Croydon Safeguarding Adults Board

Safeguarding Adult Review – Anthony

Confidential
Mike Ward
October 2023

Contents

1. Introduction

Anthony was a 58 year old black British man who completed suicide in 2021. The exact date of his death is unknown but he was found dead by police on 25 July 2021. Sadly, he could have been dead for four to five weeks. The Coroner recorded his cause of death as *"suspension (suicide)"*.

A complaint came into Croydon Adult Social Care and Health (ASC&H) from Anthony's daughter – detailing the circumstances leading up to his death and concerns that her father had been failed by services. The Mental Health Trust reported that a Serious Incident investigation was underway; however, this only focused on one agency involved and not others such as ASC&H. Therefore, the circumstances of Anthony's death were referred by ASC&H to the Croydon Safeguarding Adult Board for consideration as a Safeguarding Adult Review (SAR).

The SAR Sub-group considered the case in August 2022. It was agreed that the case highlighted a number of areas of potential learning and it was decided that a SAR should be undertaken.

This SAR covers a period from 2016 until Anthony's death in July 2021. A multi-agency panel of the Board set up to oversee the SAR identified those agencies that had or may have had information about Anthony during this period and sought information from them in the form of an Individual Management Review. Agencies were also invited to include any other information they considered relevant outside the time period identified and draw it to the attention of the panel.

2. Family contact

An important element of any SAR process is contact with family. Anthony was survived by an adult daughter and adult son. He is also survived by his ex-partner, but she was not involved at the end of his life. His daughter and his son have played a key part in arguing for this review and have contributed to the process through two meetings with the author. Anthony also has surviving siblings who were involved in his care but have not been involved in this review.

3. Purpose of the Safeguarding Adults Review

The purpose of SARs is to gain, as far as is possible, a common understanding of the circumstances surrounding the death of an individual and to identify if partner agencies, individually and collectively, could have worked more effectively. The purpose of a SAR is not to re-investigate or to apportion blame, undertake human resources duties or establish how someone died. Its purpose is:

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

There is a strong focus on understanding issues that informed agency or professional actions and what, if anything, prevented them from being able to sufficiently help and protect Anthony from harm.

4. Independent Review

Mike Ward was commissioned to write the overview report. He has been the author of more than a dozen SARs, a member of a mental health homicide inquiry team, as well as the author of drug and alcohol death reviews. He worked in Adult Social Care for many years but in the last decade he has worked mainly on developing responses to non-engaging individuals with complex health and social care needs.

5. Methodology

Following the agreement of Terms of Reference for the review (see appendix 1), the author was supplied with a series of documents:

- The initial SAR referral
- Individual Management Reviews from agencies that were involved with Anthony
- Material from Anthony's children including two letters of complaint
- Other information such as the Mental Health Trust Serious Incident report

The following agencies were involved in the process:

- London Borough of Croydon ASC&H
- GP / Primary Care
- London Ambulance Service
- Croydon Health Services NHS Trust
- St George's University Hospitals NHS Foundation Trust
- Metropolitan Police

- NHS South West London Integrated Care Board
- South London and Maudsley NHS Foundation Trust
- Hear Us – Mental Health Service User Group
- Look Ahead Housing Association

An initial SAR Panel meeting was held in May 2023 to discuss the process and timeline of the review. A Practitioner Reflection Day was held on 5th June 2023 and contributed a range of thoughts and views on Anthony and his care.

All this information was analysed by the author and an initial draft of this report was produced and went to the Review Panel in August 2023. Further changes were made over the next month, and a final draft was completed in September 2023.

6. Parallel processes

There were no parallel processes such as Police or Coronial inquiries that coincided with the SAR. However, the complaint about the circumstances of Anthony's death has also been taken up by the Local Government Ombudsman – who is awaiting the outcome of this SAR process.

7. Terms of Reference

The terms of reference for this review are included in Appendix 1. These informed the development of the Individual Management Reviews and the thinking about this SAR. However, they have not been used to structure this report because the review process opened up new learning about the themes to be prioritised and how that material should be presented.

8. The information received

It has to be noted that the information received on Anthony was not as complete as would be desired. Most notably no IMRs were received from either ASC&H or Look Ahead. However, ASC&H did provide detailed copies of file notes on their engagement with Anthony from 2019 until his death. Look Ahead provided a six page report on their contact with Anthony over the last six months of his life and answered further questions towards the end of the process. Nonetheless, much information has been provided by other agencies and it was felt by the author that there was enough information to complete the report.

9. Background and personal Information

Anthony was a 58 year old black British man who completed suicide in July 2021. Anthony had been a successful business and family man for most of his life. He had a partner with whom he had two children. He was also an owner of his own business.

His family described his mental health problems as having started around 15 years prior to his death. His GP reported a pattern of anxiety and depression starting in 2010. However, the problems seem to have become acute in 2016/17. The family describe him: *walk(ing) down the road with no shoes on in the rain; my auntie and uncle could not find him, so they contacted the police, who found him…During this year, my dad took multiple overdoses where the ambulance service was called, and on numerous occasions, he was taken to the hospital."*

In July 2017 he was found by his son having had a collapse. He had hit his head on a door frame and had some form of seizure. It was reported that a similar incident had occurred a few years before. As a result he saw both a Neurologist and a Cardiologist. He also attended the Emergency Department again a month later, and then in March 2018, with tingling sensations. It was suggested by the Cardiologist that he have an Implantable Loop Recorder inserted.[1] However, he ultimately refused this.

Anthony took an overdose in April 2018 and this led to engagement with the Mental Health Trust Home Treatment Team (HTT). They viewed this incident as a serious attempt to take his own life and were visiting him daily. At this point Anthony had been diagnosed with depression which was worsening and becoming manic, paranoid and delusional. The Mental Health Trust records report Anthony smoking cannabis which may have contributed to a decline in his mental health. (However, this is not viewed as a significant part of his presentation).

The HTT is a six week intervention followed by a move into the lower intensity contact offered by a Community Mental Health Team (CMHT). However, after this transition Anthony swiftly lost contact with the CMHT.

In May 2018, Police were called to a verbal argument between Anthony and his partner, who were in the process of separating. Anthony reported that his partner had made threats to kill him. Two Mental Health Nurses were also present and described a very volatile situation between the couple.

Following this, Anthony separated from his partner and moved into a Holiday Inn in Basildon where his behaviours continued to become more bizarre. He seemed to believe he owned the hotel and rented two rooms and a function room. Further alleged suicide attempts were reported. At the very least, this period cost him a considerable amount of money.

In mid-2019, Anthony described himself as low mood and was expressing the view that he *"had a lot going on in his personal life and finding it overwhelming, moving house, finding it very stressful trying to find somewhere permanent to live."* At this point he suffered a stroke. He had had a history of hypertension going back 15 years but he had only begun treatment for this 2-3 years prior to his death.

[1] A type of heart-monitoring device that records heart rhythm. It allows Doctors to remotely monitor the heartbeat. The small device is placed just under the skin of the chest during minor surgery.

As a result of the stroke Anthony was hospitalised and then moved from the local General Hospital to a specialist Hyper Acute Stroke Unit three or four miles away. His recovery progressed and he was discharged back to the General Hospital in August 2019. Once back in Hospital in Croydon, Anthony was now homeless and work was required to support him back into the community. Anthony reported having savings of £10,000 and that he did not want Council accommodation. The process of reintegrating him in to the community was problematic and at one point he was discharged from Hospital and then readmitted just two days later, after which the discharge planning had to start again.

As a result of the stroke, his family said that he lost the *"ability to speak and walk"* however he regained this although his speech was still slurred. The stroke affected *"his memory and behaviour."* They described him openly admitting that *"he no longer wants to be here anymore and he has never felt this bad over all the years of him suffering from depression."*

He was subsequently diagnosed with frontal lobe syndrome secondary to the CVA[2]. Following this diagnosis consideration was given to a more appropriate care pathway for someone with neuropsychiatry related issues. However, Anthony did not meet the criteria for transfer to Neuropsychiatry Services. It is unclear if an alternative plan was considered following the negative outcome of this referral.

By November 2019 he was living in a Bed & Breakfast. Over the next two months Anthony twice reported to the Police that he had had personal items stolen within the house. Due to insufficient evidence this could not be pursued.

Shortly after the reported thefts, Anthony had two altercations in local shops. He swore at members of staff and made threats he would destroy the shop. Police attended and arrested Anthony. It is reported during the interview that he made racist comments. Anthony was charged with Public Order offences. A week later Anthony made a complaint about the Police Officer who arrested him, stating that the Officer pushed him in the chest and handcuffed him causing his wrists to swell. This complaint was forwarded to the Duty Inspector.

In April 2020, Anthony reported to the Police that there were unknown youths outside his address who had damaged a window. Anthony was recorded to have been rude to the Dispatch Operator. When officers arrived at the address they noted that Anthony was 'immediately angry' and 'agitated.' It was recorded that Anthony '*does not like police and believes he has been treated wrongly by police'*. No further action was taken. Again, Anthony reported a complaint against the Police which was forwarded to the Duty Inspector.

On the first of these two complaints, no misconduct was identified and it was deemed the use of handcuffs was appropriate. The reviewing Officer noted the verbal communication used had caused Anthony further agitation. A decision was made that the Supervisor would speak to the Officer in relation to appropriate communication. Anthony was updated of this outcome. However, on the second complaint, no action is recorded. The Police IMR recognises that this is not in

[2] Cerebrovascular Accident (Stroke)

accordance with procedures and internal action is recommended by the IMR to rectify this. As this is a single agency issue and is subject to remedial action, no further recommendation is included here.

In May 2020, his daughter called the Police because she had not heard from her father for a while and suddenly received a text message stating: *'You will not here from me tomorrow'*. Both Police and the Ambulance Service (LAS) attended his address. But Anthony did not wish to speak with the Police. He was left in the care of the Ambulance Service and his daughter.

Subsequent to this incident, a Care Act assessment was initiated. However, the case was closed as it was felt the primary need was mental health.

In June 2020, Anthony's mental health appeared to deteriorate further. His daughter received a large number of "rambling" texts from him which she reported to the Police out of concern for his wellbeing. There were also three other incidents involving the Police in which Anthony had been involved in altercations or threats in his accommodation.

However, at this point the Covid-19 restrictions were beginning to impact and face to face support was described as having "reduced significantly if any at all". His Social Worker also left the organisation at this point. He had got on well with him because, his family suggest, he was also black British. However, he could not relate to his new social worker: a white woman.

It is reported that he was having difficulties accessing help at this point and Anthony's daughter wrote an open letter to various professionals about her concerns that her father was "*not receiving appropriate care*". She described him as living in a single room in a multiple occupancy house where people were entering his room and stealing things from him. The letter also identifies that Anthony was receiving support from a local service user led mental health charity and from a Social Worker. The family report receiving no response to this letter.

in July 2020, Anthony was admitted to Psychiatric Hospital due to his declining mental health. He was brought in initially on Section 136 of the Mental Health Act and then admitted under Section 2 of the Act. However, he subsequently remained an informal patient for the next three months.

In October 2020, he was discharged and allocated a caseworker from the Mental Health Trust's Mood Anxiety & Personality Treatment Team. He continued to receive care co-ordinated input until discharge in March 2021. He was supported to move to a flat run by a local Housing Association and with a Support Worker from another Housing Association that specialised in support to people with a range of needs.

In December 2020 Anthony reported to the Police that a white male banged on his door. When Anthony opened it, the unknown suspect made racially abusive comments towards him. Anthony was referred to a support group working with hate crime.

Between the start of 2021 and his death, he had relatively little interaction with emergency services. In February 2021, his daughter reported to the Police that she had been receiving phone calls from an unknown number; a male she did not recognise was on the end of the line and said "*Mr X says watch out*" then hung up. She believed this was something to do with Anthony but no further action was sought or taken. However, Anthony's Care Coordinator was contacted, who stated that he believed Anthony's mental health was relatively stable.

He was discharged from the Mental Health Trust in March 2021. Anthony was in agreement with his discharge plan and that he did not require ongoing care co-ordination or input from Secondary Care Mental Health Services. The discharge was to Primary Care with ongoing support from a Housing Association employed Keyworker. He was also on anti-depressants.

Subsequent to discharge, Anthony was in contact with Primary Care (7 telephone consultations following discharge in March 2021). Anthony was also offered 2 face to face consultations, attended one and received a COVID vaccination. The last contact with his GP was a telephone consultation on 21 June 2021 and he was also offered a booked face to face appointment which he did not attend.

When Anthony was found dead, there was a message chalked on a work surface that appeared to be critical of the support offered by the Housing Association. However, the Housing Association did appoint a Keyworker who had contact with Anthony on a weekly basis either by phone or face to face. His worker was a Black man and it is reported that this was welcomed by Anthony. A support plan was developed and this was reviewed in June 2021. Part of this was to access a cleaner from a care agency that Anthony would pay for. On one occasion, Anthony did complain that he was not seeing the Keyworker, but this was untrue as he had seen him in the last few days. As a result, he acknowledged that his memory was worsening.

The Keyworker reported that Anthony seemed relatively well on some days and on others was low in mood. When low, the Keyworker used distraction techniques to help Anthony focus on other issues or advised him to "step away from the problem and give himself time". Anthony was also taking pride and interest in personalising his flat, was enjoying buying and selling on-line and maintaining his art based hobbies and interests. On the other hand, it was acknowledged that his Keyworker never directly discussed suicidal ideation with Anthony.

On 24th June 2021 Anthony phoned his Keyworker and told him that he was going away for a while to visit a woman friend. The Keyworker sent text messages to Anthony on 28th June and 1st July but did not receive a response. He then went to Anthony's property on the 19th July to see if he had returned from his visit but didn't get a response.

On the 25th July 2021, Anthony's son called the Police due to concerns that he had not had contact with his father for a few weeks. The Police forced entry and found Anthony dead in his flat. The Coroner recorded his cause of death as suspension (suicide) with the actual date of death not known but it was believed he could have been dead for over four weeks.

NB Anthony's family have some concerns about aspects of the discovery of his body and whether it could have been found earlier by, for example, the Housing Association. It is not the role of a SAR to undertake investigative work of this nature and the initial agency notes available did not resolve the family's questions. However, in order to help address these issues, further information was sought from the Housing Association that was supporting Anthony. Unfortunately, this did not shed more light on the matter, particularly because the Keyworker who would have known most about the case had left the organisation.

10. A specific incident

At some point in 2017/18 Anthony's daughter supported her father to attend the local General Hospital to see the Mental Health Crisis Team. In a letter of complaint after Anthony's death, she raised two specific concerns about his care during this episode.

The exact date of these incidents is unknown and this has made it slightly harder to analyse these comments. These incidents are not mentioned in the General Hospital Trust IMR and it is hard to identify which of three or four Emergency Department attendances this refers to. It is also debatable whether these are incidents for inclusion in a SAR rather than a formal complaint to the Trust. However, they have been included because his family consider them to be important.

The sections in italics are from his daughter's complaint letter:

- *The (crisis) team spoke to him and said if he was sectioned, he would be pumped with drugs as he is a black man, and they recommend sending nurses to the house to check-in instead. I was shocked by this and very frustrated that they would say this to him, but to be fair, I do believe that they give black people in the system the strongest drugs, so as much as I strongly believe they were being truthful, I still thought that he needed to be sectioned to stop him trying to commit suicide. I would like to note that the workers that told him this were black themselves.*

It is acknowledged by the family that this incident involved staff who were also from Black and Minority Ethnic communities. It is likely that the language used was positively intentioned to try and avoid Anthony having a Psychiatric Hospital admission. However, if the language was used, its appropriateness may need to be considered by the Trust.

- *Whist, my father, was at Croydon University Hospital; he was made to lay on the floor on a thin mattress like a monster for days as; apparently, they had no beds. If someone is going through a crisis, why would healthcare professionals think it would be ok for a patient to spend days locked in a room lying on the hard floor. Unfortunately, as this was some time ago, I cannot remember the exact number of days, but even one day is not ok…*

This was raised at the Practitioners' event. It was pointed out by Trust staff that the "mattress incident" almost certainly refers to a room in the Emergency Department where people in mental health distress can be held safely. It deliberately has a low

mattress and cushioned flooring to avoid providing ligature points. No comment can be made on the specific quality of this approach, but it does appear to be an appropriate response to someone in a potentially self-harming mental health crisis. The Trust also noted that the height of the bed in this room has been raised recently.

11. Overview of emerging themes

Anthony's history highlights a number of areas of learning which could help improve services working with people with serious mental health problems. These cover:

- Transitions in health or mental health care
- The mental health / adult safeguarding interface, particularly in the context of an area with integrated services under a section 75 agreement
- The mental health / adult safeguarding interface – general comments
- Care coordination and multi-agency management
- Family engagement in patients who refuse contact with family members
- The care of people with cognitive damage
- Mental capacity / executive function
- Consistency of staffing
- Whether racism impacted on any aspects of the care
- The impact of Covid-19

12. Transitions in health or mental health care

At the time of his death Anthony was living in the community having been discharged from an inpatient stay in a psychiatric hospital 9-10 months previously. Inevitably, this raises questions about the adequacy of any aftercare.

The initial care plan was for Anthony to engage with a caseworker from the Mental Health Trust's Mood Anxiety & Personality Treatment Team. This transition seems to have been effective and he continued to receive care co-ordinated input until discharge in March 2021. The plan was then to step down into the care of a Housing Association Keyworker with additional support from Primary Care. He did receive phone and some face to face support from his GP Practice.

He also received, at least, weekly support from his Keyworker. This was described in section 9. In general he appears to have received positive support; however, it has to be acknowledged that this period ends with Anthony completing suicide and that, at the end of his life, Anthony expressed the view that the Housing Association input was not helping him. It also needs to be recognised that this was happening during the Covid pandemic restrictions, which may have impacted on the quality or intensity of aftercare that he received.

However, this was not the only point of transition. Anthony took an overdose in April 2018 and this led to engagement with the Mental Health Trust Home Treatment Team (HTT). The HTT is a short term intervention (six weeks) followed by a move into the lower intensity contact offered by the CMHT. However, at this point of transition Anthony and the CMHT lost contact.

Anthony's family are concerned about the lack of follow-up. In particular because, at this point, Anthony separated from his partner and moved into a Holiday Inn in Basildon where his behaviours continued to become more bizarre. There were also reported further suicide attempts. This incident raises questions about both:

- the challenge of moving someone from one service to another even within the same Trust; and
- the ongoing care of someone who then moves out of area.

In mid-2019, Anthony suffered a stroke. Anthony was moved from the local General Hospital to a specialist Hyper Acute Stroke Unit three or four miles away. He returned to Hospital in Croydon, but Anthony was now homeless and work was required to support him back into the community. A Discharge Coordinator was involved in this process as well as Ward staff and an Occupational Therapist (OT). The discharge planning was very difficult with Anthony setting boundaries on what he would and would not accept, e.g. he would not accept Council housing or a bed and breakfast. He was also at times stating that he would find accommodation, but was not carrying through on that. That made it hard to find an appropriate facility. However, the Trust IMR also highlights that: *There is no evidence to indicate who was supposed to lead the discharge process or how Anthony was supported to contact the bed and breakfast accommodation.*

The IMR also highlights other gaps:

- *It was noted that his family should support him over the bank holiday weekend if he declined this. However, there is no evidence that this plan had been discussed with his family.*
- *There is no evidence to indicate that Anthony was given an opportunity to seek and get support before attending (a key discharge planning) meeting.*

At a discharge planning meeting: *Anthony explained that he felt 'ambushed' by the decision* (to discharge) *the previous day (21/8/2019) and did not feel he was treated fairly. He stated he had been given limited time to 'get his head around' what he needs to do and what he needs to organise. The team acknowledged his concerns.* He also acknowledged that: *he would have liked more time*.

It is not surprising that a man who is in recovery from a stroke, with the problems in thinking and planning that are attendant on that, found it hard to move towards a decision about his next steps.

On the 23rd August 2019 Anthony was discharged from Hospital. The IMR notes that: *Anthony was discharged and left with all his property. He was accompanied with a friend. He was provided with take home medication. Discharged to unknown destination.* Within two days he was re-admitted because he was unable to "mobilise or self-care". Subsequent notes in the IMR state that: *Social circumstances and patient's vulnerable state made it inappropriate to discharge him without proper social planning.*

Anthony was in hospital for another five weeks, finally being discharged on the 23rd September 2019. During this second stay, more work was undertaken on developing a pathway back into the community for him. The Discharge Link for Homelessness met with Anthony this time in the presence of a Senior Sister. The Ward Sister also

considered a discharge to assess (D2A) application. However, there is no evidence that this was completed.

A Social Worker also met with Anthony to discuss his care and support needs. Consideration seems to have been given to support with cleaning and shopping which the Red Cross would be able to provide. However, there is no indication that consideration was given for further assessment under the Care Act.

Work continued to try and develop a discharge plan but this seems to founder because Anthony was struggling with the organisational requirements of this process. This is consistent with someone who had had a stroke.

In Mid-September a Joint Liaison Psychiatry and Senior OT review was completed alongside a Neuropsychologist. This meeting advised the ward to arrange a discharge planning meeting with the Neurology Team, Stroke Rehabilitation Team, Social Worker, Liaison Psychiatry, OT, and Clinical Neuropsychologist in attendance. The IMR states that: *There is no evidence that this meeting took place. This was another missed opportunity to ensure that Anthony had a safe discharge*.

On the 20th September the IMR highlights that *the Discharge Team, together with the ward manager met with Anthony and informed him that he was assessed and confirmed to be medically fit for discharge by the multi-disciplinary team. Anthony said that he was informed he was going to be discharged on Monday (23/09/2019). He was informed that he didn't have to stay in an acute hospital bed and was asked to leave that afternoon. The plan was to give Anthony one hour to pack, then he would be taken to the discharge lounge. Anthony was advised that he needed to source his own accommodation for the night and onward. Anthony could be allowed brief time to make calls and if ward staff had any resistance from him then they should call security. There is no evidence to suggest that his family were informed neither involved in the process.*

The IMR goes on to note that: *there is no evidence of mental capacity assessment to ascertain whether Anthony was able to process, understand, retain or communicate a decision regarding accommodation or discharge destination.*

On the 23rd September the IMR states that *Anthony informed the nursing team that a Discharge Coordinator had asked him to leave the ward that day…He packed his property; he was given his discharge summary and take-home medication by the nursing staff. The sister in charge spoke to Anthony about his discharge destination but Anthony told her that the Discharge Coordinator had already told him to leave therefore he was leaving. He booked a taxi and left to unknown destination. The Homeless Team was given his number to contact him.*

The IMR goes on to note that: *There is no evidence that the ward had held a Discharge Planning Meeting as recommended on 16/09/2019 by the MDT (including Psychiatry Liaison Team). Had this happened, it is more likely that Anthony would have been discharged with an appropriate support plan.*

Just over a week later Anthony phoned the hospital to complain about his poor treatment and described his discharge as inadequate. He felt that he was sent away from hospital with a lot of medication without instruction and was struggling to manage

this.

It is acknowledged in the Trust IMR that at points in this process Anthony was aggressive to staff and it must have been frustrating for staff to see his bed occupied and Anthony not moving towards a clear pathway for his future. However, this does seem to have been a pivotal point in his care. He was subsequently diagnosed with frontal lobe syndrome secondary to CVA and began to exhibit more problematic behaviour and his mental health deteriorated to the point where he was admitted to a Psychiatric Hospital under a Section of the Mental Health Act.

Each of these three transitions experienced by Anthony was different, with separate and individual challenges. However, it does highlight the ongoing need to ensure that points of transitions in someone's care are well managed. This will require:

- follow up from the agency handing over the individual to ensure ongoing care;
- support from family; and
- consideration of the person's mental capacity to make and execute the key decisions required at the point of transition.

At a wider level, this highlights the need for the SAB to ensure that there are clear pathways and procedures at each point of transition and there is training to support practitioners to support people through transitions.

13. The mental health / adult safeguarding interface - the section 75 agreement

Croydon has a section 75 agreement in place with the local Mental Health Trust. These agreements, under the NHS Act 2006, provide a contractual framework for the use of pooled funds between the Council and Health Services, to enable services to be delivered and commissioned jointly.

Therefore, safeguarding concerns are dealt with by Social Workers operating within the Trust.

Five referrals of safeguarding concerns were made on Anthony in 2020:

- A voluntary sector organisation raised one in February 2020
- The Ambulance Service raised one (date not identified)
- Police raised three Merlins[3] in May, June and December 2020

NB A safeguarding concern was also raised by the Police in August 2020 with the Bromley Safeguarding Team following an allegation from Anthony of abuse by staff in the Psychiatric Hospital.

However, it is not clear what happened to any of these Concerns. Neither the notes provided by ASC&H's Disability Team nor the Mental Health Trust IMR specify what happens as a result of these concerns. On one occasion, it can be argued that Anthony was then dealt with under the Mental Health Act (June 2020). However,

[3] Police generated adult concern notifications

there are no relevant entries in the Mental Health Trust chronology or the ASC&H notes for the period around February 2020 or December 2020.

This highlights a significant gap in the management of the safeguarding process. The author of this review has seen an identical gap in another local authority area with a section 75 agreement. More importantly the same gap was identified in Croydon's Duncan SAR published in 2021 which recommends that: *CSAB should consider seeking assurance from SLAM and ASC that a robust process is in place for decision-making regarding referrals of adult safeguarding concerns, and for monitoring the outcomes of adult safeguarding enquiries*.

Local authorities need to recognise that under a section 75 agreement they still retain responsibility for safeguarding and NHS Trusts in joint agreements need to ensure that they are fulfilling and recording Adult Social Care responsibilities.

In the Practitioners' Workshop, questions were also raised about whether the merging of Adult Social Care functions led to a dominance of the medical model over a Social Care model. It is not possible to specifically identify this in Anthony's care but it is recorded here as a related comment from the Workshop.

It is also noted within the Mental Health Trust IMR that safeguarding concerns may not have been raised when appropriate. The IMR highlights that there *were concerns regarding possible self-neglect prior to admission…however it appears that no referrals under s.42 of the Care Act 2014 were considered thoroughly nor actioned.* It is unclear whether the merger of responsibilities lay behind this omission – but it is a possible factor.

As a footnote, under section 47 of the Care Act, the local authority has a legal duty to provide protection of property. This applies where a person is admitted to hospital, residential or nursing care or removed from their home and relocated under the Care Act and no one has been identified as being able to protect the property on behalf of the client. The local authority must take reasonable steps to prevent or mitigate the loss or damage of a person's movable property or belongings. The Mental Health Trust IMR highlights that this does not seem to have happened in relation to some of Anthony's belongings. The location of some of his property was a source of stress to him after his discharge from the Psychiatric Hospital. It is unclear whether this is due to the lack of clarity over responsibilities resulting from the section 75 agreement.

It is understood that the Section 75 agreement is under review in Croydon. It is important that all the concerns above are considered in that review process.

14. The Adult Social Care / Mental Health Interface – general comments

Irrespective of a Section 75 agreement, the interface between mental health and adult safeguarding can be challenging. This is a national, not simply a local, problem. Where does responsibility lie for people with care and support needs as well as a mental health problem? This can be seen in two aspects of Anthony's care – the absence of a section 9 assessment and the allocation of a Social Worker.

Reviewing the whole history, it is unclear the extent to which Anthony had care and support needs at key points. However, at the point of his inpatient stay, the Mental Health Trust IMR does describe him as:

- *(Having) self-care (problems) to an extent that it threatens personal health and safety;*
- *Neglecting to care for one's personal hygiene, health or surroundings;*
- *(Unable) to avoid harm as a result of self-neglect;*
- *(Failing) to seek help or access services to meet health and social care needs;*
- *(Unable or unwilling) to manage one's personal affairs.*

The lack of an ASC&H IMR makes it hard to track the response to such needs; however, the notes suggest that consideration was given to an assessment under section 9 of the Care Act when he was a mental health inpatient in 2020. However, this was not completed because it was felt that his needs were primarily related to his mental health. No evidence of a section 9 assessment is recorded in the Mental Health Trust IMR.

The ASC&H notes also identify that Anthony had two consecutive named Social Workers in the Disability Team within ASC&H. The person in this post changed at the onset of Covid in 2020; but Anthony had a consistent Social Worker until mid-2020 when he was detained under the Mental Health Act. Prior to that point, both the Social Workers do appear to have been active in responding to his needs and there are 59 pages of notes on their work from ASC&H. However, this input was terminated in 2020 after he is detained under the Mental Health Act because his needs were seen to be related to mental health.

This is a very binary response to his problems – it is either one thing or the other – whereas given his history he may have had problems connected to both mental health and disability.

This interface problem is not directly related to the Section 75 agreement and these "boundary issues" exist in areas without such an agreement. However, in considering the Section 75 agreement it would be useful to review how the joint responsibility for the care of complex clients with mental health problems is managed between Mental Health and ASC&H.

15. Care coordination and multi-agency management

Anthony's care would have benefited from clear leadership: a care coordinator and ongoing multi-agency management.

He is identified as having a Care Coordinator at the time of his involvement with the Home Treatment Team in 2018. Again in June 2020, a Care Coordinator is mentioned in the run up to his admission under the Mental Health Act. On discharge in October 2020 a different Care Coordinator is appointed. However the chronological notes in the Mental Health Trust IMR only mention two meetings between Anthony and his Care Coordinator in the six month period up until March 2021. It is acknowledged that this may reflect a gap in the notes rather than a deficit in his care. It may also

reflect the challenges of the Covid restrictions. However, it may also raise questions about the adequacy of care coordination locally.

It is clear that a large number of professionals were involved in his care (see below section 19) and that there will have been multi-disciplinary meetings about his care when he was an inpatient. However, this does not seem to have continued into the community. The Mental Health Trust IMR comments: *Round table meetings with all professionals and dissemination of all plans with Anthony's consent…would on balance…have potentially supported and aided clear communication of what plans should be in situ to support Anthony.* Again this process may have been hindered by the Covid-19 restrictions.

The Practitioners' Workshop highlighted the importance of both multi-agency management and care coordination and their relative absence in Anthony's care.

16. Family involvement in patients who refuse contact with family members

One of the key concerns expressed in discussion with the family (and also highlighted in the Mental Health Trust investigation in May 2022) was a lack of family support. The Trust IMR comments that the: "*family reported not having a positive experience … and the lack of 'whole person' care. They also described a lack of responsiveness from (the Mental Health Trust), not taking concerns from family seriously and the delay in receiving care*".

This picture is complicated because Anthony placed limits on the sharing of information with family, including stopping any contact with his adult children at points in his care. He generally seems to have allowed contact with his siblings. This was true during both the care for his stroke and his mental health care. Ironically, on the other hand, a social worker in the Mental Health Trust (June 2020) identified his grandson, daughter and son as protective factors in his care.

This is a challenging area of work. Practitioners will not always understand the complexities of someone's family relationships. Yet, research highlights that family involvement in care is likely to improve outcomes.[4] While professionals need to respect a person's reasonable wishes, they also need to work to understand the reasons behind any refusals of family involvement, to know how to escalate concerns about this and if appropriate work consistently to encourage family involvement as much as possible. This may be an area for local guidance and training.

17. The care of people with cognitive impairment

In the period up to 2019, Anthony had a series of problems that could have affected his cognition. In 2017, he had a seizure and hit his head on a door frame. It was reported that a similar incident had occurred some years before. In mid-2019 Anthony suffered a stroke, as a result he exhibited elements of a functional neurological disorder. He had memory difficulties, balance issues, problems using stairs and

[4] E.g. Impact of Patient and Family Involvement in Long-Term Outcomes - PubMed (nih.gov)

problems using the phone. Ultimately, in 2020, he was diagnosed with frontal lobe syndrome secondary to stroke.

The frontal lobe controls key functions including:

- Speech and language;
- Motor skills;
- Executive functioning – the person's ability to plan, make decisions, manage their needs, and multitask. It also plays a big role in attention and concentration;
- Empathy and social skills;
- Impulsivity.

This highlights *the Frontal Lobe Paradox;* a phenomenon in which a subset of patients with frontal lobe damage are still able to able to verbally describe a logical course of action relating to a task and perform well in interview and test settings but exhibit marked impairments in everyday life due to executive function and impulsivity problems. Such cases pose a challenge with regard to the assessment of mental capacity within clinical settings. They can appear capacitous at assessment but are unable to put things into effect in the community.[5]

It is possible that this could explain some of Anthony's behaviour after the stroke. However, this is speculation.

The diagnosis of frontal lobe syndrome secondary to stroke suggested to professionals that Anthony would require a care pathway that was more appropriate for someone with neuropsychiatry related issues. The problem was that, despite this diagnosis, Anthony did not meet the criteria for transfer to Neuropsychiatry Services. The Mental Health Trust IMR comments that: *It is unclear if an alternative plan was considered following the outcome of Neuropsychiatry referral when Anthony did not meet their criteria and whether another pathway would have been more suitable*.

It needs to be considered whether this highlights a gap in access to Neuropsychiatry. Recent unpublished work on SARs by Dr Aly Norman, Associate Professor in Psychology at Plymouth University has highlighted the frequency with which head injuries and consequent executive function problems are being seen in these serious case reviews. Work may be required to consider pathways for these clients with neuropsychiatric problems who do not meet current eligibility criteria.

18. Mental capacity / executive function

The comments about executive function (section 17) also feed in to the consideration of his mental capacity.

No mental capacity assessments are documented for Anthony. For most of the review period it is impossible to say, at this distance, whether a capacity assessment would have been appropriate. However, between his diagnosis with frontal lobe syndrome secondary to Stroke in 2020 and the onset of the breakdown of his mental health which led to him being detained under the Mental Health Act, consideration of his mental

[5] Frontiers | The Paradox of the Frontal Lobe Paradox. A Scoping Review (frontiersin.org)

capacity became more important. At this point, professionals do assert that he had capacity to make key decisions about his care. For example, ASC&H notes state (July 2020): *It is in my professional opinion that there is no reason to set aside the presumption of Anthony having capacity.* However, it is not clear what these statements are based on. Indeed, the Mental Health Trust IMR highlights capacity assessments as a possible gap in his care.

More specifically, it is the view of this review, that it would be necessary to consider his "executive capacity". The frontal lobe damage he experienced does mean that he is likely to have problems executing decisions.

The Teeswide Carol SAR highlights the need to look at someone's "executive capacity" as well as their "decisional capacity". Can someone both *take* a decision and *put it into effect* (i.e. execute the decision or *use* information)? This will necessitate a longer-term view when assessing capacity with someone like Anthony. Repeated refusals of care or inability to benefit from support should raise questions about the ability to *execute* decisions. The draft Code of Practice to the Mental Capacity Act now specifically highlights the need to consider executive function as well as considering repeated failed decisions when assessing capacity.

This is a developing area of work but it does highlight a training need to ensure that frontline practitioners are considering executive capacity, particularly with people in Anthony's situation.

19. Consistency of staffing

In the ideal situation, Anthony would have had consistent input from professionals over a period of time to ensure that positive relationships were built. This does not appear to have been the case. Anthony's family were particularly concerned about the problems resulting from the loss of a Social Worker who had a good relationship with Anthony and then moved on. Again, Covid-19 restrictions clearly impacted on this at the latter end of his care

The Mental Health Trust IMR acknowledges this problem and identifies 52 separate professionals who had had some involvement in his care. This does seem to be a very large number. The IMR specifically recommends that: *Where possible, fewer staff members involve(d), to support continuity and the development of professional and patient-based rapport and relationships.*

Any comments on this situation have to acknowledge the staffing challenges in the NHS and Social Care generally. However, the Trust's own comments highlight the importance of stable relationships with professionals, particularly when thinking about the needs of people like Anthony who can be difficult to engage in services.

20. Whether racism impacted on any aspects of the care

Anthony is a black British man who is likely to have experienced racism directly and institutionally at points in his life. The question for this SAR is whether any of the

events that led to his death were driven by either individual or institutional racism. This needs to be considered because his family have questioned whether this was a factor in his care:

I believe the Police, Adult Social Care, Mental Health Service and his GP stereotyped him as an angry/aggressive black man and did not take any of the times they interacted with him seriously. Why did I reach out to my father's social worker to address serious concerns about his mental health, and she chose not to contact me or send me an email? Why did the mental health service not take his health more seriously? Why was his family not involved in his care plan? Why was he discharged from the hospital straight into his own accommodation?

The family also ask: *Is it because my father was a black man that the Police chose to ignore all these signs repeatedly and not report these concerns to the mental health services? Were the Mental Health Services aware of the Police reports but ignored them? How does someone have so many interactions with the Police, yet he is only sectioned in 2020 when a white woman reports him to the Police due to her being scared and him refusing to leave the property she managed.*

They also raise two specific incidents related to the General Hospital, which are ascribed to racism – these are dealt with separately in section 10.

It has to be acknowledged that men and women from Black, Asian and Minority Ethnic communities are negatively impacted by mental health problems and mental health services. Black men are particularly disadvantaged.

- Black adults have the lowest mental health treatment rate of any ethnic group, at 6% (compared to 13% in the White British group).
- Evidence suggests that people from Black Asian and Minority Ethnic communities are at higher risk of developing a mental health problem in adulthood. But they're less likely to receive support for their mental health.
- Black men are more likely to experience symptoms of psychosis than other ethnic groups (3.2% compared to 0.3% of white men and 1.3% of Asian men - using combined 2007 and 2014 data.) There is no significant variation by ethnic group among women.
- Black people are more likely to access treatment through a police or criminal justice route. Black and mixed black groups are between 20% and 83% more likely to be referred from the criminal justice system than average.[6]

Nonetheless, it is not possible to draw a straight line between individual or institutional racism by workers or organisations involved and the problems Anthony experienced at any point in the review period.

The Practitioners' Workshop also acknowledged that people from Black and Minority Ethnic communities may face particular challenges in mental health care. Indeed the Workshop highlighted wider equalities issues for Anthony – do men and especially older men struggle with accessing help from services? On the other hand, the Workshop did not identify any specific patterns of racism within Anthony's care.

[6] Facts and figures about racism and mental health - Mind

Nonetheless, this is an ongoing reminder of the need to build services which recognise and meet the needs of people from Black Asian and Minority Ethnic communities and the particular needs of black men.

21. The impact of Covid 19

The last 16 months of the period under review were during the Covid-19 restrictions. Whether the lockdown in March to June 2020 had an impact on his declining mental health is unclear. His family felt that this was the case. However, It is positive that despite these restrictions he was able to be admitted, and then supported back into the community.

Nonetheless, although this cannot be detailed, it does seem likely that Covid restrictions impacted on the intensity of care that he was able to receive in 2021. In January 2021, Anthony contracted Covid. This was just after he moved into his Housing Association property. His Keyworker felt that this had increased Anthony's social isolation. In another example, some of his primary care consultations were on the phone instead of face to face.

Covid-19 undoubtedly had an impact on Anthony's care and well-being. However, this cannot be seen as a reflection of poor practice, or subject to recommendations, it is simply the reality of an unprecedented situation.

22. Key Learning Points

As a Black British man Anthony is very likely to have experienced racism at points in his life. His family were concerned that racism (individual or structural) may have impacted on his care. No direct evidence exists to support this. However, national data on the unequal impact of mental health problems on black men and the poorer care they seem to receive should remind every agency of the need to be constantly aware of these equality and diversity concerns.

Anthony's care also highlights a number of more specific themes.

The most specific concern is the adequacy of the ongoing support he received at points of transition in his care. This could have been most acute in the last nine months of his life following discharge from the Psychiatric Hospital. However, at this point he appears to have had support from the Trust and then to have stepped down to support from Primary Care and a Housing Association Keyworker. Although, both these services do seem to have provided ongoing support, there are indications that Anthony did not feel supported during the period leading up to his death.

More specifically, there are problems at the transition in 2018 between the Home Treatment Team and the Community Mental Health Team – at this point of step down to lower support he disengages. In 2019, there is a challenging period following his stroke when professionals are working with him to move him back into the community but he is effectively homeless and with limited support in the community.

Each of these three scenarios involved different services and had separate individual challenges. However, it does highlight the ongoing need to ensure that points of transitions in someone's care are well managed. This will require:

- follow up from the agency handing over the individual to ensure care is continuing
- agencies working to maximise support from family
- consideration of the person's mental capacity to make and execute the key decisions required at the point of transition.

At a wider level, this highlights the need for the SAB to ensure that there are clear pathways and procedures at key points of transition and there is training to support practitioners to support people through these changes.

A second key theme is the interface between safeguarding and mental health under a Section 75 agreement. The main concern is that it was not possible in this SAR to track what action was taken in response to the safeguarding concerns that agencies raised. It may be that action was taken but it is not recorded in the notes that were provided. The Local Authority retains legal responsibility for safeguarding and it is important that they have data on both concerns and the actions taken to address those concerns. The Mental Health Trust needs to ensure that staff are clearly recording responses to safeguarding concerns. This issue has been raised in another local SAR.

The Practitioners' workshop highlighted a wider concern about the medical model being dominant in these arrangements. This was not explored in any depth but it does highlight a local concern. It is understood that the Section 75 agreement is under review in Croydon. All of these concerns should be considered in that review process.

Anthony's family were concerned about the level of involvement that they were able to have in his care and the degree of support available to them. The family particularly focused on the Mental Health Trust; however, these themes are more generalisable. In Anthony's case, this picture is complicated because he placed limits on the sharing of information with family.

Family involvement in care is likely to improve outcomes; so while professionals need to respect a person's reasonable wishes, they also need to work to understand the reasons behind any refusals of family involvement, to know how to escalate concerns about this and if appropriate work consistently to encourage family involvement as much as is possible. This may be an area for local guidance and training.

Anthony had a stroke in 2019 which left him with frontal lobe syndrome secondary to the stroke. This is likely to cause problems with executive function, impulse control and communication problems and the IMRs suggest that that he did experience such problems over the following two years. This diagnosis raised a question about a referral to Neuropsychiatry. However, the referral was rejected because Anthony did not meet the eligibility criteria for the service. This suggests a gap in the care pathway for people with lower level, but nonetheless significant, cognitive damage. Work may be required to consider pathways for these clients who do not meet current eligibility criteria.

No mental capacity assessments were documented for Anthony. This is a possible gap in his care generally. However after his diagnosis with frontal lobe syndrome secondary to stroke in 2020, consideration of his mental capacity became more important; in particular, his executive capacity. In these cases, it is vital to consider both whether someone can *take* a decision and whether they can *put it into effect* (i.e. execute the decision)? The draft Mental Capacity Act Code of Practice now highlights the need to consider both executive function as well as repeated failed decisions when assessing capacity. This is a developing area of work but it does highlight a training need to ensure that frontline practitioners are considering executive function, particularly with people in Anthony's situation.

Anthony's care would have benefited from clear leadership: a care coordinator and ongoing multi-agency management. The IMRs are unclear as to the extent that care coordination was used; however, the Practitioners' Workshop was clear that greater use needed to be made of both of these.

On the other hand, it is noticeable that a very large number of people did have contact with Anthony, particularly during his involvement with the Mental Health Trust. This led the Trust IMR to comment that where possible, fewer staff members should be involved in order to support continuity of care and the development of a positive relationship with the individual.

23. Good practice

Many agencies made efforts to help Anthony. Most professionals appear to have worked appropriately with him within the framework of their individual disciplines. In particular, some of the work undertaken with Anthony was during the period of the Covid-19 restrictions and it is clear that agencies continued to work and to maintain services during that difficult period.

It is also worth noting that some of the IMRs received, e.g. from the Mental Health Trust, the General Hospital Trust and the Police were very open and honest about practice and how it can be improved. This was very helpful in undertaking this review.

However, two specific points of good practice did emerge:

- His GP Practice was positive in supporting Anthony in the last months of his life after discharge from Mental Health Services

- The local user led voluntary organisation Hear Us appears to have built a good relationship with Anthony at one point in his care.

24. Recommendations

Recommendation A

Croydon SAB needs to reassure itself that there are clear pathways and procedures at each point of transition in care and that there is training to support practitioners to support people through transitions.

Recommendation B

Croydon SAB should work with those reviewing the local Section 75 agreement, to ensure that they are considering the concerns highlighted in this SAR (and at least one other local SAR), e.g. about the recording of action in response to safeguarding concerns.

Recommendation C

Croydon SAB should work with both the Mental Health and General Hospital Trusts to review whether a care pathway is required for people with significant cognitive impairment but which is at a level that does not meet the current Neuropsychiatry criteria.

Recommendation D

Croydon SAB should ensure that guidance and training is available to support professionals to use the Mental Capacity Act. In particular this should include reminders about the importance of considering executive capacity.

Recommendation E

Croydon SAB should consider developing guidance on training to support professionals who are working with individuals who are refusing family involvement. This will include how to escalate concerns about this and if appropriate work consistently to encourage family involvement as much as is possible.

Recommendation F

Croydon SAB should ensure that all professionals are aware of the need for clear leadership in the care of complex clients: i.e. a care coordinator and ongoing multi-agency management. In particular, the potential role of the local Risk and Vulnerability Panel should be emphasised.

Appendix 1 - Specific areas of enquiry - Terms of reference for Anthony SAR

All contributors to the review were asked to consider and reflect on the following:

- How to manage and support people who have more than one social care / mental health need.
- How to improve inter-agency working with complex cases and where someone doesn't fit into one box.
- Managing self-neglect, he was a vulnerable person with additional issues and interaction difficult which needs to be considered.
- Communication and sharing of information.
- How could agencies have worked better together, his journey before he passed away moving to voluntary services, hospital admission and criminal justice system.
- Substance misuse.
- Mental Health and discharge from services, moving into accommodation not supported by mental health.
- Working across agencies, what are the barriers?
- How to address people getting lost in the system?