LONDON BOROUGH OF BEXLEY SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW
Jonah

JUNE 2023

Contents

SAFEGUARDING ADULT REVIEW – JONAH

1. INTRODUCTION

1.1 Jonah died in in 2021, aged 35 years old, following suicide by hanging.

1.2 Jonah was a fibreglass laminator and had worked in Malta and in the Czech Republic. Jonah enjoyed fishing and motorbikes and was brought up as a Christian within the Church of England. Jonah's father described him as very tidy and orderly and a kindly soul who was always looking out for other people. Jonah's parents divorced when he was 25 years old, and he lived first with his father and then with his mother.

1.3 The information provided by agencies identified that Jonah was likely to have been conflicted about his sexuality. Jonah's use of alcohol and illicit drugs (crystal methamphetamine and cocaine) appears to have caused or exacerbated his mental health needs including intrusive and oppressive thoughts. Jonah may also have used substances as a form of "self-medication" to manage these phenomena. Jonah had attempted suicide on at least one occasion before his death and Jonah came into intermittent contact with physical and mental health services, and the police. Jonah's distress increased in August 2021 due to an exacerbation of negative and condemnatory thoughts, he also notified his mother of how he might kill himself. Jonah's risk to himself was, however, considered by professionals to be low. Jonah was diagnosed with psychosis in August 2021 and prescribed anti-psychotic medication. On the 4th September 2021 Jonah sadly died by suicide

1.4 Jonah's father contributed the following statement to be included in the review:

1.5 "It is unclear if Jonah started taking illicit drugs due to conflicting thoughts about his sexuality. What is clear, form my observations as his father, is that before Jonah started taking methamphetamines, he was a well-balanced individual; he was rational and peaceful in himself.

1.6 Jonah was in a heterosexual relationship with his long-term girlfriend from 2009-2014. The relationship began to breakdown from 2012 and finally came to an end in 2014. Since the relationship ended Jonah's mental health deteriorated due to the misuse of crystal-meths which caused psychotic episodes, paranoia and confused thinking. For example, Jonah believed that his mind had been hacked like a computer. He was tormented with troubling voices, thoughts and suggestions of action contrary to his personality. Fearing these voices would make him do something bad or damaging, Jonah took his own life".

2. SAFEGUARDING ADULT REVIEWS

2.1 Section 44 of the Care Act 2014 places a statutory requirement on the Bexley Safeguarding Adults Board (BSAB) to commission and learn from SARs (Safeguarding Adult Reviews) in specific circumstances, as laid out below, and confers on Bexley Safeguarding Adults Board the power to commission a SAR into any other case:

'A review of a case 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 –

a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

b) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or

c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAB may also –

Arrange for there to be a review of any other case 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).

…Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –
a) identifying the lessons to be learnt from the adult's case, and
b) applying those lessons to future cases.

2.2 The purpose and underpinning principles of this SAR are set out in section 2.9 of the London Multi-Agency Safeguarding Adults Policy and Procedures: http://londonadass.org.uk/wp-content/uploads/2019/05/2019.04.23-Review-of-the-Multi-Agency-Adult-Safeguarding-policy-and-procedures-final-.pdf

2.3 SARs are about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR took a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

2.4 This case was referred to the BSAB on 5th January 2022 by ASC following receipt of a subject access request by Jonah's parents. In responding to this request, ASC identified that criteria for a SAR may have been met.

2.5 The BSAB's Safeguarding Adults Review subgroup confirmed on 12th January 2022 that the criteria under s44 of the Care Act had been met and that circumstances leading to Jonah's death should be reviewed. Since Jonah had contact with services in Kent, the SAR was conducted jointly with the Kent and Medway Safeguarding Adults Board but led by BSAB.

2.6 All BSAB members and organisations involved in this SAR, and all SAR subgroup panel members, agreed to work to these aims and underpinning principles. The following team and organisations contributed to the SAR:

2.7 Kent and Medway NHS and Social Care Partnership Trust (KMPT)

2.8 London Ambulance Service

2.9 Medway NHS Trust - Medway Hospital

2.10 Dartford Gravesham NHS Trust

2.11 MCH Pentagon – (Medway GP) between 04/08/2016 – 09/05/2019

2.12 The Oaks - (Kent GP) between 09/05/2019 – 04/09/2021;

2.13 Swanley GP at time of Jonah's death.

2.14 Kent Police

2.15 Essex Police

2.16 Metropolitan Police Service

2.17 Bexley Adult Social Care

2.18 Oxleas NHS Foundation Trust

2.19 South London and Maudsley NHS Foundation Trust (SLAM)

2.20 Lewisham and Greenwich NHS Trust (LGT)

2.21 A SAR panel was formed of representatives from these organisations and teams and agreed terms of reference to guide the review (see Appendix 1)

2.22 Contact with family

2.23 The BSAB Practice Review & Learning Manager and the Safeguarding Adults Review author met with Jonah's father who provided information which has been incorporated in this review. The BSAB wrote to Jonah's mother at two different addresses known by agencies using recorded post. The letters were returned since Jonah's mother was no longer living at either address. Jonah's father was asked to share the invitation to meet and participate in the SAR process with Jonah's mother.

3 BRIEF SUMMARY OF CHRONLOGY AND CONCERNS

3.1 Jonah was 35 years old when died by suicide in 2021.

3.2 Jonah was a fibreglass laminator and had built underground fuel storage containers in Malta and carbon fibre seats in high-end sports cars in the Czech Republic. He enjoyed fishing and motorbikes and was brought up as a Christian within the Church of England. Jonah's father described him as very tidy and orderly and as a kindly soul who was always looking out for other people. Jonah's parents divorced when he was 25 years old, and he lived first with his father in Bexley and then with his mother in Kent. Jonah then bought and moved to his own house in Bexley. Jonah had a brother who lived in Essex and with whom he stayed on at least one occasion during the period covered by this safeguarding adult review.

3.3 in 2014, Jonah started to drink alcohol to excess and, according to his father, "fell in with the wrong crowd" and began to use the highly addictive crystal methamphetamine and cocaine. Jonah attempted suicide in 2016.

3.4 Jonah came into contact with mental health services in 2016 following a referral by his GP. In June 2016, Jonah was diagnosed with drug induced psychosis and was open to the Early Intervention for Psychosis service until July 2018. In September 2016 Jonah was arrested for a breach of the peace in Kent. This was considered to be psychosis-related, and support was provided by custody nurses. Jonah agreed to try Cognitive Behaviour Therapy in January 2017 and in February 2017 Jonah said that he was using crystal methamphetamine which had resulted in a "bad trip". Jonah was below the threshold for eligibility for Cognitive Behavioural Therapy but was advised that he could be re-referred if he thought that it would be useful. No alternative therapeutic interventions were offered and there is no record of a referral to substance use services.

3.5 Jonah attended Medway Hospital on 8th February 2018 with a minor physical health problem but left before being discharged. In June and July 2018, a KMPT (Kent and Medway NHS and Social Care Partnership Trust) Community Psychiatric Nurse attempted two visits to Jonah at his mother's house, where he was understood to be living, since he had not attended appointments. Jonah's mother told KMPT that Jonah was working in Malta, where he planned to stay for a few years. KMPT requested that Jonah be asked to contact them and were told by Jonah's mother that Jonah was doing well.

3.6 Jonah soon returned to the UK and on 11th September 2018, and his father reported him as a missing person to Kent Police when Jonah did not arrive to spend the day with him as planned. Jonah had, however, been taken to Darent Valley Hospital by ambulance with physical pain but did not stay for treatment. Due to the circumstances and type of physical pain that Jonah reported, exploration of consent, sexual health and exploitation could have been appropriate.

3.7 On 12th September 2018, Jonah was again brought by ambulance to Darent Valley Hospital, he reported that he had taken Acid (the drug, rather than the low pH fluid), was hearing voices and had delusional thoughts. Jonah said that he had taken crystal methamphetamine two days previously, which had triggered this. Jonah's father was notified, and Jonah was admitted to hospital under section 2 of the Mental Health Act 1983 for a week. Jonah was concerned that he might lose his job in Malta, therefore he was supported by KMPT to manage his mental health needs in the community and was discharged to live with his father, who supported him to return to Malta to live with his girlfriend. KMPT made two follow up contacts with Jonah's mother in October and December 2018 and were told that Jonah was doing well in Malta. in October 2018 KMPT also attempted to contact Jonah directly but received no response.

3.8 KMPT contacted Jonah's mother again in March 2019 to establish how Jonah was coping and were told that he was doing well. Jonah had returned to the UK in December 2018, during which time his parents said that they had kept 'an eye on him'. Jonah was reported to have a new girlfriend and was back in Malta where he wanted to put the episode behind him and to have no further contact with mental health services. Details of how to contact mental health services if necessary were left for Jonah with his mother and KMPT closed Jonah's case.

3.9 In May 2019, Jonah was back in the UK. He attended his GP for a physical ailment in November 2019 and then Queen Elizabeth Hospital in November 2019 for surgery for a suspected abscess. Jonah did not attend post-operative appointments which had been set for May 2020. No attempts to follow-up Jonah for his non-attendance are recorded.

3.10 There was no recorded further contact with Jonah until 20th October 2020 when Jonah attended his GP surgery. Jonah felt weak and requested an HIV test after unprotected sex with a man. Jonah feared that he had a sexually transmitted infection and was very anxious. Jonah also attended A&E with the same concerns that day. Jonah's GP sent Jonah a text message asking him to book a further consultation, but Jonah did not do this.

3.11 On 10th November 2020, Jonah reported to Essex Police that he had been the victim of an assault by his brother at his brother's home**.** Jonah did not want any further police action.

3.12 On 27th November 2020, Jonah contacted Kent Police stating he had taken crystal methamphetamine and was confused. On attendance the police noted that Jonah presented as highly confused, paranoid and disorientated. He initially requested help but whilst waiting for an ambulance to arrive ran off into the busy flowing traffic. Kent Police Officers were able to detain Jonah for his own safety under s136 of the Mental Health Act 1983 (see Appendix 2) and he was taken to the Queen Elizabeth the Queen Mother Hospital. Jonah was experiencing a psychotic episode due to taking crystal methamphetamine and had suspected organ failure.

3.13 When seen by a consultant psychiatrist, no thought disorder or psychosis was observed, and Jonah explained that he had no reason to take crystal methamphetamine. Jonah's brother was notified that Jonah had attended hospital (despite the recent assault) and Jonah was discharged again to his GP. This was an opportunity to have referred Jonah for follow up by the Community Mental Health Team in Kent and to have notified his GP. There are no records that these opportunities were taken.

3.14 On 1st February 2021, Jonah's GP received a report from Basildon University Hospital Accident and Emergency Department that Jonah had presented there with similar symptoms to those he had reported in October 2020: weakness, requesting an HIV test, after unprotected sex with a man three days previously. There was concern that Jonah had mental health needs and he was seen by the Basildon Crisis Resolution Home Treatment (CRHT). Jonah was noted to have a suspected bipolar disorder and was sent home with Crisis Team follow up.

3.15 On 5th May 2021, Jonah contacted South London and Maudsley NHS Trust (SLAM, which provides drug and alcohol services in Bexley) for help with crystal methamphetamine use.

3.16 On 4th June 2021, Jonah was reported by the Metropolitan Police in Bexley to have deliberately crashed his car into a lamppost and to have smashed up his flat since his girlfriend had ended their relationship.

3.17 This incident was reported to the Multi-Agency Safeguarding Hub at Bexley Adult Social Care, which BRAG (from highest to lowest concern: Blue/ Red/ Amber/ Green) rated it as Green. The police officers in attendance were initially concerned that the crash may have been a suicide attempt and called for an ambulance. The attending police officers, however, then concluded that the crash had not been a suicide attempt and cancelled the ambulance before it arrived.

3.18 The Metropolitan Police completed a Merlin report (the name of the Metropolitan Police computer system for Adult Come to Notice reports, which are completed when police officers are concerned about the welfare of an adult they encounter) but Jonah's date of birth was not included. As a result, Jonah could not be located on the Oxleas Rio electronic health records system (Rio is the name of the health records computer system used widely by NHS mental health services). Oxleas notified ASC in the MASH of this, which attempted to obtain Jonah's date of birth from the Metropolitan Police, who did not have it. On 8th June 2021 a letter was sent by the Bexley Primary Care Plus referral screeners to Jonah, who was living in his own home, asking him to make contact with them.

3.19 On 18th June 2021, Jonah was telephoned by his GP for a psychosis review. The GP noted that Jonah was drinking alcohol, was in a low mood but had no current suicidal intent and had agreed to a referral for dual diagnosis (mental health and substance use) support. Jonah was signposted to the KMPT Single

Point of Access for mental health support for the IAPT (Increasing Access to Psychological Therapies) service.

3.20 On 21st June 2021, Jonah's father telephoned Jonah's GP to say that he was very worried about Jonah and gave an account of Jonah's history including crystal methamphetamine use leading to psychotic breakdowns. Jonah was hearing voices and his father had seen a noose on the floor at Jonah's home the previous day. There is no record of any advice given by the GP to Jonah's father, but the GP notified KMPT and requested assessments by the CMHT (Community Mental Health Team) and CGL (Change, Grow Live substance use service, which did not have Jonah on its records) noting that Jonah had suicidal ideas but no plans. There is no record that the presence of the noose was communicated to KMPT.

3.21 On 28th June 2021 the Primary Care Plus team closed Jonah's case following no response to its letter of 8th June 2021. No account for Jonah could be set up on the Oxleas Rio electronic health records system since his date of birth had not been provided in the Merlin of 4th June 2021.

3.22 On 13th July 2021, the KMPT CMHT conducted an initial telephone assessment with Jonah following the GP's referral on 21st June 2021. Jonah was noted to have had paranoid thoughts but had a good relationship with his parents and brother (it appears that KMPT was not aware of the assault in November 2020). Jonah last reported the use of crystal methamphetamine a year previously and now drank four to eight cans of beer daily. Jonah agreed to contact CGL services for support with alcohol use. Jonah was not able to work due to his low mood, was not currently taking medication but was open to restarting it. According to the CMHT Jonah sounded calm, was coherent with good rapport and denied any suicidal ideation and risk to himself or others. Jonah reported that he was low on energy but was eating well. He was aware of the effects of alcohol on his mental health, was given a crisis telephone number and was encouraged to contact CGL. Jonah was placed on active review (see appendix 2), awaiting a medical review.

3.23 On 30th July 2021, Jonah's father emailed the GP asking them to visit Jonah since he was 'worried for his (Jonah's) life'. Jonah's father wrote that things were bad at home, which he could not explain further, but that Jonah required medication and counselling. The GP did not visit Jonah but held a telephone consultation with him. Despite Jonah's father's worries for Jonah's life, no concerns were identified about Jonah by the GP, who agreed to send Jonah information about counselling and to email the CMHT about medication.

3.24 On 22nd August 2021, the Metropolitan Police were notified by Jonah's mother that she had received a text message from Jonah stating that he was going to hang himself from the tree in his back garden. Police Officers attended and Jonah explained that he had drunk too much the night before and felt hungover. Jonah said that sometimes "life gets me annoyed" and explained that he says things that he does not mean. The Police Officers left Jonah taking no further action since Jonah refused to see or speak to any professionals, family members or friends and insisted that he was fine. The police had

requested an ambulance, and this was not cancelled in case Jonah changed his mind. The Bexley MASH was notified, and BRAG rated this report as GREEN. Jonah's father also reported to the police that he had received a similar text message. The London Ambulance Service attended but deemed that conveying Jonah to hospital was not required. The London Ambulance Service notified the KMPT CMHT of its contact but complied with Jonah's request not to notify his GP. Jonah has asked to contact his GP instead.

3.25 On 25th August 2021, Jonah's GP telephoned Jonah at his request. Jonah said that he just wanted someone to talk through things with. Jonah said that he had fleeting thoughts of self-harm today but did not feel at risk of acting on them. Jonah was given the Crisis telephone number as well as talking therapy telephone numbers and was encouraged to make an appointment despite the waiting list, which Jonah explained had previously discouraged him from making contact on 18th June 2021, and was signposted to the IAPT service.

3.26 On 25th August 2021, Jonah telephoned the Metropolitan Police to say that the church was trying to get the demons out of him, which were communicating with him through the television and causing him pain. The police believed Jonah to be having a mental health episode and requested an ambulance, which attended, having obtained information about Jonah from the CRHT. Jonah told the ambulance crew that he believed that "people" were making comments about his sexual identity. The ambulance crew referred Jonah to the Dartford Home Treatment Team for an urgent mental health assessment.

3.27 On 26th August 2021, Jonah telephoned the Metropolitan Police stating that from time to time he felt suicidal. Police officers attended but Jonah was calm, engaged with them and said that he had been watching a television programme about the church and that he was not righteous enough for Jesus. Jonah said that he now had a demon in him and had been drinking which made the demons worse. The Metropolitan Police officers contacted Jonah's GP surgery to arrange an emergency mental health assessment for Jonah. The police also noted that the London Ambulance Service Mental Health car had been sent to engage with Jonah and that a Merlin had been raised. The Merlin report noted that the emergency mental health doctor from the GP surgery would contact Jonah and arrange to visit him. There is no record of these contacts or actions in the GP records provided for this review.

3.28 On 27th August 2021, Jonah told a KMPT CMHT Health Care Assistant (HCA) by telephone that he was feeling better today, was not feeling suicidal and if he was would rather speak to a doctor or nurse than to an HCA. Jonah said that he would like to try medication for his nerves and paranoia and would like to talk to someone about how he felt. Jonah said that he was drinking a lot to feel better since he was hearing voices and was struggling to focus. Jonah confirmed that he had the Crisis telephone numbers.

3.29 On 27th August 2021, the Merlin sent by the police on 26th August 2021 was BRAG rated by the Bexley MASH as Amber. No date of birth was provided and so Jonah could not be identified or entered into the Rio client information system. The Merlin report was, however, sent to Jonah's GP.

3.30 On 30th August 2021 KMPT discussed Jonah at a RED (Risk Evaluation and Decision) Board meeting (see Appendix 2) and planned a medical review. On 31st August 2021, this review took place by telephone and Jonah was assessed by a CMHT psychiatrist to have a chronic psychotic illness. Jonah denied taking drugs and wanted to be prescribed diazepam which he said he used to obtain from a friend. Jonah eventually agreed to take Quetiapine, an antipsychotic which he would collect and take the necessary tests for. There was insufficient capacity within the team to allocate a care coordinator, but Jonah was to be monitored in the community until a care coordinator could be allocated to him.

3.31 On 1st September 2021, Jonah telephoned the Metropolitan Police to say that he was suffering from psychosis and made comments about feeling that he might cause harm to others. The police requested an ambulance since Jonah had psychosis and was having a mental health episode. Jonah kept saying that a demon was in his head making him want to cause harm to others. Jonah had been brought up as a Christian and believed that demons and angels existed and that demons could torment human minds.

3.32 Jonah then sent a text message to the Metropolitan Police stating that he needed the fire brigade to put the devil out and that the Samaritans were not answering his calls. Jonah wrote that he was going to call the police to waste their time because they had wasted his. This text message, and the threat of wasting police time contained within it, was classified by the police as a hoax.

3.33 Later on, 1st September 2021, Jonah telephoned the Metropolitan Police to say that he did not want to cause harm to others. Jonah spoke about demons in his head and said that he was close to hanging himself. Police officers attended but Jonah ejected them from his home and denied that he had called the police, despite having previously said that he would telephone every 10 seconds until he got help. The police cancelled the request for an ambulance.

3.34 On 4th September 2021, Jonah hanged himself from a tree in his garden.

4 THE EVIDENCE BASE FOR THE REVIEW

4.1 The analysis of Safeguarding Adults Reviews by Michael Preston-Shoot (2017) and the analysis of Safeguarding Adult Reviews April 2017 – March 2019 describe a number of “methodological” requirements and related shortcomings of SARs, which can be summarised as follows:

4.2 SARs should connect their findings and proposals to an evidence base. Few SARs compare actual practice with that suggested in guidance and few explore the reasons why there was a difference between the two.

4.3 SARs should be based on research. Over 50 Safeguarding Adults Boards have carried out SARs on the same set of circumstances on more than one occasion but have treated each discreetly. The SARs do not refer to each other, build on each other, or ask why it happened again.

4.4 SARs should be analytical. There is too much description and not enough analysis.

4.5 SARs should not shy away from difficult or sensitive topics. Few SARs engage in the legal and financial context of practice or decision making and should raise the impact of funding cuts, government strategy and reductions in services.

4.6 Consequently, a study was made of both the research evidence and practice evidence that provides insight and guidance when working with someone in Jonah's situation: using crystal methamphetamine and conflicted about his sexuality; experiencing mental health distress and talking about suicide.

4.7 **Evidence from research**

4.8 **Suicide and mental health needs**

4.9 Jonah was in contact with mental health services and had been diagnosed with drug induced psychosis in June 2016 and then with a chronic psychotic illness on 30th August 2021. Jonah was not diagnosed with depression, which is often intuitively associated with suicide (Mittal et al, 2009) but is actually a poor predictor. Predicting suicide is difficult, particularly when 60% of people who died by suicide had denied having suicidal thoughts (McHugh et al, 2019).

4.10 The move from contemplation of suicide to suicide attempts and then to completed suicide can occur suddenly (Apter and Wasserman, 2006). A significant factor in moving from depression to suicide is the contemplation of suicide (Bilsen, 2018). A significant factor in moving from contemplating to actually attempting suicide is the availability of lethal means (Milner, et al, 2017). Jonah began to talk about thinking about suicide in June 2021 and his father noted that he had a noose. Consequently, the factors identified in the research for a sudden increase in the risk of suicide were present. Jonah however denied that he intended to kill himself until he sent text messages to his parents on 22nd August 2021 stating that he would hang himself from a tree but then said that he had no intention of acting on his thoughts.

4.11 This pattern of fluctuating thoughts of suicide continued whilst evidence of Jonah's mental distress increased until his suicide. This suggests a need amongst the Metropolitan Police, Kent Police, KMPT and GP practices to better understand the factors in suicide and to share information about them to form a collective picture of risk.

4.12 **Evidence from guidance**

4.13 The Royal College of Psychiatrists' Final report of the Patient Safety Group, Self-Harm and Suicide in Adults (CR229), published in June 2020, sets out a number of "Risk factors and red flag warning signs". The report states that "*A red flag is a risk factor with special significance in that it indicates that a person is at heightened risk of attempting suicide at this particular moment in time.*

This imminent risk requires an urgent, clinically appropriate and personalised intervention with a Safety Plan".

4.14 This report provides a useful framework for understanding the risk factors and warning signs in Jonah's life. The risk factors and "red flags" are divided into a number of themes as follows, and the extent to which Jonah exhibited or may have presented these factors will be described.

4.15 **Theme 1: Demographic and social factors**

- Perception of lack of social support, living alone, no confidants
- Males (may not disclose extent of distress or suicidal thoughts)
- Stressful life events (e.g., recently bereaved, debt/financial worries, loss of attachment/major relationship instability, job loss, moving house)
- LGBT
- Ethnic minority group.

4.16 Jonah was a white British man whose relationship with his girlfriend had ended in 2014 apparently over having a relationship with a man and was experiencing persecutory delusions and hallucinations. It does not appear that Jonah was in an intimate personal relationship when he died. It is also unclear if Jonah identified as gay or bisexual (he had, according to his father, told his girlfriend that he was bisexual), but it appears that Jonah's sexual encounters with men were traumatic and often resulted, consistent with the research evidence, in Jonah attending hospital. These encounters do not appear to have been particularly compassionate or caring. There was no exploration with Jonah of the extent to which these experiences may also have been incorporated into his beliefs that he was unworthy; demon possessed and might cause harm to others before he died.

4.17 **Theme 2: Personal background factors**

- Substance misuse: Alcohol and/or illicit drug misuse especially if precipitated by a recent loss of relationship.
- Feeling close to someone who died by suicide (family or non-kin) or exposure to suicidal behaviour of key others (family, peers, favourite celebrity)
- Use of suicide-promoting websites or social media
- Access to lethal means; (If unable to remove lethal means ensure mitigation within a robust Safety Plan).

4.18 There were also a number of risk factors and "red flags" present in Jonah's personal background. These included "Substance misuse"; Jonah was known to be using crystal methamphetamine, cocaine and alcohol although it is unclear if this was, "precipitated by a recent loss of relationship", Jonah may have also been using substances as a way of managing, yet inadvertently exacerbating, his emotional health needs. Jonah's relationship with his girlfriend ended after he started to use crystal methamphetamine. Jonah had "Access to lethal means" in the relatively innocuous form of a tree and a rope, but according to his father Jonah had made a noose. The only factor that was

not present appears to have been “Feeling close to someone who died by suicide (family or non-kin) or exposure to suicidal behaviour of key others (family, peers, favourite celebrity)”, although his does not appear to have been considered or explored with Jonah.

4.19 **Theme 3: Clinical factors in history factors**

- Previous self-harm or suicide attempt(s) (regardless of intent, including cutting)
- Mental illness, especially recent relapse or discharge from in-patient mental health care
- Disengagement from mental health services
- Impulsivity or diagnosis of personality disorder
- Long-term medical conditions; recent discharge from a general hospital; pain.

4.20 Jonah had attempted suicide in 2016 and in June 2021 Jonah had crashed his car into a lamp post. This latter incident was however, quickly discounted by the police as a suicide attempt and in July 2021, Jonah denied any suicidal ideation. Jonah had mental health needs, although these were considered to be substance use related. This may have been a rather deterministic conclusion: there does not appear to have been enquiry into why Jonah was using drugs and alcohol.

4.21 This connects with a finding in several SARs (for example: Andrew, Staffordshire and Stoke, 2021; Alcohol Concern 2019) of an over reliance on substance use, and on alcohol use in particular, to explain a person’s presentation to services. This prevents exploration of underlying factors in the person’s life which led them into problematic substance use.

4.22 Jonah’s engagement with mental health services was episodic and follow up attempts were hampered by his return to Malta. Jonah had been detained under section 2 of the Mental Heath Act 1983 in 2018 in a mental health hospital. Following his request and working with Jonah and his family it was agreed that Jonah could be supported in the community, and he was discharged to live with his father and subsequently returned to Malta.

4.23 On 25th August 2021 Jonah sent text messages to his mother and father stating that he was going to hang himself. The police were called but Jonah was not taken to hospital since he explained that he had drunk too much and sometimes said things that he did not mean. Jonah also attended general hospitals on several occasions with pain which he ascribed to sexual encounters. Jonah’s post-mortem examination identified that he had no physical health problems.

4.24 **Theme 4: Mental state examination and suicidal thoughts**

- High degree of emotional pain and negative thoughts (hopelessness, helplessness, guilt – e.g. 'I'm a burden')
- Sense of being trapped / unable to escape (sense of entrapment) and/or a strong sense of shame.
- Suicidal ideas becoming worse.
- Suicidal ideas with a well-formed plan and/or preparation
- Psychotic phenomena, especially if distressing; persecutory and nihilistic delusions, command hallucinations perceived as omnipotent (pervasive).

4.25 Jonah's contacts with services in the last months of his life were too brief and episodic to establish the extent to which these factors were present. Jonah may have felt guilt and shame and may have been conflicted about his sexuality, which took the form of persecutory delusions featuring religious elements, spiritual crisis, demon possession and concerns that he may harm others. These experiences and feelings were not explored with Jonah. There is evidence that Jonah's suicidal ideas were becoming worse, which prompted his father to contact Jonah's GP to request a home visit on 30th July 2021 and particularly between 22nd to 26th August 2021.

LEARNING POINT: Mental health symptoms may be a response to underlying trauma and conflict. Do not take them at face value but instead explore how they relate the person's life experience and circumstances.

4.26 There is also evidence that Jonah was forming a suicide plan and had identified how he would kill himself. Given what is known about the rapidity with which suicidal intention can turn into suicidal acts, these contacts with services may have represented missed opportunities for intervention. However, on 27th August 2021 Jonah told the CMHT that he was feeling better and had crisis telephone numbers if he needed them. On 30th August 2021 the CMHT assessed Jonah to have chronic psychotic illness for which he agreed to take medication and was to be allocated a care coordinator.

4.27 Unaware of this, the Metropolitan Police officers visited Jonah on 1st September 2021. They recorded indications of Jonah's psychosis but do not seem to have recognised that Jonah was in mental health crisis and that a mental health or a Mental Health Act assessment might have been indicated.

4.28 This appears to have been a further missed opportunity for an intervention before Jonah killed himself on 4th September 2021. There is also a need to act on information received and observed in order to prevent or reduce the likelihood of suicide or self-harm.

LEARNING POINT: Suicidal intent may alter rapidly. Do not assume that someone who now feels better will remain feeling better. Consider and use the information you have received about warning signs and risk factors and share it with other involved agencies.

4.29 Consequently, there is evidence that Jonah was at risk of suicide and that he presented a number of the risk factors and red flags identified in the Royal College of Psychiatrists' Final report of the Patient Safety Group, Self-Harm and Suicide in Adults.

4.30 The report states that, "…*If there are red-flag warning signs/immediate risk of suicidal behaviour, the patient will require*":

- Immediate discussion with/referral to mental health services
- A robust Safety Plan
- Adequate support
- Removal of access to means.

4.31 The components of a Safety Plan are:

- Reasons for living and/or ideas for getting through tough times.
- Ways to make your situation safer.
- Things to lift or calm mood.
- Distractions
- Sources of support, to include anyone you trust.

4.32 It is important that Safety Plans are co-created with patients and encourage communication with family and friends. No Safety Plan appears to have been developed with Jonah and his family.

LEARNING POINT: Suicide can be hard to predict so it is important that you agree a Safety Plan with anyone who has suicidal thoughts or who has self-harmed. These plans should be co-created and involve the people the person identifies as important to them.

4.33 **Mental Capacity**

4.34 Jonah had a diagnosis of psychosis and used drugs and alcohol. The Mental Capacity Act sets out the process for assessing and determining whether or not someone with an "*an impairment of, or a disturbance in the functioning of, the mind or brain*" is able to make a specific decision at a specific time. The impairment or disturbance can be caused by a condition, an illness or external factors including drug and alcohol use. It can be caused by addiction and dependence or coercion and control.

4.35 Jonah had been diagnosed with psychosis and exhibited paranoid and persecutory delusions featuring religious elements, spiritual crisis, demon possession and concerns that he may harm others. He used substances including crystal methamphetamine. All of these factors indicated that Jonah may have had, in the terms of the Mental Capacity Act, an "*an impairment of, or a disturbance in the functioning of, the mind or brain*" which may have impacted on his capacity to make decisions about, for example, his safety.

4.36 The first principle of the Mental Capacity Act is the presumption of capacity even if an impairment or disturbance in the functioning of the mind or brain is present. Practitioners struggle to identify when to question whether or not an individual has the mental capacity to make a particular decision at a particular time. There are no records that Jonah's mental capacity was considered and, in the context of an impairment in the functioning of his mind or brain, how he understood, retained, used or weighed information or communicated decisions or executed decisions. A mental capacity assessment may have identified that Jonah required more direct support than signposting or that his decision to evict police officers from his home on 1st September 2021 might have been challenged.

4.37 **The wider context**

4.38 Resource restrictions, waiting lists and high caseloads impacted on the approaches taken by the CMHT with Jonah. For example, Jonah spoke to an HCA rather than a doctor or nurse on 27th August 2021 and the CMHT did not have the capacity to allocate a care coordinator to Jonah on 30th August 2021 (six days before Jonah took his own life).

4.39 Although there was no direct evidence of discrimination in the approaches to Jonah there is wider evidence that men are three times more likely to kill themselves than are women and that suicide is the most frequent cause of death for men below the age of 45 years old (Simms et al, 2019). There is also a growing literature on the difficulties faced by men when accessing services (Baker et al 2015) and on preconceived notions about their lifestyle, compliance with services and their ability to meet their own needs (see for example, Carson. 2011).

4.40 **COVID-19**

4.41 The final year and a half of Jonah's life took place within the context of the coronavirus pandemic. Following its identification in the UK on 29th January 2020, there was a surge in infections through March and restrictions on movement were introduced. 'Lockdown' measures restricting contact and ordering the UK population to "stay at home" came into force on 26th March 2020 and were intermittently lifted and reintroduced in response to the pattern of infections and hospital admissions.

4.42 To reduce contagion of COVID-19, in March 2020 UK general practices implemented predominantly remote consulting via telephone, video or on-line consultation platforms. On 19th July 2021 the government confirmed that the existing COVID-19 Infection Protection and Control (IPC) guidance continued to apply in healthcare settings and that all general practice surgeries should continue to offer a blended approach of face-to-face and remote appointments, with digital triage where possible.

4.43 Restrictions on meeting outdoors were finally lifted on 17th May 2021 and all restrictions ended on 19th July 2021. COVID-19 infection rates, however, began

to rise, impacting negatively on service capacity until a further lockdown was reintroduced in December 2021.

4.44 The national and local response to the pandemic also impacted widely. Demand for services, sometimes to replace those that had been closed or limited by the 'lockdown', increased. There was also an increase in mental health need, which had been predicted at the time but in hindsight seems to have been even greater in younger people (Ford et al, 2021; Ashton et al, 2021). There was also an increase in drug and alcohol related problems.

5 ANALYSIS

5.1 Using this research and practice evidence base it is possible to analyse the ways in which the organisations worked with Jonah and understood and responded to the needs and challenges that he presented.

5.2 Engagement with and by services

5.3 Jonah had made at least one previous suicide attempt and had been in contact with mental health services since 2016. These contacts were however intermittent and short term and attempts to follow Jonah up were unsuccessful since he had said that he did not want further contact or mental health service involvement.

5.4 In response to increasing signs of mental distress, the CMHT made an initial assessment of Jonah in July 2021. He was placed on the active review pathway (see appendix 1) following a discussion between the assessing clinician and the CMHT team manager while he awaited an appointment with the psychiatrist for a medical review. This was outside of the usual process as there was no multidisciplinary team discussion of Jonah's case as would be expected to determine the next steps.

5.5 Jonah's three contacts with the Metropolitan Police in Bexley on 1st September 2021, three days before he killed himself, did not lead to any interventions and it appears that Jonah was considered to be a nuisance and to be making hoax calls. This was despite Jonah's previous contacts with the Metropolitan Police in Bexley which featured concerns about his mental health, three of which had led to Merlin reports being made about him.

5.6 Across all the organisations involved, it was hard to gain a full picture of Jonah's needs and better interagency communication and access to information was required.

5.7 In addition, irregular engagement, frequent case closure and disengagement with services is a regular feature in safeguarding adults reviews and can be considered as a risk factor in itself (see for example, the safeguarding adults reviews, "Mark", London Borough of Camden, 2022; "Andrew", Staffordshire and Stoke-on-Trent, 2022 and the Thematic Review following the deaths of Mr G, Mr H, Mr I and Mr J, Portsmouth, 2022 and the national Analysis of Safeguarding Adults Reviews, 2017-2019).

5.8 **Abuse**

5.9 Jonah described using crystal methamphetamine which resulted in his attendance at hospital or his GP surgery on five occasions, three of which followed having sex with a man. There is no evidence that Jonah's feelings about these sexual encounters or the extent to which he was in relationships he was happy with, were explored with him. There was opportunity for this when he attended health services. Neither was there signposting to support groups or agencies with which Jonah could discuss his sexuality and how to keep himself safe. Jonah could also have been offered signposting or referral to Individual Sexual Violence Advocate or domestic abuse services. Jonah had unprotected sex and was concerned that he may have an HIV infection or other form of sexually transmitted disease. Jonah could have been signposted or referred to a sexual health clinic. There appears to have been a tacit acceptance by health services that the harm that Jonah was experiencing was a consequence of lifestyle choices, which would have raised considerable concerns had he been a woman. This may be an example unconscious biases affecting service responses to, in this case, gay men and people and who use drugs and alcohol (Casanova-Perez et al, 2021).

LEARNING POINT: Men are also the victims of abuse and of sexual assaults. Do not assume that harm is an acceptable consequence of engaging in what might appear to be high risk activities. Think about how you would respond if they were a woman who had been assaulted in a similar situation and whether your response should be any different just because they are a man.

5.10 Similarly, Jonah's use of crystal methamphetamine was not explored with him despite the evidence of its addictive nature and impact on mental health, including psychosis, paranoia, delusions and hallucinations which can persist after usage has ceased (The post-mortem examination found Jonah to have been drug free at the time of his death). Jonah had been diagnosed with psychosis and exhibited paranoid and persecutory delusions featuring religious elements, spiritual crisis, demon possession and concerns about his sexual identity. The connection between these, drug use and internal conflicts about sexuality were not considered by the Metropolitan Police, Jonah's GP or KMPT mental health services.

5.11 There appears to be a need for greater curiosity and exploration of the circumstances, understanding, motivations and consent of people who engage in sexual encounters which lead to harm (Carthy et al, 2021) and their ability to protect themselves, especially when these involve substance use.

LEARNING POINT: Asking questions about someone's sexual encounters and sexuality can be uncomfortable, but it essential when they are coming to harm. It is important to recognise that you may have unconscious biases that affect your understanding of someone's situation and the extent of their responsibility for, or ability to protect themselves in, it. This can especially be the case if drugs or alcohol are involved.

5.12 Jonah's had also been assaulted by his brother whilst staying with him in Essex on 10th November 2020 the police considered this to not be a form of domestic abuse since it was a single incident and did not involve an intimate partner. According to Jonah's father, Jonah's brother also used drugs and had experienced homelessness. At the time of the assault, Jonah's brother was living in rented accommodation and the incident was precipitated by Jonah's brother's accusation that Jonah had made too much noise whilst decorating. It would appear that when the assault took place, the noise had stopped, since Jonah was sleeping in a newly bought bed at the time. Jonah was punched multiple times and the bed was broken. According to Jonah's father, Jonah's brother had also assaulted his landlord. Jonah's brother left and went to his mother's house in Kent. Police tried to offer Jonah support, but he did not wish the matter to be taken any further by the police.

5.13 This was the only recorded incident between Jonah and his brother. They did not live together on a permanent basis, and it appears that Jonah had notified the police of the assault, but it was not shared with the physical and mental health services or Jonah's GP. Consequently, there do not appear to have been any attempts to discuss Jonah's safety further by any other services or recognition that Jonah may be at risk of fraternal domestic abuse. On 27th November 2020, for example, Queen Elizabeth the Queen Mother Hospital in Kent notified Jonah's brother that Jonah had attended hospital following a psychotic episode. If the hospital had been aware of the assault, then it might have been safer to have notified Jonah's mother or father instead.

5.14 Jonah also expressed concerns that he might to be a risk to others, but this was not responded to. Signposting or referral to organisations that can provide support with this might have been helpful for Jonah.

LEARNING POINT: Ask questions about domestic abuse, do not wait for someone to disclose it to you. Ask questions routinely, especially where there are warning signs including, injury, anxiety, depression, self-harm, chronic pain, requests for emergency contraception or sexually transmitted disease tests.

5.15 **Mental Capacity**

5.16 Jonah crashed his car into a lamppost on 4th June 2021. The initial report to the police noted that Jonah had tried to kill himself. This explanation was quickly discounted, and the incident appears to have then been taken at face-value with no exploration of what had led Jonah to take such a drastic action and acceptance of his explanation that his girlfriend had left him because of his sexual relationship with another man. RM's father told the review author and board manager that Jonah's relationship with his girlfriend had ended in 2014 and so it is unclear why Jonah referred to this event in the context of his car crash. Speculatively, certain events in Jonah's life may have led to persistent trauma reactions, particularly if he was using drugs at the time, and Jonah's car crash may have been a response to past events, rather than current events. Alternatively, Jonah may have been referring to the girlfriend he had mentioned in 2019, whom according to KMPT, he had met in Malta. Jonah also stated that

he had crashed because he was full of demons. There was an opportunity to have, for example, used police powers such as section 136 of the Mental Health Act. Whilst custody in a police station is not a particularly safe place for someone with mental health needs, it might have been an option to use to facilitate access to services that might have been able to support Jonah with his feelings of distress and to explore if he had suicidal intent. This may also have enabled a mental capacity assessment of the extent to which Jonah was able to make decisions about his own safety.

5.17 It also does not appear that Jonah's mental capacity was assessed in any of his contacts with services. Whilst a principle of the Mental Capacity Act is the presumption of capacity unless demonstrated otherwise, there were opportunities when a capacity assessment might have been useful. For example, when, despite Jonah's father's concerns, Jonah's GP did not identify any concerns about Jonah but sent information about counselling services to him or during the period between 22nd August 2021 and 1st September 2021 when the Metropolitan Police had multiple contacts with Jonah and the CMHT had one contact.

5.18 Jonah was occasionally given information on the services available and was expected to make his own contact with them including crisis services. There does not appear to have been consideration of Jonah's ability to understand, retain and use and weigh information to make decisions.

5.19 There was also no exploration of the extent to which Jonah had the executive capacity to convert his ability to understand, retain, use or weigh information and to communicate decisions, into actions. An assessment of Jonah's mental capacity to understand the importance of engaging or of how to attend appointments and to act on these may have identified that he required additional support, especially in the context of Jonah's substance use and mental health needs. Mental capacity is time and decision specific and Jonah's mental capacity to make decisions about engaging with services may also have fluctuated.

5.20 **Risk of suicide**

5.21 Jonah was reported to have previously attempted suicide and presented a number of characteristics identified in the Royal College of Psychiatrist's Final report of the Patient Safety Group, Self-Harm and Suicide in Adults (CR229), but there does not appear to have been any collective recognition of the increased, and on-going, risk of suicide for Jonah.

5.22 Following the concerns raised about Jonah by the London Ambulance Service on 25th August 2021, Jonah was contacted on 27th August 2021 by a duty HCA (Health Care Assistant) from the CMHT since there was insufficient capacity within the CMHT for contact by a health professional. The HCA was unable to clinically assess risk but could feedback concerns. Jonah had expressed delusional thoughts about his sexual identity and stated that he had demons in him.

5.23 Jonah told the HCA that he would rather speak with a doctor or a nurse but became more open with the HCA as their conversation developed. Jonah stated that he wanted to commence psychiatric medication and he was eager to be informed of a date for his medical review. The HCA discussed the conversation with the duty clinician and taking advantage of a cancellation, arranged an appointment for 31st August 2021 for Jonah's medical review by the consultant psychiatrist.

5.24 KMPT identified that a robust risk assessment was not carried out on 31st August 2021. The consultant psychiatrist responsible for this assessment recognised that Jonah presented with 'chronic psychosis' and was 'very unwell' but did not meet Jonah in person and did not ask explicit questions about suicidal ideation or the risk of self-harm or harm to others. Instead, the consultant psychiatrist asked open questions and based the risk assessment on Jonah's answers to these, including the content of the Jonah's delusional thoughts and hallucinations. Since Jonah did not mention thoughts to harm himself or others or suicidal ideation, these topics were not explored. This appears to have been the consultant psychiatrist's usual practice, but it allowed Jonah to lead the conversation and to disclose what he wanted.

5.25 The consultant psychiatrist considered that Jonah's presenting risk was psychosis, prescribed an antipsychotic and felt reassured that Jonah would attend the CMHT to collect the prescription. The consultant psychiatrist concluded that a Crisis Resolution Home Treatment (CRHT) referral was unnecessary and that the duty team could manage Jonah until a care coordinator was allocated since there was not the capacity to provide one at the time. The KMPT Root Cause Analysis suggested that a more robust risk assessment might have identified the need for a CRHT referral, which the CRHT confirmed it would have accepted and would have monitored Jonah's compliance with Quetiapine. The CRHT would also have needed to know what risks Jonah faced.

5.26 Jonah, however, would have had to be willing to work with the CRHT, and although this was uncertain, on 27th August 2021, Jonah had said that he would like to try medication for his nerves and paranoia and would like to talk to someone about how he felt.

5.27 The consultant psychiatrist discussed their concerns about Jonah with the CMHT team manager and reached agreement that Jonah required follow up but there was insufficient team capacity to allocate a care coordinator. Instead, Jonah would be managed on duty until a care coordinator was available. If the risk assessment had been clearer a care coordinator may have been allocated regardless of capacity. The CMHT duty team comprised one clinician and a Support, Time and Recovery (STR) worker. The duty clinician is the only dedicated duty worker in post. STR workers assist duty around their main responsibility for initial interventions.

5.28 The request for duty contacts with, and monitoring of, Jonah was made by the CMHT Team Manager on 1st September 2021 by email rather than in person due to workload pressures. No requirement for urgency was highlighted since none had been identified in the risk assessment. The duty worker did not sense any

urgency and prioritised other work (there were 13 other patients to contact that day plus other ad hoc contacts) and forgot to write Jonah's name in the duty book. Jonah appears to have passed out of the duty workers awareness. This meant that Jonah was not discussed again at the team's RED (Risk Evaluation and Decision) board meeting, which may have provided an opportunity for the team to consider Jonah's risk and to discuss any potential actions, including the potential for a CRHT referral. With hindsight the team manager recognised that speaking to the duty worker in person, rather than by email, might have made the priority to contact Jonah clearer and would have led to his name being written in the duty book.

5.29 The Metropolitan Police appear to have been unaware of the extent of Jonah's mental health needs and the diagnosis of psychosis when Jonah contacted them on 1st September 2021. Jonah's level of distress and ejection of the police from his home could have prompted the police officers to discuss the situation with an AMHP (Approved Mental Health Professional), which might have led to a Mental Health Act assessment. This may have identified that Jonah required detention under the Mental Health Act 1983 or if not then the need for more assertive follow up in the community by the CMHT given the level of Jonah's distress. This might in turn have prompted the CMHT to realise that Jonah had dropped out of its duty system. This was a missed opportunity to intervene before Jonah took his own life and might have enabled contact with him on 2nd September 2021.

5.30 On Friday 3rd September 2021, the team manager asked the duty worker if they had contacted Jonah yet. This reminded the duty worker about Jonah, whose name was then entered in the duty book to be called first thing in the morning on Monday 6th September 2021. It does not appear that there was a sense of urgency, and no consideration seems to have been given to out of hours contact with Jonah during the evening or the weekend. This was a further missed opportunity to intervene. These missed opportunities, however, depend upon the effectiveness of services to have assertively engaged with Jonah to overcome his resistance and be aware of the risk that Jonah might take his own life.

5.31 Predicting suicide is difficult. The Royal College of Psychiatrists identified the limitations of the assessment of suicide risk and promoted the value of developing therapeutic relationships, so that people at risk of suicide feel freer to disclose their feelings and intentions. The report warned against the assumption that people experiencing mental distress, but who do not report suicidal ideas, are not at elevated risk of suicide. The report stated that, "*The current approach to risk assessment and responding only to those identified as 'high risk' is fundamentally flawed, and the use of terms such as 'low risk' or 'high risk' is unreliable, open to misinterpretation and potentially unsafe. The absence of risk factors does not mean the absence of any risk of suicide. For a variety of reasons (e.g., stigma, shame, fear, or embarrassment) people may conceal or minimise their suicidal thoughts. Moreover, suicidal thoughts (and risk) can vary across a relatively short time period. The assessment of suicide risk by the clinician needs to be individually focused and carried out regularly*".

5.32 Such an approach would require consistency in who was working with Jonah, which was made more difficult by the fragmented nature of the services he was in contact with and the use of duty processes to manage him until a care coordinator was allocated.

5.33 **Use of adult safeguarding processes.**

5.34 Three Metropolitan Police Merlin (Adult Coming to Notice) reports were made to the Bexley Multi-Agency Safeguarding Hub. Two of these were rated as "Green" (lowest level of concern) on 4th June 2021 and on 22nd August 2021 and one as "Amber" (mid-level of concern) on 26th August 2021. No adult safeguarding action resulted from these despite concerns that Jonah had crashed his car into a lamp post (4th June) and had said that he would hang himself from a tree (22nd August) and was possessed by a demon (26th August). Whilst Jonah was in contact with his GP, his contact with mental health services had been episodic. Safeguarding enquiries or interventions might have been an opportunity to hold a multi-agency meeting to share concerns about Jonah, to assess the risk he posed to himself and to agree interventions including assessment under the Mental Health Act 1983.

5.35 No date of birth was provided in the Merlin reports, and this meant that Jonah could not be reliably found, or an account created for him, on the Rio client information system. The minimum requirement to do this is a person's name, address and date of birth. Name and address are necessary but insufficient. However, Oxleas would not have been able to access KMPT's records of contact with Jonah since Rio records are not shared across trusts. A Rio account could, however, assist in identifying who a person's GPs is so could be useful for understanding someone's contact with services and needs, therefore all efforts should be made to obtain the required details.

LEARNING POINT: Remember that name, address and date of birth have to be included in Merlin reports for a search or entry on the Rio mental health database to be made. If all of this information is not provided, then Rio records cannot be accessed or created. The consequence is that vital information may not be shared or available to protect people's lives.

5.36 The local authority is the lead agency for adult safeguarding under the Care Act and must act when it has "reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)":

- Has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from the risk or experience of abuse or neglect.

5.37 Furthermore, the Care Act Statutory Guidance makes provision for non-statutory adult safeguarding enquiries (also known as "other" enquiries) and interventions where this "three-part test" is not met, but where there is sufficient concern that someone may come to harm. It is likely that Jonah met at least the criteria for a non-statutory adult safeguarding enquiry and that either this or a section 42 enquiry might have been an opportunity to reconsider the extent to which the current interventions and approaches were proving effective. This in turn might have led to the use of different interventions and approaches to meet Jonah's needs or might have reprioritised the need for an assessment of Jonah's needs.

5.38 **Information sharing and multi-agency working**

5.39 Jonah was in contact with services across three local authority and police areas, which may have complicated communication and information sharing. The Royal College of Psychiatrists' report identifies that "*a patient journey that is disjointed and fragmented, with poor or absent communication between agencies, is itself a risk factor for suicide*."

5.40 KMPT was not aware of the presence of a noose in Jonah's home, which Jonah's father had seen on 21st June 2021 and had reported to Jonah's GP. Jonah was not discussed at a KMPT MDT meeting following his initial assessment on 13th July 2021, and instead was allocated for active review, when medial review was usual practice instead, and it is unclear what information was shared about Jonah's history. If Jonah had been discussed at the MDT meeting, the KMPT root cause analysis concluded that it would have been more likely that Jonah would have been allocated to the correct pathway.

5.41 It does not appear that Jonah's father's worries for Jonah's life expressed to Jonah's GP on 30th July 2021 were explored further. The GP contacted Jonah by telephone and did not identify any concerns and consequently did not alert the CMHT that Jonah's father was worried about him. Further discussion with Jonah's father might have identified concerns that Jonah had not disclosed to the GP.

5.42 Jonah was in contact with three police forces (Metropolitan, Kent and Essex) all of which use different terminology and systems.

5.43 **Family involvement**

5.44 No carer's assessment was offered to Jonah's father, despite his contact with services in which he expressed concerns about Jonah's welfare and mental state. No interventions were offered to support Jonah's father or mother with the emotional impact of their care for Jonah.

5.45 According to KMPT's Root Cause Analysis, no contact was made with Jonah's parents to gather more information about him following the initial telephone assessment on 13th July 2021. The clinician who undertook the assessment recalled that this was likely to have been because Jonah did not want them to contact his family.

5.46 The consultant psychiatrist similarly did not contact Jonah's family after the medical review on 31st August 2021, this time because they considered that no other information was required. The KMPT Root Cause Analysis, however, concluded that contact and engagement with Jonah's mother, for example, may have provided useful information and assistance with ensuring that Jonah collected his Quetiapine prescription.

5.47 Jonah appears to have told a KMPT clinician that he did not want them to contact his family. Following discussions during the process of this safeguarding adults review, it was recognised that the prevailing belief amongst agencies appears to have been that contact with family members was dependent on consent. Common law, the Human Rights Act 1998 and the General Data Protection Regulations (GDPR), supplemented by the Data Protection Act 2018, regulate the processing of personal data about living individuals in the UK.

5.48 The GDPR defines personal data as: "*any information relating to an identified or identifiable natural person ('data subject'); an identifiable natural person is one who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, an identification number, location data, an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person"* and sets out a number of principles covering its use and storage. Essentially, disclosure of confidential information is only allowed if consent to disclose is given, if disclosure is required by law or when it is justified in the public interest.

5.49 It is unlikely that Jonah's decision to refuse contact with his family posed a risk to other people and that his choices and should therefore be overridden.

5.50 Even if someone has made a capacitous decision that there should be no contact with their family, attempts by their family to contact services should not be rejected. The General Medical Council, for example, states that "*In most cases, discussions with those close to the patient will take place with the patient's knowledge and consent. But if someone close to the patient wants to discuss their concerns about the patient's health without involving the patient, you should not refuse to listen to their views or concerns on the grounds of confidentiality. The information they give you might be helpful in your care of the patient*".

5.51 The Royal College of Psychiatrists goes further in suggesting that professionals may initiate contact with others including family members, stating, "*There is nothing to prevent you, or any other healthcare professional, from receiving information provided by any third party about the patient, as receiving information does not equate to disclosure. Indeed, provided the circumstances do not involve disclosure of confidential information, a healthcare professional may actively request information without the patient's consent. This can be an important part of the risk assessment of a patient*".

5.52 Despite this, the GMC strikes of a note of caution and warns that, "*You should, however, consider whether your patient would consider you listening to the views or concerns of others to be a breach of trust, particularly if they have asked you not to listen to specific people. You should also make clear that, while it is not a*

breach of confidentiality to listen to their concerns, you might need to tell the patient about information you have received from others – for example, if it has influenced your assessment and treatment of the patient. You should also take care not to disclose personal information unintentionally – for example, by confirming or denying the person's perceptions about the patient's health".

5.53 There is a distinction here between a practitioner disclosing personal data (which includes health information) to a person's family against the person's wishes and receiving information from a person's family. However, Jonah had said that he did not want professionals to contact his family, and Jonah's wishes should have been respected unless it was not in the public interest to do so, or a mental capacity assessment had determined that Jonah lacked the mental capacity to make that decision.

5.54 **Impact of Covid-19**

5.55 The response to Covid-19 impacted on face-to-face contact with Jonah by health services. Health staff had to reduce the risk of transmission between themselves and patients. For example, in July 2021, KMPT offered in-person or video assessments to patients. The clinician who assessed Jonah on 13th July 2021 believed that sufficient information could be gathered by telephone and in fact, video assessments were not routinely offered. On 31st August 2021, the consultant psychiatrist's medical review was conducted by telephone since it had been brought forward following the concerns raised by the London Ambulance Service and took place at the next available appointment. The consultant psychiatrist believed that sufficient information could be and was obtained by telephone.

5.56 During the time covered by this review, health services also had to respond to increasing levels of Covid-19 infection, which led to local and then to the national lock down in December 2021.

5.57 Whilst there is evidence that video contact can prove more effective than face to face contact for some client groups who otherwise services found it difficult to engage with, face to face contact can still provide useful insights into body language, eye contact, environment and appearance which can inform clinical assessments and decision making.

6 CONCLUSIONS

6.1 **The risk of Jonah's suicide was not fully understood**

6.2 Assessments did not fully capture the risk that Jonah might kill himself, despite the increase in distress and references to a suicide method during August 2021. KMPT's policy was not followed and communication by email proved ineffective. Assessments do not appear to have considered Jonah's history of self-harm and emotional instability as potential suicide risks. Nor did they enquire into the connection between Jonah's presentation of mental health needs and spiritual conflict and his use of crystal methamphetamine, potential abuse and conflicts about his sexuality (**Recommendation 1**)

6.3 In addition, no appropriate suicide safety plan, as outlined by the Royal College of Psychiatrists, was created beyond asking Jonah if he had the relevant crisis telephone numbers. (**Recommendation 1).**

6.4 Further awareness, consideration and exploration of these factors, either with Jonah or within and between the different services in contact with him, might have helped to form a clearer picture of Jonah's circumstances and might have influenced the outcome of risk assessments beyond Jonah's immediate presentation. History taking, identifying patterns and escalation are essential activities in managing risks (**Recommendation 2).**

6.5 Jonah appears to have been in conflict about his sexuality and his religious beliefs. He also said that he had engaged in risky drug influenced sexual activities, which led him to attend hospital or his GP surgery afterwards. There was no exploration of Jonah's feelings about these sexual encounters, whether he was being abused or the extent to which he was in relationships he was happy with. There was no signposting to support groups or agencies with which Jonah could discuss his sexuality and how to keep himself safe, to an Independent Sexual Violence Advocate or to a sexual health clinic (**Recommendation 3**).

6.6 There appears to have been an assumption, perhaps based on unconscious biases, that Jonah was making lifestyle choices, which can be an unhelpful and potentially dangerous conclusion in the context of substance use and the experience of harm (**Recommendation 4 and Recommendation 5).**

6.7 Recommendations 4, 5 and 6 all link with similar recommendations made in Domestic Homicide Reviews and the BSAB and KMSAB may wish to consider engaging in joint work with their respective Community Safety Partnerships on these.

6.8 KMPT has made changes to duty processes to prevent cases being overlooked again. Every task that comes to duty is now immediately written in the duty book and every patient in the duty book is discussed in the RED board meeting each morning. The CMHT have addressed a need to ensure consistent senior oversight within the daily RED board meeting. Failure to enter a name in a duty book was an important factor in a recent safeguarding adults review ("John", Royal Borough of Kingston-Upon-Thames, 2022) and this might indicate the need to review paper-based duty systems more widely (**Recommendation 6**

6.9 **There was a lack of involvement with Jonah's family or friends.**

6.10 Jonah's father and mother reported their concerns about Jonah but there appears to have been a reticence by professionals to work with Jonah's family because of concerns about confidentiality. Jonah did not give consent for contact with his parents.

6.11 The Royal College of Psychiatrists states that all health and social care professionals should be aware of the "*Information sharing and suicide*

prevention consensus statement" (Department of Health, 2014) and adapt their practice as necessary to work with family and friends and prevent suicide. This guidance sets out the circumstances in which concerns about suicide can and should be shared even in situations where permission to do so has not been given by the person at risk (**Recommendation 7**)

6.12 There was no further exploration of the extent to which Jonah's family could be involved as partners in Jonah's care or act as protective factors in alerting services to self-harm and suicide risks. "Think Family" approaches might have been useful (**Recommendation 8**).

6.13 The "Think Family" approach builds the resilience and capabilities of families to support themselves (Wong et al, 2016). This approach recognises that individuals rarely if ever exist in isolation and that whole-family approaches are often necessary to meet individual and family wide needs. The core principles of the "Think Family" approach are that practitioners:

- Consider and respond to the needs of the whole family; including the poverty, drug and alcohol use, domestic abuse and mental health difficulties of everyone in the home (including frequent visitors) in all assessments and interventions.
- Working jointly with family members as well as with different agencies to meet needs.
- Share information appropriately according to the level of risk and escalating concerns if they are not otherwise being responded to.

6.14 Such an approach may have led to greater consideration of how Jonah's mother and father might have been engaged as partners in keeping Jonah safe and of what risks were posed to Jonah by his brother.

6.15 **There was little inter-agency coordination and opportunities for joint working and sharing information were not always taken.**

6.16 Jonah was in contact with agencies across three local authority areas (London Borough of Bexley; Kent and Essex) and there was some communication between them. However, there were no multi-agency multi-disciplinary team group conferences or risk meetings at which concerns, and information could be shared and at which multi-agency action could be agreed and monitored (**Recommendation 9**)

6.17 The Merlin reports detailing police concerns about Jonah provided his name and address but not his date of birth. This meant that Jonah could not be found, or an account set up for him, on the Rio system. It was therefore not possible for the screeners to find out more information about Jonah on Rio, which might have assisted in identifying the risk that Jonah may harm himself and may have prompted a safeguarding enquiry to establish the effectiveness of the current approaches to working with Jonah (**Recommendation 10**)

6.18 Agencies closed cases due to Jonah's non-engagement (for example when he was in Malta) or because their contact with him was episodic. This is a regular

feature in other SARs, to the extent that it could be a risk indicator in itself. There is a need for more assertive outreach rather to wait for people who are hard to engage to contact services themselves.

7 RECOMMENDATIONS

7.1 **Recommendation 1:** The BSAB and KMSAB should measure through the Self-assessment framework that organisations have clear processes in place for working with individuals who are demonstrating suicidal behaviour. The evidence for this includes training, awareness raising, risk assessments, suicide safety plans etc.

7.2 **Recommendation 2:** The BSAB and KMSAB should seek assurance from board members that risk assessments involving suicide are clinician led and based upon at least a core set of evidence-based questions.

7.3 **Recommendation 3:** Support, rape kits and assistance with reporting incidents to the police should be offered for men and for women who attend A&E reporting about sexual encounters involving the use of drugs. This could include the offer of HIV tests and anti-HIV medication, referral to a sexual health clinic and the offer of contact with an Individual Sexual Violence Advocate.

7.4 **Recommendation 4:** The BSAB and KMSAB should seek assurance that guidance is provided to professionals on avoiding the assumption of lifestyle choices as an explanation for engaging in harmful behaviours. Support and guidance should be provided for professionals who feel uncomfortable about, and are uncertain how to respond to, concerns related to sexuality and consent.

7.5 **Recommendation 5**: The BSAB and KMSAB should seek assurance that training and awareness raising interventions are used by health and social care services to support professionals to recognise and compensate for unconscious and cultural biases when working with people who engage in drug enabled high risk sexual activities. Specialist training in recreational drug use (including Crystal Methamphetamine and Ketamine) should be included in this.

7.6 **Recommendation 6:** KMPT should ensure that processes are in place to prevent paper-based duty systems from missing cases.

7.7 **Recommendation 7**: The BSAB and KMSAB should seek assurance from board members that the Department of Health, 2014's "*Information sharing and suicide prevention consensus statement*" is understood by practitioners who may work with people who are at risk of self-harm or suicide.

7.8 **Recommendation 8**: The BSAB and KMSAB should seek assurance from board members that "Think Family" approaches are being used to engage with family members.

7.9 **Recommendation 9**: The BSAB and KMSAB should lead an audit of the use of multi-agency information sharing protocols to determine whether or not they promote effective joint working, cooperation, sharing information and prevention when working with people at risk of suicide and to the extent to which they include voluntary and community organisations and families.

7.10 **Recommendation 10:** The BSAB should seek assurance from the Metropolitan Police Southeast BCU that name, address and date of birth will be included in all Merlin reports so that adults coming to notice can be correctly identified in, or their details recorded on, client information systems such as Rio.

APPENDIX 1

Terms of Reference

- To what extent did agencies act appropriately in response to Jonah's needs and risks including mental health needs, self-harm and suicide?
- How effective was the interface between mental health services and the police, including the use of and response to Merlin reports (Adult Come to Notice Reports?)
- How effectively were adult safeguarding processes used?
- How effectively was information shared, including across borders?

APPENDIX 2

Active Review

The Active Review process ensures a standardised procedure to review the risks and needs of patients waiting for active treatment. This ensures that patient safety is the key priority while people are waiting for treatment in KMPT's Secondary Care Mental Health Service. By reviewing their needs, this process enables us to understand and monitor if a person's situation changes to ascertain if they can be better helped by another service, or no longer require Secondary Care Mental Health Services. People may be required to wait for the following input:

- A medical review, if not seen previously by a doctor. If they have been seen by a doctor and a further medical review is the only intervention required, then consideration should be given to allocation of the doctor as Lead HCP.

- Core interventions – Recovery Groups, STEPPS, Change Programme for People with PD, Initial interventions.

- Specialist psychological treatment.

Those waiting for the above input will automatically be placed into the Active Review Process.

RED (Risk Evaluation and Decision) Board.

RED Board meetings should not be confused with red risk ratings. The purpose of red board meetings is to enable multi-agency discussion of people assessed to be at high risk and those who do not attend appointments.

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