharindu was seen in person after one month of disengagement with the CMHT. Priya reported that he had been smoking cannabis and expressing paranoid beliefs. He denied cannabis use, and there was no evidence of paranoia on review.	SLaM
16.09.2021	Rasika	Intentional overdose of promethazine; discharge letter received from St Georges University Hospital.	GP Practice One.
11.10.2021	Rasika	Rasika was seen in the presence of Pryia at home. It was reported that Priya or her grandson is always with Rasika because she refuses to have carers.	GP Practice One
15.10.2021	Rasika	Rasika was seen at home by the rapid response team. She reported feeling weak and experiencing nausea and a dry	CHS

[18] https://www.legislation.gov.uk/ukpga/2014/23/section/2/enacted

		cough. The notes stated she lived alone, was independent, and mobilised with a frame.	
16.10.2021 – 02.11.2021	Rasika	Rasika and Pryia went to A&E because Rasika felt ill, had a reduced appetite, and drank less. Consequently, she was admitted to the hospital ward. Rasika rejected the care package. Rasika's anxiety about returning home was recognised, but this was not explored.	CHS
08.11.2021	Rasika	Documented history of Congestive Heart Failure, hypertension, diabetes mellitus and previous stroke or transient ischaemic attack.	GP Practice One
12.11.2021	Rasika	Rasika was not brought to the Acute Care of the Elderly Clinic. Rasika was issued a letter, and the GP was asked to follow up.	CHS
30.11.2021	Rasika	A text message was sent to Rasika requesting that she make contact following her recent admission to the hospital.	GP Practice One
08.12.2021	Rasika	A Rehabilitation Worker (RW) was allocated to conduct the Sensory Assessment.	ASC
13.12.2021	Rasika	The RW contacted Rasika's grandson and arranged for a call to conduct the assessment the following day.	ASC
14.12.2021	Rasika	Sensory Assessment: Referred to the Welfare Rights Team for a benefits check and to the ASC Locality Team for a Section 9: Care Act 2014[19] assessment. Priya was referred for a Section 10: Care Act 2014[20] – carer assessment. The Croydon Hearing Resource Centre was referred, and advice on aids and adaptations was given. The grandson and Priya were present at the assessment. During the assessment, it was determined that Rasika had suffered a stroke the previous year and a myocardial infarction in 2021. After being discharged from the hospital, she was offered four visits per day of home care; however, she declined the visits and instead relied on Priya to provide care. After receiving a diagnosis of visual impairment earlier in 2021, she subsequently overdosed on promethazine. According to Priya, Rasika was exhibiting symptoms of confusion and memory loss.	ASC
15.12.2021	Rasika	A referral was made to the older person's team to conduct the Section 9: Care Act 2014 assessment.	ASC
		The RW ended their involvement, and the plan was for the assistant rehabilitation officer from the sensory impairment team to complete the remaining work.	ASC
16.12.2021	Rasika	Blood tests were taken and sent, and the document reports that Rasika was with her grandson. Rasika also received her influenza vaccination.	GP practice One
		A 999 call to report that Rasika had fallen out of her wheelchair and sustained a head injury. The grandson called back and said he would transport her to the hospital.	LAS
		Following a head injury, Rasika visited A&E. The grandson reported taking Rasika to the GP practice for a blood test when	CHS

[19] https://www.legislation.gov.uk/ukpga/2014/23/section/9/enacted
[20] https://www.legislation.gov.uk/ukpga/2014/23/section/10

		the wheelchair hit a bump in the road, causing her to fall and hit her head on the ground.	
		The GP practice received a report from A&E.	GP Practice One
17.12.2022	Rasika	Priya contacted the GP practice to seek a wheelchair for her mother. In addition, Rasika had a dry mouth, and a ramp was required. A referral was to be made to an occupational therapist.	GP Practice One
		A text message to Rasika requesting she drop off a urine sample at the practice.	GP Practice One
		The GP practice received a discharge letter from CHS.	GP Practice One
22.12.2021	Tharindu	Tharindu sought a reduction in his medication due to reported side effects; his mental state was determined to be stable, and his medication dose was accordingly decreased.	SLaM
13.01.2022	Rasika	Rasika and her grandson visited the heart failure specialist clinic. In addition to speaking with Pryia over the phone, Priya was listed as her primary carer.	CHS
14.01.2022	Rasika	A text message was sent to Rasika informing her of the medication adjustment and that a prescription had been sent to her preferred pharmacy.	GP Practice One
24.01.2022	Rasika	Rasika attended the orthopaedic clinic for a historical fracture she sustained when she fell from standing.	CHS
15.02.2022	Tharindu	Tharindu reported experiencing breathlessness, which he believed was a side effect of his medication. He was advised to visit A&E as breathlessness indicated a possible medical emergency. There was no information as to whether he attended A&E as advised.	SLaM
17.02.2022	Rasika	An assistant RW was allocated to complete the remaining sensory impairment work.	ASC
22.02.2022	Rasika	Rasika reported experiencing shortness of breath during walking and insomnia. Pryia reported providing daily support for personal care.	CHS
23.02.2022	Rasika	The practice contacted Priya, who agreed to bring Rasika in for an ear examination, and she needed a referral for incontinence pads.	GP Practice One
		Referred to the district nurse.	GP Practice One
24.02.2022	Rasika	The GP referred Rasika to the district nursing team for a continence assessment.	CHS
25.02.2022	Rasika	The assistant RW visited Rasika at her home, where Priya was present and provided translation. The RW displayed the following equipment to Rasika: clocks and a huge button telephone. Priya requested a referral to occupational therapy for a ramp so Rasika could get out of her house in her wheelchair.	ASC
03.03.2022	Rasika	A referral to the hearing aid clinic was made.	GP Practice One
04.03.2022	Rasika	A large button cordless phone was provided to Rasika.	ASC
		Rasika was placed on the waiting list for occupational therapy.	ASC
09.03.2022	Rasika	The referral was made to the Ears, Nose, and Throat service.	GP Practice Two

		The practice texted Rasika to inform her of the referral and provide a link to the document.	GP Practice One
15.03.2021	Tharindu	Pryia contacted the CMHT to report that Tharindu was not taking his medication as prescribed and that his mental state was deteriorating. Pryia stated that she was not intimidated by Tharindu.	SLaM
23.03.2022	Rasika	Rasika was not brought to her vascular appointment.	CHS
		First recorded domestic abuse incident. Police attended Rasika's home address, where a family member was an interpreter because no Tamil interpreters were available. Rasika stated that Tharindu had attended her home demanding money and threatened to hit her in the face; he said this multiple times. Tharindu was arrested, and Rasika did not wish to provide a statement supporting the allegation. Police released Tharindu without further action before he could be fully assessed by the Criminal Justice Mental Health Team (CJMHT). On a brief assessment by the CJMHT, he did not have overt acute symptoms of psychosis and stated that he was compliant with his prescribed medication, adding that it helped him sleep. There were no concerns from the custody staff regarding his mental state. A Domestic Abuse Stalking and Honor Based Violence Risk Assessment[21] (DASH) was completed for Rasika and rated as medium. Rasika did not wish to be referred to domestic abuse agencies.	MPS
24.03.2022	Tharindu	Tharindu and Pryia verbally argued about Tharindu's refusal to take his medication. Pryia requested he leave, but he refused. She left her home. Officers met with Tharindu, who claimed ignorance of the dispute. A DASH was noted for Priya and deemed standard.	MPS
31.03.2022	Tharindu	Tharindu's care coordinator (a key worker) contacted him to discuss the circumstances surrounding the arrest. Tharindu said the incident was caused by a misunderstanding on his grandmother's part. Tharindu had no psychotic symptoms or any display of paranoia. He was offered to have his medication changed to a long-acting injection (which would provide more reassurance that he was concordant) but declined, and also expressed that he was not happy to take medication orally.	SLaM
08.04.2022	Rasika	A text message sent to Rasika informing her of a change in her thyroid medication and the need for a blood test was sent to her.	GP Practice One
25.04.2022	Rasika	Rasika was brought to the practice by her grandson for a physical checkup, including blood tests.	GP Practice One
27.04.2022	Rasika	Rasika was discharged due to a lack of attendance.	CHS
		Rasika visited the heart failure specialist clinic with her grandson, and the practitioner spoke with Pryia over the phone during contact.	CHS

[21] https://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf

05.05.2022	Rasika	A phone call with Priya. Rasika was referred to the incontinence service; a week previously, she had declined pads and was now asking for them. Rasika was reported to have ongoing sleep problems and found the sleeping medication beneficial.	GP Practice One
12.05.2022	Tharindu	Documentation to state Tharindu was guarded.	SLaM
17.05.2022	Rasika	A text message containing sleep information and a website link was sent to Rasika.	GP Practice One
		During a phone call to Rasika, it was noted that she could not hear and that her daughter was called instead. Priya reported that the skin of Rasika's left heel was cracking, and her hearing aid was not functioning. Rasika also had trouble sleeping, and the prescribed sleep medication was ineffective. In addition to the requested photo of her heel, sleep hygiene advice was supplied.	GP Practice One
		A text message was sent to Rasika requesting that she upload a photo (of the heel) and provide a link.	GP Practice One
		Rasika was referred to the hearing aid clinic.	GP Practice One
27.05.2022	Tharindu	Tharindu was reviewed by his care coordinator, a junior doctor, and a consultant psychiatrist. These reviews were prompted by his hostility towards his mother and an altercation with his grandmother that led to police involvement. According to his mother, he was isolating himself, expressing odd beliefs, and had recently engaged in altercations with friends before having the locksmiths change all the locks.	SLaM
31.05.2022	Rasika	Rasika was seen at home with Pryia for an asthma appointment. No concerns were recorded.	CHS
		A text message was sent to Rasika's mobile phone informing her that she had been referred and instructing her to click the link in the message for more information.	GP Practice One
		Referral to Ears, Nose and Throat service.	GP Practice One
	Tharindu	Face-to-face review by consultant psychiatrist and care coordinator: Tharindu had no indications of psychosis or mood disorder; he appeared calm and denied any thoughts of harming himself or others. Upon assessment, it was found that he did not meet the criteria for an MHAA. Pryia expressed no concern except that Tharindu was using cannabis. If Pryia felt unsafe, it was decided that she would stay with her other son. Tharindu asked the CMHT not to involve his family in his care; the consultant and care coordinator explained that they would not share confidential information with his family unless there were risks and concerns, but they would speak with them should they contact the team. A plan was made to continue his medication, for his care coordinator to continue monitoring concordance, mental state, and risks, and to have a low threshold to bring his case back to discussion with the team. The consultant documented a decision not to discuss Tharindu's confidential information with his family but to continue to offer family support if his family contacted the team again and to obtain collateral information if there were further concerns.	SLaM

		A follow-up medical review was to be arranged in 3-4 weeks.	
07.06.2022	Tharindu	Tharindu was brandishing a knife while walking through a train (out of London).	MPS
Eleven days before Rasika's death	Tharindu	The police informed SLaM that Tharindu wished to purchase a firearm to join a Croydon shooting club as a "new hobby."	SLaM
Eight days before Rasika's death	Rasika	The GP received a letter from the CHS ophthalmology clinic.	GP Practice One
Seven days before Rasika's Death	Tharindu	Tharindu was asked about his suspicion that his family was against him. He indicated that he got along well with his family and denied having any ideas, plans, or intentions to harm himself or others. He also denied using cannabis. Pryia informed the team that she had discovered a custody record indicating that Tharindu was detained for carrying a knife on a train. Police released him with an investigation pending. Tharindu revealed he had gone to his grandmother's house and needed a knife to open the wrapping of the parcel.	SLaM

3.1 Analysis of Agency Involvement

3.1.1 This section explores the agencies' involvement with Rasika and Tharindu

Rasika had contact with the following Agencies:

1. Adult Social Care
2. Croydon Health Service
3. GP Practice One
4. Metropolitan Police Service
5. South London and Maudsley NHS Foundation Trust
6. St Georges University NHS Foundation Trust

Adult Social Care

3.1.2 In March 2014, according to an anonymous call received by ASC, Rasika and her husband were subjected to emotional abuse, seclusion in a room, and prohibition of visitors by Tharindu. Rasika and her husband informed ASC that they were both well and that no allegations of abuse had been made.

3.1.3 Although outside of the review period and before the Care Act 2014 and Domestic Abuse Act 2021, it is crucial to highlight that telephone conversations may not accurately depict the events at hand, mainly if the presence of the alleged perpetrator is unclear.

3.1.4 The second contact in April 2018, the housing department surveyor, requested an occupational therapy assessment for Rasika's urgent repairs to her wet room. Specifications and an assessment were completed.

3.1.5 SafeLives[22] published a report, 'Safe at Home'. They stated that *housing providers are in a unique position to be able to identify domestic abuse and prevent escalation by offering support and guidance to victims of domestic abuse.*

3.1.6 The report examined the correlation between repairs and the risk of physical aggression and intimidation that led to property damage, including broken fixtures, holes in walls and doors, broken locks, and damaged doors and fixtures.

3.1.7 Because Housing did not participate in the review, the panel was not informed of any additional repairs that might have been necessary.

3.1.8 MPS referred Tharindu to ASC in January 2019 in response to an allegation of an altercation involving Tharindu and his brother. The family was concerned that Tharindu was hearing voices and had been affected by his father's recent death. Tharindu spent the night with his grandmother, and ASC informed SLaM about the referral.

3.1.9 Tharindu was reported to ASC by the police in December 2020. Tharindu's brother contacted the police to report that Tharindu was experiencing a mental health crisis and that he feared for their mother's safety. The officers attended; Tharindu was verbally hostile towards the police and was accompanied by two large American bulldogs. His mother vacated the property.

3.1.10 The referral stated his mother told the police:

"has not been diagnosed with anything, but he is suffering from mental health; he had an episode several years ago which resolved itself, but this time, it is worse, and he is getting progressively worse. She explained that he has never self-harmed and has not had any suicidal thoughts, but she thinks he hears voices as sometimes he laughs to himself. He is also very paranoid; his aggression has turned towards his family as he thinks that his extended family are trying to kill him. He has not been violent but verbally aggressive. She has tried to get him to help through the GP, but he has refused to engage … She said that he is shutting out all of her family, and she has only just started to gain his trust as he has let her into his home and let her stay the past few nights, so when the GP called today she thought he was getting better and told them so.

It is the officer's concern that his MH issue has now caused him to become a harm to others. He is refusing to engage himself, so a home mental health assessment may be the only way to speak to him."

3.1.11 ASC stated they could not identify a response to this, which may be associated with the recording system. Since then, the information has been transferred to a new electronic format. SLaM, however, has disclosed knowledge of this incident.

3.1.12 ASC received a referral from MPS; Tharindu's brother called the police. Tharindu had informed their mother via telephone that an ambulance crew was outside and had

[22] https://safelives.org.uk/sites/default/files/resources/Safe%20at%20Home%20Report.pdf

attempted to enlist him for MI5. The police confirmed the absence of an ambulance upon their arrival. ASC forwarded the referral to SLaM.

3.1.13 In February 2021, the police referred Tharindu to ASC; Tharindu had attempted to enter his neighbour's home because he could hear somebody in the loft. The police called his mother. The referral stated:

"the subject is no longer aggressive with his mental health, and as he does self-harm, she is getting no help from the services who said they won't section him. She said that although his aggression, which was caused by mental health, has gone away. She states he is still not normal; he barely speaks, walks around like a zombie and doesn't communicate. He eats, sleeps and walks his dogs. And sometimes he hears things like today when he said he can listen to someone in the loft. He is on no medication. The subject was calm and had no medical needs, so he had no reason to go to the hospital. He was known to officers who had dealt with him before, and they were very shocked to hear he had never been sectioned. The subject is still suffering from mental health, has not been diagnosed and has been given no medication. If it has not been done so, he needs to be seen by a professional."

3.1.14 The referral was sent to SLaM.

3.1.15 In response to Rasika's death in June 2022, ASC initiated a Safeguarding S42 enquiry. The enquiry was concluded in February 2022. They concluded that Rasika had been subjected to physical and domestic abuse.

3.1.16 Local authorities are obligated to conduct section 42 inquiries or request others to do so when they reasonably suspect that an adult residing within their jurisdiction is vulnerable to neglect, abuse, or financial exploitation. The enquiry's objective is to determine with the individual and/or their representatives who should take appropriate action in response to the situation if any action is necessary. The duty serves as an additional responsibility for other organisations to successfully care for the individuals entrusted to their supervision or, as in the case of police, to deter and address illegal behaviour. Therefore, a Section 42 enquiry is inappropriate as Rasika was deceased then.

3.1.17 The Croydon Safeguarding Adult Social Care discussed whether to refer for a Safeguarding Adult Review and concluded:

"not of the view that this case meets the criteria for a SAR as there does not appear to have been a multiagency failure. Instead, a domestic homicide review will take place."

3.1.18 ASC made five recommendations.

Croydon Health Service

3.1.19 Rasika had contact with various services within CHS.

3.1.20 Rasika's admission to CHS in August 2021 recorded that she spoke limited English and found no evidence that her wishes around discharge planning or the recommendation for a care package were considered. The record also stated she appeared anxious about the discharge, and her daughter said she and her son would support Rasika at home.

3.1.21 The panel concluded that an interpreter should have been requested to ensure that Rasika's wishes were heard and the cause of anxiety.

3.1.22 NHS England mandates that a professional interpreter, rather than family or friends, must always be provided.[23] The CHS[24] emphasised that everyone should have equal access to health services and provided information about a 24-hour language line. Therefore, this should have been accessed to ensure Rasika could express her discharge wishes and needs.

3.1.23 Rasika was brought to CHS services by either Pryia or Tharindu. The absence of an interpreter was a common theme throughout all CHS services. The author of the CHS timeline also indicated that services should be aware that Rasika relied on others to transport her to appointments. Therefore, it was evident that she had not been brought to an appointment when she was not there.

3.1.24 Persons not being brought to appointments could be regarded as an omission of care and neglect. However, Pryia informed CHS that she was finding it challenging to manage Rasika at home, and therefore, a carer assessment should have been offered at that time.

3.1.25 The Care Act 2014 Section 10[25] is related to assessing a carer's needs. The objective is to determine the carer's needs and provide support as necessary.

3.1.26 Rasika was diagnosed with a historical fracture and referred to orthopaedics, but the records do not indicate that the cause of the injury was explored.

3.1.27 The GP referral to the district nursing team indicated that Rasika speaks Tamil; the records did not provide evidence that translation services were utilised.

3.1.28 On 16 December 2021, Tharindu transported Rasika to A&E after she fell from her wheelchair. There was no record of her being asked regarding the cause of the fall, and the record emphasised Tharindu's account.

[23] https://www.gov.uk/guidance/language-interpretation-migrant-health-guide#:~:text=Where%20language%20is%20a%20problem,accuracy%20and%20impartiality%20of%20interpreting

[24] https://www.croydonhealthservices.nhs.uk/translation-and-interpreting/#:~:text=Everyone%20should%20have%20equal%20access%20to%20health%20services.&text=In%20addition%2C%20NHS%20Direct%20%2D%20available,be%20connected%20to%20the%20line.

[25] https://www.legislation.gov.uk/ukpga/2014/23/section/10/notes#:~:text=Section%2010%20%E2%80%93%20Assessment%20of%20a%20carer's%20needs%20for%20support&text=It%20requires%20a%20local%20authority,time%2C%20or%20in%20the%20future.

3.1.29 The Department of Health[26] published recommendations for health's response to domestic abuse. It emphasises the obligations of healthcare workers and the training they must obtain to facilitate an appropriate response.

3.1.30 There was no evidence that Rasika was directly communicated with, as there was no documentation indicating that an interpreter was used; hence, no routine enquiry regarding domestic abuse was conducted.

GP Practice One

3.1.31 Most of the contact with the practice was related to Rasika's physical health.

3.1.32 The GP practice sent multiple text messages to Rasika, but as it was recognised that she had limited English, she could not read them and relied on her family for assistance.

3.1.33 The GP received a report dated 16 September 2021 from St Georges A&E to confirm that Rasika had taken an intentional overdose. This is the first occurrence of deliberate self-harm.

3.1.34 The report from liaison psychiatry sent to the GP practice said that Rasika's daughter reported her mother was suicidal due to blindness. According to the report, a Tamil interpreter was required; thus, Rasika was presumed to be given the first opportunity to voice her concerns.

3.1.35 Rasika expressed remorse for the overdose, although she had wished to die due to her perceived poor quality of life and a brief episode of depression. She had recently been registered as blind and struggled with this. She spoke of having a caring and supportive family and listed her family and faith as protecting factors. She was discharged home and stated she had no suicidal thoughts and did not believe she would attempt suicide again.

3.1.36 The author would expect the GP practice to have attempted to contact Rasika to discuss the overdose at her next appointment on 5 October 2021.

3.1.37 Pryia or Tharindu always accompanied Rasika's interactions with the GP. It was not noted if an interpreter was utilised or if her voice was only heard through Pryia or Tharindu. Additionally, it was seen that the records did not specify multiple times who accompanied Rasika to appointments, and the GP practice acknowledged that when practical, language lines or professional interpreters should be utilised.

3.1.38 Safe Lives Produced guidelines[27] for GPs and their response to domestic abuse, there is no indication in the GP notes that Rasika was asked about domestic abuse. In June 201, 75% of the staff at the GP practice received training from the IRIS[28] team.

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[26] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf

[27] https://safelives.org.uk/sites/default/files/resources/SafeLives%27%20GP%20guidance.pdf

[28] https://irisi.org/about-the-iris-programme/

Nonetheless, it is essential to mention that she informed the liaison psychiatry team that her family was attentive and loving.

3.1.39 The practice made three recommendations.

Metropolitan Police Service

3.1.40 While in the PICU, Tharindu contacted the police to allege that the ward staff had abused him. The MPS discovered that he was formally detained and had been legally restrained for demonstrating aggressive behaviour and lashing out at the ward staff.

3.1.41 On 16 April 2022, Tharindu absconded from the ward. The police found him at home with a kitchen knife on the side of the toilet and various weapons, including eight swords of varying lengths, some with sheaths and others without, and a baseball bat in another room.

3.1.42 In May 2021, the MPS visited the mental health unit twice following reports of staff assaults, and Tharindu was identified as the suspect.

3.1.43 Rasika had one contact with the police during the review period (23.03.2022), which was the first and only report of domestic abuse by Tharindu. Pryia acted as the interpreter for Rasika due to the non-availability of a Tamil interpreter. A DASH was recorded and graded as medium, which indicates: 'There are identifiable indicators of risk of serious harm. The perpetrator can potentially cause serious harm but is unlikely to do so unless circumstances change, e.g., relationship breakdown, failure to take medication, drug/alcohol misuse.' The police have been aware of Tharindu's mental health since 2019.

3.1.44 Rasika did not wish to support a police investigation against Tharindu and declined a referral to domestic abuse services.

3.1.2 Women's Aid[29] highlighted the factors that contribute to some women struggling to leave an abusive relationship.

- Danger and Fear
- Isolation
- Shame, embarrassment or denial
- Trauma and low confidence
- Practical reasons

3.1.45 Additional obstacles that older individuals could encounter include financial instability and the loss of support; Rasika was receiving support from Tharindu and Priya. Additionally, it is possible that some older women adhere to generational norms wherein discussing domestic abuse is considered "airing dirty laundry", and they would

[29] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/women-leave/

rather maintain the privacy of their matters. They may ultimately experience loneliness and fear the remainder of their days will be spent alone.[30]

South London and Maudsley NHS Foundation Trust

3.1.46 The records stated that Tharindu's grandparents were significant influences in his life, as they were active in his upbringing and acted as his parents while his mother was overseas for a year and a half.

3.1.47 In 2009, Tharindu became known to mental health services due to concerns expressed by his GP and family regarding his paranoid, suspicious thinking, and auditory hallucinations. He had been smoking cannabis since the age of 16. A consultant psychiatrist assessed him, and he was not diagnosed with any mental disorder. His mood problems were attributed to alcohol and cannabis use and difficulties in his upbringing. He was advised to reduce his alcohol and cannabis use, and a referral to primary care psychotherapy was suggested.

3.1.48 In November 2018, he was referred to the CMHT again as he was hearing voices. He was diagnosed with brief intermittent symptoms of psychosis and psychotic experiences; at the time of the assessments, these symptoms were reduced in severity, and he was offered psychological therapy and social support but not antipsychotic medication. He did not engage despite the team's many attempts to contact him and offer him support. He was discharged in June 2019 due to disengagement.

3.1.49 In December 2020, he was referred to the CMHT again due to auditory hallucinations, persecutory beliefs and cannabis use. The CMHT contacted him, but he declined an assessment. The CMHT concluded that there were no grounds to pursue involvement without his consent, and he was discharged with his GP's agreement. His mother reported that his mental health was improving.

3.1.50 Two months later, in February 2021, the CMHT re-opened the referral following a Merlin[31] report sent by the police, stating that Tharindu was psychotic and had asked to enter a neighbour's house, believing that there were people in the neighbour's loft. His family told the police that Tharindu believed his family were trying to kill him and that he was verbally aggressive but not physically violent. He declined to be assessed, but due to concerns about psychotic symptoms and risk to others, he was detained under the MHA and was an inpatient under section 2 of the MHA in April 2021. The police were called and informed that Tharindu, who was under Section 2: MHA, had absconded from the hospital and had returned home with a knife. The police received a second call from Tharindu's brother, who stated he had turned up at the home address. Police attended the address and transported him back to the hospital.

3.1.51 During the inpatient admission, he was diagnosed with unspecified non-organic psychosis. This is a diagnosis commonly given after a patient has had one episode of

[30] https://www.thehotline.org/resources/domestic-abuse-in-older-adults/
[31] Merlin is an IT application that records details of vulnerable persons.

psychotic disorder. If symptoms persist after one episode, the diagnosis is changed to schizophrenia.

3.1.52 Tharindu was physically violent to staff whilst in the PICU. The NHS Long Term Plan[32] 2022 staff survey outlined 14.7% of NHS staff who completed the survey have self-reported that they have experienced at least one incident of physical violence from patients, service users, relatives or other members of the public in the last 12 months.

3.1.53 Since April 2021, the Croydon CMHT provided Tharindu with mental health services. He was allocated a care coordinator who was assigned to Tharindu until the fatality.

3.1.54 In May 2022, his care coordinator observed that he was preoccupied with self-defence and discussed his discharge from the team. The care coordinator highlighted concerns with Tharindu presenting as guarded and hiding psychotic symptoms. The clinical view was that he might have been experiencing a psychotic relapse characterised by paranoia over his mother and brother, whom he accused of plotting against him and spreading false information about him to get him brought to the hospital. This led to Tharindu displaying irritability and inappropriate outbursts.

3.1.55 In addition, he was allegedly non-compliant with his medication and potentially using cannabis. The risks highlighted were a further decline in his mental health, self-neglect, physical health, and the potential for aggressiveness towards his family members.

3.1.56 Pryia expressed concern that Tharindu's mental health had deteriorated, as he was refusing to leave the house, not eating much, expressing odd and suspicious beliefs, recently having the locksmiths change the locks, falling out with several friends, misusing cannabis, and not taking medication. Priya also reported his recent verbal altercation with his grandmother, Rasika, which resulted in a call to the police

3.1.57 In June 2022, the CMHT received a phone call from the MPS informing them that Tharindu had asked a member of the public where he could buy a gun, semiautomatic rifle, or rifle. He told the police that he wanted to join a gun club.

3.1.58 The CMHT consultant psychiatrist had two reviews with Tharindu, and there was no clear evidence of psychotic symptoms. Tharindu received a review seven days before the fatality.

3.1.59 SlaM identified the following learning from this case:

1. Tharindu’s zoning level had not been updated since 2021.
2. Tharindu’s risk assessment had not been updated following risk events.
3. The CMHT did not recognise the behaviours of Tharindu towards his family (in particular his mother and his grandmother) as a form of domestic abuse and did not explore the support that the family needed before the incident beyond treatment for Tharindu (for example, referrals to relevant agencies, for instance, domestic abuse agencies and or adult safeguarding.

[32] https://www.england.nhs.uk/supporting-our-nhs-people/health-and-wellbeing-programmes/violence-prevention-and-safety/

3.1.60 SLaM identified five recommendations.

St. Georges University Hospital NHS Foundation Trust

3.1.61 Rasika was brought to the hospital after an intentional overdose. She was assessed in A&E, and an acute cerebrovascular accident (stroke) was ruled out.

3.1.62 They concluded that she required the services of a Tamil interpreter, yet Rasika was reportedly able to comprehend and converse to some degree. It was disclosed through a conversation with Rasika's daughter that Rasika lived alone and received assistance with daily living activities from her daughter. Additionally, the report mentioned how Rasika's dosette box was being managed by a grandson. The daughter agreed that she was able to support Rasika.

3.2 Analysis of Terms of Reference

3.2.1 The Terms of Reference (TOR) are analysed in this report section to confirm that they have been addressed and met.

3.2.2 **TOR 1**: Analyse the internal and inter-agency communications, procedures, and discussions.

Analysis

3.2.3 The CHS sent all letters and reports of Rasika's presentations and attendance to her GP, who made appropriate referrals for Rasika's physical health.

3.2.4 The MPS noted a 'Merlin Adult Coming to Notice form' was not completed at their contact with Rasika in March 2022. The Merlin system was developed as a tool for police officers to address vulnerabilities; information is shared with the local authority[33].

3.2.5 A Merlin would have been sent to ASC to alert them to the incident who would be able to triage the contact through the Safeguarding Adult Duty[34]:

a) An adult with care and support needs – Rasika met the criteria due to her long-term health needs and disability.
b) Is experiencing, or at risk of, abuse or neglect, and - Tharindu was alleged to have threatened to hit Rasika in the face when he demanded money.
c) Due to those needs, one cannot protect oneself against abuse or neglect. – Rasika was dependent on others. Pryia and Tharindu accompanied her to appointments, and there were concerns regarding continence, so she mobilised using a wheelchair.

[33] https://www.met.police.uk/foi-ai/metropolitan-police/d/march-2022/information-creation-merlin-reports/
[34] https://www.met.police.uk/foi-ai/metropolitan-police/d/march-2022/information-creation-merlin-reports/

3.2.6 In 2015, the Local Government Association[35] issued recommendations to help practitioners and management manage the overlap of safeguarding adults and domestic abuse. It acknowledged that both have distinct professional sectors and emphasised the importance of connecting them. Domestic abuse is a category of abuse within safeguarding, and the legal definition of domestic abuse was created in 2021.

3.2.7 Rasika declined a referral for domestic abuse services. SLaM was alerted to the incident by Pryia, who also advised that the police had been called.

3.2.8 MPS had shared information regarding Tharindu with SLaM, which aided in the risk assessment. However, SLaM remarked that their risk assessment for harm to others was insufficient and indicated that interaction with the family would have helped a full assessment.

3.2.9 ASC disclosed that in attending to Rasika and Tharindu's needs, they had neglected to account for the information they possessed regarding them. Furthermore, the connection between Tharindu and Rasika was not established, notwithstanding the system's capability to do so.

3.2.10 ASC noted the following:

- Five referrals were made regarding Rasika.
    - A connection may have been established in 2014 when Tharindu was identified as the alleged person causing harm.
    - Two referrals did not refer Tharindu.
    - One in 2010 and one in 2012 lacked the necessary information on the system to determine whether Tharindu's details were included.
- Five of the referrals pertained to Tharindu.
    - No identifiable information in any of the documents would have enabled ASC to conduct a search that matched the records on Rasika.
    - Although one mentioned "his granny," no specifics were provided regarding her.
    - Four did not mention her.

3.2.11 The records did not link Priya and Tharindu, which may have shown a familial connection between Rasika and Tharindu.

3.2.12 ASC emphasised the scarcity of referrals from partner agencies that contained material establishing the relationship between Tharindu and Rasika, or at the very least, information that could have assisted in recognising that link. The most notable instance was the police referral in January 2019. Concerns regarding the risk Tharindu presented to his family compelled him to stay away for the night. The report indicated that he would stay with his grandmother; nevertheless, the lack of inclusion of her name and address on the referral to ASC suggests that the potential risk to her was

[35] https://www.local.gov.uk/sites/default/files/documents/adult-safeguarding-and-do-cfe.pdf

not adequately considered. Nonetheless, ASC may have enquired more with the referral regarding this information.

3.2.13 The failure to establish a link between Rasika and Tharindu resulted in a diminished urgency regarding the January 2022 decision to place Rasika on a waiting list for a Section 9 Care Act assessment. It was presumed that she was already receiving assistance from her family and that there were no additional grounds for concern. This decision was not influenced by information already presented to the ASC, as it was based on data about Tharindu unrelated to Rasika.

3.2.14 Rasika's suicide attempt, the incident with Tharindu carrying a knife, the threat Tharindu made to Rasika, Tharindu's attempt to procure a gun, and the fact that Tharindu was not taking his medicine were all unknown to ASC.

3.2.15 SLaM and the police were similarly uninformed on ASC's involvement with Rasika and Tharindu, and neither party approached ASC with any information requests.

3.2.16 ASC notified SLaM of the police referrals regarding Tharindu due to the serious mental health concerns involved.

3.2.17 **TOR 2**: Analyse the cooperation between the agencies involved with Rasika/Tharindu [and family in general].

Analysis

3.2.18 No interagency meetings were held.

3.2.19 ASC concluded that opportunities were missed to consider adult safeguarding concerns for Rasika, such as potential coercion and control concerns when Tharindu threatened Rasika when he was arrested for carrying a knife and stated he was going to his grandmother to open a package.

3.2.20 A safeguarding adult concern would have facilitated collaboration among agencies and enabled all parties to be informed of the other's communications.

3.2.21 The responsibility for conducting a Section 9 Care Act assessment for Tharindu, which would have been SLaM's, was not fulfilled. The ASC determined the subsequent instances in which this requirement was necessary.

- **In December 2020, reports surfaced regarding his purported auditory hallucinations, persecution-motivated beliefs, and concerns about** his cannabis consumption, according to SLaM’s IMR. "With his GP's approval, SLaM had discharged him," Priya stated that her son's mental health was improving. SLaM received a police referral from that time saying that she informed the officers that she had told the GP this because she believed it at the time. However, she no longer held that opinion in light of the subsequent events that day, which necessitated police presence.

- **In February 2021,** Tharindu attempted to gain entry to his neighbour's home; during the following investigation, it was determined that he was paranoid; nonetheless, he declined an assessment in March 2021. It is possible that an assessment was indicated following Sections 9 and 11(2) of the Care Act, which would not necessitate his consent.
- **In July 2021**, after being discharged from the hospital, Tharindu ceased using his prescribed medication. Priya highlighted his worsening mental state and self-neglect. The self-neglect might have evoked subsection 11(2) (b) of the Care Act.

3.2.22 In addition, ASC identified one instance in which a safeguarding adult concern might have been raised regarding Tharindu:

1. **In March 2021,** SLaM reported that a Mental Health Act Assessment could not be processed because insufficient beds were available. That may give rise to a potential concern regarding organisational abuse.

3.2.23 **TOR 3:** Analyse the possibility for agencies to identify and assess domestic abuse risk.

Analysis

3.2.24 The sole organisation aware of the potential confinement of Rasika and her husband by Tharindu in 2014 was ASC.

3.2.25 In 2021, the MPS created a dedicated Lead Responsible Officer for Domestic Abuse and Stalking; the role is held by a Detective Superintendent, Rank, who has a background in safeguarding.

3.2.26 The College of Policing has developed a new risk assessment instrument to assist officers in identifying the indicators of coercive control and better protecting domestic abuse victims. The Domestic Abuse Risk Assessment (DARA) replaces the domestic abuse screening tool (DASH).[36] The MPS moved from the DASH to the Domestic Abuse Risk Assessment in June 2023.

3.2.27 During the pilot phase of DARA, the proportion of police reaching the same risk assessment as a domestic abuse expert increased by 38%. Officers were better positioned to decrease or remove the risk and protect the victim from further harm.[37]

3.2.28 Safe Lives emphasises that the DARA should not replace the DASH and that safeguarding officers and specialised support services should continue to use it.[38]

3.2.29 SLaM was aware that Tharindu had persecutory delusions about his mother and two elderly neighbours whom he referred to as "racists."

[36] https://www.college.police.uk/article/police-better-equipped-spot-controlling-behaviour
[37] https://collegeofpolicing-newsroom.prgloo.com/news/police-better-equipped-to-spot-controlling-behaviour
[38] https://safelives.org.uk/sites/default/files/resources/Dara_briefing_Multiagency%20partners.pdf

3.2.30 SLaM did not complete the risk assessment for Tharindu concerning domestic abuse. The CMHT were unaware that MARAC would be a suitable information-sharing forum to ensure support was offered to the victims/survivors.

3.2.31 The author of the SLaM IMR underlined the absence of professional curiosity around controlling and coercive behaviour. The family was concerned about allowing professionals to do an MHAA in the home. However, this was not discussed with the family, nor was it determined what support they would require.

3.2.32 The author has utilised the Homicide Timeline Dr Jane Moncton Smith[39] developed to review the homicide and identify the risk. However, it should be noted that this is used in intimate partner homicides. The author has used this to determine what similarities and learning can be drawn from it.

1. **Pre-relationship history of stalking or abuse by the perpetrator** – According to the MPS, Tharindu was allegedly a perpetrator of domestic abuse in a previous relationship. The Domestic Violence Disclosure Scheme[40] allows the police to inform the current partner about a history of domestic abuse. As Rasika was Tharindu's grandmother, she would not fall under this 'right to know' category.
2. **The romance develops quickly into a serious relationship** – Not applicable.
3. **The relationship becomes dominated by coercive control** – Rasika was reliant on others for her care and support. Pryia and Tharindu were caring for these, and it was observed that Tharindu was responsible for collecting her medication. It is unknown whether Tharindu exhibited controlling or coercive behaviour. CHS observed that Rasika was anxious about her discharge, but this was not explored. The only time an interpreter spoke to Rasika was during her assessment with the Psychiatric Liaison Team at St George's Hospital.
4. **A trigger threatens the perpetrator's control** – In March 2022, the police were contacted after Rasika alleged that Tharindu had threatened him. Tharindu had sought money from Rasika.
5. **The perpetrator has a change in thinking** – Pryia had reported that when Tharindu is unwell, he experiences paranoid thoughts about his family. She also spoke of him using cannabis when unwell and informed SLaM of this in May 2022. In June 2022, Tharindu visited a shooting club to acquire a gun licence, prompting them to contact the police.
6. **Planning - the perpetrator might buy weapons or seek opportunities to get the victim alone** – In June 2022, Tharindu reportedly brandished a knife while on the train. On the day of the homicide, he asked his mother not to visit the grandmother's home as he was going to sleep, and the doors would be locked. The time of this call was early afternoon. Rasika lived alone.
7. **Homicide**

3.2.33 **TOR 4:** Analyse agency responses to any identified domestic abuse issues.

Analysis

[39] https://www.glos.ac.uk/content/the-homicide-timeline/
[40] https://www.met.police.uk/advice/advice-and-information/daa/domestic-abuse/alpha2/request-information-under-clares-law/

3.2.34 Training on domestic abuse is provided to all agencies represented on the panel. The MPS service has a specific training course titled "Domestic Abuse Matters" and has trained 6,796 police officers between July and September of 2021. 700 Rape and Serious Sexual Offenses Officers attended training in October/November 2022.

3.2.35 The College of Policing and the domestic abuse charity SafeLives developed "Domestic Abuse Matters," a cultural change initiative for police officers and staff in England and Wales, in collaboration with key stakeholders. It is intended to transform the response to domestic abuse by placing the victim's voice at the centre and enhancing the understanding of controlling and coercive behaviour. The programme is intended to have a lasting effect by altering and challenging the police's attitudes, culture, and response to domestic abuse.[41]

3.2.36 Despite Priya's report to SLaM that Tharindu's persecutory beliefs were directed at the family and that he had beaten a friend with a baseball bat because he believed the friend was plotting against him, SLaM did not discuss this with the family or consider domestic abuse as a potential risk factor.

3.2.37 **TOR 5:** Analyse the access organisations have to specialists in domestic abuse agencies

Analysis

3.2.38 There are six domestic abuse agencies in Croydon.

3.2.39 The MPS has developed an app with a directory of domestic abuse resources. This allows officers to acquire guidance and policy through a portal and to offer victims and survivors information on national and local support resources.

3.2.40 **TOR 6:** Analyse the policies, procedures, and training for domestic abuse-related issues.

Analysis

3.2.41 In 2019, the central MPS Domestic Abuse Policy Unit was established. This team is responsible for policy development, implementation, and monitoring. Previously, this team was under continuous improvement until January 2023 and is currently under the Frontline Policing Delivery Group. In 2019, the policy in effect had not been reviewed since 2014, contrary to the standard practice of reviewing policies every four or five years. The team began reviewing the Domestic Abuse Policy; however, publication was delayed owing to a change in senior leadership at the commander level.

3.2.42 **TOR 7:** Tharindu's Mental Health with specific reference to:

a) Substance misuse and dual diagnosis: Mental Health and Substance misuse.

[41] https://safelives.org.uk/training/police

b) Risk to self and others, especially possessing offence weapons
c) Application of Domestic Abuse Policy
d) Application of Safeguarding Policy
e) Medication compliance and effective management

Analysis

3.2.43 The authors of the SLaM IMR highlighted the incident with the knife and indicated that Tharindu had it to open a package for his grandmother. There was no professional curiosity, discussion or consideration of the fact that the grandmother was likely to have knives in her home. Hence, Tharindu was not required to bring a knife.

3.2.44 The authors also discovered that the risk assessment was updated on 27 May 2022; however, it incorrectly stated there was no history of domestic abuse (incidents of domestic abuse from Tharindu to previous partners were shared by the police with SLaM in 2021). It did not contain an assessment of risk to others, except for documentation of incidents that occurred during his inpatient admission in 2021. There was no documentation of the events involving the police in 2022 in the risk assessment.

3.2.45 The IMR authors believe that the CMHT could have applied more professional curiosity to support and comprehend the risk in light of Tharindu's explanations about carrying a knife. According to the police investigating team, recent amendments to the Offensive Weapons Act would have rendered the patient's knife under his pillow an offensive weapon.

3.2.46 The SLAM domestic violence risk assessment was insufficient. Therefore, the Croydon domestic abuse service was not contacted to support Priya. As a result, the SLaM investigating team concluded that the description of the risk to the family members was insufficient. Due to a lack of professional curiosity, the possibility of coercion and control was not considered. Further investigation was lacking about the probability that his family members would be part of Tharindu’s persecutory thoughts.

3.2.47 Tharindu was assessed under the MHA before the fatality. The consultant psychiatrist assessed that the threshold for a recommendation for detention under the MHA was not met at this point. However, safeguarding measures to protect Tharindu's family were not examined, and the CMHT did not investigate the family's support requirements. The writers of the IMR discovered from a 2021 tribunal report that Tharindu had developed persecutory delusions against his mother and two elderly female neighbours (one next door and the other across the street) whom he described as 'racists'. The report suggested that continued treatment and review would be required to assess the risk, although Tharindu had no insight then.

3.2.48 Regarding medication management, the SLaM IMR writers believed it was challenging to determine whether he responded to the medicine because he was not complying. The CMHT was unable to obtain blood testing to determine Tharindu's antipsychotic levels at times because he refused, citing needle anxiety.

3.2.49 On a previous occasion, it is believed that Tharindu took a substantial quantity of medication to cover up his noncompliance right before his blood was drawn for an antipsychotic medication blood test (the levels resulted in being very high).

3.2.50 On 31.05.22, long-acting injection medicine was discussed. However, Tharindu refused due to his fear of needles. Notably, Priya pointed out that he had tattoos despite his claims of suffering from needle anxiety.

3.2.51 **TOR 8:** Analyse any evidence of assistance-seeking and consider what may have facilitated or impeded access to assistance and support. This should consider the effects of the COVID-19 pandemic.

Analysis

3.2.52 Pryia had expressed concern over COVID-19, which led to a decline in care package offerings. The agency records do not confirm whether or not Rasika was asked for her opinion on this.

3.2.53 A report exploring the impact highlighted isolation as a significant risk factor for victims of domestic abuse and the lack of face-to-face contact.[42][43]

3.2.54 A study also discovered that restrictions kept victims in abusive situations and that partner and family abuse worsened. In addition, the lockdown permitted the perpetrators of domestic abuse, controlling, and coercive behaviour to increase or hide their abuse.[44]

3.2.55 Pryia was identified as Rasika's primary carer and a key figure in Tharindu's care; despite her indicating to CHS that she was finding the responsibility of caring for her mother challenging to manage, neither CHS nor SLaM discussed her needs and what support she may need.

3.2.56 Rasika did accept assistance from the sensory impairment service. She consented to a Section 9 Care Act assessment, which would have allowed her to determine whether she needed more care. However, because ASC was operating with a limited subset of the information, they were only informed of a portion of the information.

3.2.57 ASC confirmed that Rasika may have been deprived of the option to request further assistance by relying solely on family members to interpret.

3.2.58 Instances arose in which agencies had knowledge of or had contact with Rasika, and there were signs that her welfare was in jeopardy or that she was subject to neglect or

[42] https://proceduresonline.com/trixcms/media/6627/dash-risk-assessment.pdf
[43] https://www.womensaid.org.uk/wp-content/uploads/2021/11/Shadow_Pandemic_Report_FINAL.pdf
[44] https://www.ukri.org/about-us/how-we-are-doing/research-outcomes-and-impact/esrc/how-the-covid-19-lockdowns-affected-the-domestic-abuse-crisis/#:~:text=Key%20findings%20and%20recommendations&text=domestic%20abuse%20problem-,restrictions%20kept%20victims%20in%20abusive%20relationships%20for%20longer,partner%20and%20family%20abuse%20increased

abuse. Illustrative instances encompass her suicidal ideation and circumstances that suggested her grandson would pose a risk to others.

3.2.59 These occurrences did not consistently result in a referral to ASC. Opportunities to address issues may have been missed if it had been apparent that an adult with care and support needs needed greater assistance or was at risk of abuse or neglect.

3.2.60 **TOR 9:** Were there issues with your agency's capacity or resources that hindered your ability to provide services to victims, alleged perpetrators, or other relevant parties? If so, did these issues impact the agency's capacity for effective collaboration with other agencies?

Analysis

3.2.61 The GP practice remarked that reduced healthcare staffing is commonplace and that time constraints in primary care frequently result in substandard documentation.

3.2.62 **TOR 10:** Is there anything to be learned from this case about how your agency protects victims and promotes their welfare or identifies, assesses, and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for working methods, training, management, supervision, and collaboration with other agencies and resources?

Analysis

3.2.63 SLaM identified four areas:

1. Tharindu's zoning level had not been updated since 2021.
2. Tharindu's risk assessment had not been updated following risk events.
3. The CMHT did not liaise with the police or Tharindu's grandmother to assess the risk to his grandmother following an incident in March 2022, where he was charged with common assault.
4. The CMHT did not recognise the behaviours of Tharindu towards his family (in particular his mother and his grandmother) as a form of domestic abuse and did not explore the support that the family needed before the incident beyond treatment for Tharindu (for example, referrals to relevant agencies: domestic abuse and/or adult safeguarding

3.2.64 ASC acknowledged the effectiveness of the sensory impairment service's provision of assistance, guidance, and equipment for Rasika. Appropriate further referrals were made, including a request for Priya to undergo a Section 10 and Rasika a Section 9 Care Act assessment.

3.2.65 ASC did not consider information within their knowledge, and Rasika and Tharindu's records were not linked. Had they utilised every information, the risk assessment might have been modified to reflect the risk to Rasika. ASC operated under the premise that Tharindu merely provided support to his grandmother despite possessing material that

should have alerted them to the fact that Tharindu was experiencing poor mental illness and posed a risk to his grandmother.

3.2.66 The most effective solution would have been for ASC to have more comprehensive data regarding the referrals received. By doing so, they might have established connections between Rasika and Tharindu or prompted them to request further information from the referrers to fill in any gaps.

3.2.67 **TOR 11:** Are there any areas where agencies can identify where national or local improvements to the existing legal and policy framework could be made?

Analysis

3.2.68 The pathways between the Tamil community and mental health service provision must be improved to ensure that agencies meet the Equality Act requirements and increase community confidence in engaging with services. Stigma, social isolation, language, and other obstacles may arise when coping with mental illness. Understanding the mental health needs of offenders can aid in developing more effective therapies. If mental health needs are neglected, interventions designed to reduce violent behaviour are less likely to be effective.[45]

3.2.69 Home Office to consider research into the following: Accessing information/research into whether patients living with mental illness who have previously shown the capability of causing serious harm and go on to commit homicide.

3.2.70 **TOR 12:** Determine best practices when responses may have exceeded the required standards.

Analysis

3.2.71 As English was not Rasika's native tongue, police officers called the language line during their engagement with her in March 2022. Officers unsuccessfully attempted to identify a Tamil-speaking officer on duty. They exerted great effort to determine what other languages Rasika could speak. Officers utilised Rasika's daughter's safe contact, allowing her account to be accessed without delay in the inquiry.

3.2.72 **TOR 13**: The reports should address any equality and diversity issues that appear to be relevant to the victim and alleged perpetrators, such as age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

Analysis

3.2.73 Please see section 1.13. Furthermore, the necessity for interpreters emerged as a recurring theme in Rasika's interactions with services; Priya and Tharindu facilitated most of these interactions.

[45] https://safelives.org.uk/sites/default/files/resources/Spotlight%207%20-%20Mental%20health%20and%20domestic%20abuse.pdf

4.1 Conclusion

4.1.1 The purpose of the review is to determine the circumstances behind the death of Rasika in June 2022 and 'articulate life through the eyes of the victims.'[46]

4.1.2 No contact was established with Rasika's family, and Rasika's interaction with the agencies was conducted through Pryia or Tharindu. Consequently, Rasika's voice in the review was limited.

4.1.3 The review revealed that health was unaware of Rasika's wishes or if she agreed with her family's recommendation that she not receive a care package.

4.1.4 There was one report of Tharindu committing domestic abuse against Rasika. Unfortunately, no independent interpreter was present, so Pryia interpreted for Rasika and indicated that Rasika did not intend to pursue the report.

4.2.5 SLaM was familiar with Tharindu, including his forensic past and the fact that he kept weapons in his home and carried a knife in public. Priya reported his risk to SLaM. Tharindu told SLaM CMHT that he stated he was carrying the knife to his grandmother's house to open a parcel. SLaM confirmed with Rasika that she had asked Tharindu to bring a knife or that she had a parcel that required opening.

4.1.6 Seven days before Rasika's death, SLaM assessed Tharindu in response to a police report over his request for a firearms licence. He said he planned to join a shooting club with a friend. He stated he got along with his family, but his mother indicated she feared him and had to move in with her other son. Tharindu had paranoid views regarding his family and two elderly neighbours.

4.1.7 Pryia had expressed concern to SLaM at the initial MHAA in 2021 that she did not wish to allow access to the assessment for fear of repercussions from Tharindu. At his last review with SLaM, Pryia did not explore this topic. The SLaM report indicated that his family had no concerns regarding his paranoia, despite his mother's statement that he was using cannabis, a recognised relapse indication.

4.1.8 The review revealed that Tharindu's risk assessment had incorrect information about his history of domestic abuse perpetration.

4.1.9 Rasika's inability to access services or communicate with them was limited by a language barrier known to the services caring for her; nonetheless, no measures were taken to ensure her voice was heard.

5.1 Lessons to be Learnt

5.1.1 The review identified the following themes to be drawn from this review:

[46] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

Response to Domestic Abuse

5.1.2 In April 2022, the Department of Health and Social Care published guidance[47] to strengthen the response to domestic abuse.

'Domestic abuse is a serious health and criminal issue. Practitioners are in a key position to identify and help interrupt domestic abuse.'

'Health professionals have a responsibility to address the health impacts on people directly or indirectly affected by domestic abuse. They also must ensure that other agencies are engaged to address the social, environmental, and broader impacts. People experiencing domestic abuse may choose to disclose it to health professionals, including GPs'.

5.1.3 Pryia had described being afraid of Tharindu, but this was not considered domestic abuse by SLaM.

Language Barrier

5.1.4 Rasika spoke limited English. Thus, she required a Tamil interpreter. An independent interpreter was not utilised during the review period, so her voice was not heard except with Liaison Psychiatry.

Risk Assessment

5.1.5 Tharindu's risk assessment contained incorrect information about his history of Domestic Abuse perpetration, and there was a lack of professional curiosity and Tharindu's justification for bringing a knife to his grandmother's house.

5.1.6 SLaM did not advise Tharindu's family on managing the risk to themselves beyond advising his mother to contact the police if the risk escalated.

5.2 Recommendations

Individual Agency Recommendations

5.2.1 Adult Social Care

1.a Learning identified in their IMR to be shared across ASC&H and acted on.

2.a This learning informs discussions on arrangements for delegating Care Act duties.

3.a Ensuring we use all our information to inform our decision-making.

4.a There is a need to manage waiting lists actively.

5.a Achieving good practice in safeguarding adult enquiries and working with statutory reviews.

5.2.2 GP Practice One

[47] https://www.guidelines.co.uk/public-health/responding-to-domestic-abuse-guideline/456939.article

1.g Use of formal interpreters when assessing safeguarding risks and hear the voice of the person themselves
2.g Flags of safeguarding and vulnerabilities on clinical record.
3.g Linking clinical records of patients who lived at the same address.
4.g Offer extended appointments when required.
5.g Allocate designated clinicians for complex health issues to improve consistency.
6.g Cascade the safeguarding SnoMed codes to all practice staff.
7.g Continue to engage with the IRIS programme and achieve at least 75% compliance with clinical and non-clinical staff training.
8.g Improve recordkeeping by documenting who accompanied the patient to an appointment or whom the staff spoke to on the phone in some cases.

5.2.3 South London and Maudsley NHS Foundation Trust

1.s Croydon North CMHT will update patient zoning levels when risk changes occur.
2.s The Trust will produce a Blue Light Bulletin to remind all teams to ensure that risk assessments are updated when Merlin reports are received from the police.
3.s Croydon North CMHT will receive training regarding involving carers and collateral information to help inform risk assessments even if the patient does not wish the family to be involved in their care. This is especially important if there is evidence of risk to the family or others. Agencies should always refer to the MARAC based on professional judgment when information is limited and the victim/survivor is perceived to be minimising the risks / is unable or too fearful to disclose the full extent of the abuse.
4.s A Trust Blue Light Bulletin to be circulated regarding when information can be shared with families where there is a risk of harm to the family or others.
5.s Croydon North CMHT to commission training from the local Domestic Violence Service on Adult Family Violence to raise awareness of this within the team.

Multi-Agency Recommendations

5.2.4 Recommendation One: Response to Domestic Abuse

1.a All agencies represented to review their training strategies to ensure domestic abuse training is included, highlighting the specific risks to older adults.
1.b All represented agencies are tasked with reviewing safeguarding and domestic abuse policies and procedures to ensure they are easily accessible to practitioners and contribute to the domestic abuse enquiry.
1.c Assurances of the resources and tools employed by agencies to efficiently address disclosures of domestic violence shall be submitted to the Croydon Community Safety Partnership.

South London and Maudsley

1.d An audit to be developed to evidence the domestic abuse enquiry and response to disclosures. The audit is to be presented to the Croydon Community Safety Partnership.

5.2.4 Recommendation Two: Language Barrier

Adult Social Care Croydon Health Service and GP One

2.a To determine and review the usage of professional interpreters.

2.b To ensure that practitioners know the procedures for obtaining independent interpreters within and outside of hours, this should be emphasised in the local induction programme for new staff and in the case notes of service users.

5.2.5 Recommendation Three: Risk Assessment

Metropolitan Police Service (The police have moved to using a Domestic Abuse Risk Assessment.[48] DARA)

3.a The MPS will assure the Croydon Community Safety Partnership of their compliance with training and using the DARA.

[48] https://library.college.police.uk/docs/college-of-policing/Domestic-Abuse-Risk-Assessment-Rationale-2022.pdf

Acronyms

Adult Social Care	ASC
Community Health Service	CHS
Croydon Community Mental Health Team	CMHT
Criminal Justice Mental Health Team	CJMHT
Community Safety Partnership	CSP
Domestic Abuse Risk Assessment	DARA
Domestic Abuse Stalking and Honour-Based Violence Risk Assessment	DASH
Domestic Homicide Review	DHR
Home Treatment Team	HTT
Independent Management Report	IMR
Integrated Care Board	ICB
London Ambulance Service	LAS
Mental Health Act Assessment	MHAA
Metropolitan Police Service	MPS
Multi-Agency Risk Assessment Conference	MARAC
Psychiatric Intensive Care Unit	PICU
Rehabilitation Worker	RW
South London and Maudsley NHS Foundation Trust	SLaM

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1st September 2025

Dear Ciara,

Thank you for resubmitting the Domestic Homicide Review (Rasika) for Croydon Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in August 2025.

The QA Panel felt that the review had been sensitively written and acknowledged the attempts that had been made to involve Rasika's family and friends in the DHR process. There was also good acknowledgement of the lack of understanding of domestic abuse by mental health agencies who were involved and the barriers Rasika would have faced.

The QA Panel acknowledged that most of the issues raised in the previous feedback letter have now been addressed the Home Office is content that on completion of the changes below, the DHR may be published.

Before publication, please amend the typo at 1.2.3, which reads Prita instead of Priya.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk
On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel

Domestic Homicide Review Rasika Action Plan

Contents

Overview Action Plans

Recommendation 1: Response to Domestic Abuse						
The desired outcome from the recommendation To ensure pathways and support are offered to victims/survivors.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1a	All agencies are represented to review their training strategies to ensure domestic abuse training is included, highlighting the specific risks to older adults.	Local	SCP	CHS- • Training strategy to be reviewed	August 2024	CHS- Completed. Strategy reflects all aspects of DASV. Separate DASV training also available. ASC - 03/09/2024 We have reviewed our training offer for our staff and published Learning and Development Handbook which includes expectations on attendance at domestic abuse training. We offer our staff a domestic abuse course which is targeted for those working within adults social care and which includes the specific risks to older people.

				South London and Maudsley NHS Foundation Trust (SLaM) – The Trust has a Training Strategy in line with the Intercollegiate for adult and children. Safeguarding training package is up to date and reviewed regularly in line with policy changes and learning from safeguarding practice reviews. In November 2024, mental health clinicians in Croydon received training regarding involving carers and collateral information to help inform risk assessments. In April FJS and SLaM delivered a bespoke joint training session to mental health professionals in Croydon which raised awareness regarding recognising and responding to domestic and sexual abuse and violence.		**SLaM have completed their combined safeguarding children and adult training package review to ensure specific risks to adults is incorporated within the safeguarding training, including within the context of domestic abuse- review completed in October 2024.** **As part of the review of the safeguarding children and adult level three package, changes have been made to the training to further highlight the importance of recognising and responding to domestic abuse including specifically when it is taking place between family members including older adults.** In November 2024, mental health clinicians in Croydon received training regarding involving carers and collateral information to help inform risk assessments even if the

						patient does not wish the family to be involved in their care, which included older adult relatives also. **In addition to this, in April FJS and SLaM delivered a bespoke joint training session to mental health professionals in Croydon which raised awareness regarding recognising and responding to domestic and sexual abuse and violence. Within the training session the mental health professionals were presented with key learning from this DHR, as the training highlighted requirements for staff within their practice when recognising and responding to domestic abuse including specifically when it is taking place between family members including older adults and referral pathways.**

1.1b	All represented agencies are tasked with reviewing safeguarding and domestic abuse policies and procedures to ensure they are easily accessible to practitioners and contribute to domestic abuse enquiry.	Local	SCP	CHS- • DASV Policy updated 2023. SLaM- DA policy updated in November 2024 and the Staff Awareness of DA Audit report completed in June 2025.		CHS – completed. Accessible on CHS Intranet Promoted during supervision and clinical discussions relating to DASV ASC - Review completed 04/09/2024 We use the London Safeguarding Adults Policy and Procedure, which addresses domestic abuse in the context of our s1 and s42 Care Act duties. We supplement this with local guidance on responding to domestic abuse in the context of our adult safeguarding work. Audit of training with all agencies started at the end of 2023, with each agency taking responsibility to provide and present their data to the board.

				Croydon DASV board –to conduct an audit of the DA training offer from agencies in Croydon and seek assurance of the inclusion/focus on older victims Highlight age-specific risks: Training should emphasise the unique risks and challenges faced by older adults experiencing domestic abuse, such as financial abuse, caregiver abuse, and barriers to seeking help due to physical or cognitive limitations Ensure that training strategies are regularly reviewed and updated to reflect changes in legislation, best practices, and emerging research on domestic abuse in older populations		Outcomes -Learning from this case is cascaded and fully understood by agencies who attend the board to disseminate further. Agencies would learn to recognise various forms of domestic abuse, including physical, emotional, sexual, and economic abuse. Increased understanding of the increased risk factors associated with domestic abuse, particularly for vulnerable groups like older people The audit of training started at the end of 2023, with each agency taking responsibility to provide and present their data at the board meeting. Outcomes - Agencies would gain better knowledge of where to find relevant policies

				Croydon DASV board to include in the audit the review of agencies SG and DA policies and procedures.		and procedures within their organisation. Develop a clearer understanding of how these policies apply to their specific roles and responsibilities. The SLaM DA Policy had extensive amendments made to it and this policy was ratified in November 2024 and promoted via the SLaM communications strategy. Key aims of the DA Policy include for staff to be aware of and consider protected characteristics and related experience of victims and how these may intersect and overlap particularly in relation to accessing services and support if they are not designed to meet specific needs. . To understand the process of managing domestic abuse in a clinical setting and consider the impact of domestic abuse

						on risk assessment and treatment planning. The DA policy sets out the SLaM position concerning the complex issue of domestic abuse (DA). There is a requirement for the trust to introduce routine enquiry for domestic violence and abuse in secondary care as stated in the NICE guidelines (2014). The Trust is therefore committed to ensuring that DA is recognised, and that service users and staff are provided with information and support to minimise risk. Within the DA policy there is a dedicated section focusing on Routine Enquiry and creating a safe environment for victims of DA to be able to safely disclose. All safeguarding policies including the SLaM DA policy are easily accessible to SLaM staff via the staff intranet system 'Maud'. SLaM has a

						dedicated safeguarding and domestic abuse page where policies and procedures are easily accessible to staff. There is also a summary of this policy- Policy on a Page- which has been circulated to all staff within the trust as part of the SLaM communications strategy. This is easily accessible to SLaM staff via the staff intranet system 'Maud'. The Staff Awareness of DA Audit report completed in June 2025 highlights that whilst only 26% of staff completing the audit felt familiar with the terminology 'routine enquiry', 96% of SLaM staff who completed the audit felt either 'very confident/confident/somewhat confident in asking patients about experiencing violence or abuse from people they are personally connected with such as, children, siblings, intimate partner, relatives etc.

						The DA audit is to be repeated in January 2026 to measure the impact of the reviewed safeguarding training that is now being delivered.
1.1c	Assurances of the resources and tools employed by agencies to efficiently address disclosures of domestic violence shall be submitted to the Croydon Community Safety Partnership.	Local	All partners	CHS- • The trust supports DASV training within SGL1&2 (E-Learning) and SGL3 (face to face). • The SG team have a Hospital Domestic Abuse Advocate and DASV Support Worker who respond to request where disclosures are made and support in Risk assessment & referrals. • The SG Adult team supplement the IDVA & DASV Support worker where they are unavailable (pathway developed). • CHS has trained 80+ DASV champions. • A DASV newsletter has been created and is circulated to champions, intranet and within wider SG newsletter.	August	CHS- Completed. See milestones. ASC - Our local guidance on responding to domestic abuse in the context of our adult safeguarding work addresses this.

				• Updated DASV specific staff intranet page with resources and tools. • Supporting DASV Awareness month with stalls/posters. • Managerial DASV training sessions arranged • DASV Policy in place IDVA/DASV/SG Adult Team attend Emergency department twice a day IRIS is currently being delivered in Croydon and uptake is monitored by the DASV board and the IRIS steering group SLAM milestones SLaM provides domestic abuse e-learning training and further training as part of safeguarding children and adult level 3 training which is mandatory. Child and adult safeguarding level 3 packages submitted to the Croydon Community Safety Partnership. SLaM reviewed and made extensive changes to the DA Policy- this policy was ratified in November 2024.		SLaM- completed- see completed milestones

				Key aims of the DA Policy include for staff to be aware of and consider protected characteristics and related experience of victims and how these may intersect and overlap particularly in relation to accessing services and support if they are not designed to meet specific needs. . To understand the process of managing domestic abuse in a clinical setting and consider the impact of domestic abuse on risk assessment and treatment planning. The DA policy sets out the SLaM position concerning the complex issue of domestic abuse (DA). There is a requirement for the trust to introduce routine enquiry for domestic violence and abuse in secondary care as stated in the NICE guidelines (2014). The Trust is therefore committed to ensuring that DA is recognised, and that service users and staff are provided with information and support to minimise risk. Within the DA policy there is a dedicated section focusing on Routine Enquiry and creating a safe		

				environment for victims of DA to be able to safely disclose. DA policy submitted to the Croydon Community Safety Partnership. In 2024, SLaM appointed a Domestic Abuse and Exploitation Lead to the safeguarding team. One of the key functions of the role is to provide specialist knowledge and advice and supervision in relation to cases of domestic abuse and exploitation. The SLaM Domestic Abuse and Exploitation Lead did a live broadcast to the organisation in November 2024 where DA support and helplines were promoted. The SLaM safeguarding team held an internal DA conference in November 2024 as part of 16 days of activism to raise awareness of DA and the specialist support and actions and to promote the use of the dash risk assessment. As part of this, SLaM Consultant Psychiatrists provided a		

				presentation on the published research regarding working with perpetrators. This work has been incorporated into the DA policy and promoted via a SLaM communications strategy. SLaM has a dedicated safeguarding and domestic abuse page where policies and procedures are easily accessible to staff. The SLaM Safeguarding team provides a specialist safeguarding advisory service Monday to Friday 9am to 5pm (excluding bank holidays) where all staff across the trust, including SLaM staff working in Croydon can access safeguarding advice and support on a variety of safeguarding concerns, including domestic abuse. In addition, SLaM have daily huddle meetings (Monday to Friday, excluding bank holidays), in each borough, including Croydon where members of the safeguarding team now attend each day to discuss all safeguarding incidents, including		

				domestic abuse, that have occurred in the previous 24 hour period. The safeguarding team provide regular supervision to all staff across the trust, including Croydon.		
1.1d	An audit will be developed to evidence the domestic abuse enquiry and response to disclosures. The audit is to be presented to the Croydon Community Safety Partnership.	Local	South London and Maudsley NHS Foundation Trust (SLaM)	The Safeguarding team developed and completed a DA audit exploring DA enquiry and response to disclosures within the organisation. This initial audit was completed in May 2024 and the most recent audit report completed in June 2025. The next audit will be completed in January 2026.		**SLaM Completed- see milestones.**