Safeguarding Adults Review: 'Alexander'
Reviewer: Fiona Bateman
February 2022

Introduction

Greenwich Safeguarding Adult Board ['GSAB'] commissioned this SAR following the death of an adult with care and support needs. For the purposes of anonymity and at the request of his family he is known within this review as 'Alexander'. The period under review is from July 2020, when planning for his discharge from an inpatient mental health hospital after a long period of detention began in earnest, until his death. He subsequently moved into a support living placement where he received 24-hr support. He was also known to the Greenwich East Intensive Case Management and Psychosis Team[1] and, in line with the Care Programme Approach,[2] had an allocated care coordinator. Alexander died on 02.01.21 (aged 39) in Queen Elizabeth Hospital [QEH'] having been admitted to hospital on 22.12.20 exhibiting signs of severe dehydration and malnutrition. In the 8 weeks Alexander spent at the supported living unit, he lost 17.9kgs in weight. A post mortem concluded that the cause of Alexander's death was a ruptured oesophagus (Boerhaave Syndrome), disseminated intra-vascular coagulopathy and urinary tract infection.'

Alexander was black British, and his family explained his Jamaican heritage was very important to him. He enjoyed hearing and speaking patois and loved Jamaican food so much that he would tell his mum which local shops sold his favourite foods so she could bring these to him on the ward. Alexander had spent much of his adult life in institutional care due to his mental ill health. He had a diagnosis of paranoid schizophrenia which was treatment resistant, dissocial personality disorder and comorbid mental & behavioural disorders due to use of multiple psychoactive substances. The main symptoms he experienced were described within his case notes as labile mood, agitation, and aggression, thought disorder, persecutory and bizarre delusions.

Alexander was described by his family as vibrant, happy, affectionate, and caring. He was close to his family, who (prior to Covid-19 restrictions) visited him frequently. He would turn to them when unwell and was responsive to their advice. As a child he was a keen footballer and was scouted by Charlton but was a life-long Arsenal fan. He also enjoyed music of every genre, liked to dance, sing and was always composing lyrics. At 16 he had started a course in bricklaying but had a lifelong dream to be a DJ.

Scope of the Review

Purpose of the review: The purpose of having a Safeguarding Adult Review (SAR) is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died; its purpose is:

- To prepare a summary report which brings together and analyses the findings of the various reports from agencies to make recommendations for future action.
- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies worked together to safeguard adults.
- To review the effectiveness of procedures (both multi agency and those of individual organisations).
- To inform and improve local interagency practice by acting on learning.

[1] Part of the Community Mental Health Team ['CMHT'] managed by Oxleas NHS Trust
[2] During the review period Oxleas Trust's CPA policy and Covid-19 operational policy were reviewed. It is the newer versions of those policies documents that have been referenced within this report.

There is a strong focus in this report on understanding the underlying issues that informed agency and practitioners' actions and what, if anything, prevented them from being able to keep Alexander safe.

Parallel Process: At the time of writing this report both a Coroner's inquest into the death of Alexander and the Police investigation in respect of possible offences[3] were ongoing. The Senior Investigating Officer was aware of the review and care was taken to ensure that the SAR process did not affect either investigation. In consultation with partners, GSAB believed it was important to commission and complete the review within a rapid timeframe, notwithstanding the ongoing investigations, because of the impact that this case could have for service delivery and design in the Covid-19 recovery period.

GSAB have prioritised the following five main themes for illumination through the SAR:

1. How were Alexander's cultural needs addressed?
2. What was understood about his history of self-neglect and what consideration was given to the views of his family and previous risk assessments regarding risks associated with institutionalisation and malnutrition?
3. Did multi-agency care management and inter-agency information sharing meet expected standards?
4. How did Covid-19 pressures impact on decision making?
5. Were plans for discharge, risk assessments and decision-making regarding community placement adequate?

It is intended that lessons from this review will form the basis of an action plan for GSAB partners. Where there is learning relevant for national or regional consideration, this will be escalated via the protocol for regional and national safeguarding Chairs networks to share concerns with the Department for Health and Social Care.

Methodology: GSAB arranged for the conduct of a SAR using a modified version of the Social Care Institute for Excellence SAR in Rapid Time methodology. This was to enable learning to be turned around more quickly than usual through a SAR, but with a more detailed report than would typically be produced for a SAR in Rapid Time. This methodology employs techniques to avoid hindsight bias so as to fully understand the complexity of the situation confronting the practitioners[4] who were involved in his care at the time. We know that decisions or actions that are followed by a negative outcome are judged more harshly than if the same decisions or actions had ended either neutrally or well. The learning produced through a SAR in Rapid Time concerns 'systems findings', which identify social and organisational factors that make it harder or make it easier for practitioners to do a good job day-to-day, within and between agencies.

This report draws on the information provided from individual agency internal management review reports, policy documents and case records made available to the reviewer. The following agencies provided documentation to support the SAR:

- Oxleas NHS Foundation Trust
- NHS South East London CCG (Greenwich borough)
- Metropolitan Police Services
- London Ambulance Service
- Royal Borough of Greenwich
- Supported Living Services (Provider)
- POhWER advocacy
- GP (Newham)
- Newham Council
- Lewisham and Greenwich NHS Trust (responsible for the Queen Elizabeth Hospital)

[3] Under s20-25 Criminal Justice and Courts Act 2015 and/or s127 Mental Health Act 1983

[4] A note about terminology. The term 'practitioner' is used throughout this report to denote anyone actively engaged in a paid role with responsibilities for the provision of health or social care support and for whom safeguarding responsibilities will arise either because of contractual obligations to provide services to an adult with care and support needs or through their own professional bodies practice standards.

In addition to a review of case and policy materials, multi-agency learning events took place with front-line practitioners who worked with Alexander, and leaders who oversaw the services involved in supporting him. Information provided by Lewisham and Greenwich NHS Trust was provided only after these scheduled learning events which prevented the reviewer's ability to test the findings of those who worked with him.

Involvement of his family: Alexander's mother was involved in his care throughout his life, she accompanied him to the clinic on the 23.12.20 and, prior to this, played an active role in advocating for him and working to support practitioners engage him in his treatment plan. At his request, she managed his finances. He was also close to his wider family, particularly his sister. Throughout his life they were in close contact with Alexander, frequently visiting him and remaining (even throughout the pandemic) in daily contact via telephone. The reviewer is grateful to both Alexander's mother and sister for taking time to meet with her and speak about their experiences. They have illuminated the report with a picture of who Alexander was and spoke eloquently about the importance of his cultural heritage and of practitioners understanding the value of pro-active engagement with families to mitigate and manage foreseeable risks faced by adults with chronic mental ill health.

Narrative Chronology

Alexander was born in 1981. There were concerns about his development from age 7, he was reported to have difficulties with his reading and concentration. At 10 he began to refuse to go to school and wanted to stay at home in order to intervene when violence occurred between his father and mother. At the age of 12 he began to truant from school. He was found a place in remedial school, but he did not attend. His IQ was assessed at 73[5], suggesting a learning difficulty. Concerns in relation to his mental health were first raised when he was 15 years old, at this time he was reported to be withdrawn, with very poor self-care and was hoarding family items in his room. In 1999, aged 18, he was arrested following a serious physical assault on his sister and was detained under the Mental Health Act 1983 (MHA). He was subsequently diagnosed with paranoid schizophrenia. Throughout this admission his self-care was reported to be poor, staff also reported physical aggression and sexual inappropriate behaviour requiring seclusion. He was prescribed Clozapine, an antipsychotic medication, but adherence to this was poor.

Alexander remained an inpatient until October 2005 when he was discharged to a low support hostel. Within a few weeks of being discharged he had stopped taking medication, he became aggressive and was reported to be using street drugs. His mental health rapidly deteriorated. He was reported to have lost a significant amount of weight and there was evidence of self-neglect. On the 22.11.05, he was readmitted to hospital (subject to MHA compulsory powers) and remained an inpatient in various wards until June 2014 when he was discharged to supported accommodation and supported under the Care Programme Approach ['CPA'] by the East Recovery Community Mental Health Team ['CMHT']. He was allocated a care coordinator, but again his engagement with his treatment plan was reported to be poor and residential placements broke down.[6]

In October 2015 Alexander was arrested and received a custodial sentence for burglary. He was discharged by CMHT in July 2016 as he was serving a sentence at HMP Pentonville. He was released from prison on the 06.08.17, but breached terms of his parole by not staying in his placement address, not engaging with probation officer, reportedly using illicit drugs, and going missing so was re-arrested 13.10.17.[7] On 26.10.18, he was transferred from HMP Brixton to Tarn Psychiatric Intensive Care Unit (PICU), Oxleas NHS Trust as an inpatient under Section 37 MHA. During this time, he was diagnosed with sinus tachycardia, believed to be a

[5] More recently a full cognitive test completed in March 2020 in anticipation of his discharge assessed his IQ at 68, placing him of the 2nd percentile, meaning that 98% of the general population would obtain a result equal or above this level.
[6] Summarised within the ADL assessment. The Complex care funding panel notes record this was 'due to antisocial behaviour and substance misuse'.
[7] Taken from the Panel and PING form records 'He has had numerous arrests, sentences and recalls into prison prior to this (mainly due to non-engagement with probation team and going missing).'

side effect of the use of Clozapine and initially prescribed Propranolol, later this was changed to Bisoprolol. He was also noted to have lost a significant amount of weight (10kgs in 3 months) which he described as intentional. His s49 restrictions ended on 29.10.18, though he remained detained under section 47 MHA[8] between 30.10.18 until his discharge to Supported Living Services [hereafter 'SLS'] on 28.10.20 under a Community Treatment Order under Section 17A MHA. By this time Alexander had spent over 14 years (the majority of his adult life) in institutional settings.

Prior to this discharge, a previous attempt in October 2019 to move him into supported living had failed as, during a planned section 17 leave[9] within the placement, he had refused his medication, broken placement rules and complained to staff that '*the ward chased him out*'. In January 2020, following a review by hospital managers where continuation of his detention under section 3 MHA was upheld, clinical staff were of the view that he would be unlikely to gain further from inpatient rehabilitation. They recognised he scored high on the Psychopathy Checklist-Revised (PCL –R) so would require long term supervision. He was reportedly stable on his medication and was using his leave appropriately. Despite this, staff were aware he had '*limited insight into his mental health and doesn't believe he needs treatment or needs to be in hospital. … is in denial about previous placements breaking down and said, "staff didn't like me that's why the placement broke down". He alleges that his care team are not doing enough to support him, and they were ganging up on him*'.[10] Consequentially, a number of possible supported living providers had declined referrals to provide care to him, so it was proposed to offer him support at TILT (an intense community support system for patients coming out of hospital with SMI, complex needs and antisocial behaviour run by Oxleas NHS Trust and Bridge). If this was unavailable, it was agreed a spot purchase placement could be arranged. Funding for a TILT placement was turned down, because he did not have a significant forensic history and he had previously not made use of placements with high levels of therapeutic support.[11]

In preparation for his discharge into a community setting Oxleas staff also made a referral for Alexander to the independent advocacy service[12] who, despite Covid-19 restrictions on face-to-face meetings, were able to speak with him on the 27.04.20. During that conversation Alexander said that he "*should not be where he is and should have been gone 2 years ago.*"[13] Subsequent attempts by the advocacy service to speak with him were thwarted either because the ward's only mobile phone was being used by other patients or because Alexander requested the advocate call another time. However, in May 2020 the advocate was able to speak with Alexander and ensure he understood his rights. Again, Alexander confirmed he wanted to move on from the ward, the advocate followed this up by speaking with ward staff and attending a ward round (via telephone) to discuss the forensic risk assessment and placement options. Following this meeting Alexander confirmed to his advocate his preference was to wait on the ward until suitable accommodation could be provided during which time, he understood he would need to demonstrate to a willingness and ability to manage in supported accommodation. He was advised that if he required further support from advocacy, he could receive this. In June 2020 Alexander requested further support, frustrated that accommodation had not been identified. It appears that he felt this was the fault of his care co-ordinator and stated he had requested a different care co-ordinator. After further enquiries, the advocacy provider was advised that the ward manager had not made a referral for advocacy support and this support was withdrawn.

Oxleas' Occupational Therapy also conducted an assessment of Alexander's ability to carry out activities of daily living between 8-10.09.19. This was revised on the 28.04.20 concluding he was '*keen to move on from the ward… that he would require some support on discharge as he has not lived independently for years.*' Whilst he demonstrated some basic cooking and shopping skills, it is noteworthy that his own view of his capabilities

[8] A restricted patient whose restriction order has ceased to have effect is treated as if he had been admitted to hospital as an unrestricted patient (often referred to as a notional s37).
[9] Patients detained in hospital under the MHA may only leave the hospital if permitted by their 'responsible clinician.' Any leave of absence from the hospital may be subject to conditions. This is often referred to as 's.17 leave' because it is s17 MHA that permits this leave.
[10] Taken from the Complex Care Panel minutes
[11] Taken from Oxleas NHS Trust's discharge summary
[12] In line with s130C MHA as Alexander was a 'qualifying patient' for independent advocacy.
[13] Taken from a summary of involvement submitted to the review by the advocacy provider, POhWER.

was more optimistic than the views of staff supporting him on the ward. The report recommended 24hour supported accommodation on discharge and concluded there was an ongoing risk of:

- Self - neglect
- Mental state deterioration.
- Absconding - as stopped engaging in the past and left the accommodation he had been placed in; and
- Illicit substance misuse- as used illicit substances in the past and recently absconded whilst under s17 leave to misuse.

Key Events in the period under review (July 2020- January 2021) and Practice Issues

Shortly before his discharge Alexander came to the notice of police on three occasions (namely 28.07.20, 16.09.20 and 28.09.20) as he was reported absent without leave ['AWOL'] from the ward having not returned at the agreed times following s17 authorised leave. Patients detained in hospital for treatment can only leave lawfully if they have been given a leave of absence by their responsible clinician in line with s17 MHA. Any leave should be risk assessed, with support and contingency plans understood by the patient, carers, and relevant community services[14] and the '*outcome of leave – whether or not it went well, particular problems encountered, concerns raised, or benefits achieved – should be recorded in patients' notes to inform future decision-making*' [pg. 27.23 MHA, Code of Practice]. Patients who fail to return to the hospital at the time required under conditions of the leave are considered AWOL under s18 MHA and can be taken into custody and returned by an approved mental health professional, police officer or anyone authorised by the hospital managers. Alexander's missing episodes were considered medium risk by the police due to his paranoid schizophrenia, cannabis, and cocaine drug dependency, and need for medication at 6pm. Efforts were made to trace him via friends and family, who he had been calling asking for money; their assumption was he was looking to purchase drugs. On each occasion he returned to the ward of his own volition within 48 hours. He did not provide details of where he had been and, on one occasion, a random UDS was completed, and he was positive for cocaine.[15] As a consequence he was encouraged to accept support from Westminster Drug Project (WDP) on the ward, but he does not appear to have engaged meaningfully with this.[16]

If it is proposed to discharge a patient, including under a Community Treatment Order [' CTO'], duties to plan for and provide 'aftercare support' for patients are set out in s117 MHA. This is a shared responsibility between the relevant Local Authority and NHS Clinical Commissioning Group. Any treatment, care and support plan should be informed by the patient's responsible clinician and meet the expectations of the Care Programme Approach, including the identification of a care coordinator. Both Greenwich CCG and Royal Borough of Greenwich confirmed that, on his discharge Alexander would be entitled to aftercare support in-line with s117 MHA. The s.117 aftercare plan confirmed he would be discharged to the care of Greenwich East Intensive Case Management and Psychosis ['ICMP'] Team and received support in line with the Care Programme Approach ['CPA'], retaining the same allocated care co-ordinator and Responsible Clinician. It was also agreed that he would have access to psychology and occupational therapy support. His care coordinator was required to:

- maintain regular 2 weekly contacts, during which there would be continuous assessment of his mental and physical state.
- monitor compliance with his medication; and
- review and report to the commissioners any concerns regarding violence or substance misuse.

Where issues arose regarding substance misuse, the Care Coordinator would have access to support from a ward-based Substance Misuse lead and would encourage Alexander to accept a referral to local substance misuse services to receive support if he continued to use cannabis. His home care package also allocated a carer that could offer daily supervision of his compliance with medication.

[14] Pg. 27.10 MHA Code of Practice provides detailed requirements for consideration before granting leave.
[15] As reported within the ADL assessment
[16] Oxleas NHS Trust's discharge summary (dated 30.10.20) reported he refused to engage.

By mid-October SLS had been identified as a possible placement and the provider completed their own assessment, having met Alexander within the ward and confirmed with him he understood the expectations regarding house rules, particularly in respect of substance misuse. They confirmed (by letter dated 16.10.20) agreement to offer a 2-week trial placement during which the '*placement will provide close monitoring of his mental health, encourage compliance with prescribed medication and provide psychoeducation in the community to address this need.* [Alexander] *will also need to be supported to continue his engagement with mental health services and other meaningful activities essential to maintain a stable mental state to resume life in the community safely. A Keyworker at the placement will have regular 1:1 session with him to build a therapeutic relationship. … the accommodation provides Drug and Alcohol Service on-site and he will be required to attend 1:1 sessions and group session with CGL if necessary.* [Alexander] *will be UDS tested and breathalysed on a regular basis if required. He was informed that the accommodation has a zero-tolerance policy on drugs and alcohol. We also discussed the importance of structured activities to keep him occupied. He agreed to accept any support required to help him stop drugs.'*

In contradiction to the discharge summary completed by his doctors, Alexander advised SLS assessor that he experienced '*no side effects of medication. …that he had no physical health conditions and feels well.'* The placement confirmed they would support him to live independently, monitor his mental and physical health conditions and carry out full health check-up with his GP and ECG annually. Aside from assurances that the placement will support Alexander to follow medical advice (e.g., a healthy diet plan) and support to prepare food, there was no explicit mention within the support plan of risks associated with self-neglect or malnutrition.

On the 22.10.20 an assessment of the Care Act eligibility outcomes was completed and confirmed eligibility because of an inability without support to maintain nutrition, maintain his personal hygiene, be appropriately clothed, make use of his home safety and maintain a habitable home, maintain personal relationships, engage in work or training, or use community facilities. This assessment recommended he receive support to:

- Attend all hospital appointments with mental health professionals, physical health check-ups and other mental health services (i.e., psychotherapy session, clozapine blood test). staff/carers to monitor his concordance with clozapine at the placement.
- Be referred for Behavioural Modification to deal with his behavioural issues.
- Be referred for Nutritionist and Dietician to manage the concerns regarding his weight.
- Attend drugs and alcohol management programme to support him with rehabilitation.
- Staff prompt and encourage him to join the gym or engage in physical activities to have structured day plan and keep healthy.
- Care coordinator/ psychiatrist will regular monitor his mental state/risk assessment/management.[17]

Within this assessment, the frequency of contact with the placement and the client were detailed with his care co-ordinator as 'regular contact fortnightly'. The care coordinator was also expected to have regular telephone contact with staff at the placement, the nature of such calls was to discuss progress, gather updates on physical and mental health needs and to discuss outstanding areas of need. Three-way meetings were to be '*carried out on a regular basis, where outstanding needs and plans are made; parties within this meeting are placement staff, [Alexander] and I as the [care coordinator]*.' He was also due to be seen 'every 6 months for his pre-CPA[18] meeting to review his needs'. This assessment, in common with the provider's proposed care plan, confirmed the aims of the placement were to '*help* [Alexander] *develop the skills he needs to live as independently as possible and then to help him to safely move on to a supported accommodation in future*.'

Agreement was reached that the Royal Borough of Greenwich and Greenwich CCG would jointly fund his placement on the understanding both SLS (the provider) and Oxleas' care co-ordinator provide monthly

[17] Taken from Panel and PING form records
[18] This refers to the 'Care Programme Approach' which is a model of care expected to be used to coordinate the care of people with mental disorders.

reports on progress and notify the commissioners as soon as possible if issues arose with the placement. Once agreement had been reached regarding his accommodation the responsible clinician could then determine conditions for his discharge. It was agreed this would be subject to a CTO with the following conditions:

- To engage with his community treatment team including his Responsible Clinician for the purpose of assessment and to attend his scheduled meetings and review appointments.
- To take his psychotropic medication as directed by his Responsible Clinician and attend for the associated blood tests to continue this medication safely.[19]
- To engage with substance use services and provide a urine sample for drug screen if so requested by his community team.
- To reside in accommodation as directed by his Responsible Clinician and to abide by the rules of the tenancy agreement.

It is understood that, during this time, Alexander had indicated he wished to lose weight to improve his health. In July 2020 he weighed 101.25kgs (BMI of 24.8) , by the 14.10.2020 the last time he was weighed before his discharge he was 89.9kgs with a BMI of 22.3. The discharge summary asked that he attend his GP regarding the extensive weight loss and review his bloods in 3 months due to an iron deficiency anaemia. In line with the CPA policy[20] his care coordinator made contact, by telephone, on the 30.10.20. Alexander was reported to be concordant with his prescribed clozapine and expressed his excitement about his flat.

However, soon after his arrival Alexander was reported to have started to disengage from support offered, including immediately refusing to take Ferrous Sulphate (prescribed for his iron deficiency and required to be taken in the morning and afternoon.) SLS reported on 02.11.2020 and 03.11.2020 he appeared withdrawn. On the 10.11.20 Alexander refused to attend group activities and the Clozapine Clinic as he complained of diarrhoea, prompting a professional meeting on 11.11.20 between his Care Coordinator, Psychiatrist and SLS staff.[21] Alexander was invited to attend, but declined. It was agreed to require him to attend the Clozapine clinic on the 16.11.20 and then move this to every 2 weeks on 30.11.20. SLS staff were asked to warn Alexander that non-attendance and concordance with medication would result in his recall to hospital (in line with powers under s17E of the MHA). He did attend the Clozapine clinic on the 16.11.20 and a physical health monitoring form was partially completed on that day, but he refused to have his weight checked. He also denied experiencing any side effects from his medication. His vital signs were checked[22] and reported to be within normal range.

On the 17.11.20 Alexander refused to attend a professionals meeting with his Care Coordinator, Psychiatrist and SLS staff. Whilst the meeting was cancelled there appears to have been a discussion between SLS staff and his care coordinator in which SLS staff advised that he was concordant with his medications but raised concerns his flat was 'messy'. Alexander again refused to attend the Clozapine clinic for blood test on 23.11.20. The frequency of reviews was changed to every 4 weeks. SLS collected the Clozapine medications from the clinic on his behalf. His care coordinator called to carry out a welfare check and was advised he had been vomiting in his room and refusing support to clean this. His care coordinator spoke with Alexander about his non-compliance with his medications and reminded him of the important of adhering to CTO conditions and the possibility of recalling him back to hospital if he continued to refuse to take his medications. He reassured his Care Coordinator that he would start to comply with his treatment. SLS records show he refused support to clean his room, even after staff provided equipment and offered to help. They warned him it wasn't appropriate to stay in a dirty room. He also continued to refuse his Ferrous Sulphate medication.

On 02.12.20 SLS staff noted that Alexander had vomited[23] and he claimed this was probably from a takeaway

[19] Namely Bisoprolol and Clozapine. He was also on iron replacement supplements.
[20] This policy requires a follow up contact is made within 7 days
[21] There is no record of above professional meeting within Oxleas NHS Trust's case records.
[22] The case notes report his bloods were taken, his temperature was taken on entry to the building and was within normal range for covid. His blood pressure was 107/81 and pulse 92. There is no recording with respect to his weight
[23] Previously (23.11.20) the case coordinator had recorded SLS concerns about the state of his room from vomit.

he had the previous night. He refused for staff to contact a GP. He continued to remain in his room, though staff noted he had food on the 03.12.20 (tuna sandwich). Confirmation that Alexander had been registered with a GP was received on 04.12.20 and he subsequently requested a telephone consultation. The GP confirmed they contacted him twice by voicemail and once by text on the 09.12.20 but didn't have further contact from him. Staff did make contact with his GP and attempted to book an appointment the following day, but were advised the earliest appointment would be 22.12.20.

SLS sought to engage Alexander to complete the Wellness Recovery Action Plan (WRAP) on the 07.12.20, but he refused. SLS recorded he was exhibiting delusional behaviours on the 08.12.20 and raised concerns with his Care Coordinator regarding his physical and mental health. By this time Alexander must have been showing very obvious signs of significant weight loss, but it is not recorded (in either Oxleas' or SLS' case notes) as having been discussed. Nor was there any attempt to arrange an urgent review of his physical health with his GP. Instead, his care co-ordinator advised SLS to send him to A&E for a check (this wasn't actioned) and it was agreed to move his medication to earlier in the day to help monitor his mental health. From the 11.12.20 his Clozapine was given during the day around 12pm.

By the 14.12.20 Alexander continued to refuse his Ferrous Sulphate, he also refused again to attend the Clozapine clinic for blood test, stating that he could not walk. SLS reported (at the learning event for the SAR) concerns about his mobility were not escalated as a member of staff reported having seen him walking in his flat. SLS staff were advised by staff at the clozapine clinic they could collect a week's supply of his medication and to ensure he had a monitoring blood test within 7 days to ensure treatment is not interrupted. Clinic staff rebooked an appointment for the 21.12.20 and explained that if Alexander refused the following week they would 'make a plan'. His care coordinator again requested SLS arrange for him to attend A&E. He subsequently barricaded himself into his room. SLS called NHS 111 who attempted to speak with him, but when that failed (given the history of non-compliance with medication and vomiting for a week) advised a '*more enhanced clinical assessment was needed'* so arranged for police and ambulance to take him to hospital. The police subsequently requested ambulance support and were advised there was likely to be a delay due to higher priority calls. At 2:36am London Ambulance Service rang SLS staff at the unit for a condition update. They were informed that a welfare check had been made at 7pm, but when asked to perform another one SLS staff declined as they believed Alexander was sleeping and they did not want to disturb him. Further calls were made by Ambulance staff at 2:59am and 3:41am. SLS staff were not willing to disturb Alexander to complete any welfare checks. There has not been an adequate explanation by SLS for why staff believed it reasonable in the circumstances to override medical advice (from LAS, NHS 111 service and his care coordinator) to ensure his physical health was reviewed in hospital. NHS 111 notified Oxleas' duty team of their involvement and requested they arrange an MHA assessment and/or treatment in the community. Oxleas Trust's duty team agreed to pass the information on to the relevant team. NHS 111 provided 'worsening advice' to the support staff on scene. NHS 111 also wrote to his GP notifying them of the actions taken.

On the 15.12.20 SLS staff reported Alexander's presentation had improved, as he had attended the office to pay his service charge and agreed for staff to buy him food. But by the 16.12.20 he was again refusing medication and 'appeared ill'. Oxleas' contemporaneous case record reports that SLS staff had advised he appeared much better in mental state and mood; that he had stopped vomiting and he disclosed that he took 'spice'. Staff supported him to clean his flat and buy some food. His Care Coordinator advised the staff to ensure he had adequate food/fluid intake and to get him to see a GP still. Between the 17th and -20th December 2020 SLS reported Alexander's appearance improved and staff continued to buy him food. SLS advised they had not seen him vomiting or seen any vomit in his flat. He was not, however, assessed by his GP.

On the 21.12.20 Alexander again refused to attend his Clozapine Clinic/blood test. His care coordinator attempted to speak to him, but he refused shouting repeatedly and becoming agitated. His mother was advised of his refusal to attend clinic/blood test, she called him to try to persuade him to attend but he was

verbally aggressive and refused to go that day. He did agree to attend the Clozapine clinic the following day as his mother had agreed to accompany him.

On the 22.12.20 SLS staff spoke with his GP, advising that Alexander appeared to have gag reflex and retched each time he took clozapine. They reported to his GP they did not think he looked pale and did not look in pain. They stated that he tends to lay in bed but still had energy to do some things. They said that they were unsure whether he had any fever, diarrhoea, or urinary symptoms. Alexander declined to speak to the doctor - stating he was fine, and he was overheard asking staff for a tuna sandwich and an orange and cherry drink. The GP did not conduct a face-to-face appointment, recording that '*he was able to speak in full sentences in the background and did not sound overtly weak over the phone*.'[24] GP advised staff to take him to A&E if he was persistently vomiting and not able to keep any fluids down at all. Later that day, following phone calls from his mother Alexander attended the Clozapine clinic on 22/12/2020. His mother, as agreed, met Alexander at The Heights, where the Community Mental Health Team is based. Alexander's mother reported shock at seeing him. He was notably weak and found it difficult to walk unaided. She reported that in her attempt to assist him she was pulled to the ground as he couldn't weight bear. At the clinic a doctor noted that he looked severely dehydrated, with cracked lips and his eyes were sunken. His mother requested an ambulance be called. SLS staff reported that his physical and mental health had deteriorated over 2-3 weeks. He was subsequently conveyed to QEH and admitted for suspected metabolic alkalosis and electrolyte imbalance due to vomiting and nausea with dehydration.

On arrival he was admitted to the intensive care unit and received treatment for intravenous electrolyte replacement and intravenous fluid resus, broad spectrum antibiotics for possible sepsis. Despite this his blood pressure dropped and he continued to experience diarrhoea. He was also assessed by psychiatry liaison, who advised sedation and restarting his Clozapine medication. He received regular interventions from the hospital speech and language. The dietetics team assessed him initially on the 23.12.21 and, concerned he was at risk of refeeding syndrome,[25] they advised a slow initiation of feed via nasogastric tube ['NGT']. The advice given complies with relevant NICE guidance [CG32].

On the 29.12.20 the speech and language team completed their initial assessment of Alexander's swallowing ability. They reported difficulty with completing this assessment because of his non-compliance but noted oral dysphagia and mild difficulty with his swallow trigger. Alexander had removed his NGT that day prompting a multi-disciplinary discussion which agreed a plan to tentatively build up his oral nutritional intake. However, when his oral intake and presentation hadn't improved by the following day it was agreed an alternative plan to meet his nutritional needs was needed. This was to reinstate the NGT feeding with additional bridle and hand restraints so it couldn't be removed. This plan was subsequently amended on the 31.12.20 following an indirect review by the SLT in part because Alexander had reportedly been '*very combative with NGT insertion and very agitated at times'* [26] so it was felt this would be kinder to him. The NGT was removed. On the night of 01.01.2021 Alexander refused observations and his arterial line stopped working. This was replaced in the early hours of the morning. He was reported to be very agitated and refused to allow anyone to come near him. A referral for 1:1 support from an RMN was completed but by the time of his death (the following morning) this had not been actioned. Alexander was sedated and it was reported that, although agitated overnight, there were no reports of any problems and his saturations remained at 94%.

At 8.45am on 02.01.21 Alexander was less responsive and hypotensive. Medical intervention was provided including the decision to intubate Alexander, but within 2-3 minutes he had a cardiac arrest. A further major haemorrhage call was put out, but the arrest team agreed to stop CPR at 10.52am. An autopsy confirmed the

[24] Taken from the s42 enquiry report

[25] 'Refeeding syndrome can be defined as the potentially fatal shifts in fluids and electrolytes that may occur in malnourished patients receiving artificial refeeding (whether enterally or parenterally). These shifts result from hormonal and metabolic changes and may cause serious clinical complications.' Taken from 'Refeeding syndrome; what it is, and how to prevent and treat it' Mehanna, BMJ. 2008 Jun 28; 336(7659): 1495–1498. doi**:** 10.1136/bmj.a301. The relevant NICE guidance was updated on 04.08.17 available at: https://www.nice.org.uk/guidance/cg32/chapter/1-Guidance#screening-for-malnutrition-and-the-risk-of-malnutrition-in-hospital-and-the-community

[26] Taken from the QEH Trust's IMR prepared for this review.

cause of death as a ruptured oesophagus (Boerhaave Syndrome), disseminated intra-vascular coagulopathy and urinary tract infection. It also confirmed that he had lost 17.9kgs in the 8 weeks since his discharge from the in-patient mental health unit.

Key Findings in respect of the themes under review in this SAR

1. How were his cultural needs addressed?

The main legislative duties owed to Alexander were under the MHA. At the time of this review, the Government were seeking to introduce major reforms to this legislation. A principal motivation for this was to address the '*profound inequalities that exist for people from ethnic minority communities in access to treatment, experience of care and quality of outcomes following mental health service care… structural factors which engender racism, stigma and stereotyping increase the risk of differential experiences in ethnic minority communities*.'[27] Research confirms that black and minority ethnic people are over four times more likely to be detained under the MHA, they are also less likely to be referred to talking therapies, more likely to be medicated for mental ill health and over ten times more likely to be subject to a CTO.[28] Traumatic, inappropriate and discriminatory experiences of services can also have a detrimental impact on chances for recovery, particularly if the same risk factors of bereavement, family breakdown, incarceration, poverty and exposure to racism continue to be present. There has also been criticism of a Eurocentric approach to recovery for black and minority ethnic people, as the definition does not take a race equality perspective and look at the external factors that impact on the individual.[29]

These systemic issues may have impacted on the outcomes for Alexander. There is little reference within case records to Alexander's ethnicity or cultural heritage. However, his family reported he responded well when efforts were made for his treatment to connect with his cultural background or interests. They gave examples of cooking groups in previous in-patient units that helped him to learn how to prepare Jamaican food. They also said that he was also more responsive when professionals supporting him were from similar backgrounds or knew something of his heritage, for example they said a solicitor who represented him at Tribunal was able to connect with him because of a shared heritage. At a very practical level Alexander's mother suggested including a section within a patient's care plan setting out a picture of the person. This section could detail a patient's cultural needs, what is important to them and how they prefer to work with professionals. This could improve the likelihood of successful engagement as well as make staff aware of any triggers that could adversely impact engagement.

In 2014 the Joint Commissioning Panel for Mental Health[30] issued guidance requesting the introduction of system wide measures to reduce ethnic inequalities in mental health. They asked local areas to devise strategies for improving mental health and wellbeing amongst BAME communities that were informed by improved data and influenced by experts by experience from BAME communities.

> **Recommendation 1:** GSAB and partners organisations should reflect on the local strategy to improve mental health and wellbeing amongst BAME communities and take steps to understand if local mechanism are robust to enable the provision of culturally responsive mental health support. The Race Equality Foundation have suggested commissioners and practitioners consider:

[27] 'Modernising the Mental health Act' Independent Review, 2018 available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf

[28] Black African and Caribbean men are significantly overrepresented in data for those compulsory admitted into hospital.

[29] Race Equality Foundation, 'Racial disparities in mental health: literature and evidence review' 2019 available at: https://raceequalityfoundation.org.uk/wp-content/uploads/2020/03/mental-health-report-v5-2.pdf

[30] Joint Commissioning Panel for Mental Health (2014) Guidance for commissioners of mental health services for black and minority ethnic communities. Joint Commissioning Panel for Mental Health www.jcpmh.info

- What strategies and mechanisms are in place to increase the representation of ethnically diverse mental health providers and allied health professionals with a view of increasing the representation of Black and minority ethnic individuals in leadership at all levels?
- How do policy makers and commissioners develop their knowledge, confidence, and cultural competencies in order to address ethnic inequalities in mental health?
- How do services provide culturally sensitive and appropriate services to users and their families?
- How do mental health services collaboratively work with the voluntary sector and community and faith groups to examine different pathways to care and address barriers to service access?[31]

2. What was understood about Alexander's history of self-neglect and was consideration given to the views of his family or previous risk assessments regarding risks associated with institutionalisation and malnutrition?

The Mental Health Act's Code of Practice underlines the importance of adopting a human rights, person-centred approach. It also reiterates the importance of compliance with related legislation; the Mental Capacity Act 2005 and the Care Act 2014 duties are particularly relevant in this case. All three Acts require practitioners from relevant agencies (including NHS Trusts) to exercise their powers and fulfil their legal duties in a manner that complies with overarching principles[32] set out within the legislation and associated guidance. This includes positive obligations under the Equality Act 2010 and Human Rights Act 1998[33] to respond appropriately where there is a real and imminent risk. There are also duties to prevent social care needs escalating (under s2 Care Act 2014) by providing advice and support before eligibility thresholds for services are crossed. Practitioners must take into account everything they can reasonably be expected to know and record why they believed any action or inaction was within legal powers, necessary in the circumstances and proportionate to the risk.

Where there are safeguarding concerns, these should be reported and responded to in line with s42 Care Act 2014. It is implicit both within the MHA Code of practice and Oxleas Trust's Care Programme Approach policy, that practitioners should remain mindful of relevant enduring duties in respect of assessment (including under s11(2) Care Act 2014) and utilise relevant legal powers, e.g. recalling a patient back to hospital,[34] if there is a risk of harm (including through neglect), irrespective of the person's capacity to refuse support. These statutory or professional responsibilities are not extinguished if an adult says they do not want support or safeguarding under s42 Care Act.[35]

Oxleas NHS Trust's CPA policy also requires safeguarding concerns to be identified and addressed as part of the care plan. Risk management and care planning is required to be person centred with a clear '*agreed plan of action which is implemented in a crisis, ensuring that the service user, their carers, and professionals know what to do and who to contact when they are in crisis*'. Similarly, contingency plans must detail '*the information and arrangements needed to prevent any unforeseen circumstances turning into a crisis, e.g., the care coordinator or carer going on leave. It should contain the information necessary for the continuation of the care plan in an interim situation*.'[36] The CPA policy requires careful consideration of the service user's circumstances and any inability that might impact on their ability to understand risks. Any self-neglect, relapse history or non-concordance with a treatment plan are grounds for use of the CPA.

[31] Race Equality Foundation 'Mental Health and wellbeing briefing paper' available at: https://raceequalityfoundation.org.uk/health-care/mental-health-and-wellbeing-briefing-paper/
[32] Full details of the guiding principles under the MHA are given in Chapter 1 of the MHA Code of Practice available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF
[33] For example, Article 2 (the right to life) and Article 3 (the prohibition on torture, inhuman or degrading treatment)
[34] Under s17E Mental Health Act 1983
[35] See 'Myths and Realities' about Making Safeguarding Personal available at https://www.local.gov.uk/sites/default/files/documents/25.144%20MSP%20Myths_04%20WEB.pdf
[36] 11.1-11.2 Oxleas NHS Trust CPA policy

The CPA policy also requires practitioners to understand safeguarding responsibilities, including the duty to recognise and respond effectively to the risk of abuse or neglect and share a common language around risk so it is understood in a multi-agency context, rather than by each agency according to their own perspective. Multi-agency coordination, information-sharing and legal literacy (predominantly in respect of the application of the Mental Capacity Act) are identified frequently within Safeguarding Adults Reviews as areas requiring practice improvement, especially where the risk arises from perceived self-neglect. This is made more acute in the context of refusal or non-adherence to medical treatment where the adult is suffering from physical and mental health conditions. National analysis identifies that often a focus on specific need or behaviour obscures recognition of foreseeable risk, reporting that:

> *'even when self-neglect was recognised, it was little understood and poorly explored, lacking detailed personal history and exploration of the person's home conditions or health management routines. Refusal of services was not explored or understood. Professional curiosity was not exercised. Assessment, particularly in the hospital context, relied heavily on self-reporting, with home circumstances not observed. In some cases, assurances about actions the individual would take were accepted at face value, despite evidence to the contrary*.'[37]

National analysis raises the possibility that a 'rule of optimism', namely an unconscious bias towards a favourable view of the situation, making it less likely that practitioners will imagine (and prepare for) poor outcomes even if these are, as they were in this case, foreseeable. During the learning events this was explored, but practitioners and his family believed that rather than an over-optimism, staff were hindered by a lack of options for Alexander. As detailed below, there was recognition of the foreseeable risk of self-neglect by those planning his discharge, but decision making should also be seen in context of all that was known at the time the decisions were made. During the learning events senior leaders and practitioners spoke of the balance that is needed when looking to support people, such as Alexander, who have spent much of their adult life in institutional care. It is widely acknowledged that prolonging periods of detention where there is little therapeutic benefit runs contrary to the letter and spirit of the MHA as it frustrates recovery and often perpetuates the institutionalisation of a patient. Given that in addition to those risks, there were real risks for Alexander (in respect of Covid-19 infection) of him remaining on the ward, the decision to find an alternative placement within the community that could mirror the high level of close supervision and support Alexander received in hospital was reasonable. It also clearly accorded with his preference.

It is clear from the CTO conditions, findings of the Occupational Therapist's assessment and the Care Act assessment that the risks of self-neglect were well understood. Indeed, SLS staff confirmed that they had understood this was one of the primary purposes of the 24hr/ 7 day a week support they had been commissioned to provide. SLS confirmed they knew about concerns regarding his weight loss at point of their assessment and that they had planned for his weight to be monitored once a month. Notwithstanding their offer to monitor, it was also understood to be an essential part of the routine checks undertaken at the Clozapine clinic. Despite this there is no evidence his weight was ever monitored by any service after his discharge from the in-patient mental health unit. SLS explained as part of this review that they can't compel residents to agree to weight checks, but it is notable that despite this being identified as a very significant risk, on-going failure to comply with the support plan and visibly significant weight loss, no alerts about weight loss were raised by them to his GP, Care Coordinator, or commissioners.

Furthermore, his family reported to this review that when they contacted the placement enquiring about Alexander's wellbeing, they were assured by staff that he was doing well. They explained, they understood that (because of the Covid-19 restrictions) they could not visit him in person but had offered to buy and deliver food for him and that this was turned down by staff. Again, they questioned whether those responsible for devising and delivering his care plan fully understood the importance he placed on being close to areas he knew well and to his family. They believe his low motivation for self-care should have been explored as it was

[37] National SAR Analysis. ADASS/LGA, Michael Preston Shoot, 2020 [p101] available at: https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf

not part of his usual mental health presentation and reflected this was similar to how he behaved following the death of his father, so he may well have been depressed.

Staff involved in the case also discussed why key aspects of the assessments' findings (namely access to nutritional advice and behaviour modification) were not transposed into the day-to-day delivery of Alexander's care plan. SLS confirmed they had access to nutritionists but had also reflected on practice following Alexander's death and put in place much more rigorous arrangements to monitor food and fluid intake where there are concerns regarding weight management. SLS reported they had also introduced weekly weight checks for residents where malnutrition is of concern and have provided training to staff on self-neglect and malnourishment.

There was debate within senior leader discussions about the recommendation that Alexander receive support for behaviour modification. Senior staff from Oxleas questioned whether this was even a 'service' that could or should be made available, recommending instead that this should be more closely defined within the care plan so that those responsible for care plan delivery understood what aspect of the care plan was expected to achieve the behaviour modifications. SLS confirmed, as they had in the assessment and commissioning process, that they used the 'WRAP' programme to work in a person-centred way with individuals to identify goals and work towards these. They accepted that, in this case, Alexander had not complied with expectations to engage with support offered to achieve recovery goals and that, whilst they had bought this to the attention of his care co-ordinator and psychiatrist at the professional meeting on the 11.11.20, more should have been done to vocalise the extent of their inability to help Alexander meet the expectations of his CTO conditions and engage with activities to improve his life skills.

Although the risk of malnutrition and self-neglect was well understood by those undertaking assessment functions, vital information about how this risk should be mitigated and what should be done if the risks were not reduced were not specified clearly within the care plan. As a consequence, those responsible for over-seeing and delivering the care plan did not have a shared understanding of the level of risk or actions required if those risks were not addressed. Safeguarding processes or escalation through the care management process were not used to review risks and act to prevent an escalation of need.

Recommendation 2: In light of this review, GSAB may wish to consider putting in place a multi-agency Self-Neglect Protocol. Consideration could be given to including:

- risks associated with a person's inability to manage their nutritional needs, including a reference to the Malnutrition Universal Screening Tool to encourage a shared understanding of the heightened dangers associated with malnutrition and facilitate professionals surrounding and supporting the person to come together to coordinate care.
- local referral routes for community based, early intervention for nutrition advice and what indicators should trigger escalating concerns for multi-agency support so that relevant professionals can participate and inform capacity assessments and protection plans.
- a clear pathway for escalating concerns that accords with the s42 safeguarding duty and links to those procedures.

Recommendation 3: GSAB should also seek assurance that commissioners ensure that providers can evidence support staff have relevant knowledge and skill base to recognise and respond effectively to self-neglect.

3. Did multi-agency care management and inter-agency information sharing meet expected standards?

Good inter-agency collaboration is reliant on the coordination of effort from all involved and clear leadership, so there is clarity on actions to be taken and accountability for decisions. This requires that practitioners from

across health and social care understand respective roles and responsibilities so that referrals are acted upon. In order to explore this fully this report has explored multi-agency practice in respect of care management and information sharing in the pre-discharge planning under this heading. Critique of the care plan delivery whilst Alexander was residing in supported living is set out within the fifth area of consideration later in the report.

There is evidence that practitioners were mindful of procedural duties to ensure Alexander was appropriately supported with independent advocacy during the assessment and care planning process in line with s.130 MHA. His family have confirmed, in conversation with the reviewer, they were satisfied he understood his rights and was properly represented when his compulsory detention under the MHA was under review and in the discharge planning processes. It is understood that, in response to this case and learning that has come from national reviews, The Local Authority have commissioned a combined Statutory Advocacy service[38] to enable more flexibility, so that the same advocacy provider can be used to provide support under the Care Act, Mental Capacity Act, Mental Health Act obligations and NHS complaints. This should improve opportunities for advocates to develop trusted relationships with the adult. However, as happened in this case when the ward manager effectively vetoed a request from Alexander for additional support in June 2020, these improvements will have limited impact if the extent of advocacy duties under different legislative frameworks or the pathways for self-referral are not fully understood by all those involved.

> **Recommendation 4:** GSAB should explore opportunities to improve all practitioners understanding of the wider legislative framework for advocacy support and the pathway to access advocacy, including for those placed out of area. GSAB should seek assurance, including through direct feedback from adults at risk using these services, that the new arrangements for advocacy are impacting positively on practice.

In the months preceding Alexander's discharge from the in-patient unit his care needs were thoroughly assessed. Consideration was given to his ability to achieve activities of daily living, his eligibility for services under the Care Act and a full cognitive evaluation and assessment of his executive functioning was completed. The cognitive evaluation concluded that, whilst he did not require additional resources associated with a diagnosis of a Learning Disability, he did exhibit '*global cognitive impairment… especially marked with regard to verbal communication and reasoning. He may struggle to fully understand verbal directives and would likely benefit from information to be presented visually and support given in reaching understanding. His ability to clearly express his thoughts is also impaired and he needs to be encouraged to express his thoughts more simply, clearly and in order. His elevated levels of anxiety may interfere with both these functions. It will therefore be important to clarify understandings with him… In comparison to the general population, he will have significant difficulty with maintaining attention, his speed of processing, controlling his impulses and self-monitoring. However, his scores on executive function are not so dissimilar to norms of Schizophrenics that an additional hypothesis of neurological injury is required*.' This assessment advised that '*individuals with his level of cognitive functioning would in the absence of other difficulties be expected largely to manage a semi-independent lifestyle with support at times of crisis and complexity. However as* [Alexander] *has other difficulty with Mental Health, Personality Disorder and drug addiction he will require long term supported housing*.' [39]

In this case, even at the pre-discharge planning stage, a relapse in his mental health or risks to his physical health had been anticipated because of his long history of institutional care, lack of insight into his mental health condition, drug misuse (and very recent non-compliance with s17 leave conditions to use drugs), history of self-neglect on discharge and general poor self-care. There is evidence within the case files of common agreement between clinicians, commissioners and, most importantly, Alexander regarding his care and treatment plan; namely to work towards rehabilitation into a community setting that could provide close

[38] Separate duties to appoint independent advocates to support individuals within safeguarding enquiries, assessments, care planning and reviews of the social care exist under s130 MHA, s44 Mental Capacity Act 2005 and s67-68 Care Act 2015. Eligibility requirements are slightly different under each piece of legislation, often resulting in a fragmented approach.

[39] Taken from the Cognitive Assessment Report completed by NHS Oxleas Trust's Clinical and Forensic Psychologists on the 09.03.20

supervision of likely signs of relapse, support him to develop skills to manage activities of daily living and work to address his substance misuse.

However, notably absent from the discharge planning process was involvement of his family. Indeed, they commented that they felt '*cut out and only called on when needed to complete paperwork for funding*'. They commented that it felt to them at the time that practitioners had run out of ideas. When asked by practitioners if they believed he was ready for discharge, Alexander's mother stated she did not think so because of the very recent breach of s17 leave conditions. She explained to the reviewer that, perhaps as a consequence of voicing her concerns, practitioners then seemed to pull away from involving the family. Holistic care requires involvement of families, particularly where they have caring responsibilities. Often this is underpinned by statutory obligations.[40] To accord with the duties to carers under the Care Act, the Oxleas' CPA policy required care coordinators offer carers assessments including when a service user declines to have their carer involved. The policy is explicit that carers are entitled to have their views and concerns respected, choose whether to continue in their caring role and have information about CPA and care planning. [pg14.4] His mother and sister raised concerns that despite the important role they played in Alexander's life they were not involved in the planning discussions for his discharge or encouraged by SLS to participate in his recovery (despite their desire to do so) or offered a carers assessment and provided with a copy of his care plan.[41] By way of an example of her willingness to support practitioners, Alexander's mother explained that she was asked if she was willing to relinquish responsibility for his finances. Having initially agreed, she stayed doing so at the request of her son. She believed it was important to him that she continued to manage his finances as it maintained her nurturing role. She did, however, agree with practitioners to limit the amount of money given at any one time to reduce the risk he could be exploited or use his money to buy drugs.

The issues of continuity of care and deliverability to meet the '*complex but not usual presentations*'[42] by a provider were also considered by those working with Alexander to plan his discharge. The case records suggest (confirmed by frontline practitioners and senior leaders in conversations with the reviewer) that significant attempts were made to identify a suitable placement within Greenwich that could meet his complex needs. Particular importance was placed on a local resource because Alexander had expressed a clear preference for staying within Greenwich so that he was in an area he knew well and close to his family. Practitioners also understood the importance of continuity of care for Alexander given his complex needs. Senior leaders explained in the learning event that, whilst there was flexibility to ensure he received continuity of care from the ICMP team, they were especially keen to keep him in Greenwich in order that the specialist Drug Misuse service could continue to offer him support within the community setting. They explained that, whilst his engagement with that service while he was on the ward was 'patchy at best' Alexander had made a connection and all those working with him saw the value in seeking to continue that relationship. Commissioning staff understood they had powers to provide flexible packages, if necessary, on a spot purchase basis. Despite those efforts, practitioners involved in this review commented they were unable to find a suitable placement within Greenwich largely because Alexander's history of failed placements. Reluctantly they widened the search, but in doing so understood this would need a provider that would meet all the identified needs.

Key aspects of how his physical health would need to be monitored was also well understood by lead practitioners. For example, because he had been treated for many years with Clozapine, practitioners knew he required close supervision in the community and careful monitoring of the significant side effects of this medication may have on his physical health. This was in compliance with NICE guidance that confirms Clozapine is 'the only drug with established efficacy in reducing symptoms and the risk of relapse for adults with treatment-resistant schizophrenia'[43] but equally advises close monitoring of the patient's physical

[40] For example, the Care Act 2014 s9(5) sets out a duty to consult and s10 to assess a carer's needs for support
[41] Shortly before the presentation of this report to the GSAB NHS Oxleas confirmed Alexander's mother had not had a carer's assessment since 2012. They stated they have records of telephone calls to her to inform her of plans or indications from Alexander that he would inform her. They believed she was in agreement, but may wish to reflect whether this is sufficient to comply with the spirit and purpose of their policy.
[42] Taken from the Serious Incident Root Cause Analysis report completed by NHS Oxleas Trust
[43] NICE, [QS80] Quality standard for the treatment of psychosis and schizophrenia in adults available at: https://www.nice.org.uk/guidance/qs80/chapter/quality-statement-4-treatment-with-clozapine

health[44] because of adverse side effects of this medication. However, whilst the need to monitor his physical health was well documented, the practicalities of how this would be achieved were not adequately considered prior to his discharge. He was not registered with a GP before discharge, nor were there arrangements in place for his care coordinator or responsible clinician to speak with a GP to ensure there was a shared understanding of the range of risks and need for careful monitoring in the community. He was discharged at a time when it was anticipated that a further wave of increased infections from Covid-19 was imminent and GP practices were not routinely offering face to face appointments, this had significant consequences (explored in more detail below) that could otherwise have been avoided.

In addition, the implication of discharging Alexander from hospital (rather than providing him with a period of leave), does not appear to have been fully understood. Under s17A-E MHA, a responsible clinician may discharge a patient from hospital for treatment in the community, subject to a power to recall if certain conditions are not met under a Community Treatment Order ['CTO'].[45] Patients do not have to give formal consent to a CTO, but should be involved in treatment decisions and be prepared to co-operate. The nature and rationale behind any conditions, and the consequences of non-compliance should be explained orally and in writing to the patient. The responsibility for recalling a patient to hospital (and, if necessary, revoking the CTO)[46] sits with the patient's Responsible Clinician with additional obligations on the hospital managers to monitor process and refer to the Tribunal when necessary. Alexander's family questioned the rationale behind discharging under a CTO when he had so recently failed to comply with the terms of his s17 leave. They explained that previously it had always been clear to Alexander that if he breached rules there would be consequences, so they had expected he would be tested further before discharge. They felt, understandably, the fact that he was discharged so soon after breaching those conditions may have sent him the wrong message, particularly in relation to compliance with the CTO conditions.

Given the positive influence and regular contact they had with Alexander, practitioners may wish to reflect on whether closer involvement of his family in the pre-discharge planning stage and rationale for his discharge would have provided opportunities for a shared understanding of the risks posed by keeping him in the mental health in-patient unit. In turn this may have enabled them to assist Alexander understand the level of cooperation needed from him to sustain the proposed placement and agree strategies for their involvement in monitoring his compliance whilst residing in the SLS supported placement.

By way of another example of the implications of his discharge being misunderstood, SLS had initially specified to commissioners that they would offer Alexander a two-week trial period. During the learning event they explained they had not appreciated that his discharge from hospital (rather than leave under s17 MHA), made it considerably more difficult to secure agreement that he might need to be re-hospitalised if the trial period failed. To some extent this is academic in this case as there is no evidence that they requested his Responsible Clinician exercise powers to recall him to hospital, though the possibility to do so was identified as a consequence if Alexander failed to attend the Clozapine clinic on the 23.11.19 or later in December.

4. How did Covid-19 Pressures impact on decision making?

As the purpose of this review is to inform and improve local interagency practice by acting on learning it is important to understand the wider context that may have impacted on decisions and care in this case. Throughout the period under review there was widespread concern about the impact that the Covid-19 pandemic and lockdown measures would have on mental health. Whilst the Coronavirus Act 2020 afforded easements for local authorities in respect of their assessment and care management duties under the Care

[44] Available at: https://cks.nice.org.uk/topics/psychosis-schizophrenia/prescribing-information/monitoring/
[45] This is intended to be used for suitable patients so they can be treated in the community in a way that promotes recovery and upholds principles of treatment using the least restrictive option whilst also providing a framework to prevent relapse and any harm (to the patient or others) that might pose.
[46] The procedure is set out in s29.52- of the MHA Code of Practice.

Act, the easements were not enacted locally. Nor was there any lessening of legal duties owed under the MHA or in respect of safeguarding responsibilities.

At a national level there was a significant reduction during February- April 2020 of new referrals to people accessing preventative mental health support[47] but by May 2020 there was a significant rise in patients accessing secondary mental health services needing urgent and emergency mental health care.[48] Many in-patients mental health units faced practical problems as it quickly became evident that psychiatric patients were more susceptible to respiratory infections than general population[49] and that some drugs used to treat the Covid-19 were associated with neuropsychiatric adverse events, posing significant new diagnostic challenges. Those medication could also have life-threatening interactions with psychotropic drugs, leading to increased toxicity and undesirable side-effects. In addition, complementary treatments such as psychological and occupational therapy, family accompaniment or coordination with the outpatient clinics had to be reduced or abolished to comply with legislation designed to prevent the spread of the virus.[50]

Whilst it is accepted that Alexander was not an in-patient in a psychiatric intensive care it is perhaps helpful to avoid hindsight bias to remember that during this period services were responding to new challenges posed by the Covid Pandemic. For many Mental Health Trusts, it became necessary to equip psychiatric intensive care units with medical equipment to manage extreme respiratory distress. For others, the physical design of units made the virus difficult to contain (e.g. a lack of respiratory isolation rooms, doors which were required to be firmly closed, poorly ventilated wards and some patients sharing rooms). Moreover, mental health staff understandably had inadequate training on the management of respiratory infectious diseases. Some features of patients with pre-existing mental health conditions, (e.g. inadequate insight or psychomotor excitement as well as limited awareness regarding the risk of infection meant they were unable to practice infection control measures) contributed to the increased risk of transmission of Covid-19. All of this placed extraordinary strain on health and care professionals, who had to balance the need for people with severe mental health conditions to receive care and work towards recovery.

We know too that within community services many of these pressures persisted as the need to reduce risk of infection hindered access to therapeutic support, face to face contact with practitioners and increased levels of anxiety and social isolation. Key challenges around the use of remote mental health support has been highlighted by the NHS Confederation who are concerned digital poverty within this cohort may have served as a further barrier to accessing psychological support.[51] There is a growing evidence base too that this is having a disproportionate impact on Black and ethnic minority communities as cultural mistrust of health services in general and fear of exposure to Covid-19 left many wary of accessing face-to-face mental health services perceived not to be safe. National[52] and local safeguarding data saw a rise in both the volume and complexity of safeguarding concerns, particularly in respect of self-neglect and psychological abuse.

In response to these pressures Oxleas published local guidance to their staff on delivering care to service users. This advised against remote consultations where (among other grounds) there are '*significant risks in relation to their mental health, physical health, social circumstances or where there are safeguarding concerns (child or adult)*'.[53] Oxleas SI report into the care Alexander received confirmed '*physical health monitoring was monitored in line with guidelines in relation to Clozapine therapy as set by the Prescribing Observatory for*

[47] Referrals into Improving Access to Psychological Therapies services reduced by 61%
[48] Nuffield Trust Quality Watch blog, published 30.11.20 available at: https://www.nuffieldtrust.org.uk/news-item/what-impact-has-covid-19-had-on-mental-health-services
[49] Xiang Y.-T., Zhao Y.-J., Liu Z.-H., Li X.-H., Zhao N., Cheung T., Ng C.H. The COVID-19 outbreak and psychiatric hospitals in China: managing challenges through mental health service reform. *Int. J. Biol. Sci.* 2020;16:1741–1744. doi: 10.7150/ijbs.45072.
[50] The impact of COVID-19 on acute psychiatric inpatient unit, Daniel Hernández-Huerta et al, 2020, NCBI, doi: 10.1016/j.psychres.2020.113107
[51] Association of Mental health Providers/ Mental health Network NHS Confederation (2020) Digital Inclusion in mental health www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/Digital-Inclusion-in- Mental-Health-Dec-2020.pdf
[52] National Insight Report 2021 available at: https://local.gov.uk/publications/covid-19-adult-safeguarding-insight-project-second-report-july-2021#part-1-safeguarding-concerns
[53] Oxleas NHS Trust CMHT Covid Operational Plan. This also set out arrangements for the continuation of a face-to-face Clozapine clinic and crisis management for clients at high risk of relapse.

mental health- UK – (POMH-UK).'[54] This will be explored in more detail within the next section of this report. However, GSAB and partner organisations should reflect on whether that should be the only standard applied when assessing if the care plan was adequate to meet identified needs and if the delay in registering Alexander with a GP of 5 weeks from date of placement amplified foreseeable risk, given the complexities of his health needs.

During the review period his GP did not believe it necessary to conduct a face-to-face assessment of his physical health following a request by Alexander for a telephone appointment, or again following notification by NHS111 of their involvement on the 14th and 15.12.20[55] or even when staff spoke to the GP on the 22.12.20. By this time, London and the East of England had entered Tier 4 lockdown, greatly restricting movement, while pressures on the NHS soared with a new wave of Covid-19 infections. With hindsight, the GP accepted that a telephone consultation should have been arranged following the NHS111 notification and confirmed they had sought to introduce improved document handling systems to address follow up actions from incoming notifications or reports from NHS111. During discussions at the learning event for this review, senior leaders highlighted that whilst necessary changes were made during the pandemic to primary healthcare delivery, this did not explain why a face-to-face assessment was not offered sooner by Alexander's GP. It is questionable whether the GP's decision was reasonable given what they ought to have known of Alexander's needs, guidance to GPs at the time from the Department of Health and the BMA's toolkit to support decision making regarding remote consultations. Whilst they accepted some adaptations to practice was necessary to reduce cross infection of Covid-19 and to assist primary health to manage increased demand for their services within their available resource, they believed there needed to be an honest conversation about how new care delivery models should be implemented and monitored to mitigate against foreseeable risks for some patients, particularly those at high risk of self-neglect who may not have capacity to understand the risks that refusing medical attention and basic nutrition pose.

> **Recommendation 5:** GSAB should seek assurance that any amendments to GP contracts or service delivery take into account learning from this case and set out clear expectations for GPs to conduct face to face appointments where there is a known risk of self-neglect and presenting physical health deterioration. GPs and providers should also be expected to share concerns with care coordinators and be confident about how to escalate concerns if they believe a review of the care plan is required or recall to hospital under MHA powers is needed.

5. Were plans for discharge, risk assessments and decision-making regarding community placement adequate?

Whilst responsibility for assessment, care planning/review and safeguarding enquiries are statutory functions that (even if delegated) remain the responsibility of the statutory bodies, it is accepted that day to day support can be and often is (as it was in Alexander's case) provided by third sector organisations. Senior staff from the supported living provider [SLS] confirmed to the reviewer that they were aware of all the risk and needs assessments that had been completed as part of Alexander's discharge planning. They also made available to this review their own assessment, completed prior to their agreement to support Alexander on discharge. However, as noted above, whilst there were numerous comprehensive assessments of his needs these were not collated into one care plan so there was not clear accountability for actions to mitigate identified risks or manage needs. Instead, concerns were spread across a number of documents, some of which would not have been easily accessible to SLS support staff providing day to day care. There appeared to be little appreciation of the protective role his family played in his care and considerable delay in registering Alexander with a local GP as this was not part of the pre-discharge planning. The impact of this fragmented approach in respect of self-neglect and weight loss has already been considered (within s.2 of this report). This section will therefore

[54] Taken from the Serious Incident Root Cause Analysis report completed by NHS Oxleas Trust
[55] The GP's IMR report confirmed that the NHS111 report and telephone consultation confirmed Alexander had been vomiting.

consider other key aspects of the care arrangements, namely management of his mental health, monitoring of his physical health and medication and interventions to manage drug misuse.

The duties to monitor Alexander's mental health are confirmed within Oxleas' CPA policy to include responsibilities under the Care Act 2014. Section 5 of that policy details the Care Coordinator's key responsibilities as including:

- Act as a reference point for other professionals, relatives, carers, and advocates.
- Ensure a comprehensive, assessment of the service user's physical and mental health and social care needs is carried out.
- To ensure service users and carers are central in the development of the care plan.
- Create and update the care plan and risk assessment, ensuring that all those involved understand their responsibilities and agree to them.
- Have responsibility for monitoring and evaluating the care a patient receives and coordinating multidisciplinary care delivered to the patient at least every 6 months.
- Ensure crisis and contingency plans are formulated, updated, and circulated.
- Maintain regular contact with the service user.

Oxleas NHS trust reported: **'***There was not a current care plan in the "My care plan" section of RiO. There is a crisis and contingency plan recorded that was last updated on 03.11.20. However, it does not seem to take into account he is in an out of borough placement or on a CTO. The crisis plan is regularly stated in the progress notes; that being to contact his "care coordinator Monday to Friday between 09:00 to 17:00hrs when in crisis. Out of hours to contact Mental Health Urgent Helpline or attend A&E if crisis becomes unmanageable".*[56]

The care plan was not centralised; it was split between the assessment record taken by SLS, the commissioner's recommendations and Oxleas Trust's various documents including the CTO conditions. There was a general agreement that Alexander's day to day needs (for social inclusion, attending appointments, medication adherence, and monitoring of mental state) would be supported by SLS staff and any concerns should be relayed to the ICMP Team who would support placement staff remotely. His care coordinator would also continue to have telephone contact with Alexander.

As commented on above, notably absent from the plan was any involvement of his family. Likewise, there was no clear guidance for Alexander or SLS staff about how professional judgment would be applied if he did not comply with the conditions of his CTO and if there were clear signs of relapse. Responsibility for oversight of his physical health was not clearly defined and as a result, even the most important first step (registering with a GP) was not prioritised and progressed for 5 weeks.

Alexander breached all of the conditions of his CTO, including missing two appointments with his psychiatrist for a review, failed to attend the Clozapine clinic for essential health checks or engage with keyworker support. Despite this there was no record of any discussions between SLS, the Responsible Clinician or Care Coordinator of the possibility of recalling him to hospital. At the time immense pressures on in-patient beds meant that practitioners (reflecting in discussions during the learning events) could not discount that as a conscious or unconscious factor in respect of that decision. His Consultant Psychiatrist reported he was regularly discussed in the multi-disciplinary team (MDT) meetings but accepted that these discussions weren't within his clinical record. He confirmed '*no point during this period was a CTO recall deemed by anyone in the team as being needed.'* In line with Oxleas' Covid-19 operational policy he was originally categorised as within the red zone, meaning those at the highest risk and in need of face-to-face appointments. That zoning changed from red to green on 13.11.20 as the discharge from hospital period had exceeded 2 weeks. Oxleas Serious Incident ['SI'] report concluded '*By virtue of not being recorded under the headings red or amber zone, it is assumed that he was zoned green. It does not appear that patients zoned as "green" are routinely discussed in zoning meetings*

[56] Taken from the Serious Incident Root Cause Analysis report completed by NHS Oxleas Trust

and it is left to the discretion of a single clinician to determine whether a patient should be re-zoned to amber or red.' Practitioners accepted that this should not have been automatic, that it required much more careful consideration of his specific needs and evaluation of his adherence to the CTO conditions and relevant care plans.

The report recognised *'the ICMP Team was working under enormous pressures exacerbated by the Covid- 19 pandemic. Whilst the ICMP Team may be experienced in managing patients subject to CTO, assessment should have been made by an ICMP professional* [in a face-to-face meeting] *to determine whether further intervention and/or recall would be appropriate or not, rather than relying on second-hand information from non-clinical placement staff.'* [57] Such an opportunity arose on the 15.12.20, following notification by London Ambulance staff that they believed he required clinical input. It remains unclear to the reviewer why no action was taken by ICMP given the reported concerns. It appears that this oscillated back and forth from placement staff to ICMP without anyone taking an assertive lead. Oxleas' SI report concluded that Alexander should have been re-zoned as red and reviewed face to face by the ICMP Team as '*had he been seen face to face by qualified professionals, the degree of his physical deterioration would have been observed and the necessity to assertively engage him in medical intervention recognised and actioned, prior to his Clozapine monitoring blood test at the Heights on 22 December 2020*'.

Senior practitioners also spoke about the complexities of recalling a patient to hospital under s17E MHA, of the bureaucratic processes and time-consuming paperwork. They questioned whether CTOs were 'fit for purpose' and whether the current mental health legislative reforms were a missing an important opportunity to improve discharge and recovery pathways.

There was also concern about whether expectations placed on care co-ordinators roles were fair or achievable. Oxleas Trust CPA policy provides that the care coordinator has '*responsibility for monitoring and evaluating the care a patient receives and coordinating multidisciplinary care delivered to the patient at least every 6 months*.' Arguably, a care coordinator could meet this duty by carrying out cursory checks with the patient and placement twice a year. Some senior leaders felt the role itself was ill-defined, meaning that it is often up to local interpretation. GSAB may wish to explore whether those undertaking care coordination roles have sufficient seniority and time (given their caseloads) to actively challenge where they have concerns regarding placement or recall decision making. Concerns regarding the use of the Care Programme Approach have been raised as an issue within the National Analysis of Safeguarding Adult Reviews. This found '*SARs provided multiple other examples of failure of coordination. Multidisciplinary assessment of an individual with multiple diverse needs and trauma was not provided, resulting in a lack of understanding and shared perspective. The lack of a fully defined care pathway with appropriate senior clinical oversight, early specialist input, close case management and multiagency understanding meant that an individual's care fell outside the national expectations and guidance for personality disorders*.' [58]

It should be noted that the task of supporting recovery is a challenging one. It requires more than just a coordination of information, as important as that is. It requires a workforce who can demonstrate empathetic, trauma informed practice, practitioners who understand the legal framework and operational processes across primary and secondary health for physical, mental health and substance misuse so these are used to establish and sustain effective care delivery. In most cases this will require defined expectations of what the adult will do, how practitioners, friends or family undertaking carer roles will support and being clear what the adult can expect if they do comply with the care plan or, conversely, what will happen if they don't and risks or their needs increase.

[57] Taken from the Serious Incident Root Cause Analysis report completed by NHS Oxleas Trust
[58] National SAR Analysis. ADASS/LGA, Michael Preston Shoot, 2020 [p136] available at:
https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf

Recommendation 6: GSAB and partners should review how best to monitor locally the use of Community Treatment Orders and those who receive support under the CPA. The GSAB should seek assurance that both are utilised effectively to enable recovery. GSAB may wish to explore whether those undertaking care coordination roles have sufficient seniority and time (given their caseloads) to actively challenge where they have concerns regarding placement or recall decision making. If national change is required, they may wish to raise this at a regional level, but in the interim GSAB should work with their partner agencies to better support Responsible Clinicians and care coordinators in undertaking the responsibilities of their role within a supportive, but accountable framework. In line with recommendation 1, particular consideration should be given to decision making for patients from BAME backgrounds.

During learning events, commissioners across both geographical areas accepted there were limitations, given their resources, of their ability to robustly monitor contracts, including spot contract for those placed out of borough. Whilst they were aware of protocols for alerting host boroughs of placements and obligations to conduct joint enquiries or provide notifications where there were ongoing safeguarding enquiries into providers, these were not entirely clear or consistently applied. Again, National SAR analysis picked up concerns regarding out of area placements (see p149) and reported system wide concerns that:

'*Commissioners had insufficient time to monitor contracts and contracts were sometimes too imprecise about staffing arrangements to facilitate detailed monitoring. One SAR questions how effectively commissioners pursued active oversight of out of area placements, particularly without local intelligence; another noted that a clinical commissioning group did not undertake quality assurance measures in relation to out of area placements*.' [59]

Recommendation 7: GSAB may wish to highlight to partner agencies the expectations set out in the statutory Care and Support guidance, NHSE/I and ADASS practice guidance in respect of out of borough placements. GSAB may also wish to request London SAB review and, if necessary, revise regional pan London Safeguarding guidance on out of borough placements where individuals are at high risk of foreseeable harm or have complex care needs. This should also consider obligations to involve practitioners responsible for care management and review, as well as commissioning and safeguarding officers in placing authorities who have responsibilities for provider concerns or large-scale enquiries.

Recommendation 8: Given the outcome in this case and increased dependency across health and social care commissioners on unregulated supported accommodation providers to meet complex care needs, GSAB may also wish to request (via the London SAB Chair's Network) whether there is an evidence base now to justify the need for a national regulatory framework for supported accommodation, including those where the provision of personal care may not be a primary identified need, but recovery/ rehabilitation does envisage close monitoring and/or contingency planning where risks of self-neglect is high.

Regarding the management of Alexander's medication, commissioners confirmed that they were aware that SLS (as unregistered supported living providers) were not required to dispense medication or complete medication charts for Alexander. This would only be expected in registered nursing provision. There was widespread agreement that Alexander's care did not require that level of support and this is in line with previous assessments. Alexander had confirmed he understood the consequences of non-compliance with his medication, albeit he understood that this might result in his recall to hospital, rather than a relapse in his mental health or deterioration in his physical wellbeing. Notwithstanding this, SLS did complete medication charts. These were made available to the review (belatedly, only after the learning events leading to some confusion over the extent of his compliance) suggesting that throughout the 8 weeks he resided at the

[59] National SAR Analysis report, p160

placement he did (save for 3 days) take the required dose of clozapine and bisoprolol (the latter was prescribed to manage the risks regarding elevated blood pressure and tachycardia linked to long-term use of clozapine). He refused medication for anaemia and this was reported by SLS to his care coordinator. Case notes mentioned on 22.12.20 that Alexander wanted to discontinue Clozapine and take Olanzapine instead. This was the day he was admitted to the acute hospital due to dehydration. Oxleas confirmed his psychiatrist was unaware of this request and that '*he thought it likely that had his care coordinator discussed this with him, it would have been recorded in the RiO records*.'[60]

With respect to meeting his physical health needs, NICE guidance recommends regular monitoring in primary care 'depending on the person's care plan' for the first 12 months or until the condition has stabilised. This includes advice to monitor weight, a full blood count, pulse and blood pressure and to conduct an Electrocardiogram (ECG) at least annually. Records suggest Alexander did undergo an ECG on the 02.10.20 prior to discharge. Within the care plan and CTO conditions responsibility for monitoring of his physical health was shared between his GP, the clozapine clinic, SLS staff providing day to day supervision and his care coordinator. Oxleas Trust's CPA policy required the care coordinator '*ensure a comprehensive, assessment of the service user's physical and mental health and social care needs is carried out*.' This had been completed and SLS accepted, as part of their contract to provide services, responsibility to make arrangements for Alexander to register with a GP and monitor his physical wellbeing, alerting commissioners and the care coordinator if they had concerns.

The care plan required a GP to monitor every 3 months (p3 of the care plan) and asked for extensive health checks due to excessive weight loss (on p5). It is of concern that both requests were missed by the GP as they acknowledged their own failures to properly record within Alexander's notes his full care plan due to a scanning error which resulted in only the first page being included in his notes. Had a local GP been identified as part of the discharge planning process and been involved in care planning this could have removed opportunities for misunderstandings regarding responsibilities for managing physical health issues. Whilst the CPA policy requires a care coordinator to act as 'a reference point for other professionals' and the commissioned care packaged identified SLS would monitor his health, this does not replace the need for clinical assessment and safe treatment decisions. The heightened, foreseeable risks in Alexander's case would have justified active engagement with the GP by the responsible clinician or care coordinator either at pre-discharge planning phase or immediately after Alexander had moved to ensure that there was a shared understanding of his needs and that the GP knew how best to engage with him. SLS staff reported that it can be difficult to liaise on behalf of their residents with GP practices as often they are advised that rules regarding data protection prohibit their involvement without the express permission of the patient. This, of course, does not prevent support workers providing information to GPs. In this case insufficient information was passed by SLS staff to clinicians, equally clinicians did not probe or exercise professional curiosity regarding Alexander's physical health or weight. For the avoidance of doubt, there are clear legal duties and information sharing agreements to enable practitioners from across health and social care to share information, particularly if this is necessary to meet care needs or prevent abuse and neglect of an adult with care and support needs,[61] but clarity within a centralised care plan about how his physical health and medication compliance would be shared across the GP, care coordinator and SLS staff would have managed this far more effectively.

> **Recommendation 9:** Given the importance of physical wellbeing to recovery and on-going monitoring of adverse side effect of mental health medications, commissioners and secondary care providers should amend their policy and practice to ensure that GPs are fully aware and involved in care planning for discharge. Where a GP has not been identified at the point of discharge, temporary arrangements

[60] Taken from the Serious Incident Root Cause Analysis report completed by NHS Oxleas Trust

[61] Section 7-8 Care Act 2014 permits the sharing of information and requires 'relevant agencies' to cooperate in promoting an adult with care and support needs wellbeing. Paragraph 14.43 of the Care and Support Guidance that accompanies the act advises '*no professional should assume that someone else will pass on information which they think may be critical to the safety and wellbeing of the adult. If a professional has concerns about the adult's welfare and believes they are suffering or likely to suffer abuse or neglect, then they should share the information*.' The Pan-London data sharing agreement is available from the London ADASS website.

should clarify who will lead on ensuring necessary physical health checks are completed and how providers and GPs can alert the responsible clinician and care coordinator to any concerns or if regular reviews are not completed.

Recommendation 10: GSAB should seek assurances (perhaps through their audit programme) that the local authority, CCG and Oxleas NHS Trust have amended care management processes to ensure that all care plans address statutory responsibilities and clearly articulate how eligible needs and identified risks to wellbeing will be met. All care plans should detail contingency plans if conditions are not complied with. Care plans should include information about cultural needs, preferences of the person and an analysis of the extent to which interventions that have been trialled with the person have been successful. This pen picture should 'travel' with the individual, to build practitioners understanding and truncate the timescale for developing a positive relationship as each new worker/service is introduced. There should be mechanisms to clearly record whether family or wider support networks have been consulted and involved in care planning.

Recommendation 11: Taking into account the SAR National Analysis improvement priority 23, GSAB and their partner agencies should review how it seeks assurance on individual agencies' practice standards particularly in relation to multi-agency care delivery for adults subject to CTO and Carer assessment and support under s10 Care Act 2014.

Finally, within this case there were further examples of gaps in shared understanding of how to deliver the care plan. This included a debate at the learning event about the recommendation for behaviour modification. Senior staff from Oxleas Trust questioned whether this was even a 'service' that could or should be made available, recommending instead that this should be more closely defined within the care plan so that those responsible for care plan delivery understood what aspect of the care plan was expected to achieve the behaviour modifications. SLS confirmed, as they had in the assessment and commissioning process, they used WRAP to work in a person-centred way with individuals to identify goals and work towards these. They accepted that Alexander had not complied with expectations to engage with support offered to achieve recovery goals and that, whilst they had bought this to the attention of his care co-ordinator and psychiatrist at the professional meeting on the 11.11.20, more should have been done to vocalise the extent of their inability to help Alexander meet the expectations of his CTO conditions and engage with activities to improve his life skills.

As with concerns regarding self-neglect, it was well understood that a move into the community would increase the risks of substance misuse for Alexander and that this would have serious consequences for his mental health recovery. To mitigate those risks, arrangements were in place for his care coordinator to receive on going advice from the specialist provision with whom had had (limited) engagement whilst on the ward. In addition, SLS were commissioned on the understanding that they too had access to on-site drug and alcohol support services. In turn, they accepted the contract to provide support having been assured by Alexander that he was committed to his recovery and understood this would mean he refrain from using illicit substances and engage with drug misuse support. In reality, because of the Covid-19 lockdown and infection control measures, their in-house service had moved to virtual meetings. During discussions with the reviewer, they accepted this was not ideal for newly placed residents as they would not have had the opportunity to have formed trusted relationships with that service and so engagement would be more challenging. SLS are now exploring the possibility of directly employing an in-house substance misuse worker.

All practitioners spoke of limited positive impact of substance misuse services on behaviour changes has if an individual lacks insight and impulse control (as Alexander did) and so fails to recognise the impact of substance misuse on their mental health. They accepted that the CTO conditions provided powers to check whether he was compliant with support but understood why (with only one reported lapse) Alexander was not recalled to hospital for breach of this condition. Practitioners spoke about the need to balance some risks in order to

achieve benefits that providing opportunities for recovery in the community can bring. In short, often staff have to take a calculated risk that, even where they can predict some misuse, there is value for the adult in pursuing a community placement rather than continued in-patient provision. They agreed that to require abstinence as part of any CTO would simply be setting too many people up to fail and potentially keeping them safe at too high a price of their liberty and independence. On balance staff felt that in this case there was sufficient support in place to respond to any escalation of need if his substance misuse became problematic. In reality, however, that support was not called upon.

Within Oxleas Trust's SI report the reviewed the Care coordinator's supervision notes, which reported '*the deterioration in his physical and mental health is attributed to his use of illicit drugs.'*[62] It isn't clear why this judgment was formed as SLS report only one incident where Alexander is alleged to have reportedly used spice. This alone would not have explained the visible loss of weight, obvious signs of physical ill health and mental health deterioration. It raises questions as to whether professionals exhibited conscious or unconscious bias regarding his presentations. His family also questioned why practitioners were so quick to assume his deterioration was linked to substance misuse when he had reportedly not left his room for much of the time. They explained he had moved to an area that he did not know and had no contacts, so at a very practical level would likely have found it difficult to buy drugs. Safe care would expect practitioners to use the powers available to them to verify drug misuse and carry out basic medical checks to challenge their own assumptions. In this case CTO conditions required Alexander '*engage with substance use services and provide a urine sample for drug screen if so requested by his community team*' and PH had confirmed they access to UDS testing, but as noted within the Oxleas' SI report neither of these steps were taken to substantiate practitioners' hypotheses.

At the learning event practitioners highlighted the persistence of substance misuse workers who work on the wards with in-patients and spoke of the benefits to patients that good collaboration between them and treating clinicians brought. They recognised that this was not always as good for adults with severe mental health conditions who are supported in the community. Professor Black's recent review found '*the current system of local commissioning is fractured, with different bodies responsible for different services and no real incentive for them to work together. These challenges have exacerbated the impact of cuts in local authority budgets.*' The report recommended increased central government investment to expand peer support recovery communities and improving skills across the workforce, including within specialist mental health services.[63]

At the learning event practitioners reported (and it is widely understood) that a large number of adults with worsening mental health also have significant substance misuse issues and that dependency can make it much harder for people to access mainstream mental health support aimed at early intervention before a crisis or compulsory hospital admission becomes necessary. Again, the importance of assertive support for Alexander to manage his substance misuse in the community was well understood prior to his discharge. Commissioners had directly addressed this when looking for suitable providers and his Responsible Clinician had put in place conditions to enable monitoring. It is therefore not clear why there is no evidence that SLS engaged their own resource to support Alexander. This may have been better managed if there had been clarity within his care plan about the likelihood of some misuse and what level of risk they believed could be safely managed in the community. Equally though SLS should reflect on whether their staff had sufficient knowledge, skills, or empathy to work with individuals with complex needs.

Alexander's needs were complex but not unique, the importance of assertive substance misuse support was central to his recovery plan and yet there wasn't sufficient community resource to adequately manage this. This remains a significant gap and a much wider public health issue. It requires significant resources to address,

[62] Taken from the Serious Incident Root Cause Analysis report completed by NHS Oxleas Trust, p19
[63] 'Review of drugs part 2: prevention, treatment and recovery' Professor Black published by DHSC 2021 available at: https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery#radical-reform-of-leadership-funding-and-commissioning

but failure to wrestle with this issue including across local authority boundaries, is likely to continue to have a disproportionate impact on populations already at higher risk of compulsory admission or criminalisation and require more costly in-patient mental health provision.

Recommendation 12: GSAB (perhaps working with neighbouring SABs) should seek assurance from partners about the steps taken to implement recommendations from the DHSC's 'Review of drugs' 2021 report. Specifically, they may want to ascertain how statutory partners will work collectively locally to increase the number of professionally qualified drug treatment staff (psychiatrists and other doctors, psychologists and other therapists, nurses, and social workers), and ensure the forthcoming occupational standards, competency and training requirements for drug workers and peer recovery workers are applied. They may also wish to seek assurance that local authorities have a strategy to commission a full range of evidence-based harm reduction and treatment services to meet the needs of their local population in line with a new national Commissioning Quality Standard arising from the 2021 review.

Summary of Recommendations Emerging from this Review

This review was commissioned by GSAB, but informed by practitioners working within organisations in the London Borough of Newham. The GSAB is invited to share this report with Newham SAB so partners within that Safeguarding Adult Board can consider the recommendations and apply the lessons from Alexander's untimely death.

Recommendation 1: GSAB and partners organisations should reflect on the local strategy to improve mental health and wellbeing amongst BAME communities and take steps to understand if local mechanism are robust to enable the provision of culturally responsive mental health support. The Race Equality Foundation have suggested commissioners and practitioners consider:

- What strategies and mechanisms are in place to increase the representation of ethnically diverse mental health providers and allied health professionals with a view of increasing the representation of Black and minority ethnic individuals in leadership at all levels?
- How do policy makers and commissioners develop their knowledge, confidence, and cultural competencies in order to address ethnic inequalities in mental health?
- How do services provide culturally sensitive and appropriate services to users and their families?
- How do mental health services collaboratively work with the voluntary sector and community and faith groups to examine different pathways to care and address barriers to service access?[64]

Recommendation 2: In light of this review, GSAB may wish to consider putting in place a multi-agency Self-Neglect Protocol. Consideration could be given to including:

- risks associated with a person's inability to manage their nutritional needs, including a reference to the Malnutrition Universal Screening Tool should encourage a shared understanding of the heightened dangers associated with malnutrition and facilitate professionals surrounding and supporting the person to come together to coordinate care.
- local referral routes for community based, early intervention for nutrition advice and what indicators should trigger escalating concerns for multi-agency support so that relevant professionals can participate and inform capacity assessments and protection plans.
- a clear pathway for escalating concerns that accords with the s42 safeguarding duty and links to those procedures.

Recommendation 3: GSAB should also seek assurance that commissioners ensure that providers can evidence support staff have relevant knowledge and skill base to recognise and respond effectively to self-neglect.

Recommendation 4: GSAB should explore opportunities to improve all practitioners understanding of the wider legislative framework for advocacy support and the pathway to access advocacy, including for those placed out of area. GSAB should seek assurance, including through direct feedback from adults at risk using these services, that the new arrangements for advocacy are impacting positively on practice.

Recommendation 5: GSAB should seek assurance that any amendments to GP contracts or service delivery takes into account learning from this case and sets out clear expectations for GPs to conduct face to face appointments where there is a known risk of self-neglect and presenting physical health deterioration. GPs and providers should also be expected to share concerns with care coordinators and be confident about how to escalate concerns if they believe a review of the care plan is required or recall to hospital under MHA powers is needed.

Recommendation 6: GSAB and partners should review how best to monitor locally the use of Community Treatment Orders and those who receive support under the CPA. The GSAB should seek assurance that both are utilised effectively to enable recovery. If national change is required, they may wish to raise this at a

[64] Race Equality Foundation 'Mental Health and wellbeing briefing paper' available at: https://raceequalityfoundation.org.uk/health-care/mental-health-and-wellbeing-briefing-paper/

regional level, but in the interim GSAB should work with their partner agencies to better support Responsible Clinicians and care coordinators undertake the responsibilities of their role within a supportive, but accountable framework. In line with recommendation 1, particular consideration should be given to decision making for patients from BAME backgrounds.

Recommendation 7: GSAB may wish to highlight to partner agencies the expectations set out in the statutory Care and Support guidance, NHSE/I and ADASS practice guidance in respect of out of borough placements. GSAB may also wish to request London SAB review and, if necessary, revise regional pan London Safeguarding guidance on out of borough placements where individuals are at high risk of foreseeable harm or have complex care needs. This should also consider obligations to involve practitioners responsible for care management and review, as well as commissioning and safeguarding officers in placing authorities who have responsibilities for provider concerns or large-scale enquiries.

Recommendation 8: Given the outcome in this case and increased dependency across health and social care commissioners on unregulated supported accommodation providers to meet complex care needs, GSAB may also wish to request (via the London SAB Chair's Network) whether there is an evidence based now to justify the need for a national regulatory framework for supported accommodation, including those where the provision of personal care may not be a primary identified need, but recovery/ rehabilitation does envisage close monitoring and/or contingency planning where risks of self-neglect is high.

Recommendation 9: Given the importance of physical wellbeing to recovery and on-going monitoring of adverse side effects of mental health medications, commissioners and secondary care providers should amend their policy and practice to ensure that GPs are fully aware and involved in care planning for discharge. Where a GP has not been identified at the point of discharge, temporary arrangements should clarify who will lead on ensure necessary physical health checks are completed and how providers and GPs can be alert the responsible clinician and care coordinator to any concerns or if regular reviews are not completed.

Recommendation 10: GSAB should seek assurances (perhaps through their audit programme) that the local authority, CCG and Oxleas NHS Trust have amended care management processes to ensure that all care plans address statutory responsibilities and clearly articulate how eligible needs and identified risks to wellbeing will be met. All care plans should detail contingency plans if conditions are not complied with. Care plans should include information about cultural needs, preferences of the person and an analysis of the extent to which interventions that have been trialled with the person have been successful. This pen picture should 'travel' with the individual, to build practitioners understanding and truncate the timescale for developing a positive relationship as each new worker/service is introduced. There should be mechanisms to clearly record whether family or wider support networks have been consulted and involved in care planning.

Recommendation 11: Taking into account the SAR National analysis improvement priority 23, GSAB and their partner agencies should review how it seeks assurance on individual agencies' practice standards particularly in relation to multi-agency care delivery for adults subject to CTO and Carer assessment and support under s10 Care Act 2014.

Recommendation 12: GSAB (perhaps working with neighbouring SABs) should seek assurance from partners about the steps taken to implement recommendations from the DHSC's 'Review of drugs' 2021 report. Specifically, they may want to ascertain how statutory partners will work collectively locally to increase the number of professionally qualified drug treatment staff (psychiatrists and other doctors, psychologists and other therapists, nurses, and social workers), and ensure the forthcoming occupational standards, competency and training requirements for drug workers and peer recovery workers are applied. They may also wish to seek assurance that local authorities have a strategy to commission a full range of evidence-based harm reduction and treatment services to meet the needs of their local population in line with a new national Commissioning Quality Standard arising from the 2021 review.