Lewisham
Safeguarding Adults Board
A working partnership to prevent abuse

Safeguarding Adults Review "Earl"

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Independent Reviewer and Author

The independent reviewer and Lewisham Safeguarding Adults Board (LSAB) wish to convey their deepest and most sincere condolences to Earl's family and friends following his tragic death.

We dedicate this report to Earl's memory, with the hope that its findings will lead to meaningful learning and sustained improvements in the services intended to support individuals in similar circumstances.

Contents

1. Background and Methodology

1.1. To protect dignity and privacy, and to comply with the Data Protection Act 1998, the subject of this review is referred to under the pseudonym of Earl[1].

Why commission a Safeguarding Adults Review (SAR)

1.2. Earl was a Black British male of Caribbean heritage who lived alone. He had a prolonged history of mental ill health, resulting in multiple detentions under the Mental Health Act (MHA) and had a diagnosis of Paranoid Schizophrenia[2]. In August 2024, Earl was discharged from a secure mental health unit under a Community Treatment Order (CTO). However, in time, due to the Community Mental Health Team (CMHT) being unable to make contact with Earl, a Section 135(2) warrant was issued and on 27 February 2025, Earl's Care Co-ordinator attended his property with police officers to execute the warrant. Upon forced entry, Earl was tragically found deceased. His home was in a severely neglected state, and malnourishment was suspected as a contributing factor to his death.

1.3. The Lead Operational Manager for Adult Mental Health Safeguarding, referred[3] Earl for a Safeguarding Adults Review (SAR) and those present at the Lewisham Safeguarding Adults Board (LSAB) Case Review Sub-Group (May 2025) agreed that the criteria, as set out in Section 44 of The Care Act 2014, was met[4] for a mandatory SAR. This decision was confirmed by the wider Board in July 2025. The purpose of a SAR is clearly defined in the Care Act 2014. It is to promote effective learning and improvement actions to prevent future deaths or serious harm occurring again. The lessons learnt for this case should be applied to future cases to ensure continuous improvement of practice. It is not the purpose of this review to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law, and systems of professional regulation.

1.4. This report has been authored by Allison Sandiford. Allison is an independent safeguarding consultant with no links to LSAB or any of its partner agencies. Allison has a legal background and has gained her experience in safeguarding whilst working for a police service. Since leaving the force in 2019, Allison has undertaken review training with SILP[5], the Home Office and Advocacy After Fatal Domestic Abuse[6] (AAFDA) and has conducted serious case reviews in both children's and adults safeguarding, and domestic homicide reviews.

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[1] Pseudonym chosen by LSAB
[2] Refer to Appendix 1 for information
[3] In February 2025
[4] (1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—
(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) condition 1 or 2 is met.
(2) Condition 1 is met if—
(a) the adult has died, and
(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).
(3) Condition 2 is met if—
(a) the adult is still alive, and
(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.
(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).
(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—
(a) identifying the lessons to be learnt from the adult's case, and
(b) applying those lessons to future cases.
[5] SILP School – Review Consulting
[6] Home - AAFDA

Methodology

1.5. A multi-agency SAR panel[7] was established and the panel and LSAB identified the following specific Key Lines of Enquiry for the review to address:

- Mental Capacity.
- Challenges of Engagement.
- Referrals, Follow up and Monitoring.
    - What would good have looked like.
    - Barriers to good practice.
    - Self-neglect.
- Neurodiversity.
- Explore whether protected characteristics (codified by the Equality Act 2010) impacted on Earl's care management and if so, how?
- Identify areas of good practice.

1.6. Panel members agreed that the SAR should concentrate on a specific timeframe starting from the 12 August 2024 (when Earl was discharged from hospital) until the 27 February 2025 (when Earl was found deceased). Whilst the report will include brief background information re. any significant events and safeguarding issues prior to the scoping period - where agencies consider that it would add value and learning to the review, this timeframe was deemed sufficient to allow examination of Earl's circumstances focusing in particular on the Section 135 process and the risks associated with execution delays. Due to the particular focus of this review, participation has been limited to two agencies: the Metropolitan Police Service (MPS) and the South London and Maudsley NHS Foundation Trust (SLaM). The review has examined their work from a systemic perspective. It has acknowledged areas of good practice and strengths that can be developed further, as well as identifying areas where changes are needed to promote improvements.

1.7. There have been limitations to this review in respect of discussions around practice and decision-making being had with frontline practitioners and their managers. This has not been possible due to parallel processes. However, comprehensive Individual Management Reports have been received from both organisations and have proved sufficient in assisting the review to understand why the professionals supporting Earl acted in specific ways at specific times, and to understand learning for future practice.

1.8. The following reviews/investigations have also been undertaken in relation to Earl, and their processes have been considered/respected by this SAR:

- The circumstances of Earl's death were referred to the MPS Directorate of Professional Standards. The matter was reviewed and assessed as not meeting the criteria for a Death or Serious Injury Investigation. The matter has not been referred to the Independent Office for Police Conduct, and the case has been closed.
- Earl's death has been referred to HM Coroner, and Southwark Coroners' Office has referred the circumstances to the MPS Inquest Team for review. The MPS has been identified as an Interested Party in proceedings, but an Inquest hearing had not been held at the time of writing this report.

[7] See Appendix 2 for panel membership.

Involvement of Family and Wider Community

While learning of the subjective experiences of the deceased's family members and close friends regarding the support and services provided is an important component of SAR methodology, the LSAB was, in this instance, unable to seek input. This was because the professionals who had worked with Earl had no contact details for any immediate family and were unaware of any close associates. As a result, it has not been possible to notify or invite any individuals to contribute to the review.

Dissemination of Learning

1.9. The publication of this SAR report has been approved by the LSAB Board, and it will be made available on the Board's website and on the National SAR Library.

1.10. The Board will also determine the most effective methods for disseminating the learning, which may include a seven-minute briefing and/or regular e-bulletins, and will consider how best to incorporate the learning into training programmes, as appropriate.

2. Earl's Journey

Pre-Scoping Period

2.1. Earl had a complex history marked by struggles with sustained engagement and subsequent mental health deterioration which is evidenced by seven prior detentions under the Mental Health Act. His history highlights instability and the significant challenges faced by services in providing him continuous, effective care.

2.2. Prior to the scoping period of this review, in September 2023, professional concerns for Earl escalated when police and Approved Mental Health Professionals (AMHPs) found his flat in a squalid, unfurnished state (leading to an amber-rated risk assessment). A Section 42 Enquiry was raised - the outcome of which was that because Earl was self-neglecting and would not allow any support, he needed to be recalled on his CTO. Earl was recalled on the 14 November 2023 and admitted to hospital where he remained an inpatient until January 2024. Upon discharge under a new CTO, Earl was placed in 'step down' accommodation whilst his flat was deep cleaned and made habitable. However, Earl absconded and returned to his flat before this could be done. Initial attempts to manage this non-compliance using the powers of the CTO were unsuccessful on two occasions due to a lack of available secure beds and Earl's condition and living circumstances continued to decline. When a successful Section 135(2) warrant was executed, on 15 May 2024, police found Earl's flat squalid and without power. Officers also discovered items such as a Stanley knife, drugs and about £1000 in cash. Earl presented severely unwell and was admitted to hospital, where his antipsychotic medication was restarted.

3. Brief Overview of the Scoping Period

3.1. The formal scoping period begins on the 21 August 2024 when, following a pre-discharge deep clean[8] of his flat, Earl was formally discharged from hospital[9] under a renewed CTO (initiated and authorised by the inpatient consultant psychiatrist on the ward, with responsibility for follow-up care transferred to Lewisham CMHT). However immediate attempts to provide Earl with follow-up care proved difficult when on the 23 August, a planned 72-hour follow-up visit found Earl absent

[8] This involved commissioning Clouds End to de-clutter it, as it was more than the Special Duty Team could manage. The Section 42 was closed at this point as Earl's living conditions had been made habitable.

[9] Earl's discharge had been delayed because Earl had declined temporary accommodation and chosen to remain in the hospital while awaiting a deep clean of his flat.

and, on the 27 August, the Care Co-ordinator was unable to administer Earl's crucial depot injection. Following an emergency welfare check by the London Ambulance Service - where entry was forced, Earl was found to be mentally stable but refusing to engage with the CMHT.

Consequently, on the 28 August, the medical team completed the CTO recall form, which was then provided to Earl's Care Co-ordinator in the community mental health team, and the MHA Office was informed. (An overview of the CTO recall process can be found at Appendix 3.)

3.2. Attempts to serve the CTO documentation[10] included a home visit on the 30 August 2024 by the Care Co-ordinator, followed by a letter sent by recorded delivery. Subsequent unannounced visits also proved unsuccessful but, on the 6 September 2024, a housing officer enabled access to the building, allowing the Care Co-ordinator to deliver the CTO3 form and a compliment card through Earl's letterbox, urging him to make contact.

3.3. Documentation dating from the 9 October indicates that the Care Co-ordinator from the community mental health team attempted to obtain a Section 135(2) warrant, but this first application failed due to administrative and technical errors, including the Court's inability to open electronic documents. This review has been informed that the CMHT lacked familiarity with the complex CTO recall documentation and the task, which had originally been assigned to the Care Co-ordinator had been handed over to duty staff - who did not complete it promptly. This is discussed in more detail later in the report starting at paragraph 5.10[11].

3.4. Following a three-month delay, on the 10 October 2024, the Care Co-ordinator initiated a new Section 135(2) warrant[12] application on behalf of the CMHT due to continued non-engagement. Over the subsequent month, weekly phone calls to Earl and doorstep visits remained unsuccessful.

3.5. On the 18 November, a Care Co-ordinator and Consultant Psychiatrist initiated a police welfare check after they failed to get any response at the door but concluded Earl was likely inside due to radio/TV noise. However this check was subsequently cancelled after an ambulance crew deemed Earl safe based on a verbal exchange through the door (though crew had not gained entry or physically seen Earl). Following this a consultant from the medical team issued a second CTO recall and on the same day, the community consultant re-completed the CTO3 form and sent it to the MHA Office after earlier paperwork had to be re-done. The re-completed CTO3 form was then posted again to Earl (also on the same day – the 18 November 2024).

3.6. The Care Co-ordinator and other team members continued unsuccessfully to attempt contact with Earl until on the 24 December, a newly allocated Care Co-ordinator was met with shouting from inside the property and thereafter approached the AMHP service for specialist advice in navigating the warrant process. A warrant was finally obtained on the 13 January 2025 and the CMHT requested police support for its execution. A date was initially set for the 5 February 2025, but this had to be postponed due to a lack of available police officers. Thereafter there was further delay when on the 14 February, police risk assessment increased to 'high' due to intelligence concerning potential weapons (screwdrivers) on the premises. This information necessitated specialist officers which delayed execution until the 27 February 2025 when tragically upon forced entry, Earl was found deceased (suspected to have hit his head). The property was in a state of severe neglect and malnourishment was suspected as a contributing factor. It was estimated Earl had passed away approximately one week prior.

[10] Responsibility for attempting to hand-deliver and post the CTO documentation sat with the Care Co-ordinator and CMHT, supported by housing officers where access to the building was required.
[11] SLaM has since delivered training on CTO form completion, and integrated AMHP support into the recall process.
[12] A Section 135(2) warrant, issued under the Mental Health Act 1983, specifically authorises a constable to enter a premises, using force, if necessary, for the purpose of finding and removing a patient who is liable to be taken to or returned to a hospital (for example, a patient absent without leave or on a CTO recall).

4. Equality and Diversity

4.1. The Equality Act 2010 makes it illegal for organisations to discriminate against individuals based on specific characteristics. It aims to protect people from unfair treatment in various settings and in the provision of services and public functions. Given this framework, Earl's diagnosis of Paranoid Schizophrenia constituted a protected disability under the Act, meaning his care management and outcomes must be considered against the Act's non-discrimination principles.

4.2. Furthermore, while Earl did not have any formal diagnosis of neurodiversity, this review has considered whether his clinical presentation - marked by struggles maintaining engagement, social isolation, and non-compliance - required the 'Reasonable Adjustments' typically afforded to neurodiverse individuals under the Equality Act 2010. The review found that Earl's complex presentation did require highly tailored strategies and has recognised that agencies sufficiently attempted to adapt their approach accordingly, for example, through unannounced home visits, joint agency attempts at contact[13], and moving to a 'signs of life' approach – listening for the TV or radio to confirm Earl was alive and inside without forcing a confrontation that could have escalated Earl's behaviour.

Learning Point 1[14]: Agencies should not wait for a formal diagnosis to change how they talk to someone. If a person is struggling to communicate professionals must treat them with the same specialised care they would give a neurodiverse person.

4.3. Other examples of 'Reasonable Adjustments' attempted by professionals working with Earl include them:

- Recognising that Earl's living conditions were a potential driver of his decline and attempting to fix the environment by commissioning a specialist service that works with people who struggle with hoarding and self-neglect. This is an example of a 'reasonable adjustment' because it recognised the psychological impact of hoarding, not just the physical mess. Agencies also attempted a 'buffer' by moving Earl to the temporary accommodation whilst his flat was made habitable – acknowledging that Earl couldn't manage to fix his home conditions on his own, and;
- Seeking specialist support - The Care Co-ordinator proactively sought guidance from the AMHP service, and the police worked to upgrade their risk assessment to high (when they learned about potential weapons) to ensure that when entry was forced, it was done by specialist officers who could manage Earl's specific presentation safely.

4.4. Sadly despite the professional's 'reasonable adjustments' the communication interventions proved unsuccessful and Earl could not be accessed without legal intervention – but administrative and technical errors (which delayed both the CTO recall and execution of the warrant), and (prior to the scoping period) a lack of hospital beds, meant that when professionals did move from their adaptive engagement to compulsory recall, the system was not able to receive Earl. Notably, the

[13] CMHT coordinated with a housing officer to gain access to the building.

[14] The agencies involved with this review have demonstrated that they are already addressing this learning point:

- SLaM has assured the review that they are making it easier for mental health teams to get advice from specialists in neurodiversity and are training staff to recognise that when a patient 'refuses to engage' or 'won't open the door,' it might not just be 'being difficult' - it might be because their brain processes social interaction or stress differently.
- The Metropolitan Police has assured the review of a Public Protection Portal, which is an online toolkit for police officers. It gives them specific tips on how to talk to people who have "non-visible" disabilities (like neurodiversity or severe trauma). They have also advised of a specialist police unit - the Front-Line Policing Delivery Unit Central Mental Health Team. If a regular police officer is at a doorstep and does not know how to handle a complex situation like Earl's, they now have a specific team they can call for expert advice on the spot.

reliance on bed availability as a condition for executing a CTO could be argued to constitute Indirect Discrimination. While this practice applied to everyone – not just Earl, it disproportionately disadvantaged Earl by preventing a person with severe mental illness from accessing immediate, life-saving care.

4.5. It is important to highlight that the factor of Race (Black British, Caribbean heritage) intersects critically with Earl's disability as national data indicates that Black service users are nearly 4 times more likely to be detained under the Mental Health Act than White service users[15]. Therefore this review must ask agencies whether Earl's care relied excessively on coercive measures (CTO/warrants) rather than culturally competent community engagement[16]. If enforcement measures are the primary tool used for Black service users who have withdrawn from services, it may represent Indirect Discrimination and Earl's withdrawal may have been a direct consequence of this systemic bias.

4.6. The ultimate breakdown lies in the intersectionality of Earl's high vulnerability (created by his disability) and compounded by potential racial bias, not being protected because the legal safeguards (CTO recall and Section 135(2)) were rendered inoperable by operational failures. The inability to execute such interventions represents a systemic failing within the duty to protect a vulnerable citizen whose protected characteristics placed him at extreme risk.

5. Analysis and Response to Key Lines of Enquiry

This section of the report will analyse the actions of the agencies, focusing on decision-making, multi-agency communication, and the impact of systemic barriers. The analysis has been developed from examination of the information gained from the agency reports and documentation shared with this review, and discussion and analysis with panel members. The learning points are presented within the body of the report. For any issues not already addressed since the scoping period of this review, recommendations are provided later in the report. These recommendations should guide LSAB and its partner agencies to develop an improvement plan that directly responds to the findings of this review.

Risk Management and Assessment of Discharge, Engagement and Delay

Hospital Discharge

5.1. This review will begin by exploring the decision-making around Earl's discharge from hospital on the 21 August 2024. Earl had refused secure accommodation[17] which would have mitigated the immediate environmental and safety risks, and as such, despite his history of non-engagement and the pre-existing knowledge of self-neglect, Earl was discharged back to the same environment under a renewed CTO. (The decision to renew the CTO at discharge was made by the inpatient consultant psychiatrist, with the expectation that Lewisham CMHT would use the CTO as the primary contingency for non-engagement.) It was good practice that the discharge was delayed whilst Earl's property was subject to a deep clean, but the fundamental risk, i.e., Earl's inability to maintain his home conditions and to engage with support – had not been resolved (and perhaps may not have been resolvable).

5.2. The CTO was the designated, robust contingency plan for Earl's non-engagement, but the issuance of CTO recall papers on the 28 August 2024 - due to the inability to engage Earl whilst in the community and to administer his depot injection - immediately exposed the plan's weaknesses. Whilst CMHT had correctly and immediately triggered their robust legal contingency (the CTO

[15] Mental Health Act Statistics, Annual Figures, 2024-25 - NHS England Digital
[16] This was also a factor for SAR Tyrone Goodyear (LSAB SAR Report TG) and SAR Joshua (Lewisham Safeguarding Adults Board - SAR Joshua)
[17] Orchard House

recall), the response was stalled due to administrative errors and resource delays, the details of which are explored in the next section of this report.

Engagement

5.3. Staff correctly recognised Earl's inability to engage as symptomatic of his illness, marked by paranoia and mistrust of services, and CMHT's efforts to engage Earl whilst the CTO recall was being actioned were comprehensive. They included:

- Scheduled and unannounced home visits.
- Joint visits with housing officers and consultants.
- Welfare checks via the ambulance service, and;
- Written communication being left at the property.

But despite their efforts, strategies proved ineffective and actually highlighted that the decision to issue CTO recall papers in recognition of the immediate risk posed by Earl's non-compliance on the 28 August 2024, had been correct.

Procedural Delay

5.4. The failure in managing Earl's risk lay in the fact that though his non-compliance continued and the CTO recall process and warrant application dragged on for months - this review has seen no evidence of any supervisory processes within the CMHT[18] which would have ensured that Earl - a CTO patient refusing medication, known to previously have lived in squalor, and subject to an outstanding warrant application - was prioritised at the highest level during weekly clinical review meetings and his circumstances escalated as appropriate. Crucially, there is no evidence of any formal risk assessment being conducted that would have factored together the loss of medication, the concerns around potential deterioration of the living environment, the delays of the CTO safety net, and the lack of physical health checks. This lack of proactive oversight serves as a clear indicator of significant organisational and structural barriers to 'professional curiosity'.

Learning point 2: Supervisory processes failed to ensure a CTO patient, refusing medication and subject to an outstanding warrant, was prioritised. Additionally, there was no formal, documented risk assessment that integrated the cumulative and escalating risks (loss of depot, self-neglect, failure of CTO, no physical checks).

5.5. The absence of a formal assessment may have led to the cumulative risk being underestimated, potentially delaying appropriate escalation. SLaM has recognised this as an area requiring improvement and has provided assurance to the SAR that its engagement protocols for patients who are harder to reach have been reviewed and strengthened.

5.6. The execution delay in Earl's warrant later in the scoping period was not deemed a safeguarding matter or considered appropriately in terms of relevant escalation channels. Had escalation channels been exhausted, a formal multi-agency safeguarding planning meeting (which has the remit to compel multi-agency action) could have been convened and could have provided a high-level forum to address the resource, administrative, and police scheduling failures, potentially coordinating the complex Section 135 process and securing the intervention necessary to save Earl's life.

Learning Point 3: The warrant execution failure was not considered as a safeguarding concern.

[18] Responsibility for progressing the warrant application sat with the CMHT and the Care Co-ordinator.

5.7. Not escalating a delay in warrant execution may be a reportable issue and could breach the Statutory Duty of Candour (CQC Regulation 20), depending on the outcome. By failing to categorise the delay as a reportable incident, the organisation effectively bypassed the transparency mechanisms designed to protect patients from systemic neglect.

5.8. This is now at odds with the Mental Health Act 2025 (which received Royal Assent in December 2025). The Act is built upon four statutory guiding principles that must now inform every clinical decision:

- **Choice and Autonomy:** Ensuring patients have a say in their care even when detained.
- **Least Restriction:** Using compulsory powers only when absolutely necessary and for the shortest time possible.
- **Therapeutic Benefit:** Treatment must be effective and appropriate, not just for containment.
- **The Person as an Individual:** Treating patients as people with unique personal and cultural backgrounds.

These principles turn best practice into legal duties and under this framework:

- the procedural delays in Earl's case could represent a breach of the Least Restriction principle[19];
- the lack of engagement with his refusal of treatment could be deemed a failure of Choice and Autonomy; and
- the absence of a holistic risk assessment could fail the Therapeutic Benefit test, as no active path to recovery was managed.

5.9. Furthermore, the 2025 reforms introduce Statutory Care and Treatment Plans and the oversight of a new Chief Inspector of Mental Health. These mechanisms ensure that procedural drift which leads to avoidable harm, is no longer viewed as just administrative but as a direct violation of a patient's legal rights - that should be reported under the strengthened Duty of Candour.

Barriers to Good Practice and Inter Agency Coordination (Execution Failures)

5.10. This review has identified that 'good' practice would have seen the timely completion of CTO recall paperwork and the immediate execution of the legal powers, supported by a coordinated multi-agency safeguarding plan, clear escalation pathways when engagement failed, and regular multi-disciplinary reviews of risk. This section details the specific administrative, staffing, and police failures that prevented this.

5.11. In relation to the aforementioned administrative failures within the CMHT when recalling the CTO, this review has learned that the CMHT team lacked familiarity with completing the lengthy and complex CTO recall paperwork, and this issue was exacerbated by operational challenges as at the time the CMHT lacked an AMHP or Advanced Practitioner to guide the legal process. Hence, the administrative burden of completing the lengthy CTO recall paperwork fell to less

[19] By failing to act while Earl's deterioration was still manageable, the system effectively waited for a crisis, which is the exact opposite of what the Least Restrictive principle requires.

experienced staff, directly leading to administrative inefficiency and delay in progressing the warrant.

Learning Point 4: CMHT staff lacked familiarity with complex CTO recall paperwork, a problem exacerbated by the lack of an available AMHP or Advanced Practitioner to guide the legal process.

5.12. Additionally, there were changes in Care Co-ordinators for Earl and Consultants within the CMHT (including one brief vacancy). The Team Manager was on sick leave, and a new Service Manager had been appointed. This period of transition and the frequent staff changes may have compromised the team's collective understanding of Earl's case history, affected the momentum of the warrant process, and diminished the sense of urgency required - particularly during a time when the team was managing several high-risk cases. These factors likely contributed to delays in escalation and co-ordination.

Learning Point 5: Multiple changes in Care Co-ordinators, Consultants, and Managers risked undermining continuity of knowledge and the necessary urgency of Earl's situation.

5.13. Earl's case has underscored the critical need for robust inter-agency protocols and SLaM has since reviewed its supervision protocols to ensure that high-risk cases trigger senior oversight earlier, and that internal escalation pathways are clearly defined and documented. Furthermore, SLaM has established clearer escalation protocols and incorporated an Inter-Agency Escalation Policy in line with the relevant LSAB framework. This structural change aims to improve inter-agency escalation procedures and clarify roles in complex safeguarding cases, addressing the systemic fragmentation that plagued Earl's care.

5.14. In relation to the warrant, the police – who were the sole agency empowered by law to execute the warrant using force - were also plagued by time-consuming delays:

- An initial warrant execution scheduled for the 5 February 2025 was cancelled due to a lack of available police officers - the police have informed this review that this reflected limited resources and the prioritisation of criminal matters, but have reflected that the decision to postpone was made outside of the Basic Command Unit process - which requires the authorisation of an Inspector to cancel any attendance at a Section 135 warrant. This procedural breach highlights a failure in internal police governance at a critical decision-making point, though the police have assured this review that this has since been addressed by the relevant Line Manager as a matter of personal learning.

- The MPS has confirmed that whilst policy states that the decision regarding police attendance is processed within 48 hours of the form being received, there is no timeframe stipulated in the policy for the execution of the warrant, as this is influenced entirely by the risk assessment. This allowed the operational de-prioritisation to extend the delay to six weeks without technically breaching any warrant execution deadline.

- A further interruption contributing to the overall six-week delay was brought about as a result of intelligence on the 14 February 2025. This information raised the police risk assessment to 'high', and necessitated specialist officers. Conversely, this scenario highlights a systemic conflict in that the intervention (warrant) designed to reduce risk, was delayed because the risk was too high.

5.15. The failure to allocate officers within a clinically reasonable timeframe, justified by the prioritisation of non-urgent criminal/regulatory matters, affected the legal authority granted by the court being effectively disregarded for six weeks. (A delay that was combined with the initial three-month delay prior to this in actually obtaining the warrant). This delay, driven by resource

limitations and internal governance failures, highlights a profound deviation from national best practice - which mandates stringent protocols to manage the risks inherent in such delays. National guidance, derived from the MHA Code of Practice, establishes that the primary duty is the immediate protection of life (Article 2 of the European Convention on Human Rights[20]), requiring the police to execute the statutory duty within a reasonable timeframe based on urgency.

Learning Point 6: MHA warrants for compulsory intervention should be treated as a high-priority, statutory duty to protect life (Article 2 ECHR).

5.16. Delayed execution of warrants escalates the risk significantly to both the patient and the public and in this case led to Earl remaining without medication or assessment, which allowed his mental deterioration and self-neglect to worsen. The six-week delay in Earl's case ultimately led to fatal risks that the warrant was intended to mitigate and highlights why warrants for compulsory assessment must be given high priority by the police. If police officers are unavailable, there must be a clear, immediate escalation pathway requiring Duty Sergeants or Inspectors to actively source resources or authorise cancellation. The failure to seek Inspector authorisation in Earl's case was a direct lapse from this required best practice standard.

Systemic Failure of the MHA Framework

5.17. The overriding issue in Earl's care was not a failure to recognise his need for protection, but a systemic paralysis resulting from *bottlenecks* in the delivery of that protection. While clinical staff initiated the protective mechanisms of the MHA, the multi-agency system failed to execute them in a timely manner, resulting in an 'Operational Lockout.'

Learning Point 7: The safeguarding system became paralysed due to bottlenecks in execution (administrative errors, police delay, lack of beds).

5.18. The prompt issuance of CTO recall papers (on the 28 August) repeated on the 18 November, provides clear evidence that the clinical team had made the critical assessment that Earl was not making a capacious, unwise choice, but was deteriorating to a point of high risk - requiring compulsory detention under the MHA. The paralysis was therefore not due to clinical indecision, but the inability of the multi-agency system to *action* the assessed need for protection.

5.19. There is an argument that there was a missed opportunity to also escalate Earl's disengagement and suspected self-neglect to a Safeguarding Enquiry. However Adult Social Care have noted that while a Safeguarding Concern could have been raised, the CMHT lacked the objective evidence of current self-neglect due to non-access. Furthermore, Adult Social Care validated the CMHT's decision, advising that the Safeguarding Lead's advice would have remained the same: i.e., to recall Earl on his CTO for urgent psychiatric treatment.

5.20. This has validated the CMHT's choice of the CTO recall as the primary protection tool and reaffirms that the systemic failure is not the choice of intervention, but the execution of it. The necessary reliance on the CTO recall process placed the entire weight of Earl's protection onto the successful and rapid coordination of the MHA's legal tools. The inability of the multi-agency system to execute the assessed need for protection for Earl in a timely manner went across three critical stages:

- Administrative Failures: Once the decision was made to recall under the CTO and to seek the warrant, months of delay were caused by administrative errors and a lack of specific legal expertise. The first attempt to obtain the Section 135(2) warrant failed due to a combination of administrative errors and the Court's inability to open electronic documents

[20] European Convention on Human Rights - Article 2 | European Union Agency for Fundamental Rights

and as mentioned, this was exacerbated by the CMHT lacking an AMHP or Advanced Practitioner to provide specialised guidance, causing a three-month delay between the confirmation of risk and the successful acquisition of the warrant.

- Multi-Agency Coordination: Even after the warrant was legally secured (on the 13 January 2025), the final act of protection was subject to operational delays.

- Lack of Secure Beds: Prior to the scoping period, the system's inability to guarantee the necessary resource was a fundamental constraint. The documented instances of two separate failed CTO recall attempts between January and May 2024 were due to the explicit reason of 'unavailability of secure beds'.

5.21. The lack of secure beds represents a critical breakdown of the statutory framework. When a Responsible Clinician legally determines that a patient requires immediate, compulsory detention to prevent harm, the necessary resources (a secure bed) must be available. The inability to provide these beds affected the legal instrument, designed to save Earl's life and ensure public safety, being rendered inoperable due to an operational resource deficit.

5.22. SLaM has informed this review that the unsuccessful attempts to admit Earl due to the lack of available secure beds critically undermined timely intervention. The delay prolonged Earl's exposure to unmanaged risk in the community and weakened the effectiveness of the CTO as a safeguarding tool.

5.23. This is not an isolated local scenario. There is a known systemic crisis of mental health bed capacity and national data confirms that NHS mental health bed occupancy remains consistently above the Royal College of Psychiatrists' recommended 85% maximum, often exceeding 90%. This reflects high pressure and poses a direct risk to patient safety, with the total number of mental health beds having fallen significantly nationally - while demand has risen. This national pressure is severely felt in London. Local capacity issues, driven by high demand and challenges in discharging patients due to a lack of available community care, social care, and supported housing, create significant bed blockages. The lack of capacity across the system meant that when Earl, a patient subject to a legal safeguard, required a bed for compulsory care, the resource was simply non-existent[21].

Learning Point 8: A fundamental barrier to recall was the lack of secure beds, transforming the CTO into an unreliable tool. The problem is a national systemic crisis.

5.24. The system's failure to provide a bed had severe consequences. By leaving Earl unchecked, his mental and physical condition deteriorated rapidly. Recalling Earl to the hospital would have ensured he restarted medication and would have immediately addressed the risks associated with his severe self-neglect and squalid living conditions. The lack of this essential resource (secure bed) directly contributed to the worsening of Earl's clinical condition and his living circumstances.

5.25. The policy of linking a CTO recall to the immediate availability of a secure bed - rather than to Earl's immediate legal and clinical need for compulsory detention - is a fundamental flaw and arguably constitutes Indirect Discrimination against individuals with severe mental health disabilities. While the policy was applied to all patients, it disproportionately disadvantaged Earl, who relied entirely on the service's ability to provide immediate, legally mandated, life-saving care that the system could not deliver.

5.26. This consistent capacity issue points to a failure at the highest level of strategic commissioning (the planning and funding of services) to ensure that resources (secure beds)

[21] Acute mental health bed availability - Active Care Group

match the demand for statutory (legally required) services. As a result, this review must ask key strategic questions: What urgent actions were taken by CMHT and Trust management when beds were unavailable? What specific contingency plans were in place? Were alternative options, such as transferring Earl's detention to a unit outside the immediate area, explored and rapidly escalated across senior management to procure the necessary resource?

5.27. SLaM has recognised the need to strengthen bed management escalation pathways, prioritisation for high-risk recalls, and coordination with system partners to address structural capacity issues. This learning is now being embedded into safeguarding and risk escalation frameworks – however the (national) problems around shortages of beds will continue.

5.28. The government's strategy to address the national shortage of secure mental health beds is relying upon transforming community care instead of increasing the overall bed supply. Significant funding (e.g., the £2.3 billion annual commitment in the NHS Long Term Plan) is being directed towards expanding mental health services in the community. This aims to create a stronger safety net, improve crisis intervention, and provide timely alternatives to hospital admission, thereby reducing the fundamental demand for inpatient beds.

5.29. Efforts are also focused on streamlining patient flow, primarily by tackling delayed discharges. By improving social care provision and supported housing in the community, the goal is to free up existing inpatient beds that are currently occupied by patients who are clinically ready to leave.

5.30. However despite these efforts, as mentioned at paragraph 5.20, national data confirms a persistent crisis. This high pressure leads to dangerous delays, inappropriate out-of-area placements, and, as seen in Earl's case, renders statutory legal safeguards like the Mental Health Act inoperable when the required resource is unavailable.

5.31. A SAR is primarily a local learning tool, but when the findings point to issues that cannot be solved locally - such as a national mental health bed shortage - it becomes a national issue.

Learning Point 9: This SAR highlights issues of national policy as it is concerned with the systemic crisis in national mental health bed capacity and strategic commissioning and also challenges the national policy or practice that links compulsory care to resource availability, raising a legal issue under the Equality Act 2010.

6. Similarities with other Lewisham SARs

6.1. This review has identified parallels between Earl and three previously published[22] Lewisham SARs (Maureen, Joshua, and Tyrone Goodyear). These cases collectively highlight recurring themes of self-neglect, neurodiversity, and the challenges of multi-agency coordination for individuals of Black Caribbean heritage.

6.2. Earl, Joshua and Tyrone were all men of Black Caribbean heritage. The reviews for Joshua and Tyrone noted that a lack of cultural competence could have led to diagnostic overshadowing or coercive rather than supportive intervention. And like Earl, Tyrone had a diagnosis of Autism, which significantly influenced his ability to navigate housing and mental health systems.

6.3. In another previously published SAR - SAR Maria, the review explored whether undiagnosed neurodiversity/trauma contributed to her refusal of traditional support services. A central theme in this SAR and SAR Maureen was the professional tendency to mislabel the refusal of services as a

[22] https://www.safeguardinglewisham.org.uk/lsab/lsab/publications/safeguarding-adult-reviews

‘capacious’ unwise choice. In Earl’s case, his ‘non-engagement’ was treated as a barrier to service rather than a clinical indicator of decline that should have triggered a Section 42 Enquiry.

6.4. SAR Joshua focused heavily on the use of the Mental Health Act and the escalation to police force for Black men in crisis. Similarly, the SAR for Tyrone highlighted how a lack of coordination between housing and mental health services meant that risk assessments (like those in Earl's case) failed to account for the person's actual living reality.

6.5. Across all four reviews, there is a recurring recommendation for Professional Curiosity. This includes the failure to look beyond a shout through the door or a patient's verbal claim that they are fine, which was a direct factor in the failure to assess Earl’s deteriorating environment.

7. Good Practice

7.1. Discussion around Earl’s care have highlighted some examples of good practice[23] from the professionals involved with him. It is important that such practice is highlighted and further encouraged. Some examples are included within the body of this report, but other examples are:

- Professionals correctly recognised the risk to Earl when he refused his depot injection and immediately activated the legal safeguard CTO recall.
- The CMHT showed persistence in trying to fulfil their duty of care with consistent attempts to engage Earl, even after repeated failures.
- The Metropolitan Police Service has resources (the Public Protection Portal and FLPDU Central Mental Health Team) designed to provide officers with advice on effective communication with neurodiverse and non-visible disabled adults. This demonstrates a commitment to organisational learning and supporting tailored responses.
- Following the incident, SLaM proactively reviewed and enhanced its protocols for hard-to-reach patients, incorporating concepts like peer support and trauma-informed care. This is a commitment to improving clinical practice based on critical learning.

8. Conclusions and Recommendations

8.1. This review concludes that the tragic outcome for Earl was the result of an ‘Operational Lockout’, where the multi-agency system failed to execute the protection that clinical staff had correctly identified as being necessary. The CMHT decision to issue a CTO recall on 28 August 2024, was clinically and legally correct given that the lack of access to Earl would result in his condition and home conditions deteriorating and he required compulsory detention. However, the subsequent execution of the CTO recall was stalled by administrative, resource, and governance failures. For six weeks, the legal authority granted by the Court - the Section 135(2) warrant - was rendered inexecutable, which left Earl, a high-risk CTO patient, without medication or compulsory care.

8.2. The failure to safeguard Earl highlights systemic vulnerabilities that go beyond individual agency errors. Most critically, whilst this review has been informed that local data indicates that bed availability has recently stabilised and targets are being met, the broader context of Earl’s history reveals how national pressures on acute psychiatric beds can fundamentally alter the management of CTOs. This is because a CTO only works as an effective safety net if the recall process is fast and reliable. However, when the national mental health system is under high demand, there is a risk that the threshold for intervention is raised, and this can create a revolving door effect where discharge decisions are influenced by the urgent need for bed capacity. For individuals like Earl, who struggle to engage with community support, this could result in being returned to the community before they are stable, significantly increasing the risk of relapse.

[23] Good practice in this report includes both expected practice and what is done beyond what is expected.

8.3. The extensive delays in executing the warrant, impacted by police resource limitations breached the core duty to protect life (Article 2 ECHR). This review highlights that the systemic weaknesses of MHA enforcement disproportionately impacts vulnerable individuals. The findings of Indirect Discrimination link to the lack of secure beds, coupled with parallels to other SARs involving Black service users subject to coercive intervention, demand priority and scrutiny.

8.4. Future practice must focus on eliminating the identified administrative bottlenecks, guaranteeing resource equality for statutory duties, and embedding robust inter-agency protocols.

8.5. The learning points from this Safeguarding Adults Review commissioned by LSAB are highlighted in bold text throughout this report, but for reference, are repeated below alongside the relevant recommendation if the learning has not been already addressed:

	Learning Point	Has this learning been addressed?		Recommendation
1	Agencies should not wait for a formal diagnosis to change how they talk to someone. If a person is struggling to communicate professionals must treat them with the same specialised care they would give a neurodiverse person.	Yes - SLaM and MPS have provided assurances regarding specialist training, tools (Public Protection Portal), and access to specialist teams.		Not required.
2	Supervisory processes failed to ensure a CTO patient, refusing medication and subject to an outstanding warrant, was prioritised. Additionally there was no formal, documented risk assessment that integrated the cumulative and escalating risks (loss of depot, self-neglect, failure of CTO, no physical checks).	Yes - SLaM has reviewed and enhanced its protocols for supervision and integrated risk assessment in high-risk cases.		Not required.
3	The warrant execution failure was not considered as a Safeguarding Concern.	No - a specific, actionable Recommendation is required.	1	LSAB and partner agencies to ensure that procedure commands that future failures in the execution of MHA warrants (Section 135/136) automatically trigger a formal escalation process, which will involve the police, SLaM and the Lewisham AMHP Service, to plan the earliest possible attempt to re-execute the warrant and consider any risk-minimisation steps in the interim.
4	CMHT staff lacked familiarity with complex CTO recall paperwork, a problem exacerbated by the lack of an available AMHP or Advanced Practitioner to guide the legal process.	Yes – SLaM has assured the review of enhanced training on legal processes and future utilisation of AMHP support for complex legal and safeguarding interventions.		Not required.
5	Multiple changes in Care Co-ordinators, Consultants, and Managers risked undermining continuity of knowledge and the necessary urgency of Earl's situation.	Yes - SLaM has reviewed supervision protocols, established clearer escalation pathways, and incorporated an Inter-Agency Escalation Policy linked to the LSAB framework.		Not required.

6	MHA warrants for compulsory intervention should be treated as a high-priority, statutory duty to protect life (Article 2 ECHR).	No - a specific, actionable Recommendation is required.	**2**	Police, NHS Trusts, and Local Authorities must establish clear, multi-agency protocols for Section 135 warrants. These protocols must treat the warrant as a statutory duty to protect life (Article 2 ECHR) and include agreed-upon risk criteria to determine urgency and guarantee resource allocation within a clinically and legally reasonable timeframe.
7	The safeguarding system became paralysed due to bottlenecks in execution (administrative errors, police delay, lack of beds).	No – but the other Recommendations will collectively address this learning point.		
8	A fundamental barrier to recall was the lack of secure beds, transforming the CTO into an unreliable tool. The problem is a national systemic crisis.	Partially - SLaM has made an internal recommendation to improve bed management and admission pathways, but the national systemic resource shortage remains unresolved.	**3** **4**	SLaM to actively and transparently outline and demonstrate to LSAB their improvements to bed management and admission pathways. LSAB to actively engage the ICB SEL and bring to their attention the failure in resource provision for secure mental health beds and for ICB SEL to outline and demonstrate future commissioning intentions for secure mental health beds.
9	This SAR highlights issues of national policy as it is concerned with the systemic crisis in national mental health bed capacity and strategic commissioning and also challenges the national policy or practice that links compulsory care to resource availability, raising a legal issue under the Equality Act 2010.	No - a specific, actionable Recommendation is required.	**5**	LSAB to utilise the National Escalation Protocol to formally bring the systemic issues identified - specifically the failure in resource provision (secure mental health beds) and the potential for Indirect Discrimination under the Equality Act 2010 - to the urgent attention of the Department of Health and Social Care and NHS England.

Appendix 1 What is Paranoid Schizophrenia?

www.nhs.uk[1] describes Schizophrenia as a long-term mental health condition that causes a range of different psychological symptoms which can include:

- hallucinations – hearing or seeing things that do not exist outside of the mind.
- delusions – unusual beliefs not based on reality.
- muddled thoughts and speech based on hallucinations or delusions.
- losing interest in everyday activities.
- not wanting to look after yourself and your needs, such as not caring about your personal hygiene.
- wanting to avoid people, including friends.
- feeling disconnected from your feelings or emotions.

While the exact cause of schizophrenia remains unclear, most experts agree that it results from a mix of genetic and environmental influences. Some individuals may have a higher risk of developing the condition, with factors like stressful events or drug use potentially acting as triggers.

Individuals diagnosed with schizophrenia do not experience split personality, nor is the condition typically associated with violent behaviour. Treatment commonly involves a personalised approach integrating medication and therapeutic interventions. Professional care and ongoing management can minimise the effects of schizophrenia in everyday life, and many individuals achieve recovery, although symptom recurrence may occur periodically.

Paranoid Schizophrenia is the most common type of schizophrenia[1].

Appendix 2 The Review Panel Members

- Lewisham Safeguarding Adults Board Business Manager.
- Lewisham Safeguarding Adults Board Co-ordination and Development Officer.
- Independent Reviewer.
- Representative from Metropolitan Police Service.
- Representative from South London and Maudsley NHS Foundation Trust.

The LSAB Case Review Sub-Group members also provided oversight and input to the review.

Appendix 3 Overview of the Community Treatment Order Recall Process

The CTO recall process in the UK is governed by the Mental Health Act 1983, allowing a patient to be quickly returned to the hospital if their condition deteriorates. The Responsible Clinician (RC) can issue a Notice of Recall (Form CTO3) if they determine that the patient meets two strict criteria:

- they require treatment in hospital for their mental disorder, and
- there is an associated risk of harm to the patient or others if they are not recalled.

This notice compels the patient to return to the named hospital. Upon arrival, the patient is detained for a maximum of 72 hours to allow the RC to assess whether the patient can be safely released back to the community under the existing CTO or if the CTO must be revoked, leading to full inpatient detention (usually under Section 3).

If the patient receives the Notice of Recall but fails to return voluntarily, they are legally considered Absent Without Leave and the MHA grants powers under Section 18 to Police Constables and authorised hospital staff to take the patient into custody and convey them to the hospital. The decision to initiate this compulsory return is based on a clinical risk assessment rather than a fixed time limit, meaning enforcement action must be taken urgently if the risk of harm is immediate.

Where the patient's whereabouts are known but they are refusing entry, the mental health team (typically the Approved Mental Health Professional may apply to a magistrate for a Section 135(2) Warrant. This warrant authorises a Police Constable to enter the premises, by force, if necessary, to remove the patient and take them to the hospital. This highly restrictive measure is used as a last resort when voluntary engagement fails, and the patient is liable to be detained under the MHA. If the patient is not apprehended and returned to the hospital within six months of becoming Absent Without Leave, the CTO automatically expires, and the patient is legally discharged.

Appendix 4 Internal Agency Recommendations

Created by and for SLaM:

1. Strengthen Face-to-Face Engagement Protocols.
2. Improve Continuity of Care.
3. Enhance Training on Legal Processes.
4. Embed Escalation Pathways for Non-Engagement.
5. Improve Bed Management and Admission Pathways.