Lewisham
Safeguarding Adults Board
A working partnership to prevent abuse

Safeguarding Adults Review 'Arthur'

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1. Introduction

1.1 Arthur was an 81-year-old Black British Caribbean man who lived in a private residence in the London Borough of Lewisham with his wife, who was also his carer. In September 2021, Arthur was unlawfully killed by his son, [Anthony].

1.2 The decision to undertake a Safeguarding Adults Review (SAR) was agreed following a Lewisham Safeguarding Adults Board (LSAB) Case Review Sub-Group meeting. This decision was endorsed by the LSAB Independent Chair and the Chair of the Safer Lewisham Partnership Board, as the details of this case met both the criteria for a SAR and a Domestic Homicide Review, but in accordance with local procedures it was decided a SAR would take precedence. The Case Review Sub-Group meeting considered information provided by all the agencies involved with the person, who is the subject of this review, and following discussions concluded that there was reasonable cause for concern about how the LSAB members worked together to safeguard the adult who sadly died.

1.3 The purpose and underpinning principles of this SAR are set out in section 2.9 of the London Multi-Agency Adult Safeguarding Policy and Procedures. All LSAB members and organisations involved in this SAR, and all SAR panel members, agree to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

1.4 At the request of Arthur's family, we have used his real name but to protect the identity of his son, Anthony is a pseudonym agreed by the Independent Chair and has been used throughout this review to also protect the identity of the wider family.

2. Family Involvement

2.1 A Safeguarding Adults Review should be informed by family members and the social network of the deceased; their experiences and perspectives, as well as the information they hold, are relevant and invaluable to the process.

2.2 Lewisham Safeguarding Adults Board notified the family by letter about the review that was to be undertaken. This was followed by the independent reviewer making contact with three of Arthur's daughters by letter, sent via email, inviting them and their family to participate or contribute to the review. One of the daughters replied as representative of the family and confirmed that the family would like to meet with the independent reviewer.

2.3 The family were provided with a copy of the draft review report and opportunity to comment upon it. The independent reviewer then met with Arthur's wife and three of his daughters, who were supported by [1]Hundred Families. The family agreed with the contents and findings of the report and the recommendations that have been made.

2.4 The family of Arthur and Anthony have written a statement that accompanies this review.

3. Background to The Review

3.1 This review reflects on an incident of unlawful killing at a private residence in Lewisham involving members of the same family. To be able to thoroughly identify learning and recommendations means that we must focus not only on the victim but also the care and

[1] Hundred Families is a commissioned service of Victim Support. It aims to offer accurate information and practical advice for families bereaved by people with mental health problems along with evidence-based resources for mental health professionals and others interested in serious violence by the mentally ill.

support provided to the perpetrator prior to the incident. This approach will allow us to fully understand what took place, what needs to happen to achieve understanding, remedial action and, provide answers for the family and friends of the adult who has died. This focus should in no way be seen to detract from the significance and consequence of what happened to the victim.

3.2 Arthur was born in 1940 and was married to his wife, together they had one son and four daughters. He lived with his wife in a private property, his wife was also his main carer, two of his daughters also provided carer support to their father. Arthur had diagnoses of type 2 diabetes, hypertension and had been disabled by a right-sided stroke in March 2017. Arthur was also sight impaired. Apart from his General Practice, Arthur had not been in recent contact with local services.

3.3 Arthur's son, Anthony, was 54 years old at the time of the incident. Anthony, also of Black British Caribbean ethnicity, lived alone in a flat provided by the local authority. He had been known to the police since the 1990's when he came to notice for a number of offences including common assault, actual bodily harm, affray, and possession of an offensive weapon. He did not come to police attention again until 2015 when a report of noise disturbance was received from Anthony's neighbours. These reports escalated in late 2019 with five reports to police about noise nuisance being received between December 2019 and April 2020.

3.4 Anthony had a diagnosis of Treatment Resistant Schizophrenia, he had been known to local mental health services since 2000, had previously been detained under the Mental Health Act 1983 in June 2011, and was therefore entitled to section 117 aftercare. Anthony was also recorded as having major depressive episodes. Anthony displayed positive symptoms of his diagnosed illness and he did not believe that he was unwell. It was reported that prescribed medication was unable to eradicate the persistent complex paranoid delusions he experienced. At times Anthony did not take the prescribed medicines for his mental ill health and at the time of the incident he had not taken them for over a year. Agency records indicated that there was a deterioration in Anthony's usual behaviour from December 2020, finally leading to crisis in March 2021.

3.5 Following Arthur's death, the police investigation has established from family members that Anthony had suffered with mental ill-health issues for some time, spanning back to his early twenties when he lost a child at 14 months, assaulted his partner, and was hospitalised. Family told police that Anthony was diagnosed with Paranoid Schizophrenia and Stress Psychosis and that they had recently become concerned that he was not taking his medication as prescribed and had lost vast amounts of weight. Upon visiting him they noted that Anthony's flat was in disarray, and he had painted aliens and strange creatures on the walls. He appeared unhappy with his mother and father and had called them Black "sinners." He had also recently sent his mother a text message saying that he no longer wanted anything to do with her.

3.6 On the 29 September 2021 Anthony was charged with the murder of Arthur. He appeared at Magistrates Court on Thursday 30 September 2021 and was remanded in custody to appear at the Central Criminal Court. Anthony was deemed unfit to plead to the murder of his father and on the 1 June 2022, Anthony was found by a jury at the Central Criminal Court to have committed the act of stabbing and killing Arthur. Anthony was made subject to a Hospital Order under Section 37 of the Mental Health Act, with a Section 41 restriction.

4. Terms of Reference

4.1 A multi-agency panel was established by LSAB to conduct the review. Membership included an independent Lead Reviewer/Chair and representatives from key agencies with involvement in the case.

4.2 The SAR covers the time period of 1 December 2020 until 28 September 2021. The review also seeks to include relevant information prior to this on Anthony's history.

4.3 The purpose of the review was to identify multi-agency learning by exploring information for the time period above and under the following themes: adherence to relevant legislation and statutory guidance; monitoring and review to ensure protection; risk recognition, risk assessment, risk management and the protection of others; recognition and inclusion of carers; awareness and understanding of familial domestic abuse; information sharing; case co-ordination and organisational factors; mental capacity and advocacy; domestic abuse, specialist advice and support; self-neglect; and equality.

5. Legal Context

5.1 Under the Care Act 2014 Safeguarding Adults Boards (SABs) are responsible for Safeguarding Adults Reviews (SARs) in the following circumstances.

(1) A Safeguarding Adults Board 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) A 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).

6. Methodology

6.1 This SAR was undertaken using a hybrid methodology including an analysis of Individual Management Reviews; an analysis of the combined chronology; and from practitioner discussions and reflections via the delivery of a practitioner workshop. This ensured that all of the relevant information was captured from the professionals involved in this case, whilst also providing an opportunity for reflection and development. This approach was also selected as it would allow for the best opportunity to identify lessons to be learned across the partnership.

7. Chronology

7.1 The following chronology covers the period from the 1 December 2020 until 28 September 2021 and focuses on agency involvement with Anthony. Aside from contact with his general practice, Arthur had not been in recent contact with services.

7.2 On the 2 December 2020 Lewisham Homes received a report of Anti-Social Behaviour (ASB - noise disturbance) from one of Anthony's neighbours. The case of ASB was logged and the Housing Officer contacted Anthony's Care Coordinator at Speedwell Community Mental Health Team (CMHT), who agreed to speak to him about the noise disturbance. The Care Coordinator telephoned Anthony on the 4 December 2020 to discuss the complaints of noise disturbance. Anthony said he felt persecuted. The Care Coordinator offered support to him if he was being harassed and offered to visit him at home.

7.3 On the 24 December 2020, the Care Coordinator telephoned Anthony. Anthony expressed paranoid ideas which were ongoing. The Care Coordinator discussed the complaints received from neighbours relating to noise disturbance and Anthony responded that music kept him in good spirits. Anthony was advised not to open the door to others late at night and they discussed plans for Christmas.

7.4 Anthony had a telephone consultation with his GP on the 30 December 2020 and a face-to-face consultation on the 31 December 2020.

7.5 Between the 6 and 20 January 2021 Lewisham Homes received twelve noise complaints, including noise recordings, from Anthony's neighbours, which included reports of loud music, shouting, and banging. The Housing Officer informed the Care Coordinator who telephoned Anthony the following day. The Care Coordinator informed Anthony that he might receive a letter from housing with regards to noise complaints. The Care Coordinator emailed the Housing Officer stating that Anthony denied making noise, that he used soothing music to regulate his mood and had been doing DIY.

7.6 On the 23 January 2021 Lewisham Homes received an email from the police reporting a noise complaint that had been reported to them.

7.7 On the 25 January 2021, a neighbour submitted a noise recording to Lewisham Homes, which consisted of banging, shouting, screaming and loud music. The neighbour reported that the noise could happen at any time of the day and lasted from a few minutes to hours, they further said they used to speak to Anthony but now felt too afraid to approach him.

7.8 Between the 29 January 2021 and the 23 February 2021 Lewisham Homes received six reports of noise, including music, screaming, and banging, from two neighbours. One of the neighbours said the noise was affecting their sleep; they had approached Anthony, but he responded by swearing at them. One of the incidents of noise was also reported to the police. As a result, Lewisham Homes sent a warning letter to Anthony.

7.9 The Housing Officer notified Anthony's Care Coordinator of the ongoing reports of noise disturbance, and the Care Coordinator agreed to speak to Anthony. Following unsuccessful attempts to make contact with him, the Care Coordinator contacted Anthony's mother who reported he was last seen on the 20 February when he appeared unsettled, his father had subsequent contact by telephone, and he appeared okay. The Care Coordinator visited Anthony on the 26 February and found that he appeared delusional regarding being abducted and objects being moved in his property. The Care Coordinator proposed a review by a psychiatrist to which Anthony did not object. The Care Coordinator updated Anthony's mother that he was okay.

7.10 Police were also called to a report of antisocial behaviour caused by a neighbour who was having mental health issues and playing loud music at all times of the day and night. Police

did not attend the address and advised it was a noise issue for the Council. The local Safer Neighbourhood Team (SNT)[2] were sent the details.

7.11 On the 1 March 2021 police were called twice to Anthony's address after reported noise nuisance: At 7.02am police attended the address and Officers spoke with Anthony leaving him in the care of the ambulance service; Police did not attend to the second report and advised the neighbour to speak with Environmental Health. Lewisham Homes received two noise recordings from the neighbour and the Housing Officer contacted the CMHT Duty Officer about Anthony's 'worrying behaviour,' sharing a copy of a noise recording. The CMHT Duty Officer agreed to raise the case at the next daily clinical meeting, consider visiting Anthony and liaise with the police. The Housing Officer also contacted the ASB team to gain further advice.

7.12 The following day, the Care Coordinator confirmed with the Housing Officer that a medical review would be carried out in the next few weeks and that Anthony had denied the reported noise. Lewisham Homes also received reports of noise nuisance, and suspected theft of parcels from a neighbour, and a second warning letter was sent to Anthony by Lewisham Homes.

7.13 Police attended Anthony's address on the 5 March 2021 after neighbours called complaining that he was causing a disturbance and having a mental health breakdown. Police attended and on arrival Anthony was calm and no offences were identified. Officers advised the neighbour to report the behaviour to the Council. Lewisham SNT also attended the address later in the day to conduct a welfare check. Anthony answered the door but would not let police in. His conversation was erratic, but he denied having mental health issues. He said he was not the only one in the block of flats making noise and he screamed when he was in pain and sometimes, he heard gunshots outside his address. Officers felt that Anthony would benefit from assistance from the mental health intervention team and a [3]MERLIN was created and shared with Lewisham Adult Social Care.

7.14 On the 7 March 2021 police received a call stating Anthony was having a psychotic episode. He was deemed a significant danger to himself and others as he had a hammer and was smashing up his property. Police attended, Anthony had his music turned up loud but there was no sign of a hammer or property damage. No further action was taken as it was believed to be a neighbour dispute.

7.15 On the 8 March 2021, neighbours called police complaining about Anthony playing loud music, shouting, and thumping the floor, they stated this had been going on for six years. Police did not attend the address and the controller advised contact with Environmental Health due to a lack of police resources. A neighbour also reported noise nuisance and abusive language, from Anthony, to Lewisham Homes.

7.16 On the 9 March 2021 the Housing Officer emailed the Care Coordinator reporting an escalation in behaviour, the Care Coordinator confirmed that a medical review was scheduled for the 15 March 2021. Following conversations with neighbours on the 10 March 2021, the Housing Officer contacted the Care Coordinator again to advise that Anthony was still shouting and sounded distressed, sometimes for a 24-hour period with verbal aggression which was sometimes directed at neighbours. The Care Coordinator advised that the neighbours should contact police if they felt threatened.

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[2] The SNT is a group of Met police officers based in the area (or 'ward'), supported by additional officers from the wider area. Each team consists of at least one Police Constable and one Police Community Support Officer. The SNT works closely with local authorities, community leaders and residents to decide upon policing priorities for the area. This assists in finding useful, long-term solutions to local problems, while maintaining a wider focus on reducing crime across London.

[3] Metropolitan Police Service - The Merlin system is a vehicle for police officers to deal with vulnerability. This allows the recording and sharing of concerns with partners in order to effectively safeguard members of the public.

7.17 On the 15 March 2021, a home visit was undertaken to assess Anthony's mental state. Anthony appeared to be hallucinating, mainly in relation to physical sensations in his body, he spoke about identify theft and being abducted. He appeared perplexed by what was happening to him, suspicious in relation to medication but was not objecting to the prescription of anti-psychotic medication and home treatment. The GP was notified of the review and subsequent outcomes. The Care Coordinator reported to Lewisham Homes that Anthony was unwell but co-operative. Anthony denied the allegations of noise and said neighbours had been wrongly attributing noise to him.

7.18 Anthony was accepted for Home Treatment Assessment and the Care Coordinator updated the risk assessment identifying that he had been non-compliant with medication with no adverse consequences until now. The Home Treatment team visited Anthony daily for three weeks whereby he took his medication, usually at the door and with reluctance.

7.19 A neighbour called police on the 21 March 2021 about Anthony swearing, banging on the floor, and shouting outside the window at people walking past. On attendance there was no reply from Anthony and the circumstances did not justify using force to enter his flat. A noise recording was also submitted to Lewisham Homes by a neighbour. The matter was escalated to the ASB team, and the Care Coordinator was notified.

7.20 A multidisciplinary team clinical meeting was held on the 23 March 2021 where Anthony's limited engagement with Home Treatment and variable compliance with medication was discussed. Anthony explained due to coronavirus he did not want people entering his property and said the medication was affecting his teeth, which was considered an ongoing delusion as for many years, he believed the medication had a negative impact on his physical health. It was agreed to persist with visits but review with the Care Coordinator within the week.

7.21 On the 24 March 2021, the Housing Officer requested case escalation to the ASB team in relation to the noise nuisance.

7.22 A further noise complaint was made by a neighbour on the 28 March 2021.

7.23 A clinical meeting was held on the 30 March 2021 with the consultant psychiatrist. It was agreed to start reducing the number of Home Treatment visits, acknowledging Anthony's minimal engagement and relatively poor response to medication as he remained paranoid.

7.24 On the 1 April 2021, the Care Coordinator advised the Housing Officer that it could take time for behavioural change following new medication and suggested a physical meeting with Anthony. No meeting was held.

7.25 A further clinical meeting was held on the 6 April 2021 which reported that whilst there was minimal engagement from Anthony, he had been willing to take medication. It was queried whether he would accept a care package to oversee medication being dispensed.

7.26 On the 7 April 2021, the ASB team manager agreed that if there was one more breach of tenancy then the case would be escalated, and tenancy enforcement action considered. At a Home Treatment discharge meeting the same day, Anthony said the medication had made him feel worse physically with no change in his mental state. Risks relating to self-harm/suicide, harm to others, harm from others and substance misuse were assessed as low, with a medium risk with regards to his adherence to treatment.

7.27 A neighbour filed two noise recordings with Lewisham Homes on the 12 and 14 April 2021.

7.28 The Care Coordinator undertook a telephone review with Anthony on the 16 April. Anthony said he felt the medication was poisoning him.

7.29 On the 21 April 2021 there was an increase in noise nuisance, after a short period of reduction, with complaints made by two neighbours and noise recordings submitted. As such, the Housing Officer again requested escalation to the ASB team. The ASB team asked for more information on the type of noise recorded and whether these breached the tenancy. Two further noise recordings were submitted by a neighbour on the 23 April 2021.

7.30 The Care Coordinator reviewed Anthony by telephone on the 26 April 2021 and found no overt evidence of psychotic symptoms.

7.31 A noise disturbance was reported by a neighbour on the 27 April 2021, the Housing Officer made a further request for the case to be escalated to the ASB team.

7.32 The Care Coordinator visited Anthony at home on the 30 April 2021 during which he appeared calmer which was thought likely to be due to medication.

7.33 Throughout May 2021 there were seven further separate reports of noise nuisance. The case was finally escalated to the ASB team and was awaiting allocation.

7.34 On the 3 June 2021, the Care Coordinator and Consultant Psychiatrist discussed Anthony's medication. Anthony said he wanted a reduction, and the consultant suggested the introduction of an injection.

7.35 On the 18 June 2021, a neighbour called police twice in five minutes to complain of ongoing issues with a neighbour. They said they were concerned for Anthony's ongoing mental health issues and the constant shouting and swearing coming from his flat. The neighbour said the noise was unbearable and they had had issues with Anthony for the last five years. Police did not attend, and the neighbour was advised to contact Environmental Health. A noise recording was also submitted to Lewisham Homes.

7.36 Between the 21 and 23 June 2021, five noise recordings were sent to Lewisham Homes from three individual neighbours. The noise was reportedly most frequent between 8pm and 7am.

7.37 On the 1 July 2021 Anthony's case was allocated to a worker in the ASB team.

7.38 The Care Coordinator visited Anthony at home on the 8 July 2021. He appeared quiet and guarded, he said he had stopped his medication about two weeks earlier and he was encouraged to restart. Anthony was not willing to engage in too much conversation and the Care Coordinator planned to review again in two weeks.

7.39 Five noise recordings were sent to Lewisham Homes on the 18 July 2021 by a neighbour which were forwarded to the ASB team.

7.40 Between the 8 and 11 August 2021, seven noise recordings were sent to Lewisham Homes.

7.41 On the 20 August 2021, the Care Coordinator visited Anthony at home. The Care Coordinator observed a good level of self-care. Anthony displayed ongoing delusional thoughts with regards to his physical health.

7.42 In late August 2021, the GP undertook a mental health review of Anthony. The GP contacted the Care Coordinator as he did not appear to have had any anti-psychotic

medication since his discharge from Home Treatment Team. Anthony had reported that he had been told to stop the medication and the GP wondered if he needed to be referred back to the Home Treatment Team. The Care Coordinator assured the GP that Anthony was being monitored and that he would refuse medication and that stress could make his delusions worse.

7.43 Between the 20 August and the 14 September 2021, Lewisham Homes received seven complaints of noise nuisance.

7.44 The Care Coordinator attempted to review Anthony on the 20 September 2021 but there was no response to telephone contact. The Care Coordinator contacted Anthony's mother who expressed concern about his appearance, as it looked like he had lost weight, and looked dishevelled. When his sister and nephew visited him, he would not let them in.

7.45 On the 22 September 2021, a neighbour called the police as Anthony was making threats to rip her head off, was shouting abuse and banging on the front door. The caller stated they were scared as their nine-year-old daughter was with them. Police attended later in the day, but it is unclear whether police saw or spoke to Anthony. The neighbour also reported to Lewisham Homes who advised the neighbour to contact the police if they felt unsafe.

7.46 On the 23 September 2021, a neighbour called police stating Anthony had been screaming all night long about 'killing'. He was also banging on his door and the neighbour was frightened. The neighbour said police had attended previously and left without speaking to him, but he carried on screaming. Police did not attend due to insufficient resources, but the ambulance service were notified of a male having a mental health episode at the address.

7.47 On the 24 September 2021, the Care Coordinator visited Anthony at home. Loud shouting could be heard on arrival and Anthony refused entry to the Care Coordinator. Contact was made with his mother who reported that Anthony had not been answering the telephone but did send a text stating not to try contacting him again. The Care Coordinator planned to attempt further contact, move Anthony to Amber risk zone, and discuss with the multidisciplinary team.

7.48 On the 26 September 2021, a neighbour notified the ASB team that Anthony was screaming from 'morning till night.' The ASB Officer agreed to contact the community mental health team, share information with the police, and take legal action.

7.49 Two further noise recordings were sent to the ASB team on the 27 and 28 September 2021. A neighbour also sent in a video showing Anthony having an argument with a third party. In the recording, he was shouting and using abusive language. The neighbour said Anthony was 'getting worse' and she feared for her and her daughter's safety. She also said that she saw him put his foot out to trip up a member of the public who was running for a train.

7.50 At 01:30 hours on the 28 September 2021, a neighbour contacted police saying they could hear sounds of an argument coming from Anthony's address. The neighbour said she heard shouting and swearing, and things being smashed along with loud music being played. At 04.51 police attended his address but the flat was in darkness and there was no reply.

7.51 At 09:45 hours police attended Arthur's home address after receiving several calls that Anthony had stabbed his father multiple times.

8. Analysis

8.1 The analysis will respond to the specific areas of enquiry outlined in the terms of reference. In doing so it will also explore whether the care provided by all organisations and professionals was consistent with expected standards, and in line with primary legislation, statutory guidance, and codes of practice. Areas of good practice will be identified through discussion of the individual themes arising, as well as lessons to be learned and any changes that have already been implemented by the agencies involved.

Monitoring and Review to Ensure Protection

8.2 The responsibility for the monitoring and review of Anthony sat with the CMHT, and he was allocated a Community Psychiatric Nurse Care Coordinator. The review highlighted that Anthony was seen in person by the Care Coordinator in August 2020 and then not again until February 2021. In the intervening time all contact took place by telephone, which appears to be largely attributable to the Covid-19 pandemic and associated changes in practice, and in how services and support was being delivered. The lack of face-to-face contact was also explained in the context of Anthony's low tolerance to intrusion from others. Engagement was on his terms as he tolerated little intrusion and there was a fine line in keeping him engaged. Contact with Anthony was carried out carefully and sensitively so as to not damage the relationship between him and his Care Coordinator. Home visits to Anthony started to occur on a more frequent basis from February 2021, with visits occurring almost monthly, save for the period of time that the Home Treatment Team were involved who visited Anthony daily but during which time the Care Coordinator did not.

8.3 A formal review of Anthony's mental health took place in March 2021 which led to the provision of Home Treatment. The involvement of Home Treatment also seemed to affect multi-disciplinary meetings within the CMHT which were previously and subsequently not notable.

8.4 What is prominent is that the frequency of monitoring and review did not correlate with the increase in reports of concern for Anthony's welfare and mental health, and noise nuisance reports. There were no formal inter-agency arrangements in place for monitoring and review, although Lewisham Homes did maintain contact with the Care Coordinator throughout.

8.5 The review has also noted the lack of involvement by Lewisham Adult Social Care, whose last involvement dated back to 2017 when a Care Act assessment was completed, with no review since that date. Whilst, Lewisham Adult Social Care had a duty to assess Anthony's needs for care and support, which would have enabled further consideration of his wellbeing, vulnerabilities, and risks, and a duty to provide aftercare services, it is notable that equally no requests were made of Adult Social Care to assess Anthony's needs.

Risk Recognition, Risk Assessment, Risk Management, and the Protection of Others

8.6 Anthony had a history of violence and aggression. In 1990 he was convicted of common assault and, later in the same year, of Actual Bodily Harm (ABH) and common assault. In 1991 he was convicted of ABH and affray, and in 1999 with possession of an offensive weapon (an article with a blade). Historical risk assessments undertaken by SLaM highlighted the risk of violence clearly. However, since that time there had been no further criminal convictions or records of violence or aggression.

8.7 Whilst there were historical incidents of Anthony being physically aggressive, threatening, and having delusions about his sister, risk to others, and particularly family members, this was not considered. There was no consideration of the role family members played in supporting Anthony and no consideration of their own vulnerabilities which may have increased risk for them. Equally the risk to Anthony from his neighbours and the risk posed by Anthony to his neighbours, given the noise nuisance, was not explored.

8.8 Anthony had not had a hospital admission for a number of years and had trials of a range of anti-psychotic pharmacological treatments, with periods of no medication, without any elevation of risk to others. There was a plan in place from 2019 relating to Anthony's abstinence from medication, however there was not a sufficient crisis plan in place for a deterioration in mental health, monitoring was not sufficient, systematic, or purposeful. Anthony did not accept he had a mental illness and any medication he was prescribed did not appear to relieve his symptoms. He was seen as managing his own psychosis by avoiding too much contact with the outside world. The review has evidenced that detention under the Mental Health Act 1983 was not considered in this case. Therefore, it has not been possible to explore whether mental health clinicians and practitioners met the standards of the Mental Health Code of Practice (14.10) by including relevant details of the patient's clinical history and past behaviour, such as contact with other agencies and criminal convictions and cautions, when deciding whether to detain.

Police Risk Assessment

8.9 The review details twelve calls to police from January 2021 until the day that Arthur was murdered. Police attended Anthony's address six times (including the day that Arthur was murdered), police spoke with Anthony only three out of the six times. One MERLIN report was created and three ASB reports were created. The THRIVE+ assessment tool[4] was only used four times. All calls other than an immediate grade call should have a THRIVE+ assessment; only one call to police was graded as immediate response and that was the day Arthur was murdered.

8.10 The SNT were made aware of the deterioration of Anthony's mental health, and these were detailed in ASB reports. The SNT did speak with him on several occasions and created one MERLIN report with concerns for his mental health which was shared with Lewisham Adult Social Care. Of the three ASB reports that were created only one was identified by SNT. There appears to have been no other way for SNT to be aware of the volume of calls to police unless regular intelligence checks were carried out and there was no evidence of this on the ASB logs. The main source of information for SNT appears to have been the neighbours.

8.11 The police highlighted an issue relating to how the Metropolitan Police Service (MPS) links relevant incidents and calls to police. This is in part due to the limitations of the current Computer Aided Despatch (CAD) system which only links incidents from the previous twenty-eight days. It is anticipated that the new 'command and control' system will be introduced and will have the ability to link incidents going back 365 days as well as providing additional information on previous calls to an address. This should negate the need for Officers to have to look for linked incidents.

8.12 Police further identified that the issue of linking incidents is compounded by the lack of consistency in completing the THRIVE+ assessment and relevant intelligence checks. The correct use of THRIVE+ would have highlighted a potential risk and should have highlighted the need for a different police response. Relevant intelligence checks would have also highlighted the previous history of calls to Anthony's address and the decline in his mental health.

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[4] Police use the THRIVE (threat, harm, risk, investigation, vulnerability, and engagement) definition of vulnerability. This states that a person is vulnerable if, as a result of their situation or circumstances, they are unable to take care of or protect themselves or others from harm or exploitation. Applying the THRIVE approach requires the following four steps.

1. Identify an individual's vulnerability or vulnerabilities.
2. Understand how these vulnerabilities interact with the situation to create harm or risk of harm.
3. Assess the level of harm or risk of harm.
4. Take appropriate and proportionate action if required, involving partners where they have the relevant skills and resources.

8.13 Airspace is an MPS system where all ASB should be recorded and where SNT record all communication and actions taken in relation to those incidents. It is not linked to any other police systems and would not appear on any standard search. Once an ASB report is created it should be noted by a supervisor and allocated to an Officer. If police receive further reports they can be linked, however only the original reference number remains, and the others are removed from the system. This could be the reason some of the reports in relation to Anthony could not be found. With the introduction of CONNECT[5] the process for managing ASB will change.

8.14 CONNECT was due to go live in May 2023, however, there have been delays and it is anticipated that the system will go live in February / March 2024. CONNECT will enable that when an ASB incident is recorded, either by the operations room or front-line Officer, a Proactive Management Plan (PMP) will be created. This PMP will allow different types of records to be automatically linked together based on a specific person, address or other identifier and the owner of the PMP will be notified. This will mean ASB will no longer be recorded on a standalone system. Part of the PMP process for ASB will ask if there are any safeguarding issues and if so, will automatically send a report to the Multi-agency Safeguarding Hub (MaSH) team. CONNECT will not be linked to the CAD system and will still require an ASB to be created. For this reason, a recommendation about training has been made by the police.

8.15 It is believed that had Command and Control and CONNECT systems been in place, there could have been a different police response to the volume of ASB calls concerning Anthony. The MPS has been assessed as 'inadequate'[6] in responding to the public and this is one of the reasons the organisation has been placed into Special Measures. The report goes on to say "The force doesn't have the capacity in its call handling teams to meet the demand for service in a timely way. It doesn't meet the national thresholds for answering calls. Its response to vulnerable people isn't consistent, and it isn't always based on effective risk assessment."

8.16 In this case, the police failed to complete checks and assessments on several occasions, or police were not deployed to the address, or did not have the capacity to deploy. THRIVE+ was not used consistently, which potentially resulted in risk not being identified on every occasion when Anthony came to the notice of the police, and as a result police did not identify the accumulative effect of the concerns raised which would have enabled onward referral to the relevant services.

8.17 In terms of the response provided by the Metropolitan Police Service it is important to note the introduction of Right Care, Right Person[7] which will change the way police across the country respond to calls involving concerns about mental health, with the intention to 'improve outcomes, reduce demand on all services, and make sure the right care is being delivered by the right person.' As yet there is no policy in place which clearly identifies when it would still be appropriate to deploy police, and expect a police response, when mental health is a factor, as it was in this case. The implementation of Right Care, Right Person has the potential for significant implications in the response provided to people with mental health issues, not just locally, but across the country.

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[5] CONNECT is the new integrated policing computer system and will replace eight current systems including Crime (CRIS), intelligence (Crimint), custody (NSPIS), missing/vulnerable persons (MERLIN) and Anti-social behaviour (Airspace)

[6] PEEL 2021/22 – An inspection of the Metropolitan Police - His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (justiceinspectorates.gov.uk)

[7] Introduction of Right Care, Right Person model | Metropolitan Police

South London and Maudsley NHS Foundation Trust (SLaM) Risk Assessment

8.18 Anthony was not taking medication for a number of months and SLaM's perception was that he had not shown any signs of deterioration or relapse; his symptoms were forever present, but he was living with them without too much distress or disturbance to others.

8.19 The SLaM risk assessment did not address the issues relating to Arthur or Anthony's other family members. When Anthony was visited at home by the Care Coordinator on the 26 February 2021 the indications were that he was mentally unwell and showing signs of relapse. It was evident that his existing level of care and support required review. There was a delay before action was taken, but the change to Anthony's care and support needs were proportionate, resulting in a referral to the Home Treatment Team, and in Anthony re-commencing anti-psychotic medication.

8.20 The Home Treatment Team provided approximately one month worth of home treatment, completed an assessment of risk and his mental state, and supervising medication. It was acknowledged that he had Treatment Resistant Schizophrenia with paranoid delusions, which included that the anti-psychotic medication was making him physically unwell. Anthony mostly accepted medication at the front door but rarely engaged with staff. This made it very difficult to monitor or assess his response. It was clear that the medication was having very little impact on his delusional thoughts and his symptoms did not improve despite daily medication supervision. Following home treatment intervention, he was discharged back to the care of the community team.

8.21 There was an updated risk assessment when Anthony moved to the care of the Home Treatment Team in March 2021. This should have been reviewed and further updated when he was known to have discontinued his medication.

8.22 SLaM reflected that the documentation of risk and management plan was inadequate and suggested that increased risk was not communicated in a timely manner. The chronic nature of Anthony's condition and absence of any recent risk assessment would have compromised how risk was responded to.

8.23 The review identified that Anthony was isolated and that the Care Coordinator also appeared relatively isolated in terms of his engagement with him, with SLaM identifying that there appeared to be an absence of effective supervision, outside scrutiny, or management oversight. The Home Treatment Team did evidence their regular multi-disciplinary reviews in a focused way in terms of exploring if the intervention was working. The CMHT did not evidence any formal discussion which could have opened the case for consideration with other professions, or family members, and thus risk was not fully explored and documented.

8.24 Overall, there was a lack of consistency by agencies in assessing risk. There was lack of urgency from mental health services, including missed opportunities to review risk and undertake a Mental Health Act Assessment, particularly in light of a person who was not taking their prescribed medication. It appeared that there was a normalisation of risk, perhaps developed over the number of years professionals had worked with Anthony, and the rule of optimism applied to Anthony's illness and the associated risks. Any risk assessment undertaken focused on Anthony and did not consider risk to others, did not wholly take account of information from other agencies, or from his family, and was not reviewed when circumstances changed.

Recognition and Inclusion of Caring Roles and Responsibilities in Plans and Assessments

8.25 There were no risks to family members identified during the scoping period by the agencies involved. SLaM stated that Anthony's thought disordered conversations did not indicate that he felt persecuted by his father, or any other members of the family; delusions about his sister were historical. The risk was viewed in general terms as he appeared to view everyone as a potential alien who had the capacity to abduct him.

8.26 The review highlighted that a care planning meeting, including Anthony's whole network, would have been useful. If the family were historically the focus of his delusions, then they may not have wished to participate. However, the offer of support and inclusion of his parents may have been useful in terms of helping to monitor Anthony on a more frequent basis without intruding too much in terms of face-to-face meetings.

8.27 It is recognised that carers are often a good source of information and aware of the difficulties experienced by their relatives, but the urgency with which this is expressed is not always recognised by professionals. Anthony's mother highlighted her concerns regarding his physical wellbeing and mental state, and his need for physical investigations. Such considerations should have been pursued more robustly. When she raised concerns about Anthony's wellbeing in August 2021, consideration could have been given to a Mental Health Act Assessment, and a referral made to the Approved Mental Health Professional service.

8.28 The Care Act 2014 defines a carer as 'an adult who provides or intends to provide care for another adult'[8] and as such the local authority has a duty to undertake a carer's assessment and meet the carer's need for support. Anthony's mother was a carer for Arthur, his daughters also provided support, and it appears that Arthur's wife and other family members played a caring role in respect of Anthony. However, there were no recorded carers assessments for any of the family members in respect of either Anthony or Arthur, as the cared for persons, despite being entitled to this, or as a minimum being considered as part of any assessments and care plans relating to Anthony.

Agency Awareness and Understanding

8.29 Older people have historically been a hidden group of domestic abuse victims, yet for 44% of domestic abuse victims over 60 years of age, an adult family member is the primary perpetrator, compared to 6% for those under 60.[9] However, as this group is hidden, they are less likely to access domestic abuse services and therefore professionals tend to believe that domestic abuse does not occur amongst older people. Older people are also statistically more likely to suffer from health problems, reduced mobility, or other disabilities, which can exacerbate their vulnerability. Adult familial abuse also presents challenges when adult children experience mental health issues whereby, unless they are a risk to the community, services are less likely to intervene.

8.30 Agencies recognised that the awareness of adult family violence is not as prevalent as is practitioner awareness of intimate partner violence domestic abuse and, as already stated, the risk to Anthony's parents was not explored. As such, the agencies recognised the need to increase awareness of adult child to parent abuse and the risks to parents who are supporting adult children with mental ill-health.

Information Sharing

8.31 Lewisham Homes demonstrated regular multi-agency working with SLaM and police before the case was escalated to the ASB team. The service felt that Anthony's behaviour was impacted by poor mental health, and they shared these concerns readily. However, Lewisham Homes reflected that they could have done more to communicate the extent of their concerns, for example, by sharing more copies of noise recordings with Anthony's Care Coordinator, escalating concerns internally and to the CMHT, and arranging a multi-agency meeting with all professionals involved in the case.

8.32 Lewisham Homes also identified challenges with internal communication. Two warning letters were served prior to the escalation of the case, which was in line with Lewisham

[8] s10(3)

[9] Safe Later Lives - Older people and domestic abuse.pdf (safelives.org.uk)

Homes' procedures. The decision to escalate the case and consider legal action was appropriate. The discussions around escalation were affected by staff illness and the decision to still hold the meeting despite staff absence was appropriate and in line with Lewisham Homes' policy. There was no 'handover' meeting between the ASB and Housing Officers, which is something that has been implemented since. Cumulatively, this may have resulted in the ASB team having less knowledge of the case and speculatively, with a better handover, the case may have been treated differently.

8.33 Part of the intention of escalating a case to the ASB team was in part so that more robust action could be taken, but in this case, it had the opposite effect. There was a delay in the case being allocated to an ASB Officer, and a further delay in him acting on the case. This fell short of Lewisham Homes' expected standards in response to an ASB complaint. Their records did not show that the allocated ASB Officer was reviewing the case in the period up to the 28 September. In addition, there is no recorded managerial monitoring of the case, because of this, an opportunity to share information about the escalation of Anthony's disturbances and behaviour with other agencies was missed. The ASB team had been restructured on 6 April 2020, a change that had resulted in a completely new cohort of staff in the team. This meant that staff in post at this time had fewer local connections and less knowledge of local services.

8.34 A formal Safeguarding Concern under the category of self-neglect was never raised, and Lewisham Homes did not refer Anthony to the Community MARAC, where issues pertaining to anti-social behaviour are often addressed.

8.35 As highlighted above in relation to risk, the police did not routinely assess risk and only submitted one MERLIN to Lewisham Adult Social Care. As such information sharing was compromised by the absence of following routine procedures.

8.36 Overall, the sharing of information including risk was limited. With regards to consent to share, Anthony had been in the system for so long his consent to share information may not have been checked, or his mental capacity assessed to determine whether he could consent.

Case Co-ordination, Care Planning and Organisational Factors

8.37 The Care Programme Approach (CPA) was introduced in 1990 to provide a framework for effective mental health care for people with severe mental health problems. Its four main elements are:

- systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
- the formation of a care plan which identifies the health and social care required from a variety of providers;
- the appointment of a key worker (Care Coordinator) to keep in close touch with the service user, and to monitor and co-ordinate care; and
- regular review and, where necessary, agreed changes to the care plan.

8.38 The importance of close working between health and social care was stressed, as was the need to involve service users and their carers in the assessment and planning of service users' support and care.[10] However, there is little evidence to suggest that the implementation of the CPA has led to high-quality care planning when it is used, and in general there is a need for services to significantly improve the quality and relevance of care planning for people with moderate to severe mental health problems.[11]

[10] Care Programme Approach - Mental Health Law Online
[11] Care Programme Approach: NHS England position statement

8.39 A CPA review was recorded to have taken place on 25 November 2020, which Anthony attended. A summary of need was not recorded at the time, which was significant given that he was no longer taking medication for his illness. A summary of need was however recorded and dated 1 July 2021, but there was no evidence that this coincided with a CPA review or that the content of the summary of need and formulation of a Community Care Plan was shared with Anthony.

8.40 One of the five overarching principles of the Mental Health Act 1983 is the 'least restrictive option and maximising independence' which means where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.[12]

8.41 A Mental Health Act Assessment for the purposes of considering detention under the Mental Health Act 1983 was not instigated during the period under review. This may have offered an opportunity to fully explore the circumstances with the benefit of outside professionals, and to allow evaluation of the effectiveness of any treatment. It is possible that the Covid-19 pandemic and associated restrictions played a part in this decision as it is understood that the threshold for detention during this time was higher as practitioners considered the additional risk of Covid-19 transmission and infection.

8.42 There was also little consideration given to less restrictive interventions which would have been available to Anthony. With regards to services, support and treatment that were considered, following support from the Home Treatment Team a package of care was suggested but not explored further. Consideration of commissioning a bed at the National Psychosis Unit[13] may have been an option as the team had appeared to have exhausted options for treatment locally. It was also noted that psychological treatments were not explored or offered. Whilst these options may have been considered previously and discounted, it would have been worth revisiting treatment options on a regular basis, with a documented rationale of decision making around including or excluding any such options.

8.43 Anthony had been previously detained under section 3 of the Mental Health Act 1983 (June 2011) and as such SLaM and Lewisham Adult Social Care had a duty to provide mental health aftercare to Anthony in accordance with section 117 of the Mental Health Act[14]. This entitlement had not been formally ended and thus remained a duty. However, there was no evidence of aftercare services being considered and none were made available to him, and no aftercare plan was in place. As referenced above, Adult Social Care had not assessed Anthony's social care needs since October 2017. Whilst it was recognised that there was potential for his non-engagement or refusal of services this did not mean that Anthony did not need such services and would not have absolved Adult Social Care and SLaM of their aftercare duty.

8.44 The provision of s117 aftercare has been highlighted as a recurring theme in Lewisham and neighbouring borough areas. In 2020/21 the Local Government and Social Care Ombudsman (herein referred to as the Ombudsman) investigated the London Borough of Lewisham, SLaM and NHS South East London Clinical Commissioning Group (CCG) following a complaint relating to s117 aftercare; the complaint was upheld.[15] The Ombudsman stated that 'the Council and its partners appeared not to understand their legal duties regarding section 117 of the Mental Health Act 1983; and appeared not to have

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[12] Mental Health Act 1983 (publishing.service.gov.uk)

[13] An Overview of the National Psychosis Unit – Mental Health Matters (mental-health-matters.org)

[14] Ibid.

[15] 20 006 910 - Local Government and Social Care Ombudsman

systems in place to keep accurate records of people for whom they provide or commission aftercare and what aftercare services they provide'.

8.45 As a result of the investigation, amongst other actions taken, the organisations confirmed they had implemented a section 117 register and joint section 117 policy to ensure they were aware of who was entitled to aftercare in their area. SLaM was also developing a new section 117 dashboard which would display all residents identified as eligible for section 117 aftercare.

8.46 The Ombudsman identified through their investigation that as of 1 December 2020, the Council, CCG and SLaM owed a section 117 duty to 814 people in Lewisham. An estimated 93% of them had an up-to-date plan setting out what they should get as section 117 aftercare. The Ombudsman further recommended that with regards to the 57 individuals without an up-to-date plan, these would be updated within two months, or that the annual s117 review would ensure that there was a comprehensive documented section 117 aftercare plan on their record, or a clear rationale for one not being on the record.

8.47 In addition, a previous Lewisham Safeguarding Adults Review[16] (Adult Z), published in July 2021, highlighted the absence of section 117 aftercare services, and recommended that 'The Local Authority and NHS Trust ensure they are aware of all individuals for whom they hold responsibility to provide section 117 aftercare, whether or not they are currently receiving services. This information should be easily available at the front of the respective client databases.' A similar recommendation was made in a Safeguarding Adults Review for the London Borough of Croydon, where SLaM is also the mental health provider, in March 2022.[17]

8.48 It is noted that the Ombudsman's investigation, findings, and recommendations were concluded in April 2021, and that Adult Z was published in July 2021, and therefore coincided with the period subject to review here. Whilst it is not known if, how and when the learning from these two reports was disseminated across the agencies, there was time, albeit limited, for the learning to have affected change in Anthony's case.

Mental Capacity and Advocacy

8.49 Anthony's mental capacity was not considered or formally assessed during the period subject to review, despite there being indicators present to suggest that he may lack capacity to make decisions about his care, support, and treatment.

8.50 The Mental Capacity Act 2005 provides the statutory framework for people who lack capacity to make decisions for themselves. It sets out who can take decisions, in which situations, and how they should go about this. The Act's overarching principle is it should be presumed that an adult has full legal capacity to make decisions for themselves unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made.[18] It is important to note that a lack of capacity cannot be established merely by reference to a person's condition or an aspect of their behaviour which might lead others to make unjustified assumptions about capacity. Given that Anthony was able to voice his views and wishes vehemently in relation to medication, professionals said 'he argued his medication well,' it is possible that professionals assumed he had capacity to make decisions in this and other areas of his life.

8.51 However, in practice the presumption of capacity can be problematic when applied in practice. The House of Lord's Select Committee said in their review of the Act that:

[16] Lewisham Safeguarding Adults Board Safeguarding Adult Review Adult Z (safeguardinglewisham.org.uk)
[17] Safeguarding Adult Review: DUNCAN (croydonsab.co.uk)
[18] Mental-capacity-act-code-of-practice.pdf (publishing.service.gov.uk)

‘The presumption of capacity, in particular, is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm. In some cases, this is because professionals struggle to understand how to apply the principle in practice. In other cases, the evidence suggests the principle has been deliberately misappropriated to avoid taking responsibility for a vulnerable adult’[19]

8.52 There was evidence giving rise to question Anthony’s capacity, particularly in relation to treatment. He experienced delusional beliefs and believed that medication affected his physical health, however there is no medical evidence to suggest that this was in fact the case. Anthony’s mental capacity should have been assessed in relation to care, support, and treatment.

Domestic Abuse, Specialist Advice and Support

8.53 Domestic abuse is defined as behaviour by one person towards another when those two people are over the age of 16 and are ‘personally connected’. The behaviour can include physical or sexual abuse, violent and threatening behaviour, controlling or coercive behaviour, economic abuse, or psychological or emotional abuse. ‘Personally connected’ includes people who are or have been married or in a civil partnership, have agreed to marry or enter a civil partnership, are or have been in an intimate personal relationship, they have or have had a parental relationship in respect of the same child, or they are relatives.[20]

8.54 Anthony and Arthur did not live together but were related. It was reported that Anthony engaged with his family, meeting up with them for family occasions, such as birthdays and Christmas, and his family would visit him. Historically he felt belittled by his family, and he had experienced delusions in respect of family members. It is of note that Anthony and his family were well known to their GP practice. His mother had worked as a receptionist there for over 30 years and his sister worked in the adjacent pharmacy. No concerns around safeguarding were raised by family members or staff during the period. Whilst agencies were not able to provide any evidence of current or historical abuse perpetrated by Anthony towards any of his family members, it cannot be said with certainty that this was not the case.

8.55 There were missed opportunities to engage family members more fully in Anthony’s care which may have highlighted the occurrence, or risk of abuse. Furthermore, how Anthony might have pulled his family into his delusions was not explored. This may have highlighted opportunities to undertake routine enquiry, inform the family of the support available to them, including specialist domestic abuse services, and manage risk. However, agencies recognised that the awareness of adult family violence is not as prevalent as practitioner awareness of intimate partner domestic abuse and therefore the warning signs may not have been identified.

Self-Neglect

8.56 The Care Act statutory guidance defines self-neglect as ‘a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings, and includes behaviour such as hoarding.’[21]

8.57 There were indicators of self-neglect in this case; Anthony was refusing medication for his mental health, there was reported destruction of his property and comments from family that his flat was in ‘disarray,’ his sleep was likely affected given the reports of noise

[19] Microsoft Word - Mental Capacity Act 2005 Committee Report - Final (parliament.uk). Para. 105.
[20] Domestic Abuse Act (April) 2021
[21] Care and support statutory guidance - GOV.UK (www.gov.uk) para. 14.17

nuisance occurring throughout the night. In September 2021 Anthony's mother reported concerns about his appearance, as it looked like he had lost weight, and looked dishevelled. Whilst SLaM acknowledged that there were elements of self-neglect at times, from Anthony's perspective non-compliance with medication was not self-neglect, it was self-preservation. The Care Coordinator commented that Anthony was eating and drinking, and that his property was relatively well maintained.

8.58 Given Anthony's isolation and intolerance to letting people into his home it would have been difficult to identify and assess signs of self-neglect. His non-compliance with medication was the most obvious sign but was considered to be a capacitated decision given the view that his non-compliance was self-preservation. An assessment of capacity would have been able to determine whether or not medication compliance was a choice based on a capacitated decision. Only the Care Coordinator and Anthony's family visited him, and the family had raised concerns indicating self-neglect as late as the 20 September 2021.There was one visit to Anthony by the Care Coordinator following this report, but the Care Coordinator was denied access.

8.59 The Care Act statutory guidance states that:

'It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case-by-case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour.'[22]

8.60 Neither a s42 enquiry nor an assessment were undertaken in response to the reports and indicators of self-neglect.

Equality

8.61 In terms of equality and protected characteristics, there were three factors of particular significance in this case: race, disability, and age.[23]

8.62 Government statistics show that Black/African/Caribbean/Black British people have higher rates of mental illness and are therefore more likely to encounter mental health services.[24] Black men are the group most likely to have experienced a psychotic disorder and are ten times more likely than white men to experience such a disorder.[25] Black people were more than four times as likely as white people to be detained under the Mental Health Act with Black Caribbean people experiencing the highest rate of detention out of all ethnic groups.[26] Black, Asian and minority ethnic groups also experience poorer recovery rates leading to inequality of outcomes.[27]

8.63 These statistics are a stark reminder of the experience of Black men in particular who experience poor mental health and illustrates the intersectionality between disability and race, which can result in health inequalities.

8.64 There is also a growing body of evidence locally that illustrates the inequalities experienced by Black African and Black Caribbean people in the London area. The BLACHIR Report[28] gathered insights on health inequalities within Black African and Caribbean communities in Lewisham and Birmingham. The report identified thirty-nine opportunities for action across the eight themes explored as part of the review, one of which included Mental Health and Wellbeing. The report recommends: co-produced awareness campaigns for Black

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[22] ibid
[23] Equality Act 2010 (legislation.gov.uk)
[24] Mental health statistics: prevalence, services and funding in England - House of Commons Library (parliament.uk)
[25] Psychotic disorders - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)
[26] Detentions under the Mental Health Act - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)
[27] Advancing Mental Health Equalities Strategy - V6.docx (england.nhs.uk)
[28] BLACHIR report | Birmingham City Council

communities to promote a better understanding of different mental illnesses; facilitation of early interventions and self-referral in collaboration with carers, families, health services, community and faith centres; ensuring practitioners use culturally competent trauma informed patient-centred engagement styles and interventions; ensuring mental health workers acknowledge service users' personal histories of racism and recognise them as trauma to enable more effective intervention; the promotion of cultural competency training within healthcare services, the criminal justice system, and the police force and application of culturally competent language, including using language that considers stigma within communities, such as 'wellbeing' rather than 'mental health'.

8.65 In relation to the police, the Casey Review[29], recently published in March 2023, considered racism, and concluded that the findings pointed to:

> 'a collective and continued failure by the Met to understand, accept and address the existence of racism at all levels in the organisation. We have found complacency in the Met to tackle problems, a lack of curiosity about what people of colour are telling them; and a wilful blindness to seeing the evidence all around them, within and outside the Met.'[30]

8.66 The recently published SAR Joshua[31] has also identified the wider issues of disproportionality and racial disparity for adults from Black, Asian and minority ethnic backgrounds in relation to the quality of care they received from mental health providers and other services in the Borough. It recommended that all LSAB partners review training and policies, to strengthen anti-racist perspectives and include the involvement of people with lived experience, their families and third sector organisations. It further stated that training needs to be part of a wider programme of change, developing multipronged diversity initiatives that tackle structural discrimination.

8.67 Whilst these reports highlight the inequalities for Black men experiencing poor mental health, and evidence of structural racism, there is little evidence of such in this case. Although Anthony may have experienced discrimination from others in relation to his mental ill-health, and this may have increased the risk to him from others, particularly his neighbours, and especially when his mental health deteriorated leading to an increase in ASB.

8.68 Lewisham Homes did not identify that equality issues were a relevant factor in the case, and none of these factors were mentioned in their case records. Lewisham Homes reflected that they focused on Anthony's mental health rather than taking enforcement action which demonstrated a response which was sensitive to his needs and circumstances. As the ASB was considered an aspect of Anthony's mental ill health it was downplayed, and legal options were not explored as they might have been with other tenants.

8.69 SLaM said there was nothing to suggest that they had not been culturally sensitive, or that either of the parties involved had been discriminated against on account of their protected characteristics. Whilst the research suggests higher detention rates for Black Caribbean people detention under the Mental Health Act 1983, in contrast detention was not even considered in this case.

8.70 The police identified that the main subjects in this case were Black Caribbean. They identified no information or inference in police records to indicate that any incident was motivated or aggravated by ethnicity, faith, sexual orientation, linguistic or other diversity factors. Where Anthony had contact with police, or in any of the joint working that took place, there was nothing to suggest that any diversity factors were relevant in decision making or in how they were treated.

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[29] BARONESS CASEY REVIEW Final Report (met.police.uk)

[30] Ibid. p.329.

[31] *Lewisham Safeguarding Adults Board - SAR Joshua (safeguardinglewisham.org.uk)

8.71 Age was relevant in this case with respect to Anthony's parents who were both older people. This review has already highlighted that as both parents and older people, they were less likely to be identified as victims of domestic abuse, Arthur even more so, given that he was also a man. These factors have been explored above.

8.72 Whilst the agencies identified that the subjects were not discriminated against or treated unfairly on the basis of any protected characteristics, they did not demonstrate how protected characteristics *were* considered, how they affected agency responses, or how they might have provided further insight into the subjects' lived experiences. It is also important to recognise intersectionality which describes the ways in which systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, class, and other forms of discrimination "intersect" to create unique dynamics and effects.

Impact of the Covid-19 pandemic

8.73 In March 2020, the UK Prime Minister introduced a nationwide lockdown. All non-essential contact and travel was prohibited, and many services moved to remote working. Restrictions began to ease in July 2020 and people were able to meet up in limited numbers outside. There was further easing of restrictions in August 2020.

8.74 There was a further national lockdown introduced for four weeks on the 2 November 2020 and from the 21 December 2020 London and the Southeast entered its third lockdown, this was extended nationwide on the 6 January 2021. The 'stay at home' order was finally lifted on the 29 March 2021 with most legal limits on social contact being removed on 19 July 2021.[32]

8.75 All organisations felt additional pressure during the Covid pandemic. This was evidenced in the police's report which cited resource issues. Many organisations moved to remote working during this time, and although this was not the case for the police, other agencies such as SLaM would have risk assessed which cases were worked 'in person.' It is evident in this case that the majority of contact between Anthony and the Care Coordinator during this time was remote by telephone.

8.76 For Lewisham Homes, the Covid-19 pandemic had a significant impact across the business in terms of workload and recruitment. The Housing Management team had vacant posts throughout the relevant period. This will have resulted in increased pressure on staff and likely to have impacted the Housing Officer's 'thinking time' which may have been mitigated by additional managerial supervision on the case.

8.77 There was no face-to-face or direct contact between Lewisham Homes and Anthony during the handling of the case. This meant that casework relied on his Care Coordinator, and his relationship with Anthony.

8.78 The ASB case was opened during the Covid-19 Pandemic, with various levels of restriction until April 2021. During this time staff were still carrying out essential visits but had significantly fewer face-to-face interactions with residents. Interaction with Anthony was difficult as he did not answer the phone, and the reduced capacity of staff to visit residents for non-urgent matters would have impacted upon case management. Lewisham Homes' lack of face-to-face contact with Anthony was a missed opportunity and meant there was a reliance on third parties who did not appear to appreciate the severity of the noise.

8.79 Meeting with him at home would have allowed Lewisham Homes to present Anthony, and his Care Coordinator, with evidence of the disturbance. It would also have enabled them to build a more informed view of the case; there were frequent reports of banging and smashing in the property, and visible property damage would have supported investigation. Similarly, they may have been able to pick up concerns in Anthony's presentation.

[32] timeline-coronavirus-lockdown-december-2021 (instituteforgovernment.org.uk)

8.80 During the Covid-19 pandemic Lewisham Homes experienced a large increase in ASB cases. In the relevant period, the team of four Officers, managed four hundred and thirty-one cases, which was three and a half times the nationally recognised average. Officers were prioritising the most urgent cases, ‘category A’ cases. As a noise case, Anthony’s case was automatically prioritised as a ‘category B’ case. Lewisham Homes ASB Policy defines the categorisation by case type and there is no discretion in the case management system for this to be ‘overridden.’ The ASB Officer’s decision not to ‘prioritise’ this case, whether conscious or not, was understandable in the context of the volume of urgent work he was responsible for.

8.81 It is difficult to evaluate the impact upon Anthony. It is likely that there were periods of time when his family were unable to visit him. Anthony contained himself by staying indoors and it is possible that his desire to isolate himself from others was validated by professionals in the context of the pandemic.

8.82 For Anthony’s neighbours, with more people being at home and working from home, it was more likely that they were experiencing a lower tolerance due to stress and anxiety caused by the pandemic and restrictions, which may have accounted for the increase in noise nuisance reports.

9. Conclusion

9.1 Anthony had Treatment Resistant Schizophrenia, and whilst he displayed positive symptoms of his diagnosed illness, he did not believe that he was unwell. Prescribed medication was unable to eradicate the persistent complex paranoid delusions he experienced, and he often had periods of time where he declined to take prescribed medication. Anthony experienced a decline in his mental health in late 2020 which manifested in anti-social behaviour by way of excessive noise. This caused nuisance and distress to his neighbours, but despite this he stopped taking prescribed medication in late May 2021.

9.2 Anthony’s family were involved in his life and had regular contact with him. Despite this there was an absence of their inclusion in assessment and care planning for him. Furthermore, no family member was offered a carers assessment or considered as part of any assessment of risk relating to Anthony, despite a known history of violence and aggression.

9.3 Risk assessment for Anthony was sporadic and did not reflect the escalating reports of ASB and decline in his mental health. Despite entitlement to section 117 aftercare services, there was no evidence of this being provided or an aftercare plan being in place, his social care needs had not been assessed since 2017 and no request for such was made. When he appeared to reach a crisis point in March 2021, Home Treatment was provided, but once discharged from that service alternatives were not considered, probably due to the knowledge that he would not engage, or an assumption that they would not be effective, although no rationale was given.

9.4 The assessment and management of risk was further compromised by the lack of multi-agency approach which could have been achieved through the use of the Community MARAC.

9.5 Concerns were raised about self-neglect but not pursued and at no time was Anthony’s mental capacity assessed in relation to care, support and treatment for his mental health despite indicators that he may lack capacity in these areas.

9.6 The events leading up to Arthur’s death took place in the context of the Covid-19 pandemic which impacted upon the agencies involved, particularly in terms of resources, and changed the way agencies interacted with their clients with a decrease in face-to-face

contact, which meant there were few opportunities to observe Anthony and his environment.

9.7 However, systemic long-standing issues have also been identified by this review. The police response was inconsistent; the police acknowledged this inconsistency and have made recommendations to improve future responses, including the implementation of new systems to replace those that are decades old and no longer fit for purpose.

9.8 Equality issues were not considered by any agency which meant that they were unable to consider factors contributing to, and therefore understanding, Anthony's lived experience. Doing so may have resulted in a more effective approach in responding to Anthony and his family's needs.

10. Lessons to be Learned

10.1 The review has highlighted a number of areas of learning, and these are summarised as follows:

10.2 Monitoring and Review - The Covid-19 pandemic led to a shift in working practices which has seen an increase in remote working. When monitoring clients, face to face contact should be considered the default option and any deviation from this should be risk assessed and a rationale provided as to why remote contact is appropriate in the circumstances. Crisis plans should be regularly reviewed and demonstrate what a decline in mental health looks like for the person and the threshold for escalation. Assessments and care plans should be regularly reviewed and should involve and consider significant others such as family and carers.

10.3 Risk Recognition, Risk Assessment, Risk Management – The assessment of risk is fundamental in managing risk to and from the person. Agencies should adhere to their own policies and procedures in relation to risk assessment. Risk assessment should be reviewed at regular intervals, as determined by the agency, and following any change in a person's circumstances or presentation. Risk assessment should consider other significant people in the person's life, for example, family and carers. Risk assessment and management benefits from a multi-agency approach and professionals should be aware of the forums available to them such as the Community MARAC.

10.4 Aftercare – Adult Social Care, SLaM, and the South East London Integrated Care System (replaced CCG in September 2022) must understand their duties in relation to section 117 aftercare. They should know who is entitled to aftercare in their area and ensure there is an aftercare plan in place which is reviewed regularly.

10.5 Information Sharing - There should be clear guidance in each agency which dictates the threshold for information sharing and onward referrals following an assessment of risk. Care plans should also detail arrangements for sharing information between the agencies involved in the person's care and with their families/carers. Organisational systems should allow the easy retrieval of information and intelligence gathering so that links can be made (for example: s117 after care registers, Command and Control, and CONNECT).

10.6 Carers – Practitioners should be able to identify carers and, depending on their role and legal duties, either signpost or refer carers for an assessment or undertake a carers assessment. Practitioners need to be mindful that carers can include family and non-family members, that there is no requirement for the carer and cared for person to be living in the same household, and that 'care' can include emotional support not just practical support with tasks of daily living. Carers should also be involved in the assessment and care planning for the person and considered in any risk assessments. The impact upon family

members of having a relative with mental ill-health should be considered and carers should be provided appropriate support to support them in their role.

10.7 Familial Abuse – Practitioners need to be aware of, and professionally curious about, familial abuse, with recognition of the hidden nature of older people who experience such abuse and awareness of the services and support available to them. Any concerns of familial abuse should be responded to appropriately including risk assessment, safeguarding procedures and referral to support services.

10.8 The principle of Least Restrictive Option– Whilst the Mental Health Act 1983 operates on the principle of least restrictive intervention, this does not exclude the option of detention. Practitioners need to demonstrate accountability for their decisions by detailing the available options and providing a rationale for the inclusion or exclusion of any available option, including the rationale for action/inaction.

10.9 Mental Capacity – Practitioners need to be cautious that the presumption of capacity does not lead to non-intervention or poor care, which risks leaving vulnerable adults exposed to a risk of harm. Practitioners should use their professional judgment and curiosity to recognise indicators that may call a person's capacity into question, and in response undertake a mental capacity assessment to determine capacity. When a person lacks capacity, any decision should be made in the person's best interests and in consultation with significant others.

10.10 Self-Neglect – Practitioners should be confident in identifying self-neglect and should respond to concerns about self-neglect appropriately either through safeguarding procedures or assessment.

10.11 Equality – Practitioners should identify a person's protected characteristics, how those characteristics impact upon the services they receive and how they experience them. Consideration should be given to past experiences and how those protected characteristics interact.

11. Recommendations

11.1 For the SAB to seek assurances from partner agencies that protocols for visiting clients are reviewed, ensuring that in-person visits are the default and that any remote contact is supported by a risk assessment and rationale.

11.2 SLaM to ensure that all crisis plans demonstrate what a decline in mental health looks like for the person, and the threshold for escalation, and are regularly reviewed.

11.3 For SAB partner agencies to raise awareness of Carers to enable staff to identify carers, signpost or refer carers for an assessment.

11.3.1 London Borough of Lewisham to refresh carer awareness amongst staff and promote their responsibilities for Carers as per the Care Act 2014.

11.4 Adult Social Care and SLaM to ensure that carers and family members are involved in the assessment and care planning and considered in any risk assessments. (While people may not consent for their personal information to be shared with carers or family members by mental health services, patient confidentiality should not prevent services from seeking collateral information from known carers and family members in order to assess and manage risk).

i. There is a clear record of the rationale when carers/family members are not included in assessment, care planning and risk assessment.

ii. The impact upon carers/family members of having a relative with mental ill-health is considered and are provided appropriate support to support them in their role.

11.5 SLaM to ensure that their practitioners record decision making by detailing the available options and providing a rationale for the inclusion or exclusion of any available option, including the rationale for action/inaction.

11.6 For the SAB to seek assurances from partner agencies that they have clear guidance, within their agency, for the sharing of information, including thresholds for sharing information and making onward referrals, and are signatories to the local safeguarding inter-agency Information Sharing Agreement.

11.7 SLaM to ensure that all care plans detail arrangements for sharing information between the agencies involved in the person's care and with their families/carers.

11.8 For the Metropolitan Police Service to evaluate the effectiveness of Command and Control and CONNECT (following implementation) in linking events, identifying a pattern of ASB, and responding to and managing ASB.

11.9 For the Lewisham Violence against Women and Girls Board to measure the quality, impact and effectiveness of awareness raising activities in relation to familial abuse experienced by older people (including recognition and response) and consider new methods to better embed into practice.

11.10 For SAB partner agencies to measure the quality, impact and effectiveness of awareness raising activities with regards to available risk management/multi-agency forums (e.g., the Community MARAC) and consider new methods to better embed into practice.

11.11 For SAB partner agencies to measure the quality, impact, and effectiveness of:

i. Existing mental capacity training packages to ensure they provide consideration of indicators that may call a person's capacity and the presumption of capacity into question and consider new methods to better embed into practice.

ii. Existing self-neglect training to ensure their staff are confident in identifying self-neglect and respond to concerns appropriately as per the local policy and procedures.

11.12 For SAB partner agencies to ensure that a person's protected characteristics are identified and recorded.

i. To ensure staff are confident in understanding how those characteristics will intersect and shape a person's identity, and as such are carefully taken into account by working in a person-centred way.

ii. To ensure staff are confident in considering the impact of past experience (trauma informed practice).

11.13 For the SAB to seek assurances that previous recommendations[33] relating to section 117 aftercare have been completed and learning disseminated to staff within the relevant agencies.

[33] Ombudsman and Adult Z

12. Glossary

ASB	Anti-Social Behaviour
ASC	Adult Social Care
CMHT	Community Mental Health Team
ABH	Actual Bodily Harm
SLaM	South London and Maudsley NHS Foundation Trust
SNT	Safer Neighbourhood Team
MPS	Metropolitan Police Service
MaSH	Multi-agency Safeguarding Hub
PMP	Proactive Management Plan
SAR	Safeguarding Adults Review
LSAB	Lewisham Safeguarding Adults Board
SABs	Safeguarding Adults Boards
GP	General Practitioner
CAD	Computer Aided Despatch
PMP	Proactive Management Plan
MARAC	Multi-agency Risk Assessment Conference