SAR-Grant

Statutory Safeguarding Adults Review (SAR) Report and Findings in respect of an individual to be known as Grant

This report has been prepared under the statutory requirements of the Care Act 2014 by External Reviewer, Philippa Smith, Independent Chair of the Bexley Safeguarding Adult Board

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1. Preface

The subject of the SAR has been referred to as Grant to provide some measure of protection to the subject and their family's right to confidentiality and privacy. Pseudonyms have been used where required for members of Grant's family.

The Independent Chair and SAR panel members offer their deepest sympathy to Grant's family and all those affected by Grant's death. It was clear during the review and from the findings that Grant was a much-loved member of a close family and well thought of outside of the family.

The Independent Chair wishes to thank the SAR panel members for the professional way in which they conducted the review. This review commenced during the Covid-19 pandemic and required an online approach consistent with public health measures taken by UK Government, the SAR greatly appreciated the full engagement, sensitivity and time of the SAR panel throughout the process.

The Independent Chair wishes to acknowledge that at the time of completion of this review the Coroner's Inquest into the death of Grant has not been concluded. This report is sensitive to that and does in no way seek to influence any outcome but instead aims to identify learning for all involved organisations at the earliest opportunity.

2. Introduction

The subject of this review is a British Asian Male who was in his forties at the time of his death in June 2020. Grant had been diagnosed with Depression, anxiety, Emotional unstable personality disorder, mental and behavioural disorder due to stimulant abuse, drug induced psychosis paranoid schizophrenia.

He was prescribed medications which included Atorvastatin, Clozapine, Folic acid, Omeprazole and Propranolol. He was also believed to have been self-medicating obtaining medication from on-line internet suppliers at the time of his death.

At the time of his death Grant had recently returned to his supported living placement following a period of time spent living at the family home address with his mother and father. In the years prior to his death, he was well known to mental health services, had been detained on several occasions under the Mental Health Act (1983) and had spent some time in one of Her Majesty's Prisons.

A Safeguarding Adult Review (SAR) is carried out so that the agencies involved in providing services can learn lessons and improve practice.

By finding out more about why people died we can understand what needs to be changed to make a difference to people's lives.

It was agreed that the SAR should be led by the Independent External Reviewer of the Safeguarding Adult Board, to consider the findings of that review, to identify if there is any additional relevant information and to determine any wider safeguarding lessons.

It was agreed that the SAR would be conducted as a learning process, with the information brought together and considered at a number of joint meetings. The final meeting was held in November 2021.

3. Criteria for undertaking a SAR

A Local Safeguarding Adults Board must undertake reviews of serious cases in specified circumstances under Section 44 of the Care Act 2014 which sets out the criteria for a Safeguarding Adults Review (SAR). This includes circumstances involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if there is reasonable cause for concern about how the Safeguarding Adults Board, members of it or other persons with relevant functions worked together to safeguard the adult, and the adult has died.

The purpose of the review is primarily to:

(a) identify any lessons to be learnt from the adult's case and
(b) apply those lessons to future cases.

4. Information considered

Summaries of involvement were received from:

1. Oxleas NHS Foundation Trust
2. GP Practice – Dartford (Bexley CCG)
3. Crisis Intervention Team – MARAC
4. Adult Social Care Bexley
5. Chapel Hill Supported Living Care Home, Crayford, Dartford
6. Priory Hospital, Kneesworth House, Hertfordshire - Priory Group
7. London Metropolitan Police Service
8. British Transport Police

Greenwich Adult Social Care responded to state they had no record of the subject in their system.

National Probation Service responded to say they had no record of the subject in their systems and therefore concluded they had never managed him.

The family of Grant were contacted and were made aware of the SAR. They were invited to be involved in the review but declined, making thanks for the contact.

5. Background

Grant was a British Asian Male, of Indian Sikh heritage in his forties. He was single, unemployed at the time of his death and was in receipt of welfare benefits. Grant had previously been a PHD student up until 2016 when his mental health issues increased. His registered GP Surgery at the time of his death was Crayford Town Surgery. He had been well known to mental health services since 2003 and previously been diagnosed with Depression, anxiety, Emotional unstable personality disorder, mental and behavioural disorder due to stimulant abuse, drug induced psychosis paranoid schizophrenia.

Grant was born and bought up in and around Belvedere, Southeast London. Grant was the second youngest of four siblings, he has two older sisters, one who lives abroad as well as a younger brother who also lives abroad. He grew up in an extended family setting which consisted of his mother, father and siblings sharing the family home with his uncle and his family. Both his parents survive him, his father is registered disabled, and his mother has suffered from cancer, having been undergoing treatment for this in the period prior to Grant's death. Both are elderly and were clearly actively involved and concerned in his welfare and support as were other family member including his uncle and cousins.

Grant described to others an unhappy childhood bought on mainly by an overbearing attitude of his father. Grant reported that his father was domineering however he did say he became closer to him after the onset of his mental health problems. His mother was quiet, and Grant said he found it difficult to communicate with her perhaps due to language barriers as English was not her first language. It is clear from reports that Grant loved both his parents dearly and they him. Both his parents had medical concerns, were elderly but were generally well in themselves.

Grant was reported to have struggled at school and says he was bullied although he is described as doing well by teachers.

Grant left school at 16yrs and completed a one-year apprenticeship in engineering, after living and working abroad for a few years he returned to the UK and studied at University College London and later started a master's degree at Westminster University in Philosophy. Between 2003 and 2015 he held a number of sales and administration jobs. He never married and is reported to have had one serious girlfriend and a small number of friends in the community. Grant was described by his family as outgoing, engaging and a highly intelligent individual.

Grant developed depression approximately 20 years before his death, he managed this over the years with medication. Grant's previous mental health inpatient admissions were in 2003 when he was admitted due to suicidal ideation, diagnosed anxiety and depression, 2004 due to obsessional thoughts and ruminations, 2015 for alcohol detoxification, 2016 for drug induced psychosis, ADHD and Emotionally Unstable Personality Disorder.

In August 2018 Grant was remanded in custody to HMP Belmarsh after pleading guilty to two counts of threats to kill and criminal damage. The incident involved his parents at their home address, he is reported to have had an altercation with his father in which Grant chased him with a knife and threatened to burn down the house. In October 2018 Grant was transferred on section 48/49 from HMP to Oxleas NHS Foundation Trust Psychiatric Intensive Care Unit (PICU) due to his deteriorating mental state. He remained in hospital until his hearing in January 2019 where the outcome was further detention under section 3 of the Mental Health Act. He remained on the Psychiatric Intensive Care Unit (PICU) until he was stepped down to an acute ward at the end of May 2019. In July 2019 Grant was transferred to Kneesworth

House Hospital, a secure private mental health unit managed by Priory Group as he required a period of rehabilitation in a locked unit which Oxleas NHS Foundation Trust did not have facilities for. In March 2020 he had made improvements and was taken off section and was ready to be discharged however required support and a placement was located and secured for him at Chapel Hill Supported Living Care Home in Crayford, Kent located in the London Borough of Bexley. This was a non-secure supported living unit.

Grant had an extensive history of misusing prescribed medication and purchasing stimulants/amphetamines over the internet. There is also indication that he was using cocaine in 2017 after he tested positive on four occasions. He also used and at times abused alcohol. His behaviour whilst intoxicated has been described as being more erratic and violent and in recent years there were allegations of financial, physical and emotional abuse towards his father. This prompted safeguarding processes to be actioned by the local authority for the parents.

It is to be noted that his parents were heavily involved in supporting Grant with his mental health. The relationship that he had with them when he was undergoing treatment away from the community was described as positive. His parents were very keen for him to be a part of the family and to be supported by them as his parents. It is clear that whilst at times his parents acknowledged and requested help for themselves when this was explored further by services, they then often refused help for themselves with the request for help being directed towards Grant rather than for themselves. The reports received for this review outlined the great involvement and concern his family had for Grant and his well-being.

6. Summary of known events prior to Grant's death

Events up to and including 2018:

Grant's mental health started to decline approximately 20 years prior to his death in June 2020 and there are reports of extensive engagement and communication between Grant, Health, Local Authority, Police and Grant's parents which is outlined in Appendix A.

Events from Oct 2018 to June 2020:

After being arrested and remanded in custody to Her Majesty's Prison (HMP) Belmarsh after pleading guilty to two counts of threats to kill and criminal damage, Grant was described by the prison as being difficult, he questioned his medication levels and was argumentative. He was described as being well educated however his behaviour and demeanour were eccentric, he was stubborn and quite dismissive of others including staff. It was noted that at the beginning of September 2018 that his behaviour and mental state was deteriorating, he wasn't looking after himself, was not sleeping and was often found talking to himself. He was therefore closely monitored by staff up until his transfer to hospital.

In October 2018 Grant was transferred on section 48/49 from HMP Belmarsh to Oxleas NHS Foundation Trust Psychiatric Intensive Care Unit (PICU) due to his deteriorating mental state. He had an assigned Care Co-ordinator from Oxleas NHS Foundation Trust.

In January 2019 a court case outcome was for a mental health discharge from court and at this time his parents had asked for him not to return to the family home. The court disposal was to detain Grant under s3 of the Mental Health Act and he remained in the inpatient unit. In July 2019 Grant was transferred to Kneesworth House Hospital.

In July 2019 Grant was admitted to Kneesworth House Hospital, a secure private mental health unit, with a diagnosis of Schizophrenia, a severe and enduring mental disorder. The nature of his disorder was reported to be chronic, complicated by non-compliance and the overuse of ADHD medication which can trigger episodes of psychosis.

Kneesworth House Hospital was located approximately 70 miles away from Bexley and was identified as Oxleas NHS Foundation Trust did not have a locked rehabilitation unit and so patients had to go to private hospitals for this type of long-term treatment.

During his time in Kneesworth Hospital Grant and his family were continually supported by the same allocated Care Co-ordinator from Oxleas NHS Foundation Trust. Grant was described as having a positive relationship with his family who he kept in regular contact with by their visits and phone calls. His family had visited him in hospital up to three times a week at times. Grant stated to staff that he and his father argued a lot when he was younger as he felt a pressure to succeed however its reported that their relationship had improved, and they had begun to talk regularly. The care provided to Grant whilst he was a patient at Kneesworth House Hospital was person centred, he was encouraged to make his own decisions and his treatment plan was reviewed regularly. This is evidenced in his Keeping Well Care Plan, the Keeping Safe Care Plan and associated Risk Assessment. These adhered to NICE Guidelines; Psychosis and Schizophrenia in adults; prevention and management Clinical guideline (CG178) published Feb 2014

Grant and his parents were continually involved in reviewing and planning his care and nursing staff closely monitored him for signs of self-harm, changes in his mental state and his intent to self-harm. Throughout his time at Kneesworth House Hospital Grant appeared to have capacity to consent to treatment and at times had good insight into his mental illness and the need for medication, it was noted that there were limitations in his further understanding of psychotic illness and the treatments required which resulted in his insight into overall circumstances being limited.

It is reported that Grant remained compliant with his treatment programme from admission to discharge, he had unescorted ground leave and escorted community leave with no issues.

Towards the end of his time at Kneesworth House Hospital Grant was focused on being discharged from hospital, reasons being, he stated, was that he was bored and was well. It was explained to him he would benefit from being engaged in insight work and relapse prevention work before this could be considered which he was accepting of. Grant's parents were involved in the decision-making arrangements and they and staff agreed that he should have unescorted home leave. It was noted at this time, the frail health of both Grant's parents, who lived on their own and had their own limitations on supporting Grant. The Care Co-ordinator and Multi-Disciplinary team reassured the family and stated to them once ready for discharge the likely route would be for Grant to have supported living in place to develop his skills further for living in the community.

On the 28th of January 2020 Grant's Care Co-ordinator contacted a supported living placement in Greenwich making a referral to them for Grant. On the 4th of February 2020 Grant was assessed by a member of staff from Peace Manor Residential Care and the following day Grant's Care Co-ordinator received an e-mail confirming the assessment and that Grant was suitable for a placement. This supported care home, Peace Manor Residential Care, was located in Greenwich and was one that the Care Co-ordinator knew and had previous experience working with. Between the 5th of February 2020 and the 12th of February 2020 Grant's Care Co-ordinator and Grant's Consultant Psychiatrist at Kneesworth House Hospital discussed Grant's discharge. On the 12th of February 2020 a Section 117 Mental Health Act Aftercare discharge meeting was held with Grant where it was agreed he would remain on section with a view to discharge in the weeks to come.

During this time there were discussions between Greenwich and Bexley CCG's and London Borough of Bexley as to which authority should be leading on commissioning and brokerage arrangements for Grant's stepdown placement. S117 Aftercare is a shared responsibility between CCG's (determined by GP registration) and Local Authorities (determined by Ordinary Residence). In Grant's case, responsibility fell to Greenwich (health) based on his GP registration at the time of his detention under S3 of the Mental Health Act and London Borough of Bexley. In both boroughs, the usual practice is that the Local Authority leads on commissioning and brokerage of placements for S117 Aftercare. The London Borough of

Bexley holds a block contract with Choice Support for mental health community rehabilitation and, in light of known vacancies at the time, it was requested that Grant be assessed for their step-down unit at Chapel Hill, Crayford in the first instance, rather than initiate a separate cost per case arrangement with Peace Manor. Both providers are utilised by London Borough of Bexley and are known to provide a similar level of care and support to individuals with mental health rehabilitation support needs. On the 13th of February 2020 the Manager at Chapel Hill Supported Living Care home received an e mail from Grant's Care Co-ordinator indicating that Grant was to be referred to them for an assessment.

Therefore, his Care Co-ordinator, who worked and was familiar with processes in Greenwich, was advised that he should be re-assessed, and a placement found in Bexley. On the 13th February 2020 the Manager at Chapel Hill Supported Living Care home received an e mail from Grant's Care Co-ordinator indicating that Grant was to be referred to them.

Whilst Grant's family were involved in his care management whilst at Kneesworth House Hospital and were keen for him to have unescorted home leave there is also evidence that they had anxieties about him being discharged from hospital and having home leave which is documented on Care Notes. One entry on the 11th of February 2020 states that at the request of his father Grant should not be granted home leave to parents without their consent and that they requested contact with Grant Consultant prior to each approval of home leave. Grant's father requested that this request should not be shared with Grant.

On the 25th of February 2020 Grant was made an informal patient at Kneesworth House Hospital as he continued to show signs of improvement in his mental stability. A Making Feasible Plans for the Future Care Plan was created which highlighted Grant's informal status and detailed the agreement between Grant and the hospital to keeping him safe. Grant's comments to this were *'today is the best day of my life, having that feeling that I am no longer sectioned it means so much for me, I agree with the care plan that during my stay here as an informal patient I will truly abide by the ward rules and take my medication as usual'*

On the 27th of February 2020 the Manager from Chapel Hill Supported Living Care home attended Kneesworth House Hospital to conduct an assessment on Grant for suitability for a placement with them. The assessment, once completed, identified that Grant was suitable for a placement and Grant and his family were informed of this on the 28th of February 2020.

Grant's Care Co-ordinator was updated on Thursday, 5th March 2020 stating that Grant's planned discharge was to be Monday 9th March 2020

On Monday 9th March 2020 Grant was discharged from Kneesworth House Hospital with a 7-day supply of medication.

Grant's Care Co-ordinator contacted Chapel Hill Supported Living Care home the day after his arrival, which constituted the 72 hours follow up guidelines, to speak to him however he was not in.

From his arrival at Chapel Hill Supported Living Care home Grant is reported as having engaged very well with staff practising and evidencing the skills required for daily living. Family members enquired after him requesting contact details. He visited at least two members of his family during the first few weeks of his residing there, each time returning to Chapel Hill Supported Living Care home. He regularly attended bloods tests which were required as he was prescribed Clozapine which requires differential white blood cell monitoring to manage the risk of agranulocytosis. Chapel Hill reported the blood test results were Green and so he was able to collect further prescriptions. Grant's care team were notified of this, and his medication was collected by a member of the care team. Grant was under the Care Programme Approach, had a Psychiatrist, Care Co-ordinator, and support staff at the care home available to him. He had risk assessments and care plans completed for his mental and physical health and blood tests for his medication.

Grant registered with the local GP practice Crayford Town Surgery on the 13th of March 2020.

On the 23rd of March 2020 the UK Government announced that there would be a national 'lockdown' due to the Covid-19 Coronavirus pandemic.

On the 3rd of April 2020 Grant's Care Co-ordinator received an e mail from Chapel Hill Supported Living Care Home Manager stating that Grant wanted to go back to live at his parents' house.

On the 5th of April 2020 it is reported that his parents had returned to the UK from being overseas (they had left the UK prior to Grant being transferred from Kneesworth House Hospital to Chapel Hill Supported Living Care home)

It appears that Grant was under the impression that he was to move back to his parents address and remain there for the duration of the 'lockdown'.

On the 5th of April 2020 the Care Co-ordinator received an e mail from Chapel Hill Supported Living Care home staff informing them that Grant had in fact returned to his parents address against their advice and that as he was at Chapel Hill Supported Living Care home voluntarily and not under section, they had no power to insist he remain there. The Care Co-ordinator tried to call Grant however there was no answer. They then called his father who confirmed that Grant was at the family home and that he and his wife were happy to have him there for the time being. At this time the Covid-19 Pandemic had stopped all one-to-one visits so contact between Grant and the Care Co-ordinator was limited to phone calls. Over the next 24 hours the Care Co-ordinator spoke to both Grant and his father, informing them both that Grant should return to Chapel Hill Supported Living Care home and that as there was no power for the Care Co-ordinator to insist that Grant return, his father was told that if he did not want Grant at the home address he could use the police to ask him to leave. Grant stated he was willing to return to Chapel Hill Supported Living Care home after 'lockdown'. The Manager at Chapel Hill Supported Living Care home was updated to this effect.

Over the next few weeks Grant's Care Co-ordinator attempted to keep in touch with Grant, he rarely answered his phone and contact had to be made through his father at times. On the 14th of April 2020 Grant's father was advised that Grant's placement at Chapel Hill Supported Living Care home would remain open for Grant to return. It was reported that during the period where he was at home with his parents his communication with his Care Co-ordinator was regular, he stated he was happy and that he didn't want to go back to the care home, it was of the opinion of his Care Co-ordinator that he was very much engaged with them. He had attended a Clozapine clinic to have his bloods taken of which the result was green, and he continued to attend the clinic for the blood tests through to mid May 2020.

Towards the end of April 2020 Grant's father also asked the Care Co-ordinator not to share any details with his daughter, Grant's sister. There is also some confusion at this time that advice given to the Care Co-ordinator by Chapel Hill Supported Living Care home was that due to the pandemic Grant could not return until after 'lockdown'. This was not correct, and the advice was that if Grant returned to Chapel Hill Supported Living Care home, he would have to follow Government guidelines and self-isolate for a period of time.

On the 15th of May 2020 Grant booked an appointment with a private Psychiatrist, speaking to them over the phone where he requested a review of his mental health treatment with a view to recommencing stimulant treatment for ADHD. Grant stated that to the on-line private Psychiatrist that his 'GP' had discontinued the original prescription that was first issued three years ago six months previously to this call. The 'GP' apparently had stated to Grant it was too expensive and stating that Grant didn't require it.

On the 19th of May 2020 Grant submitted an on-line e consultation request to his current GP at Crayford Town Surgery (due to covid restrictions) asking for his ADHD medication to be restarted. He was advised by his GP that they were not able to initiate this and that he should speak to his MH Team. He stated on this electronic communication that he was not suicidal.

In this first letter dated the 18th May 2020 from the from the private on line Schloen Clinic, the Dr advises methylphenidate XL as a medication and explained the side effects and requirement for future monitoring, the letter does not explicitly state this was prescribed however a letter dated 24th May 2020 from Psychiatry – UK states that it was prescribed at 18mg once a morning for 7 days with it being increased each week after up to a 4 week period.

These letters dated the 18th and 24th May 2020 and were forwarded onto his GP at Crayford Town Surgery date marked 2nd and 3rd June identifying a diagnosis of ADHD and suggesting medication to be prescribed. No safeguarding concerns were raised on the GP record as he was under the care of a MH team and so subsequently Grant's contact was not made aware to the safeguarding lead.

A day after the electronic request to his GP at Crayford Town Surgery, Grant's father spoke to his Care Co Ordinator and stated that Grant had started to order private medication online. He also said that he had asked Grant to return to Chapel Hill Supported Living Care home but that he had refused. The Care Co-ordinator spoke to Grant on the phone and asked him to return to Chapel Hill Supported Living Care home however Grant refused and advised that he would return after 'lockdown'

A day later on the 21st of May 2020 the Care Co-ordinator again spoke to Grant's father who said he wanted Grant to return to Chapel Hill Supported Living Care home and that he would call the police to get Grant removed. The Care Co-ordinator emailed Grant's Consultant Psychiatrist to update them of the current situation. Five days later Grant attended the Clozapine clinic for blood tests which were green. The following day the placement at Chapel Hill Supported Living Care home was discussed between Greenwich and Bexley Intensive Case Management of Psychosis (ICMP) teams as Grant had not been resident for seven weeks yet the placement was still being funded.

On the 28th of May 2020 a Multi-Disciplinary Team meeting is recorded where the case was discussed with the Care Co-ordinator. A Safeguarding alert concern was raised by staff at Chapel Hill for Grant's parents, identifying the inability of his parents to look after Grant as his father frequently called them to request Grant return there as they could not cope. Staff had stated to Grant's parents that he could return at any time. The Care Co-ordinator believed informed them that they were in contact with Grant and his parents, and the aim was to encourage Grant to return of his own accord. It was agreed that the Care Co-ordinator was to speak to the family together with the Consultant Psychologist, an e mail was to be sent to Oxleas NHS Foundation Trust police liaison team outlining concern for Grant's parents and the Safeguarding Adults Team (SGA) were to be contacted for advice. It was also agreed that the placement at Chapel Hill Supported Living Care home would remain open and funded.

June 2020

On the 1st of June 2020 concern was raised by the Chapel Hill Supported Living Care Home Manager to Bexley CCG stating that family members of Grant had raised concerns about Grant's parents and their general well-being. They stated that although the parents had said Grant could stay with them, they were scared of him. The family member was reassured by Chapel Hill Supported Living Care Home Manager that the placement was still available for Grant and the hope was that he would return. The Manager also said that their concern was that if he did return, as Chapel Hill Supported Living Care home, was not a secure unit they would be unable to contain him, and he would still be able to go back to his parents' house which was of great concern to the family. An email was also sent by the Clinical Commissioning Group (CCG) Bexley to a number of Oxleas staff members asking for any update with regards to Grant, outlining those current safeguarding arrangements felt less than ideal. It also asked for some further assurances before a termination of his placement was agreed.

Bexley CCG was advised by Oxleas NHS Foundation Trust that there were plans to speak to the family and they asked for more time to persuade Grant to return to Chapel Hill Supported

Living Care home. It was agreed between Bexley CCG and Oxleas NHS Foundation Trust that the placement would be kept open for Grant to return with Bexley CCG outlining that in an ideal world the Commissioner wouldn't/shouldn't be intervening in case management however they did so due to the suggestion from Greenwich CCG that the placement should be closed.

The CCG were also updated on the same day by the Intensive Case Management of Psychosis (ICMP) team (Oxleas) of the actions that evolved following the multi-Disciplinary meeting on the 28th of May 2020. The team manager requested further time to persuade Grant to return to the placement in Chapel Hill Supported Living Care home.

On the 2nd of June 2020 a multi-Disciplinary meeting was again held, and Grant was placed in the red Zone due to a safeguarding risk to his parents and the potential of Grant losing his placement at Chapel Hill Supported Living Care home, a Care Planning Document was also created. Notes also show that the Safeguarding Adult concern for the parents was discussed with the Oxleas Safeguarding Adults practitioner and the advice was that it could be raised with London Borough of Bexley for the parents. The case was discussed, and the plan was to have a professionals meeting to look at all the issues including safeguarding for the parents.

On the same day the Care Co-ordinator and the Psychologist attended Grant's parents' address. Grant's father stated that he was concerned that his son was residing with him, it was reported that since moving back home Grant had become verbally aggressive and demanding towards his parents which included asking his father to break lockdown rules to make 'purchases'.

It was also reported that he was taking amphetamines that he had purchased from the internet. The Psychologist was also advised by a family member (cousin) that they had been told by the police that they, the police, could not forcibly remove Grant from the family home, that he needed to be provided with three formal eviction notices and then it could be heard in local court.

On the 3rd of June 2020 the Care Co-ordinator spoke to a family member who said that Grant had stated to him that he was going to kill himself on the 2nd of June 2020 as he was schizophrenic. This family member also stated that Grant had not shown any signs of aggression or violent behaviour towards his parents.

On the same day the ICMP team manager conducted a supervision case review, this indicated that the Care Co-ordinator believed that Grant may be relapsing in his mental state.

On the 4th of June the Care Co-ordinator contacted a family member and who said that the family plan was to take Grant to his Clozapine blood test on the 9th of June 2020 and then afterwards return him to Chapel Hill Supported Living Care home, later on this family member informed the Care co-ordinator that this plan would not work.

The Care Co-ordinator contacted Grant and an Approved Mental Health Professional (AMHP) by telephone for a family meeting. It was agreed that the Approved Mental Health Professional (AMHP) and Care Co-ordinator would assess Grant's mental state which they did the same day by telephone. During this assessment Grant said he was feeling okay and had spent time watching tv and going for a walk with his father, he said his mood was about 5/6 out of 10. The telephone call ended, and it was agreed that a further meeting would be held and that they would speak again on the 9th of June 2020. This was confirmed in a letter delivered to Grant by the Care Co-ordinator on the same day.

The Psychologist also sent an e mail to the police liaison officer which outlined how they should proceed with Grant and police contacted Oxleas NHS Foundation Trust the following day with suggestions on how they should proceed with Grant.

On the 5th of June 2020, the Care Co-ordinator was contacted by a family member, they said Grant had been aggressive towards his father asking why he was speaking to the Care Co-ordinator. The family member said that Grant's parents were planning on leaving their house over the weekend. A social worker from the Approved Mental Health Professional (AMHP) service also received a call from the Care Co-ordinator with the circumstances explained to them as well.

On the 7th of June 2020 Grant attended Queen Elizabeth A&E having taken an overdose. It was reported that he had left the family home saying he was going for a walk. Grant's family later found out that he had taken himself to Belvedere train station and had been drinking, he normally did not drink. When he returned to the home, he said that he wanted to take his own life and that he allegedly had taken an overdose after purchasing the medication online and taking it with the alcohol. It was clear he was in mental health crisis and his family called an ambulance where he was voluntarily taken to Queen Elizabeth A&E. At the hospital when assessed it was agreed by staff that Grant should have a psychiatric review which should involve his Care Co-ordinator.

When in A&E Grant denied taking any medication or of a suicide attempt. He appeared to be coherent but was unaware as to why an ambulance had been called for him. The Ambulance service notes indicate a four-day history of taking all his anti-psychotic medication as well as other medication. It was reported he had stated to his family he wanted to die but had no plan. It was recorded that family had avoided visiting due to his increased aggression and the fear of him harming them. A family member gave an overview of his behaviour and also said that Grant would wake his parents up through the night complaining of suicidal ideation.

Grant was kept in overnight and transferred to a ward, he was referred for a parallel mental health assessment and medical review. Whilst he was there, he requested to call his parents a number of times however his parents did not support this contact and did not speak to him. Due to his erratic behaviour his canula was removed by hospital staff.

In the early hours of the morning of the 8th of June 2020 Grant left the ward at Queen Elizabeth Hospital without notifying any member of health staff and was seen by security as having left the hospital. A phone call was made to the family home, and it was confirmed by a family member that Grant had returned to a family address. Family was advised by a nurse to contact police to return him to hospital.

During the 8th of June 2002, one of Grant's family members contacted police reporting that Grant was outside their home and trying to get in. Police attended but Grant was not there. Due to his presentation the previous day at Belvedere train station, the police informed British Transport Police who deployed officers to the nearby stations in case Grant was heading to one of them, however whilst the officers were speaking to the family member a call came in and it was reported Grant had been seen near the parents' address.

Police attended and found Grant walking down the road. It is reported he was non-confrontational, relaxed and was willing to sit with officers whilst various calls were made. The officers stated he looked a little dishevelled but was otherwise coherent and possessed sound logic. He was asked if he was suicidal and replied no and then stated, 'I am no danger to myself or society'.

Grant's family members were also present but remained out of sight expressing their concerns to the officers. The officers explained the powers they had under s136 Mental Health Act and that it was for emergencies where there was an immediate fear of harm, the family confirmed that no one had heard Grant say anything about suicide or harming himself that day, the 8th of

June 2020. Officers also spoke to Grant's Care Co-ordinator who expressed their concerns for Grant and said that he should return to the hospital to complete his assessment. It was explained to the Care Co-ordinator by the officer that they could not force Grant to return and that they had no powers to do so, he was not under section, he didn't have a Community Treatment Order (CTO) in place and there was no immediate risk identified by the officers. The Care Co-ordinator stated again that their advice was for him to be taken to Queen Elizabeth Hospital. Grant was asked a number of times if he would re attend the hospital voluntarily which he refused and as he was reported by the officers to coherent, calm and as there was no evidence to say he would harm himself or was suicidal the officers had no power to force him to attend.

After waiting with Grant for a number of hours to be confident there was no identified risk, the police returned him to Chapel Hill Supported Living Care home to which he went voluntarily to and police advised his family and staff at Chapel Hill Supported Living Care home that if they were concerned about him they should call an ambulance in the short term and in the long term arrange a s135 warrant under the Mental Health Act. The police gave a full handover to staff at Chapel Hill Supported Living Care home so that they were informed of developments and could manage risk that may arise going forward. Until the police attended Chapel Hill Supported Living Care home staff were unaware of the events involving Grant for the previous few days. The Chapel Hill Supported Living Care Home Manager contacted the Care Co-ordinator by e mail stating that Grant had been returned to the unit by police.

Later that day, the 8th of June 2020, Grant's Care Co-ordinator saw Grant at Chapel Hill Supported Living Care home at the request of staff there, Grant stated he had had a good sleep, had eaten, and taken his medication. He denied having abnormal perception, hallucinations, paranoia, or delusions. The Care Co-ordinator completed a risk assessment and informed staff at Chapel Hill Supported Living Care home that Grant said he was not suicidal and that the alleged overdose was due to the fact he took more than he should.

Later, on the 8th of June 2020 staff noticed that Grant was leaving Chapel Hill Supported Living Care home and asked him where he was going, he stated 'for a walk'. He later returned that day and then left again without informing staff. Grant's family and Care Co-ordinator were informed that he had again left Chapel Hill Supported Living Care home and the Manger activated a missing person's report with the Metropolitan Police due to his mental state and the potential threat to himself or others. He was returned again later by a family member after being found outside the family home. At this time, it is believed his parents had left the family address to stay elsewhere.

Concerns were raised on the 8th of June 2020 Chapel Hill Supported Living Care home to Grant's Care Co-ordinator and also by Bexley CCG to Oxleas NHS Foundation Trust in regard to how the placement of Grant was being managed, the risk around his whereabouts, potential risks to his family and the placement itself. On the same day after receiving this update concern was raised by Bexley CCG to Oxleas NHS Foundation Trust in regard to how the placement at Chapel Hill was being managed.

On the 9th of June 2020 Grant informed a family member that he was going for a walk, whilst out on the walk Grant himself phoned an ambulance as he was experiencing chest pains. His family member informed Chapel Hill Supported Living Care home that Grant had been taken to Princess Royal University Hospital. Grant was kept in overnight for observation, Chapel Hill Supported Living Care home were informed of this by a medical doctor at the hospital and that the reason for his attendance was for chest pains and possibly having taken an overdose of Methylphenidate.

Grant's Care Co-ordinator was contacted by another of Grant's family however details of Grant could not be passed due to data protection, the Care Co-ordinator also contacted the Mental Health Liaison Team at Princess Royal University Hospital and informed them that Grant was in need of a psychiatric review. (This conversation was backdated and recorded on the hospital notes on the 11th of June 2020 confirming the conversation had occurred on the 9th of June 2020).

On the 10th of June 2020 the Mental Health Liaison Team at Princess Royal University Hospital conducted an assessment on Grant. Grant claimed to have purchased medication online with a private Doctor, he denied suicidal intent, thoughts and/or plans. He was reported as displaying no aggressive behaviour and no psychotic symptoms were noted. Grant was medically cleared from the hospital and agreed to his up-coming medical review appointment on the 12th of June 2020. Grant was discharged from Princess Royal University Hospital. Grant's Care Co-ordinator was not made aware of his discharge.

On the same day, the 10th of June 2020, Grant's Care Co-ordinator sent the Mental Health Liaison Team an e mail detailing the concerns that they had for Grant, that they had been struggling with his behaviour and that although he was very intelligent and knows what to say, he did need support with his mental state and that they wanted to contribute to the assessment. On the same date the Mental Health Liaison Nurse e-mailed the Care Co-ordinator stating that Grant had been reviewed and that an urgent follow up was recommended. His discharge papers stated that after his mental health assessment they did not deem him to require hospital admission. The Intensive Case Management of Psychosis (ICMP) team manager, after contacting the Mental Health Liaison Team was advised that Grant had been discharged.

Grant returned to Chapel Hill Supported Living Care home with a family member, the Care Co-ordinator was updated and also informed that Grant had only missed one night of taking his Clozapine medication however its believed that the pharmacy who had been contacted by the Care Co-ordinator had two weeks of medication for Grant waiting to be collected.

On the 11th of June 2020 Grant's Care Co-ordinator contacted Chapel Hill Supported Living Care home and was advised that he had taken his medication, had slept overnight and had received a visit by a family member. Grant is reported to have stayed at Chapel Hill Supported Living care home all day on the 11th of June 2020 and staff spoke to him on the evening of the 11th of June about medication and reported that at no time did he express suicidal thoughts or ideations.

On the 12th of June 2020 Chapel Hill Supported Living care home staff reported that Grant was administered his morning medication but that at half past nine he called the office and asked for further medication that was not prescribed to him. He was advised that he had an appointment at 11:15am with his Consultant Psychiatrist where he could discuss it further. He is reported as being agitated but it was unknown why. On his Clozapine tests, Chapel Hill Supported Living Care home staff advised that Grant's blood count was recorded as 11 when it should be 35-60 which may have indicated that he had not been taking his prescribed medication however there were questions raised about the accuracy of this and the test was to be repeated. There is a record of the 11:15am appointment on video link however Grant never attended it. Staff at Chapel Hill. Supported Living Care home last saw Grant at 10:00am where he was reminded of his appointment an hour later. It was then noticed that he had left the care home at 10:30am. Grant's family were contacted approximately 15 minutes later as Grant often gravitated towards the family home which staff knew was now empty.

On the same day British Transport Police received a report that a person had been struck by a train at Belvedere station, officers and paramedics attended the station and at 12:21pm life

was pronounced extinct. The driver stated they saw a male person standing on the edge of the platform as they approached the station, the driver believed they would jump in front of the train, they did not have enough time to stop and as the male jumped the train fatally struck them, CCTV at the station confirmed this. Whilst officers were on scene members of the public outside of the station informed them that they believed the deceased to be their family member

Grant's family contacted Chapel Hill Supported Living Care home at 12:30pm on the same day and said that there had been an incident at Belvedere train station and that they were trying to ascertain if Grant was involved. Chapel Hill received a phone call from Grant's family member just after 3pm confirming that the incident had involved Grant.

7. Summary of safeguarding considerations that influenced this report

Following the initial concerns raised by Grant's father in 2015, it appears these were raised as a safeguarding concern but were not elevated to a statutory Safeguarding enquiry as further contact to explore and get further details of these concerns could not be completed due to Grant's father being uncontactable.

It appears in 2016 a Safeguarding referral was made but was not recorded on the Bexley Adult Social Care systems as by then Grant had been detained under s3 of the Mental Health Act and admitted to an acute mental health admission ward.

A number of Multi Agency Risk Assessment Conference (MARAC) referrals were made by Metropolitan police in 2017 which was good practice and it was noted from reports received that the police referral reports were of a high standard providing all relevant details where possible all relevant known information was shared via an approved secure system demonstrating knowledge of information sharing responsibilities, there is a pan London protocol agreement in place to support this flow of information and robust governance in place to ensure its adhered to.

The Multi Agency Risk Assessment Conferences (MARAC) instigated various offers of support to Grant's parents which included Interpreters, Black, Minority Ethnic Services (BME), Housing and Legal advice and support and Independent Domestic Violence Advocacy (IDVA) support as well as discussions in respect of considering a non-molestation order taking place. All these offers of support were declined by Grant's family and reading reports it appears there was a reluctance to take these offers of support up due to a perceived sense of shame that the family felt would be viewed within the community. There is also evidenced throughout the reports received the importance the family placed on support for Grant being obtained above the need for their own support and needs. There are limited notes to evidence if or how this was further explored by agencies to be able to understand influences the family were under as concerned parents, members of the local community and as victims themselves of Grant erratic and often violent behaviour.

From these conferences risks were clearly identified including Mental ill health, financial abuse, domestic abuse, disabilities, honour, communication, substance misuse, all of these should have been included into a safety plan however according to the reports received for this review there appears to be no evidence of this within the action plan.

Therefore, risk factors were not factored into a safety plan and information sharing not recorded and actions raised did not appear to be risk based or SMART.

After Grant's discharge from the Mental Health Unit in 2017 Grant was followed up daily for a period by the home treatment team, Dr and nurses and was then under the Greenwich ADAPT and had a full therapy program which he was attending, he was seen by a variety of professionals who were in contact with his parents. During this time further concerns were raised by Grant's family in regard to his behaviour and it was identified that the security of

Grant's parents address needed to be reviewed by the Independent Domestic Violence Advocacy (IDVA) Safeguarding Co-ordinator who advised that this referral needed to be passed through for an urgent safeguarding assessment and that a multi-agency meeting was required for Grant's parents whilst Oxleas NHS Foundation Trust continued to work with Grant. It appears from Adult Social Care direct discussions were held with Grant's parents, views respected, and independent domestic violence advisors (IDVA) were involved together with support from interpreters. There was a referral made recognising the parents as carers and recognition of cultural appreciation.

During 2017 and 2018 Grant's behaviour within the family home increased to the point at which he was arrested for the offences of threats to kill and criminal damage involving his parents at their home address. He was subsequently sent to Her Majesty's Prison at Belmarsh in August 2018, where his behaviour deteriorated, he was then transferred from HMP Belmarsh in October 2018 to Oxleas NHS Foundation Trust Psychiatric Intensive Care Unit and then subsequently in July 2019 he was transferred to Kneesworth House Hospital. Grant remained at Kneesworth House Hospital until March 2020 when he was released into supported community living at Chapel Hill Supported Care home.

It appears the Kneesworth House Hospital offered Grant the opportunity to have stability, positive social engagement, therapeutic interventions, and support.

It is acknowledged in the IMR notes from Kneesworth House Hospital that Grant's Care Co-ordinator was an important professional partner in the ongoing care and treatment for Grant as were his parents who were very supportive. It was agreed between everyone involved when discussing his release that regular contact and monitoring to assess risk and mental state, assessment of his needs and a plan to achieve this was required and a six monthly review of needs and compliance was agreed which is a standard time frame within the Care Programme Approach which was in place at this time however this does not negate other meetings and agency reviews being agreed and set as required. https://www.england.nhs.uk/wp-content/uploads/2021/07/Care-Programme-Approach-Position-Statement_FINAL_2021.pdf

Throughout Grant's time in Kneesworth House Hospital there was frequent contact and communication with Grant's parents. His care continued to be person centred. It is to be noted the high level of one-to-one support Grant received during his time here and that his risk of deterioration of his mental health was significantly reduced whilst residing in an inpatient setting, taking medication under supervision and with a degree of high-level support. The hospital offered stability, positive social engagement, therapeutic interventions, and support. In effect it appeared to be a protective arm around Grant.

From spending twenty months in secure psychiatric accommodation (and before those 3 months in HMP Belmarsh) away from family but with supervised support within 12 days of having the section lifted Grant was released into supported living back near his family, who although loved and supported him as much as they could, had their own health and safety concerns.

When in the process of being discharged from Kneesworth House Hospital there was a number of meetings held however at the discharge meeting a plan was completed but did not give full summary of Grant's complex psychiatric history nor was anyone from the community Mental health team present who would ultimately be taking over Grant's care management within the community. The Risk assessment plan, keeping well plan and keeping safe plan it appears were not updated prior to discharge and so therefore could not have been shared with his community team prior to him being discharged to enable them to consider contingencies or envisage issues that may arise whilst he adjusted to living back in the community and near family. This has already been identified by the Priory Group Designated Safeguarding Lead Nurse and will be reviewed across the Priory Group. Safe hospital

discharge must be focus for everyone involved in agreeing and managing discharge from in patient to community placements.

The Care Co-ordinator at this time in their opinion was struggling as they felt they had limited control over the decisions being made to prepare Grant for discharge back into the community. They were concerned timescales were short and it felt 'kind of rushed', perhaps because of the possibility of a pandemic and possible restrictions and concerns that it was raising within all organisations and personal lives however there is no record shared to evidence this was raised as a concern at the time. It must be reflected that pressures from the pandemic increased workloads for all including Care Co-ordinators, many were of few professions having to carry on working, not shielding and manging dwindling resources at the same time. It added a lot of pressure.

It is also noted from the time frame that Grant's Care Co-ordinator, who was not present at the discharge meeting, was notified on the Thursday of Grant's transfer to Chapel Hill Supported Living Care home on the following Monday, giving them just one working day to make or consider any further support that he or they may have required. It is noted by the reviewer that due to the often-large distances away from local areas where placements may be made, it is appreciated that it is not always possible for Care Co-ordinators to get to every discharge meeting and due to the high costs of these placements when it is felt that it is the right time to complete a discharge those considering the discharge cannot wait for everyone to be available. There is also the risk that as Grant was an informal patient at this time, he may have considered discharging himself.

Once transferred from Kneesworth House Hospital Grant appeared to do well and adapt to community living at Chapel Hill Supported Living Care home whilst his parents were away from the family home. It cannot be ignored that whilst the option was not available to him to return to the family home it influenced his behaviour to living either within a health environment or community setting in a positive way. However, when he realised the option was available for him to move back into the family home this culminated in him moving back to the family home on the 5th April 2020 as soon as he was aware his parents were there and subsequently refusing to move back to Chapel Hill Supported Living Care home until they left the family home for, it is believed, a trip abroad a few days prior to his death. It is whilst at home where his behaviour, mental ill health and relationship with his family deteriorated.

Whilst living within the family home in the two months of April and May 2020 Grant's behaviour from reports received started to become more erratic and he appeared to be displaying concerning patterns in his use of online medication and alcohol although the latter only seemed to be reported on one occasion. This pattern repeated his behaviour prior to his arrest in 2018 this like pattern was understood and identified by Oxleas NHS Foundation and is recorded in notes. Trust despite his father raising concerns. During this time Grant was able to gain a diagnosis and order prescription drugs online without being referred back to his registered GP or contact being made with the registered GP prior to any diagnosis or decisions being made, he was being assisted in this by his father of which its acknowledged that Oxleas NHS Foundation Trust were not aware.

The discharge summary for Grant's time in A&E on the 7th of June was not forwarded onto his GP and so they had no record of the outcome or result of the MH assessment/referral. It is the Mental Health Liaison Team policy to contact the Mental Health team and they only provide information to the GP if it is a new patient attending the A&E department. There is no record of any liaison with Grant's MHT within the GP IMR. The lack of discharge summary has already been identified by the IMR author and they will in future seek response when no discharge summary is received in a timely manner from secondary care and will notify the board on receipt of the summary.

It must also be noted that throughout this period, whilst face to face contact was difficult Grant's Care Co-ordinator stated that there was regular contact between them as there also was

between the Care Co-ordinator and Grant's father. Grant was repeatedly requested to return to Chapel Hill Supported Living care home by his Care Co-ordinator explaining it was the best, safest and most supportive place for him.

Over a short period of time between May and 12th June there were a number of concerns raised in respect of Grant by Chapel Hill Supported Living Care home staff, Grant's family, Bexley CCG, Oxleas NHS Foundation Trust Mental Health Team in A&E and Grant's Care Co-ordinator and a number of meetings were held to discuss these concerns. Over this period from reports it was the view that encouraging Grant to return to Chapel Hill Supported Living care home of his own accord was in the best interests of his wellbeing, the least restrictive option and of course should always be considered as the ideal.

There also seems to have been uncertainty between organisations of the powers each had to influence and encourage of force Grant to return to a health environment whether it was a hospital or supported living. This its sensed through reports outlining increased frustrations and personal feelings of a lack of support by others trying to make Grant safe. Grant's parents were advised to call police by Oxleas NHS Foundation Trust when they wanted him to return to Chapel Hill Supported Living Care home if he became aggressive or violent and in the report from Oxleas NHS Foundation trust it is described as 'police inability' to help in the absence of a court injunction as the police presence was for aggression and violence and criminal incidents rather than his mental health. There may therefore have been confusion at this time as to what the role of police attendance was, understanding of aggression and violence levels and what legally the police were able to do.

When Grant returned to Chapel Hill Supported Living care home on the 8th June 2020 staff reported it was the first they has seen of him for two months Both Grant's parents and Car Co-ordinator reported Grant as being lonely between April and May 2020 and this may well have influenced his desire to remain with family and his not wanting to remain in an environment that maybe he didn't perceive as home and his relationship with staff at Chapel Hill Supported Living Care home who he had not yet built that rapport or trust with although he had allocated a Psychiatrist, Care Co-ordinator and access to support staff.

Throughout the period between March 2020 and June 2020, Grant had regularly attended appointments to monitor his physical health and his blood taken for the regular monitoring required for patients taking Clozapine. Blood tests are RAG rated and are required to be Green i.e., the blood count is within normal range before further Clozapine can be prescribed. These had all been positive and Green for Grant. A separate test is required to see Clozapine plasma concentration levels which may be an indicator of compliance with taking the medication however the time of last dose, when the test was taken, and metabolism rates can affect this.

There had been a test for this on the 26th of May 2020 which staff reported in the meeting on the 12th of June 2020 that his blood count was recorded as 11 when it should be 35-60. It was agreed that the Clozapine plasma level test was to be repeated as there was a question about when the last dose was administered, and the test taken therefore may not be accurate to state that Grant hadn't been tasking the Clozapine as prescribed.

It is noted that Rebound psychosis with rapid increase of symptoms of psychosis may occur on abrupt clozapine with drawl especially after long term treatment, Grant had been prescribed it for 18months.
https://www.cambridge.org/core/journals/the-psychiatrist/article/rebound-psychosis-following-withdrawal-of-clozapine/6F73238F7D7902764FDD847BA19DA727

It is obvious and clear there were additional pressures placed on all organisations and staff members from March 2020 onwards. The Covid-19 pandemic bought about additional pressures, Oxleas NHS Foundation Trust noted there were resourcing concerns which effected how staff worked with patients especially around their face-to-face work and there

must have been concerns from Grant and his family although Grant was seen face to face throughout this time due to his medication. Its clear tried and tested working practices had to be adapted and changed without warning and personal concerns and wariness for own welfare and safety were experienced by everyone. This ultimately had a huge personal impact on everyone including Grant and his family and influenced and was used at times to explain actions taken, such as Grant not wanting to return to Chapel Hill Supported Living Care home due to Covid restrictions and communications between professionals getting confused.

Whilst there were reports from early on of Grant and self-harm and suicidal thoughts, in the immediate days prior to Grant's death no suicidal intent was noted of Grant by Chapel Hill Supported Living Care home staff, the report states that if this had of been the case, they would have instigated a procedure to arrange a Mental Health Assessment and alert his Care Co-ordinator. In fact, on a number of occasions when asked by professionals if he was suicidal, prompted by comments he made to family, he reported back that he wasn't. In respect of this it must be noted that suicide and risk of suicide is very difficult to predict even for the most experienced and educated of people. There are reports of suicidal ideation in 2003, 2016 and then mention of it and Grant's comments to his family on the 3rd of June and again on the 7th June 2020 yet when asked directly he denied any suicidal thoughts.

Even for highly trained and experienced mental health professionals, the use of clinical risk assessment tools to 'predict' future suicide risk is not recommended by the National Institute of Health and Care Excellence (NICE). The accurate prediction of suicidal behaviours to try and identify those most at risk is notoriously difficult, if not impossible, and will not be achieved by the utilisation of simple 'tick box' risk assessments. Suicidal behaviour can be carefully planned out and people may go to great lengths to take care to hide what they are planning from others, but it can also be impulsive behaviour. Having easy and convenient access to potential lethal means of suicide that is perceived to be effective, instant and/or painless can increase the risk of dying by suicide. The likelihood of a suspected suicide occurring utilising lethal means that requires very little pre planning or preparation may also be increased when an individual's judgement is adversely affected by drug or alcohol use. In the hours prior to Grant's death blood tests indicated he had not been taking his medication as prescribed.

8. Conclusion/Recommendations

It is noted from a number of reports that many organisations involved in this review have already indicated their own internal learning which includes

- Refresher risk assessment training and management skills for individuals presenting with risk behaviours to themselves and others,
- Care planning and reviewing of Crisis and Contingency plans,
- Review of staffing in teams where there are large amounts of team sickness
- Record keeping and completion of discharge papers and plans
- Reminders to partners for discharge summaries to be received in a timely manner and notification to the Safeguarding Board

1. In a situation where one or more professionals raises concerns about deteriorating mental health and increasing care needs of them or others, these should be proactively followed up as soon as possible. In this situation a multi-disciplinary team meeting should be held in a timely way with key partners. Immediate safeguarding actions/powers should be considered and recorded. Timelines and target action dates should be identified, and options/contingencies considered when these are not achieved identified when the actions are set.

2. Record keeping and access to reports, throughout this review one recurring concern kept appearing, as in many reviews, which was the accurate and timely record keeping. Whilst assured many conversations and considerations would have taken place and been recorded, access to these were limited. As part of each organisation's regular reviews and inspections,

record keeping and access to records (in line with relevant disclosure/relevant organisational management of information rules) should form a key area of focus and be consistently reviewed.

3. It is acknowledged that timeliness of decisions and actions in ensuring placements and release from health establishments happen as swiftly as possible in order to ensure future availability as well as inappropriate further detention are important however accessing information, intelligence and records that may influence this decision making should not be underestimated and considered any less important than the need to release someone from section or discharge them from a health care environment. The need to consider delaying decisions to enable full understanding of risk and ensure all relevant parties are available to partake in discussions should always be a priority to ensuring the onwards safety of any person where legally possible.

4. If safeguarding concerns are raised during hospital admission or whilst in hospital, enquiries should be progressed in a timely way and not deferred until the discharge planning process. Whilst the process relating to discharge of patients with complex needs and meeting the criteria for Continuing Health Care has changed since 2018, it is important to ensure that all relevant partners involved in the on-going care are present or a part of the discussions before final decisions are made. Once the final decision is agreed there should be time to ensure the agreements in place are suitable and enable contingencies or safety measures for both patient and staff to be considered and implemented. No discharge should occur without all relevant safety planning and documentation being completed and shared appropriately with organisations responsible for on-going care and whilst there are guideline on standard timeframes of reviews this should not influence any party to not be able to consider and suggest smaller or tighter timeframes rather than standard time frames. https://www.england.nhs.uk/wp-content/uploads/2021/07/Care-Programme-Approach-Position-Statement_FINAL_2021.pdf

5. All agencies should ensure greater awareness amongst front line staff and managers on understanding impact of cultural, community and parent/child/adult-child relationships. Identifying pathways and key partners experience in understanding, mitigating, and managing these difficult situations will help staff and members of the community understand limitations, identify appropriate support available and understand that no one person, family or organisation can operate or work alone. Personal responsibility or the perception of and individuals' responsibility especially in parent/adult child relationships can be very complex.

6. The death of anyone in any way but especially through suspected suicide can have a devastating impact on all involved in their care, whether personally, face to face or through reviews and reports. It cannot be underestimated the short- or long-term effects it can have on anyone. All organisations should ensure they have in place appropriate well-being support, staff support and bereavement support for their staff. That staff are able to access this in a timely way and in a manner that suits them. This support should be available at any time within any timeframe. By being involved in health, social care, crisis support and response, staff members are ultimately more exposed than many other professions of the accumulation of such impactive incidents and this should also be acknowledged and recognised with well-being and occupational strategies and pathways.

7. When various organisations all work together there will be levels of expectation on each to respond, manage and implement policies, procedures and pathways. Having an understanding of what each organisation has available to them to keep someone in crisis or suffering declining mental ill health or capacity is critical to maintaining professional and supportive partnerships. It is also imperative when passing information on to others and informing safety plans that the right advice and pathways are identified. Joint multi agency training and exchanging of polices and protocols should be considered to enhance each organisations knowledge. A good example of joint agency training can be seen in the Northeast of England -

https://www.cntw.nhs.uk/resource-library/respond-multi-agency-mental-health-simulation-training/

8. The ability for a patient who is currently under the care of a Mental Health Team and registered with a GP who is aware of their Mental Health diagnosis and support, to be able to arrange and facilitate a private consultation and obtain diagnosis and medication on-line without consultation with either the allocated NHS Consultant Psychiatrist or his GP being informed is concerning. This together with the incorrect information that was passed by the patient to the private professional and the lack of knowledge the private professional had of the previous history of obtaining medication, drugs and overuse of prescribed drugs by the patient prior to the consultation and his detention under the Mental Health Act should be escalated higher within professional bodies who can influence change.

Appendices

- **Appendix A Events up to and including 2018**
- **Appendix B Clozapine**
- **Appendix C Mental Health Act Sections**

Appendix A - Events up to and including 2018:

Grant developed depression approximately 20 years before his death, he managed this over the years with medication. Grant's previous mental health inpatient admissions were in 2003 when he was admitted due to suicidal ideation, diagnosed anxiety and depression, 2004 due to obsessional thoughts and ruminations, 2015 for alcohol detoxification, 2016 for drug induced psychosis, ADHD, and Emotionally Unstable Personality Disorder.

In 2015 Grant's father attended the Civic offices, Bexley to raise concerns for his son, Grant, who was currently residing at the family home. He stated Grant was suffering depression and didn't know how to deal with it, that he was not attending GP appointments and had suffered two seizures in the past six months which had resulted in hospital admissions, apparently this was as a result of taking excess prescribed medication. Grant had also been stopped for drink driving by the Metropolitan police.

Grant's father stated that Grant was verbally abusive to both himself and his wife, Grant's mother, he would smash things within the family home and ask them for money. Grant's father stated both he and his wife were scared of Grant, but that Grant had never been physically abusive to them but had come close. Grant's father stated that he didn't know who to turn to for support but that both he and his wife needed some help as they were scared and very tired. His father requested that Grant not be made aware of his request for help as he was scared that he, Grant, may kill him. He asked for contact to be made via his mobile phone in case Grant answered the family home phone.

Contact with Grant's father following his attendance above was made several times by Adult Social Care, Bexley however no call was ever responded to and so a safeguarding enquiry could not be progressed.

From records Grant first presented to A&E in September 2015 possibly but not confirmed following an overdose but he left without being seen, he attended again in October 2015 and was subsequently taken on by Mental Health Services in December 2015 under the Bexley Home Treatment Team and then the ADAPT team. He was moved to the Greenwich ADAPT team as he was under the care of a Greenwich GP and continued to be seen by them until August 2016 when he was detained by police under s136 Mental Health Act and then placed on a s2 at Oxleas NHS foundation Trust inpatient unit between 24th August 2016 and 26th September 2016 following him being taken off the section on the 20th September 2016, he then became an informal patient and was then discharged back into the care of his parents.

In September 2016, three days after being discharged Grant presented to Queen Elizabeth Hospital in Southeast London feeling anxious and with suicidal ideation. He had attempted to cut his wrists with a knife. He was initially admitted to a psychiatric hospital informally. On the 12th of October 2016 he was placed on a s5(2) and then was detained under s2 of the Mental Health Act and then a s3. During this admission he was diagnosed with drug induced psychosis and personality disorder which included delusions, hallucinations and confused thinking He was prescribed medication and received Electroconvulsive treatment. It is also documented at this time that there were concerns about his using illicit substances as it is reported that Grant had a history of misuse of both legal and illegal substances and prescription medicine, and it was confirmed that his stimulant abuse was causing the paranoia

and psychosis. There is also evidence of excessive alcohol use. The date of his admissions above were from the 29th of June 2016 to the 11th August 2017.

In early 2017 Grant came to notice of Metropolitan police on three occasions, one as a victim of assault within the Mental Health (MH) unit where he had resided (a period of 12 months over 2016 and 2017 under s3 MHA). Then again, the following month after a verbal argument between Grant and his girlfriend and a few months later when a quantity of unspecified tablets had been found hidden in Grant's room when resident on the ward in the MH unit.

In May 2017 he was moved from the Greenwich Mental Health team to a Bexley Mental Health Team and a new medical team assessed him and changed his diagnosis from psychosis to Emotional Unstable Personality Disorder and stimulant abuse. The notes show that the plan for him was not to return home on the mental health teams' advice however its reported that his parents wanted to give him a chance and Grant was discharged back into the community to his parents.

Following Grant's discharge , he was followed up daily for a period by the home treatment team and was then ADAPT Greenwich with a full therapy programme in place which it reported he was attending. He was seen by a variety of professionals, Dr's, Nurses, psychologist, and social workers where were all apparently in contact with his parents.

Approximately six weeks after release from the MH unit police were called to the family home address where Grant was residing. It's believed his parents had been struggling with his current presentations, he was reported to be self-medicating and taking additional prescribed medication and was becoming aggressive with his father when he was denied more medication than prescribed.

It was reported at this time, possibly by Grant to that he was supported by a community mental health nurse however was still yet to meet them following his discharge from the MH unit, Grant appeared agitated when police spoke to him. The police also noted that Grant's father was elderly and physically impaired, his mother was suffering from cancer and that they had limited awareness of Grant's illness or strategies to cope with him.

Safeguarding reports were raised by the Metropolitan police officers (known as MERLIN's after the database they are held on) and a referral was made into the Complex Care Team (the case was referred to the Multi Agency Risk Assessment Conference (MARAC) on three occasions by the Metropolitan police during 2017/2018). A home visit was carried out by Adult Social Care, Bexley in Oct 2017 and the Mental Health Team and Independent Domestic Violence Advocates (IDVA) liaised with. The investigation recommended carers support and counselling for Grant's parents and a safeguarding concern was raised for Grant's mother however this investigation then ceased at her request in 2018, the assessment was assessed as of high risk of harm however Grant's father was repeatedly seen to be forgiving of Grant's behaviour towards him and his wife and he often reiterated that he wanted Grant to return to the family home. From the Multi Agency Risk Assessment Conference (MARAC) meeting there were services offered to Grant's parents including Black, Asian and Minority ethnic (BME) services, housing advice and legal services, all were declined by Grant's parents.

A non-molestation order was also discussed with Grant's parents but declined by both parents and again Grant's father was clear in the options given that he wanted Grant to remain in the family home. Special measures were placed on the on the property, the family home, in order to prioritise a 999 call should one be made. The main influence, from reading through various documents, that provided a barrier to the parents asking, accepting, and receiving support was due to the perceived shame they believed this would bring on the family within the community.

During this period of time Grant was also offered and took up substance misuse services and was engaging with the Oxleas NHS Foundation Trust mental health team.

In late Oct 2017 police were again called to the family home by Grant's parents as they were concerned for Grant as he had become agitated, asking for more medication, and trying to

access knives in the kitchen to self-harm with. The parents called their social worker who in turn called the police.

In July 2018 notes from Oxleas report that a family member had contacted them concerned that Grant's father had been buying prescription drugs for Grant costing £900 since the end of 2017 which they couldn't afford and saying that Grant's parents were scared of him. A professionals meeting was held, and a safeguarding alert was raised for the parents with the current GP being made aware. At the beginning of August 2018, a further professionals meeting was held, Grant's parents were currently away out of the country at this time.

On the 4th of August 2018 upon Grant's parents return home from overseas, Grant was arrested at the home address and then remanded in custody to Her Majesty's Prison (HMP) Belmarsh after pleading guilty to two counts of threats to kill and criminal damage. The incident involved his parents at their home address, Grant is reported to have had an altercation with his father with Grant chasing his father with a knife and threatening to burn down the house.

Appendix B - Clozapine

High risk medicines: clozapine | Care Quality Commission (cqc.org.uk)

Clozapine is an antipsychotic medicine used to treat schizophrenia. It can cause serious side effects.

It is used when:

- at least two other treatments have not worked or
- where a person is unable to take other antipsychotics because of their side effects.

Prescribing - Consultant psychiatrists prescribe clozapine in secondary care. People might start to take clozapine as a hospital inpatient or with support from a community mental health team. Before starting to prescribe clozapine, the prescriber will complete a physical health check.

People remain under the care of mental health services while they are on clozapine. GPs should make sure people have an annual health check. People are registered with the clozapine patient monitoring service (CPMS). They will be given a patient registration number and an information pack. The pack should be used to support discussions with the person about safe use of clozapine. People should only be prescribed one brand of clozapine. They will be registered with the monitoring service of that brand.

Monitoring - People must give informed consent for regular blood testing before prescribing is started. People usually will have a blood test at least every four weeks. This could be more frequent when clozapine is started or if their blood level is not stable.

The blood test is used to check the persons' white blood cell count. The results are reported by the CPMS in three categories:

- category one: continue treatment
- category two: continue treatment with caution and more frequent blood tests
- category three: stop treatment with clozapine immediately

People will receive a supply of clozapine if the blood test shows that treatment can continue. Clozapine will be supplied from a clinic or pharmacy registered with the CPMS. This may not

be your usual pharmacy. The amount of clozapine supplied will be enough for the time period between blood tests.

Side effects

There are many common side effects which can be found on the Patient Information Leaflet (PIL). Staff should check regularly for side effects.

There are some serious side effects that care staff must be aware of. These include:

- Blood disorders
- Signs of problems include flu-like symptoms such as sore throat and temperature
- Seizures
- Heart disease
- Signs of a problem include chest pain, palpitations, or a rapid pulse
- Diabetes
- As many as a third of people taking clozapine may develop diabetes after 5 years of treatment, the majority of these within the first 6 months
- Bowel obstruction
- Clozapine can cause slowing of bowel movement resulting in constipation, blockage and a 'paralytic ileus' which may be fatal
- Staff should make sure people are not constipated. A laxative could be prescribed, if needed.
- Skin reactions
- People taking antipsychotics may be more sensitive to sunlight. You should consider how to protect people's skin from direct sunlight.

Considerations for providers and staff

- Check if a person you are caring for is prescribed clozapine
- Clozapine is prescribed by a hospital prescriber
- It does not always appear on the GP summary care record.
- Has the person had a physical health check?
- If the person consents, are you aware of any issues raised from health checks?
- Is there any further action?
- Where appropriate, record the person's smoking status and caffeine intake
- Smoking and caffeine can both cause changes of levels of clozapine in the blood
- Stopping smoking or increasing caffeine intake both cause an increase level of clozapine in the blood
- The dose of clozapine may need to be changed if there is a change in smoking or caffeine drinking habit
- Do you or the person know to seek advice if their smoking status or caffeine intake changes?
- Put support in place for people to have regular blood tests
- Making and attending appointments
- Receiving and acting on results
- People's prescriptions and medicines must be available when needed
- It is important that clozapine is taken as prescribed - it can be dangerous to miss doses and then restart at the full dose
- Seek advice if more than one dose is missed - treatment may need to be restarted at a lower dose and closer monitoring may be needed.
- Know how to identify possible side-effects, both troublesome and potentially serious
- Know who to contact for advice and support
- Know which CPMS the person is registered with
- Care plans should include possible serious side effects that need immediate medical attention.

Last updated 2020 High risk medicines: clozapine | Care Quality Commission (cqc.org.uk)

Appendix C - Mental Health Act Sections

Below are some commonly used MHA sections. Please also refer to the below links for more detailed explanations -
https://www.legislation.gov.uk/ukpga/1983/20/contents

https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983/www.nhs.uk/mental-health/social-care-and-your-rights/mental-health-and-the-law/mental-health-act/

Section 2; the power to detain someone for up to 28 days for assessment and treatment (by an AMHP and Dr). It cannot be renewed
Section 3; the power to detain someone for treatment of a mental disorder for up to 6 months (by an AMHP and a Dr) It can be renewed
Section 5(2) is a holding power for Dr's (72hrs) & **section 5(4)** gives nurses a holding power (6hrs) in hospital for an inpatient (patients already admitted, not waiting in A&E's/ED's) to allow them to receive an assessment in order to determine if further detention under the Mental Health Act is necessary.
Section 17; the right of hospitals to grant leave as part of rehabilitation and recovery, time frames can vary depending upon the patient and their treatment plan
Section 17A; the right of a hospital to release a patient from detention to supervised community treatment subject to a Community Treatment Order (CTO)
Sections 35 and 36; the power to remand an 'accused' person to hospital for assessment and/or treatment
Section 37; the power of a Crown Court to impose a hospital order upon a person convicted /found responsible for an offence following a successful defence of insanity or after conviction for manslaughter on the grounds of diminished responsibility. The order lasts until a responsible clinician believes it needs to be discharged
Section 38; an interim hospital order for the above to undertake an assessment/treatment to ascertain whether a full hospital order is required
Section 47; known as a transfer direction, this authorises the movement of a convicted prisoner to a hospital if they develop a need for mental health treatment whilst serving their sentence, they are then under s47 (3); treated as if sentenced to a s37 hospital order by court (sometimes referred to as a notional s37)
Section 48; the same as s47 but for remand and other detainees such as immigration detainees
Section 49; is a restricted transfer direction which imposes restrictions upon leave, discharge or transfer without the Ministry of Justice permission, sometimes known as a 47/49 order
Section 50; is a remission direction to remove a s47 patient back to prison if their detention in hospital for mental health treatment is no longer required but their sentence is not yet fully served
Section 117; this is a legal duty placed on health and social services to provide aftercare services for individuals who have been detained under s3,s37,s47, s48 and s45a. The duty comes into effect once the person has been discharged from hospital.
Section 135; are warrants under the act for assessments (1) on private premises (applied for by an AMHP and may include a power of entry for police where it is necessary) and recovering patients (2) who are absent without leave
Section 135 (6); legal definition of a Place of Safety
Section 136; police power of detention of someone in immediate need of care and control and remove them or keep them at a place of safety, this power lasts 24hrs and is available for police officers only in a public or private place but not in a home address
Section 137; the authority to regard someone subject to an admission as being in legal custody