Lewisham

Safeguarding Adults Board

A working partnership to prevent abuse

Safeguarding Adults Review
Joshua

Annie Ho

Independent Reviewer

‘At 16 years old, I was admitted into a mental health ward. Unfortunately, on that day, the police were called as a safety precaution. They made the situation feel more like a crime than an individual who was distressed and in need of help. I was treated like a criminal before I was offered support… This is where my frustration with the police began. They saw nothing more than another 'Black boy', at a point when I was struggling with my mental health. To them, this was a criminal - not a lived experience.

‘Turning my frustration into action,’ I would (also) approach officers on the street and every conversation would start with "look around, everyone already thinks we’re against each other." Society deems we have no place in engaging in conversations with each other.’

Antonio, ‘Another Black boy’[1]

‘We’re not stronger than anybody else. We're not madder than anybody else. We're just trying to breathe, because somebody is on your neck.’

Marcia Rigg, Sister of Sean Rigg[2]

‘We have a chance to prove ourselves as a different kind of society than we have experienced thus far… to make sure we are progressing towards equitable and accessible mental health care for all. This work must yield tangible outcomes for those who have been discriminated for too long – we can no longer work in a system that assumes the same approach fits all. The cost of this dissonance can be fatal.’

Jacqui Dyer, Chair of the Advancing Mental Health Equalities Taskforce[3]

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[1] https://www.mind.org.uk/information-support/your-stories/race-the-police-and-my-mental-health/
[2] https://www.inquest.org.uk/police-racism-report-2023
[3] https://www.england.nhs.uk/blog/making-mental-health-care-fairer-for-all/

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1. Introduction

1.1 Brief overview of the circumstances that led to this review

1.1.1 This Safeguarding Adults Review (SAR) is commissioned by the Lewisham Safeguarding Adults Board (LSAB) in response to the circumstances surrounding the death of Joshua (Pseudonym).

1.1.2 Joshua died on 9 March 2018 at the age of 35.

1.1.3 A Coroner's inquest was opened on 28/03/2018 and concluded on 09/10/2020. At the inquest, the jury found system-wide failures contributed to his death. A Regulation 28 Report to prevent future deaths was issued to the Metropolitan Police Service (MPS) and the London Ambulance Service (LAS).

1.1.4 The jury recorded the medical cause of death as Acute Behavioural Disturbance (ABD) (in a relapse of schizophrenia) leading to exhaustion and cardiac arrest, contributed by restraint struggle, and being walked.

1.1.5 It is of note that the Jury Directions highlighted the insufficient scientific knowledge of a direct causative link between schizophrenia and ABD.

1.1.6 Joshua presented with mood and psychotic disorder. During his admissions to hospital, his diagnosis was recorded as either paranoid schizophrenia or schizoaffective disorder. His severe and enduring mental illness was characterised as a chronic, relapsing and partially remitting disorder.

1.2 Statutory duty to conduct a Safeguarding Adults Review

1.2.1 The Care Act 2014 stipulates that a Safeguarding Adults Board (SAB) must arrange for a Safeguarding Adults Review (SAR)[4] where:

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

1.2.2 Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt from the adult's case and applying those lessons to future cases[5].

1.2.3 A SAR is not an inquiry into how someone died or suffered injury, or to find out who is responsible. The purpose is not to allocate blame or responsibility[6].

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[4] Sections 44(1)-(3), Care Act 2014
[5] Sections 44(5), Care Act 2014
[6] Para 14.168, Care and Support Statutory Guidance updated 16 June 2022

1.2.4 SARs should reflect the 6 safeguarding principles[7].

- Empowerment – supporting people to make their own decisions and informed consent.
- Prevention – it is better to take action before harm occurs.
- Proportionality – the least intrusive response appropriate to the risk presented.
- Protection – support and protection to those in greatest need.
- Partnership – local solutions through work with communities.
- Accountability – accountability and transparency within safeguarding.

1.3 LSAB decision to conduct a review

1.3.1 The SAR referral was jointly made by Public Protection and Safety, Lewisham Council, and MPS on 16/04/2018. (The referral was not received and was re-sent to LSAB on 15/05/2018.)

1.3.2 At the October 2020 LSAB Case Review Sub-group meeting, it was agreed that the mandatory criteria were met for this case, and a review would be conducted under S44(1) of the Care Act 2014.

1.3.3 The concerns raised in the SAR Notification were the provision and management of urgent mental health care to Joshua on 08/03/2018 and 09/03/2018, the police intervention, and a delay in the ambulance response on 09/03/2018.

1.3.4 Further concerns have become known following the HM Coroner's Inquest.

1.4 Delays and parallel enquiries

1.4.1 The commencement of this SAR has been significantly delayed due to parallel enquiries and the Covid-19 pandemic.

1.4.2 This review links to:

1.4.2.1 South London and Maudsley NHS Foundation Trust (SLaM) – Serious Incident (SI) Investigation

1.4.2.2 NHS South East London (SEL) Integrated Care System (ICS) – SI Monitoring

1.4.2.3 Independent Office for Police Conduct (IOPC) – Ongoing Investigation

1.4.2.4 HM Coroner – Inquest complete

1.4.2.5 NHS England – via NHS SEL ICS

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[7] Para 14.166, Care and Support Statutory Guidance updated 16 June 2022

1.4.3 The SAR started on 20/04/2021, was paused on 08/06/2021 due to the IOPC investigation and re-started on 01/08/2022.

1.5 The lead reviewer

1.5.1 Annie Ho is an independent social work consultant and has no current or direct employment relationships with any local authorities or partner agencies. She is a registered social worker and has over thirty years of experience working in local authority adult social care.

1.5.2 Annie previously held strategic positions in relation to safeguarding adults, mental capacity, and Deprivation of Liberty Safeguards with three local authorities. She was actively involved in the work of SABs including SARs and Domestic Homicide Reviews (DHRs).

1.5.3 Annie was actively involved in the pilot of the Department of Health and Social Care (DHSC) Workforce Race Equalities Standards (WRES) in 2021. She continues to be involved in participating in practitioner research and facilitating reflection in anti-racist practice and equalities work.

1.6 SAR Panel membership and Terms of Reference for this review

1.6.1 It has been determined that the members of the LSAB Case Review Sub-group will act as the panel for this review.

1.6.2 The Terms of Reference for this SAR were set by the Case Review Sub-group and reviewed by the reviewer.

2. Review Methodology

2.1 The review methodology included an analysis of Individual Management Reviews (IMRs) and the combined chronology, as well as a number of learning conversations with representatives of key agencies involved in the care of Joshua.

2.2 The reviewer usually includes as part of her standard review process an offer of reflection sessions to key staff members of relevant agencies. These help to provide insight to the reviewer of the challenges individuals faced in working on this complex case, and the learning they have taken to inform their continuing practice in safeguarding adults. In this case, the long delay in resuming the SAR process restricted the opportunity of practice reflection.

2.3 The reviewer opened the offer of learning conversations to representatives of the key agencies. Informal meetings were arranged with representatives of the supported living provider, SLaM, and the GP practice where conversations were facilitated on the learning, changes and improvement individual organisations have put in place since the death of Joshua. These learning conversations helped to inform the critical analysis in this report and recommendations put forward by the reviewer.

2.4 The reviewer was also able to have a meeting with Professor Frank Keating[8], facilitated by the LSAB Business Unit. This helps to provide insight into the wider picture of systemic and practice issues and relevant research.

2.5 The methodology adopted by the reviewer seeks to promote a thorough exploration of the significant episodes prior to the death of Joshua, whilst trying to avoid hindsight bias which risks isolating practice from the wider issues of organisational systems and processes.

2.6 To focus on learning, the review starts with an acknowledgement that organisational and systemic factors can cause incidents. Avoiding hindsight bias counters our usual tendency to ignore information that challenges our initial understanding.[9]

2.7 '*It is vital, if organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them.*'[10]

2.8 A learning workshop was led by the reviewer on 10/01/2023 and attended by all agencies who were involved – the provider service, SLaM, GP, Police and LAS. A safe space was facilitated for sharing and learning, taking into account the potential sensitivities and discomfort which may be trigged by the case. It was acknowledged at the start there was good practice as well as areas for improvement both at a single agency and at a multi-agency level. There were practice issues, and organisational and systemic factors. As a group, we reflected on what got in the way, what needs to change, and what we can do to create change.

2.9 It came to the attention of the reviewer, after the learning workshop, that an invitation had not been extended to Lewisham Community Forensic Team (LCFT). The reviewer subsequently met with two key staff members of the team. It is to be noted, however, that their experience of and learning from working directly with Joshua, has not been shared with other partners in the review process.

2.10 Participation by Joshua's family

2.10.1 Family engagement, if possible, is key to a Safeguarding Adults Review. The reviewer offered opportunities to family members to communicate with her and bring their information, experiences, and perspectives, to the learning.

2.10.2 Updates on the progress of this SAR have been provided to Joshua's family via his mother, and repeated invites have been offered for the family to be involved in the review process.

2.10.3 The reviewer attempted to engage with family members at different stages of the review process, where possible.

[8] https://pure.royalholloway.ac.uk/en/persons/frank-keating

[9] Safeguarding Adults Reviews under the Care Act: implementation support, SCIE March 2015 https://www.scie.org.uk/files/safeguarding/adults/reviews/care-act/safeguarding-adults-reviews-under-the-care-act-implementation-support.pdf

[10] Para 14.140, Care and Support Statutory Guidance updated 16 June 2022

2.10.4 We have received no response from the family to date.

2.10.5 This report has been anonymised to protect the confidentiality of the person who is the subject of the report and his family. They have not been directly involved in the review process and have therefore been unable to give their consent for Joshua's real name to be used.

3. Joshua: The Person

3.1 Sources of information

3.1.1 There were limited details from agencies' submissions on Joshua as a person.

3.1.2 In the absence of involvement with the family, what agencies shared about Joshua was largely focused on the functional aspects of the care and support arrangements.

3.1.3 Further, though limited, information was gathered by the reviewer from the individual learning conversation meetings.

3.1.4 The long delay in undertaking this review after Joshua's death meant that many who knew and worked with him were no longer available to be involved. At the learning workshop on 10/01/2023, only the manager of the provider service knew Joshua for the whole period he stayed at the accommodation.

3.1.5 The reviewer later met with the consultant forensic psychiatrist and the team leader (previously care coordinator) of the LCFT, who knew Joshua well, and were able to provide additional information.

3.2 A pen portrait

3.2.1 Joshua was a 35-year-old Black Caribbean man. He was of Guyanese background and came to the UK as a child.

3.2.2 Joshua was close to his family, especially his mother, who also live in Lewisham. Joshua was the eldest child and had four siblings.

3.2.3 The LCFT representatives described the 'calm, positive outlook' Joshua had. He 'expressed gratitude' and talked about 'being blessed' with relationships he had with his family and friends.

3.2.4 Records of the supported living provider referred to visits to Joshua by his mother and a brother, and Joshua's visit to his mother at home. Joshua had daily communication with his mother. She attended clinical meetings on invitation from his care team.

3.2.5 Joshua was recorded as both a Christian and a Rastafarian. He was a habitual Marijuana user.

3.2.6 Joshua was also recorded as a talented footballer. He was keen on sports, including swimming and the gym. He had a history of back problems. It was noted that he had a long conversation with his key worker about football in November 2017 and he was keen to return to playing football.

3.2.7 Joshua was known to be a well-liked resident and interacted well with staff and other service users where he lived. He enjoyed different social opportunities, including the breakfast club and visits to places of interest.

3.2.8 The LCFT representatives described Joshua as a 'popular' man; 'other residents looked up to him.' He was recognisable and well known in the local area.

3.2.9 The manager of the provider service shared at the learning workshop that Joshua was 'someone you could have an intellectual conversation with.' He had a good sense of humour.

3.2.10 The LCFT representatives also described Joshua as a 'good negotiator.' He expressed his views about medication in a firm way, e.g., food came first before medication. They referred to an occasion when Joshua had a long negotiation with his consultant about his medication, and they were observed to end the negotiation by standing up and shaking hands with each other.

3.2.11 The provider reported that Joshua sustained a back injury before he joined them which affected his ability to engage in more structured education or work-related activities. He held a cleaning job at a sister service for some time which he regularly attended up to the time he injured his back.

3.2.12 The provider informed the reviewer that during the last six months before Joshua died, he was remaining stable and 'getting on with life.' Joshua had been at the service for just over 2 years and was making 'good progress'.

3.2.13 The GP who met with the reviewer shared a similar view, in that Joshua was 'mentally quite well' when he attended surgery appointments.

3.2.14 The reviewer shared at the learning workshop that it was difficult to come to a whole picture of Joshua outside of his mental health diagnosis and professionals' task-focused approach. The reviewer's conversations with individual professionals, from the provider and from the LCFT in particular, indicated that they had a good picture of who Joshua was as a person, but much of this personal information was not recorded.

3.2.15 The LCFT later made representation that members of this team knew Joshua very well, but this had not been reflected in the documentation which was reviewed. Details of conversations with Joshua, his mother and the supported living provider were not recorded.

3.2.16 The LCFT representatives explained it was difficult to engage with Joshua because he had negative experiences with the Mental Health Act. He did not have faith in mental health services – things had not worked out for him, and he did not believe that mental health services had his best interests at heart.

3.2.17 The view of Joshua's mother was not clear. She was displaced as Nearest Relative[11] for a short period in 2013 when she appeared to object to Section 3 of the Mental

[11] https://www.legislation.gov.uk/ukpga/1983/20/section/26

Health Act[12] being used but did not apply for Joshua's discharge from hospital. When she later understood that the hospital could not make the application without her consent, she did not object to the Section 3.

3.2.18 Joshua was a 'private' person. He felt he was entitled to his own life and there were lots of times when he was not willing to talk about certain areas, e.g., his use of cannabis.

4. Critical Analysis of Case Chronology and Significant Episodes

4.1 The period in scope of this review is 01/09/2017 to 09/03/2018. Agencies' chronologies and reflective analysis in their IMRs covered this period.

4.2 Joshua first came into contact with mental health services in 2002, at the age of 19. He was a patient of Mental Health Forensic Services since 2006 and of the Community Mental Health Team since 2014.

4.3 Joshua had 9 admissions to hospital under the Mental Health Act (MHA) 1983. Seven of his nine admissions involved the police, the last four via Section 136. Some of his admissions were long, the longest being 2 years and 10 months. The LCFT reported that his illness was only partially remitting, and he continued to have some symptoms between episodes.

4.4 All of Joshua's admissions included extended periods often in supervised confinement. He also had treatment in locked psychiatric rehabilitation / challenging behaviour units.

4.5 Joshua would become very unwell very quickly, aggressive, and difficult to manage when he was unwell. During his admissions, his diagnosis was recorded as either paranoid schizophrenia or schizoaffective disorder.

4.6 It is documented that Joshua had limited and fluctuating insight into his illness. When he was more stable in the community, he had a more accepting attitude to treatment, although he did not accept that he had a mental health diagnosis. The LCFT shared that Joshua did not accept that he had a mental illness, or the medication was for his mental illness.

4.7 The LCFT shared it was believed that Joshua's relapses were linked to cannabis use and non-compliance with medication.

4.8 A trigger factor for his violent behaviour was the involvement of the police in MHA assessments. This was illustrated by his in-patient admission in May 2003 when he had to be restrained by the police.

4.9 Joshua was convicted in February 2004 of assault on the police causing actual bodily harm and resisting arrest, relating to his re-admission to the Bracton Centre in October 2003.

[12] https://www.legislation.gov.uk/ukpga/1983/20/section/3

4.10 Joshua moved to his last place of supported living accommodation on 01/02/2016. He was pro-active in going to the accommodation service office to ask for help with some practical aspects of everyday living, e.g., with his gas card for heating, Freedom Pass, booking appointments with the GP and communicating with his care coordinator.

4.11 It is of note that Joshua's mental health was considered to be stable within this review period. There were no incidents reported by the agencies of physical or verbal aggression.

4.12 The provider worked closely with the LCFT in monitoring his mental health and recovery in the community. Joshua had mental health review meetings at his accommodation, with the support of staff from the provider service.

4.13 Joshua required support from the supported living provider with taking his medication of Clozapine on a daily basis. The provider reported there were no issues with Joshua's compliance with medication during the review period.

4.14 It was noted, however, that Joshua expressed he was 'unhappy at taking medication' in his meeting on 12/09/2017 with the Specialist Registrar. It was unclear whether his mental capacity for this specific decision was considered and, if so, what the determination was.

4.15 The LCFT confirmed that Joshua's wishes and feelings about his mental health medication were explored on many occasions, but he continued to have limited understanding of it, despite repeated and lengthy discussions.

4.16 In November 2017 when the consultant reduced his Olanzapine, Joshua delayed going to the pharmacy for the medication change. Joshua did not attend his meeting in December 2017 with the consultant, who later made the decision to stop Olanzapine and increase the dosage of Clozapine. It was noted that Joshua said he was 'not happy' with this medication change and felt it was 'too much for him' (even though it was a significant reduction in overall dosage) and refused to take the prescribed dosage of Clozapine. This was resolved in January 2018 when the dosage of Clozapine was reduced to the level Joshua was agreeable with.

4.17 It was noted in the SLaM chronology that it was 'unclear' as to 'why Joshua felt medication wasn't right;' he was unable to explain his reasons clearly. Joshua had very mixed feelings about medication which his consultant and the trainee psychiatrists explored with him on many occasions. He struggled with the dosage; at times he was ambivalent and at other times he worried about being over-medicated.

4.18 Both the chronologies provided by the GP practice and SLaM highlighted Joshua's continuing daily use of cannabis. The GP record shows that this was discussed with Joshua at an appointment on 02/10/2017 but 'Joshua said he was not interested in help to stop'.

4.19 Notes of the mental health review meeting of 12/09/2017 stated that he was 'continuing to use cannabis daily and was unable to explain why he's on a

Community Treatment Order (CTO)'[13]. This could have been a missed opportunity to explore with Joshua his understanding of continuing cannabis use alongside the relevant decisions relating to his CTO. The SLaM record of the CPA (Care Programme Approach) review of 17/10/2017 states that Joshua continued to use cannabis at a level of approximately £20 per week.

4.20 It was unclear whether and to what extent Joshua's mental capacity for this specific decision of continuing cannabis use was fully considered – whether he was determined to have capacity for this decision and what decision-making support he was provided with; or whether he was assessed to lack capacity for this decision and what consultation took place for a specific best interests decision to be made.

4.21 The LCFT shared that Joshua's cannabis use was 'in keeping with his Rastafarian belief system and thus he had cultural reasons for use.' The team reported that he disagreed with the appraisal of the negative impact of cannabis on his mental health state.

4.22 The provider reported that they discussed with Joshua the impact of cannabis use on his mental health, but he made it clear to staff that 'he takes it because it is part of his culture and had no intention of stopping.'

4.23 Whilst the reviewer accepts the LCFT's submission that the implications of regular mental capacity assessments for cannabis use always have to be considered carefully at an individual level, this continued to be a grey area for professionals working with Joshua.

4.24 The chronologies and IMRs appear to indicate that Joshua lacked 'insight' into his mental health condition and the treatment decisions. It remains unclear how much he was supported to understand the potential adverse impact of regular cannabis use on his mental health and wider well-being.

4.25 The IMR from the GP practice stated that their role was in monitoring Joshua's physical health whilst his mental health remained the responsibility of the mental health team. Adoption of a wider multi-disciplinary and holistic approach would have been beneficial in supporting Joshua to understand the inter-relationship between specific aspects of his physical health and mental health.

4.26 From September 2017, Joshua reported at both GP appointments and CPA review meetings his continuing struggle with back pain, which affected his sleep and limited his ability to play football and go to the gym. The chronology noted Joshua felt the pain was 'caused by psychiatric medication injected into his bottom that went into his back' and he was keen to have an MRI scan. This could have been another missed opportunity to explore further with Joshua his wishes and feelings about his mental health medication, and his mental capacity about specific treatment decisions relating to his mental as well as physical health.

4.27 Joshua was voicing his unhappiness about his medication in September 2017, when his consultant was making changes to his medication. He started asking

[13] https://www.legislation.gov.uk/ukpga/1983/20/section/17A

questions about his medication and acting differently compared with his usual compliance, which did not appear to have been further explored and followed up.

4.28 In November 2017, the practice pharmacist undertook a medication review and explained to Joshua that blood tests were necessary to ensure that his medication was ‘not negatively affecting his health’. Although there were no issues with Joshua having his annual blood tests in March 2016, he said in November 2017 ‘he was sure he did not want to come in’.

4.29 It was good practice for the GP to inform the mental health team, and consequently his blood tests were arranged via the Clozapine clinic. The named GP’s letter to the mental health team stated, ‘lack of capacity to give consent about treatment decisions.’

4.30 Joshua was subject to a Community Treatment Order (CTO), but this came to an end on 04/03/2018. It was noted in the SLaM chronology that when Joshua was seen by the consultant on 05/02/2018, he ‘denied any symptoms’ (mental health) and ‘looked a bit out of sorts but he denied this’. The plan was for ‘review at the next clinic.’

4.31 Joshua was seen by the consultant at his accommodation on 05/03/2018, where no signs of relapse were noted. It is unclear how the observations noted from the meeting one month ago (05/02/2018) that he was ‘out of sorts’ were aligned with the conclusion of this meeting (05/03/2018) that there were no signs of relapse, around the same time when his CTO came to an end.

4.32 Joshua was informed his CTO had come to an end. Joshua said in response he would continue with treatment, but ‘denied any symptoms.’ ‘He spoke very little and was not forthcoming (? had been smoking cannabis).’ ‘He denied any thoughts about harming himself or others.’ He acknowledged he was using cannabis but ‘would not quantify.’ There were continuing concerns which professionals appeared to be unable to engage with him to address.

4.33 The provider staff reported at this meeting that his mental health had been stable and there had been no concerns. The staff member at his supported living accommodation suggested Joshua needed structured activities, but he responded, ‘he does not want to do anything currently.’ The provider’s report at the same time stated that Joshua enjoyed engaging in social activities. The LCFT shared that this was Joshua’s usual presentation – he enjoyed social activities but did not want to do more structured activities.

4.34 Over the course of 07/03/2018 and 08/03/2018, Joshua’s mental health began to deteriorate.

4.35 It appears that alert signs started emerging on 07/03/2018 when supported living staff noticed the fire panel flashing for Joshua’s flat although it did not set off the fire alarm. Staff phoned Joshua who ‘said all was OK.’ Staff asked Joshua if he would be coming to the service office to take his medication. He said he would come but didn’t attend. Staff phoned him several times and buzzed his flat but there was no answer.

4.36 It was at this point that staff tried to contact Joshua's mother ('next of kin') but the number did not work. It was discovered only during Joshua's mental health crisis when the police intervened, that staff had used a previous/outdated contact number for Joshua's mother.

4.37 On 08/03/2018, Joshua attended the office (but only 'after being prompted by staff by phone') and took the medication. Staff reported that he 'appears unwell, moving very slowly, staring into space and mumbling something is not right.' Staff asked him four times if he was OK, but Joshua did not respond. Staff then suggested Joshua should go to his room and rest, 'which Joshua agrees to do.'

4.38 The provider emailed out-of-hours an update on Joshua's presentation to the consultant, care coordinator and copied in all the supported living staff. The staff member who was coordinating the next morning's shift was contacted and updated about Joshua.

4.39 The SLaM record shows the provider reporting 'he seemed very unwell.' The consultant replied, stating 'experience tells us that he gets very unwell very quickly and is most likely to come in on a section 136'.

4.40 What was noted and reported about Joshua's presentation and sudden deterioration should have prompted immediate concern and contact with Joshua by the supported living staff and then the mental health team, considering his history of the potential risks of rapid decline in his mental health state.

4.41 Joshua was seen by the supported living staff on the street at different times on 09/03/2018. When he later became unresponsive and staff were unable to locate him, staff escalated their concern to the LCFT. The LCFT duty worker advised for the police to be called and S136 to be requested, as this would be 'the quickest way to get him assessed'.

4.42 A care coordinator attended the supported living accommodation to see another client and observed Joshua outside on the street. He attempted to engage Joshua in conversation. It was noted 'he appeared distracted' and to be 'visually hallucinating.' When he was asked whether he was OK, he replied, 'you can't see?' He 'appeared thought disordered,' saying 'evil's doing it.' He 'did not engage in any fluent meaningful conversation.' He 'continued to mumble words like evil and wow repetitively' and continued to look around. The care coordinator reported his observations to the supported living duty staff, and they confirmed they had contacted the police and were waiting for them to arrive.

4.43 After concerns were raised to the LCFT by the supported living provider, a referral for an urgent MHA assessment was made, in addition to the police being called.

4.44 Police later located Joshua but informed supported living staff that they had spoken to Joshua and 'he did not warrant' S136. It appears that staff were informed of this decision of the police at the same time when they noted Joshua was 'running down the street.'

4.45 The LCFT representatives made the observation that the police took a snapshot of the situation and concluded that Joshua was 'not a problem right now.' The police were happy to leave Joshua at their first contact with him – they did not involve the

supported living provider in this decision, and they did not see him as mental health services would have done.

4.46 Police were called by a member of the public as a male was seen climbing over residential fences and made his way onto the school playing fields. It is of note that this call was made to the Police only 4 minutes after they left Joshua's accommodation. This indicates that the snapshot the police took for their decision making changed within an extremely short period of time and therefore makes their assessment at the time questionable.

4.47 The police requested an ambulance.

4.48 On the arrival of the ambulance, they reported that Joshua was being restrained on the floor by the police and was in the recovery position. He was in two pairs of handcuffs and two leg constraints, and he was alert. It was unknown how long Joshua had been restrained. Joshua was assisted to get up by the police and followed commands from the ambulance staff. The police removed the ankle restraints and started walking Joshua to the ambulance. Joshua walked with aid from the police for 2-3 minutes before becoming unresponsive. Joshua was transferred to a carry sheet and onto the ambulance. On examination, Joshua was in cardiac arrest and cardiopulmonary resuscitation (CPR) was commenced. Joshua's breathing was assisted, and a full drugs protocol was administered. Joshua was conveyed to hospital whilst CPR was continued throughout the journey. He was declared deceased at the hospital.

5. Specific Areas of Enquiry

The Terms of Reference agreed by the Lewisham SAB Case Review Sub-group include the specific areas of enquiry as below.

5.1 Whether the care provided by all organisations and professionals was consistent with expected standards within primary legislation, statutory guidance and codes of practice including:

5.1.1 Care Act 2014

5.1.2 Mental Health Act 1983

5.1.3 Mental Capacity Act 2005

5.1.4 London multi-Agency Safeguarding Adults Policy and Procedures

5.1.5 Making Safeguarding Personal

5.1.6 Assessment of risk and management of harm

5.1.7 Information sharing

5.2 An assessment on, if the quality assurance mechanisms each agency had in place, were robust enough in monitoring the care and/or support being provided in relation to the welfare of Joshua; and in responding to a deterioration, change in circumstances, increased risk, or other concerns.

5.3 An assessment of the adequacy of management of the Community Treatment Order (Section 17A MHA 1983) and therefore the support given.

5.4 An assessment of the quality and appropriateness of nursing and clinical care delivered.

5.5 Examination of 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 the mental health provider and other relevant services in the Borough.

5.6 An assessment of the resourcing of local mental health facilities to accommodate and respond to people with acute mental health needs.

5.7 Determination and insights into the way organisations worked together in this case.

5.8 Determination of what the relevant agencies involved in the case might have done differently that could have helped to prevent harm.

6. Thematic Analysis

The key themes here are taken from section 5 (5.1-5.8), plus additional themes identified by the reviewer during the review process.

6.1 Before addressing any other themes identified in this review, it is important to put ‘race’ at the centre so that it informs our thinking, reflection, and analysis of what happened, as well as our aspirations and commitment to create change.

6.1.1 The core issue of race is a central part of all the key themes.

6.1.2 It is also important to acknowledge that ‘race’ was a core part of Joshua’s identity. Taking a person-centred approach, we must ask questions whether and how race influenced the way organisations worked with him and shaped the systems within which he was situated.

6.1.3 ‘Every single person working in mental health has a role to play in making our services and systems fairer and challenging racism in all its forms.’[14]

6.1.4 ‘You cannot talk about any other issue without talking about how race informs that issue.’[15]

6.1.5 In her book, ‘White Fragility,’ DiAngelo wrote that the question to ask is not ‘if I am racist,’ but ‘how I have been shaped by the forces of racism.’ In this review, one key question is how all agencies have been shaped by the forces of racism.

6.1.6 In thinking through the specific areas of enquiry, we need to do the hard work of integrating race in our looking back and looking forward. The intersectionality between race and other protected characteristics of the person must also be acknowledged.

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[14] https://www.england.nhs.uk/blog/making-mental-health-care-fairer-for-all/

[15] DiAngelo, R, International Journal of Critical Pedagogy, Vol 3(3)(2011) pp 54-70 https://libjournal.uncg.edu/ijcp/article/viewFile/249/116

6.2 The care provided by all agencies and professionals in line with expected standards within primary legislation, statutory guidance, and codes of practice.

6.2.1 Wider wellbeing outcomes as outlined in the Care Act 2014 were not adequately captured in Joshua's care planning paperwork of mental health.

6.2.2 SLaM representatives acknowledged in their learning conversation that Joshua's care plan was 'not personalised' and indicated a medicalised approach. The LCFT shared, however, that the team 'had detailed knowledge and understanding of his needs, wishes, preferences and desires,' but these were not fully reflected in their records.

6.2.3 Since people with mental health conditions are more likely to experience poor mental wellbeing, wellbeing promotion is an important intervention to promote recovery from mental health conditions. For example, psychosocial interventions, social skills training, physical activity promotion, supported employment and skills-based training, supported housing, positive psychology interventions, and mindfulness.[16]

6.2.4 The LCFT agrees that the psychosocial interventions that were available to Joshua, including physical activity promotion and supported housing, were limited.

6.2.5 Joshua's mental capacity for specific decisions relating to his medication was unclear. The GP had a letter from the mental health team in May 2017 that he had capacity to make decisions about his medication. A later letter of 16/11/2017 stated 'lack of capacity to give consent about treatment decisions'. The GP said capacity can fluctuate and change according to a person's illness.

6.2.6 SLaM appeared to use the term 'insight' loosely in relation to his understanding and acceptance of his diagnosis. They reported that there was reason to doubt Joshua's capacity regarding his decision to want to remain on two anti–psychotic medications (Olanzapine and Clozapine) against medical advice.

6.2.7 A mental capacity assessment completed by his consultant on 26/04/2016 concluded that he lacked capacity to make the decision about being on both medications. He was unable to understand and use the relevant information. It was noted that he was 'thought' to have capacity to consent to this when he was under his previous care team. 'He is on this combination at his request as there is not thought to be a medical need for it.' It was further noted that 'there is an increased risk of side effects and medical complications associated with being on more than one anti-psychotic medication at one time.'

6.2.8 A further mental capacity assessment completed by the same consultant on 17/10/2017 concluded that he lacked capacity to understand, retain and use the relevant information and to communicate his decision. Despite being offered information and advice, Joshua maintained 'a number of false and irrational/delusional beliefs about his medication.' It was noted that his mother's understanding about his medication was limited and impacted by his beliefs. Joshua

[16] https://www.gov.uk/government/consultations/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence/mental-health-and-wellbeing-plan-discussion-paper - next-steps-and-implementation

had been on two anti-psychotic medications for several years. A Second Opinion Appointed Doctor (SOAD) referral was made.

6.2.9 In contrast, the Recovery Star[17] which the supported living provider completed with Joshua on 24/10/2017 and on 25/01/2018 stated that Joshua 'has a very good insight into his illness', continuing to say, 'he remains compliant with his treatment plan, and he engages well with his care team'. Perhaps Joshua's compliance was taken to imply his consent and understanding of his condition and treatment.

6.2.10 The IMR provided by the supported living provider stated that up until 07/03/2018, 'there were no issues identified around mental capacity as Joshua was maintaining compliance with his medication and engaging with the Lewisham Forensic Mental Health Team'. Joshua's compliance was clearly equated with having mental capacity for relevant decisions.

6.2.11 When the provider notified the mental health team on 07/03/2018 that Joshua missed his medication, and on 08/03/2018 that they had concerns about his presentation (unusual speech), it is not known whether mental capacity was considered.

6.2.12 Joshua's mental capacity for the decision relating to his use of cannabis was also unclear. It is questionable how much support he was given in decision making if he was deemed to have capacity, or how much he could weigh or use the relevant information including the increased risks to his mental health.

6.2.13 The IMR provided by the GP practice stated there was no record of a mental capacity assessment; 'Joshua's capacity was assumed.'

6.2.14 The IMR provided by SLaM stated, 'there is no indication that Joshua's cannabis use was addressed with him during the period under review, therefore the assumption is that Joshua was making unwise decisions in respect of this.'

6.2.15 Whilst the starting point must be the presumption of capacity, it was shared at the learning workshop that professionals lack the time for professional curiosity and perhaps also for mental capacity assessments.

6.2.16 Principle 3 of the Mental Capacity Act (MCA 2005) is often misunderstood as the 'right' of capacitated individuals to make unwise decisions. This can preclude exploration of the rationale and context for decision making, as it appears to be the case in this review.

6.2.17 Questions were asked at the learning workshop as to whether Joshua was using cannabis as a kind of self-medication for pain or as part of a social circle. These were not explored with him.

6.2.18 It remained that the cumulating risks to Joshua's mental health from his continuing use of cannabis were not addressed. SLaM representatives shared that the lack of

[17] https://mentalhealthpartnerships.com/resource/recovery-star/

quality engagement with Joshua, partly because it was difficult to engage with him, may have resulted in professionals 'under-estimating' his level of 'unwellness.'

6.2.19 The LCFT shared there was no evidence that mental health medication together with cannabis use should have increased Joshua's risk of psychosis. However, it is understood that cannabis use contributes to psychosis in those who are vulnerable.

6.2.20 The risk assessment completed on 17/10/2017 at the time of his CPA review provided a short list of incidents dating back to January 2013, under the section 'history of related risk events'. There was one combined question of 'current or historical risk of violence and aggression,' to which the response was 'yes.' Further comments referred to only two 'current' risk factors – (1) diagnosis of psychopathy – paranoid schizophrenia; and (2) alcohol/substance misuse – continues to use cannabis. All other risk factors were 'historical.'

6.2.21 The actions listed on the risk assessment form were (1) to monitor Joshua's compliance; (2) if he becomes non-compliant, to book to see RC as soon as possible with a view to seek compliance; (3) if continued non-compliance, CTO recall process to begin. Clearly, the third action was no longer relevant when his CTO came to an end on 04/03/2018, but his risk assessment was not reviewed and revised at that time.

6.2.22 This risk assessment was not dynamic as there was an absence of person-centred support or therapeutic interventions. The short list of actions indicated following the standard process without any considerations of a risk management plan specific to the person and circumstances of Joshua and his family. Joshua, his mother, and the supported living provider staff did not appear to have contributed to the assessment.

6.2.23 The recovery plan of SLaM, also dated 17/10/2017, did not provide a full picture of Joshua for the reviewer. This document started with the section 'summary of need' – 'try to ensure this assessment is holistic taking into consideration the client's aspirations and strengths consulting the client on their own definition of their needs.' The contents of the plan were focused on clinical observations and tasks – mood, medication, GP contact, activities of daily living, self-care, and budgeting. There was limited information on Joshua's aspirations and strengths in this document.

6.2.24 The IMR completed by SLaM acknowledged that the active recovery and support plan had not been updated since it was first drafted in March 2015.

6.2.25 Professor Frank Keating shared in our reflection meeting that it is easier for practitioners to work to a standard 'professional script,' than to work with the person's script. Professionals fail to make connections and build relationships with people they work with, resulting in a process of 'invisibilising' the 'other.'

6.2.26 Joshua may have benefitted from more personal quality engagement with mental health professionals. The LCFT acknowledged that 'there were barriers to communication with Joshua at times, not least the impact of his illness on his ability to fully trust people.'

6.2.27 It is of note that the supported living provider's risk assessment dated 23/10/2017 appeared to portray a different picture of Joshua from the Recovery Star completed by the same key worker on 24/10/2017. Whilst the key worker was largely in

agreement with Joshua's positive self-score in the second document, the risk assessment put the risk level of dangerous behaviour as medium and risk level of self-neglect and abuse also as medium. Even though it is accepted that historical background information was useful in reviewing risks, the risk assessments did not appear to provide a holistic picture of Joshua.

6.2.28 Joshua's substance misuse was identified as a risk trigger and it was stated on this risk assessment that Joshua often became confused, forgetful, anxious, and agitated when unwell. He was described as 'currently stable' but 'his mood appears to oscillate quite often.' Again, the risk management plan only detailed procedures in an event of relapse, including a request for an urgent psychiatric assessment, call for police intervention and notification to his care team.

6.2.29 The supported living provider's risk assessment of 24/01/2018 was identical to the assessment of 23/10/2017. The Recovery Star document for the two time periods also appeared to be identical.

6.2.30 The supported living provider's IMR identified the good working relationship and information sharing between the service and the mental health team. However, it appears to the reviewer that the rules of communication were governed by the crisis plan which detailed procedures to be followed in case of relapse. The LCFT is of the view that there were opportunities for informal discussions about day-to-day care and support as the psychiatric reviews took place at the accommodation.

6.2.31 When partners were asked to reflect on why difficult questions about Joshua's views were not asked, the responses included 'lack of time,' 'fear' of asking the question and 'fear' of knowing the answer, and 'someone else's responsibility.' Partners acknowledged the common barriers to professional curiosity including disguised compliance, normalisation, and professional deference. They also admitted that they continue to find these conversations challenging, especially when there are additional considerations relating to race and culture.

6.3 Quality assurance mechanisms in place for monitoring the care and/or support being provided in relation to the welfare of Joshua.

6.3.1 In reviewing what agencies had in place for appropriate responses to a 'deterioration, change in circumstances, increased risk or other concerns' relating to Joshua, the reviewer was 'surprised' by his rapid and unexpected decline within a matter of days in March 2018, from a situation when he was observed to be stable, mentally quite well and getting on with life. When I met with the service manager of the supported living project who knew Joshua throughout the time he was residing there, she described her feelings of 'shock.' The GP also said she could not understand what could have caused his death.

6.3.2 The LCFT highlighted that Joshua 'had a pattern of abrupt relapse of his mental disorder on previous occasions and the rapid relapse was not unusual. What appears to be in question was the management of the 'crisis' when it happened, despite the known history of previous relapses.

6.3.3 The term 'mental health crisis' appears, in this case, to have provided an automatic, quick leap of agency responses from stability to crisis.

6.3.4 The Discussion Paper on Mental Health and Wellbeing Plan provides a definition for a mental health crisis. It refers to someone experiencing extreme distress. This may lead to self-harm or suicidal ideation. Someone may experience a crisis for a range of reasons, such as a big life change, or because an existing mental health condition is getting worse. All crises will be different in their cause, presentation, and progression.[18]

6.3.5 The monitoring arrangements for Joshua's care and support appears to be based on a largely medicalised and crisis management approach. It fails to explore real options of earlier intervention before a crisis stage is reached.

6.3.6 The SLaM IMR author highlighted the need for an 'anticipatory management approach' detailing multi-agency responsibilities, considering the history of previous rapid decline in Joshua's mental health. The LCFT responded to say they are experienced in 'more nuanced' ways of providing care and support, but these were not well enough documented and not successful in Joshua's case because of how unwell he was.

6.3.7 'The support that someone needs won't always be 'clinical', and it's important that we do not over-medicalise people's experience of distress. The 'right' support will depend on someone's individual needs, how those needs affect them, the severity of their symptoms, their individual strengths, and their wider circumstances. Sometimes the most appropriate intervention will include providing support and information to important people in a person's life.'[19]

6.3.8 SLaM representatives shared at our 'learning conversation' that adopting a psycho-social model could have been more helpful alongside the medicalised approach of Joshua's crisis plan including risk assessments. Despite the known fact of the close relationship Joshua had with his mother, there was no joined up approach in working with her in situations of increased risk and deterioration.

6.3.9 The LCFT acknowledged there was not enough psycho-social thinking in Joshua's crisis plans. Although his mother was very involved in his life and attended his CPAs, she was not fully involved by the team in the development of his care and crisis plans.

6.3.10 There was a lack of the voice of Joshua and the voice of his mother in his 'crisis plan.' The IMR by SLaM acknowledged there was little documented evidence that Joshua was involved in the decisions about his care.

6.3.11 It is of note that there was some confusion with the up-to-date contact number of Joshua's mother when the supported living provider and the police attempted to contact her. It is questioned whether a more robust, planned approach to managing and monitoring Joshua's mental health and wider wellbeing, could have included an appropriate role of his mother. Perhaps a first line of call to her before Joshua's

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[18] https://www.gov.uk/government/consultations/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence/mental-health-and-wellbeing-plan-discussion-paper - next-steps-and-implementation

[19] https://www.gov.uk/government/consultations/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence/mental-health-and-wellbeing-plan-discussion-paper - chapter-3-how-can-we-all-intervene-earlier-when-people-need-support-with-their-mental-health

mental health 'crisis' escalated, could have facilitated a timelier update to her and an agreed plan including her support (e.g., telephone call or visit to Joshua).

6.3.12 The provider was clear about the different steps they should take in linking up with mental health services when Joshua became unwell. However, a more joined up way of working between mental health and the supported living provider would have promoted a more robust, planned approach to managing and monitoring Joshua's mental health and wider wellbeing. Care staff at the project were involved in the day-to-day care and support of Joshua and therefore able to identify and share concerns about changes in his moods and behaviours at an earlier stage before the crisis point. His care plan should have included real options of earlier intervention, including the important role of his mother as well as key care staff.

6.3.13 A care and support plan which was focused on interventions when Joshua became severely unwell or had reached crisis point, was not adequate, considering his history of a long-standing mental health condition. A person-led and person-centred care plan should have included support to Joshua at the earliest possible stage, when observations were picked up that he was struggling with his mental health, to promote least restrictive options and to minimise taking over his choice and control at the point of crisis. This should be a coordinated plan between Joshua, his mother (and any other appropriate family members), the supported living provider, his GP and mental health services.

6.3.14 The Serious Incident report completed by SLaM found that there were infrequent reviews of key care plan documentation by the mental health team that might have supported Joshua's recovery and relapse prevention. There was no indication the plans that were in place had been shared with the supported living provider team. There is no evidence that support, and recovery crisis and contingency plans were reviewed routinely at CPA reviews or shared with the team providing daily support to Joshua. Given previous experiences of Joshua's rapid relapses, including five admissions under S136 by the police, his history of significant risk of harm to others when his mental health deteriorated due to non-concordance with prescribed medication and/or illicit substance misuse, the review of his care plan including risk management should have been kept under regular, close monitoring.

6.3.15 Whilst this significant gap appears to have been mitigated to an extent by the strong working relationship between the mental health team and the provider, in reality it meant that the provider was left without a clear framework in the event of a crisis.

6.3.16 There was inadequate information in the risk assessment and crisis plan about the involvement of the police in Joshua's previous admissions. It did not cover details about the reluctance of the police to use S136 authority in June 2017 and the fact that Joshua identified police involvement as a potential trigger for violent behaviour.

6.3.17 The SLaM IMR highlighted the police's reluctance of using S136 in the case of Joshua and the 'need for greater police liaison' moving forward. At the time of Joshua's final admission under the MHA in June 2017, the police were not willing to use S136 when they arrived because Joshua presented as relatively calm during the initial period, they were speaking with him. They would only use S136 after witnessing themselves that Joshua was being aggressive.

6.3.18 It was known that Joshua was ‘acutely antagonistic’ towards police when they were involved in the past. During an in-patient admission in 2003, Joshua had to be restrained by 8 police officers and disarmed by the Police Territorial Support Group.

6.3.19 In the absence of these important relevant details, the crisis plan (last reviewed in September 2016) documented that calling the police should be considered if Joshua’s mental state deteriorated.

6.3.20 The rationale for involvement of the police in an emergency context was the history of challenging situations and the known history of Joshua’s rapid relapse, considering the reality of the potential delay of days to coordinate a MHA assessment. LCFT shared that Joshua’s rapid mental state deterioration did not allow time for coordinating a MHA assessment as he would quickly present a risk to himself and to others.

6.3.21 The LCFT is of the view that by the time Joshua became acutely unwell with a florid psychosis, he was in need of urgent clinical treatment.

6.3.22 The IMR of SLaM acknowledged that the risk management did not include consultation with Joshua and his mother. It was likely that Joshua and his mother could have different views about the involvement of police. There was no discussion with the police about the crisis plan that centred on their emergency response. No consultation or agreement was sought about other helpful actions in a crisis.

6.3.23 The SI Investigation report concluded that the care in Joshua’s case did not meet the standards set out in local or Trust policy relating to updating care plans and ensuring appropriate risk management and crisis plans were in place.

6.3.24 The Coronial Inquest jury concluded on ‘a serious failure in the quality of care.’ ‘Decisions taken to manage relapses were not appropriate to Mr C’s needs. Opportunities for earlier, less restrictive interventions were therefore missed which could have avoided Mr C’s physical exertion and exhaustion.’

6.4 Management of the Community Treatment Order (Section 17A MHA 1983)

6.4.1 The rates of Community Treatment Orders have continued to rise among Black people, rising to over 11 times the rate for white patients.[20]

6.4.2 Joshua’s CTO started on 05/09/2017 until 04/03/2018.

6.4.3 The documented rationale for Joshua’s CTO was that ‘it is necessary for his health and safety and the protection of others.’ It was noted that when he relapsed, he became disorientated and confused, and had assaulted a police officer and mental health staff and had been threatening other patients. These align with the legal criteria for detention under the MHA.

6.4.4 At the point of consideration of discharging Joshua from his CTO, discussion was undertaken within the Community Forensic Team.

[20] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2020-21-annual-figures

6.4.5 The supported living provider was consulted on his mental state and adherence to medication. On the basis of their response, the decision was made not to renew the CTO. His mother, who was Nearest Relative and had a close relationship with him, was not consulted about this specific decision. Joshua's mother's view that she did not like him being on a CTO was known, but it would have been good practice to consult with her on this.

6.4.6 The clinical rationale for the decision of not renewing the CTO on 19/02/2018 appears to align with Joshua's and his mother's previously expressed wishes, and therefore a potential positive effect on their relationship and engagement with the services. It was reported that Joshua was dissatisfied with the potential limitations on his freedom that the CTO represented.

6.4.7 The CTO came to an end on 04/03/2018. It would have been best practice to discharge the CTO at the point the decision was made in February, following discussion with Joshua and consultation with his mother. An alternative care plan should have been devised but this was missing.

6.4.8 The IMR of SLaM identified the end of the CTO on 04/03/2018 as a missed opportunity to complete a review of risk assessments and crisis planning.

6.5 Quality and appropriateness of nursing and clinical care delivered.

6.5.1 The Discussion Paper 'Mental Health and Wellbeing Plan (updated 26/09/2022) starts with a statement from the Lived Experience Advisory Network at NHS England and Improvement. 'For many people, medication will be an important tool to manage mental health conditions. But it is only one component of care. We need a broader range of tools. And crucially we need more immediate access to those tools to help keep us well and support us to recover when we are struggling.'[21]

6.5.2 'We also need to empower and enable clinicians to work with us to understand our needs as a whole person before agreeing a course of action to keep us well. We need choice and to practise shared decision-making.'[22]

6.5.3 The approach in Joshua's case was predominated by the focus on his medication. His care plan illustrated a clear separation between the management of his mental health and his physical health. This was confirmed in conversations with the GP practice as well as with the supported living provider.

6.5.4 The GP's chronology stated that their role was in monitoring Joshua's physical health whilst his mental health remained under the responsibility of the mental health team. The communication between the provider and the mental health team was similarly functional. A more holistic approach would have been beneficial.

[21] https://www.gov.uk/government/consultations/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence/mental-health-and-wellbeing-plan-discussion-paper - statement-from-the-lived-experience-advisory-network-at-nhs-england-and-improvement

[22] https://www.gov.uk/government/consultations/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence/mental-health-and-wellbeing-plan-discussion-paper - statement-from-the-lived-experience-advisory-network-at-nhs-england-and-improvement

6.5.5 The GP explains that a patient with complex mental health needs is cared for by a specialist team, and the GP manages the physical health which is often poor in patients with a mental health diagnosis. GPs try to be holistic despite their limited time and resources.

6.5.6 The IMR completed by SLaM acknowledged that there was no community physical health care plan, although there was evidence of liaison with the GP.

6.5.7 Joshua's Recovery Star review with the supported living provider noted that there had been an improvement in managing his mental health to a full self-score of 10, but a decline in his physical health to 5. He continued to express concern about his back and wrist pain.

6.5.8 'There are not enough joined-up approaches across physical and mental health care.'[23]

6.5.9 The IMRs completed by SLaM and by the supported living provider agreed on the positive aspects of joint working, information sharing and frequent communication. The supported living staff supported Joshua at monthly clinics with the consultant and provided updates to the mental health team.

6.5.10 Professionals appeared not to be able to challenge Joshua's ongoing use of cannabis; yet he was believed to lack 'insight' into his mental health condition.

6.5.11 The IMR of SLaM acknowledged that Joshua's 'mental health problems were also affected by his habitual cannabis use.' It was noted that Joshua used cannabis from a young age and confirmed he used it on a daily basis but was vague when he was questioned about the quantity he used.

6.5.12 The LCFT pointed out that 'it was common for Joshua to resist quantifying his cannabis use because he saw this as a private issue' and did not want interference by the team. Joshua was aware that the team thought it was bad for his mental health, but he disagreed with this view.

6.5.13 Research has found a link between cannabis and developing psychosis or schizophrenia. Regular cannabis use is linked to an increased risk of anxiety and depression. Long term use can have a small but permanent effect on how well you think and concentrate. Smoking cannabis can cause a serious relapse if you have a psychotic illness.[24]

6.5.14 It is unclear how much and in what way Joshua was supported in his decision making.

[23] https://www.gov.uk/government/consultations/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence/mental-health-and-wellbeing-plan-discussion-paper - chapter-3-how-can-we-all-intervene-earlier-when-people-need-support-with-their-mental-health

[24] https://www.rethink.org/advice-and-information/about-mental-illness/learn-more-about-conditions/cannabis-and-mental-health/

6.5.15 The LCFT reported that Joshua's cannabis use was an issue which ran throughout the time of his contact with mental health services but acknowledged that documentation on this could have been better.

6.6 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 the mental health provider and other relevant services in the Borough.

6.6.1 Wider issues of disproportionality and racial disparity are evident from reported data and research. Amongst the five broad ethnic groups, known rates of detention for the 'Black or Black British' group (343.5 detentions per 100,000 population) were over four times those of the White group (74.7 per 100,000 population). Amongst broad ethnic groups, known rates of CTO use for the 'Black or Black British' group (78.9 uses per 100,000 population) were over ten times the rate for the White group (7.8 uses per 100,000 population).[25]

6.6.2 There is an established link between ethnic minority backgrounds and diagnosis of psychoses such as schizophrenia and major depression. There is strong evidence that severe mental health conditions are particularly elevated for people from black ethnic backgrounds and that people from South Asian, white other and mixed ethnicity groups are also at increased risk.[26]

6.6.3 The Five Year Forward View for Mental Health, a report from the independent Mental Health Taskforce to NHS England, was published in February 2016. The Taskforce made a series of recommendations for improving outcomes in mental health by 2020/21, on tackling inequalities, including the higher incidence of mental health problems among people who already face discrimination. It also addresses inequalities in access to services among certain Black and minority ethnic groups, whose first experience of mental health care often comes when they are detained under the Mental Health Act, often with police involvement. These were again repeated in the Mental Health Policy research briefing earlier this year.[27]

6.6.4 The recent rapid review of the evidence on Ethnic Inequalities in Healthcare undertaken for the NHS Race and Health Observatory identified barriers to help seeking by ethnic minorities, through mainly qualitative studies. These were rooted in a distrust of both primary care and mental health care providers, as well as a fear of being discriminated against in healthcare.[28]

6.6.5 The review also found a number of cross-sectional studies showing that ethnic minority groups face greater barriers in accessing Improving Access to Psychological Therapies (IAPT) compared to the White British group and are less likely to self-refer, be referred by a GP, be assessed or receive treatment. Ethnic

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[25] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2020-21-annual-figures

[26] https://research.manchester.ac.uk/en/publications/ethnic-inequalities-in-the-incidence-of-diagnosis-of-severe-menta, Halvorsrud, K, Nazroo, J, Otis, M, Brown Hajdukova, E & Bhui, K, 2019, Social psychiatry and psychiatric epidemiology, vol. 54, no. 11, pp. 1311-1323.

[27] https://researchbriefings.files.parliament.uk/documents/CBP-7547/CBP-7547.pdf

[28] https://www.nhsrho.org/wp-content/uploads/2022/02/RHO-Rapid-Review-Final-Report_v.7.pdf, Kapadia D, and others, NHS Race and Health Observatory (2022)

minority people with psychosis are less likely to be referred for Cognitive Behavioural Therapy (CBT).[29]

6.6.6 The review also confirmed very large and persisting disparities in that people from Black Caribbean, Black African and Black British backgrounds with severe mental illness experience higher rates of contact with the police and criminal justice system (both as victims and as offenders), more admission to psychiatric hospitals, more compulsory inpatient care, and fewer primary care interventions.[30]

6.6.7 There is also evidence of harsher treatment with more frequent use of restraint of people from mixed ethnicity backgrounds and black backgrounds in mental health inpatient units, compared to people from white backgrounds[31], and greater use of the prone position and seclusion[32].

6.6.8 Research also demonstrates the intersectionality between racial disparity in mental health with other known areas of inequality and discrimination. 'Many communities in London are at disproportionate risk of poor mental health and wellbeing, with shared experiences of discrimination, inequality and inequity which often intersect with other parts of their social identity.'[33]

6.6.9 The Lammy Review proposes a new rule, 'explain or reform,' where the expectation should be placed on institutions to either provide answers which explain disparities or take action to eradicate them. The core principles of delivering fairness, building trust, and sharing responsibility, underpin the recommendations of this review.[34]

6.6.10 The lack of trust of the community in policing extends to the justice system as a whole, resulting in a culture of 'them' and 'us'.

6.6.11 In his speech to the Criminal Justice Alliance, Lord Neuberger said, 'what we mean when we say that justice must not only be done, but it must also be seen to be done.'[35]

6.6.12 The IMR report of SLaM identified a couple of occasions when Joshua made comments about being black, in the context of being detained under psychiatric intensive care. He made reference to people being scared of him due to his colour and size, but there was no evidence that practitioners explored this further and supported him with this.

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[29] https://www.nhsrho.org/wp-content/uploads/2022/02/RHO-Rapid-Review-Final-Report_v.7.pdf, Kapadia D, and others, NHS Race and Health Observatory (2022)

[30] https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/making-a-difference-ethnic-inequality-and-severe-mental-illness/03FFD6DA621D528D5741897CD0D977AA, Kamaldeep Bhui, Kristoffer Halvorsrud, James Nazroo, BJ Psychiatry 2018 Oct 2013 (4) 574-578

[31] https://raceequalityfoundation.org.uk/wp-content/uploads/2022/10/mental-health-report-v5-2.pdf, Bignall and others, 2019, Race Equality Foundation

[32] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2020-21-annual-figures, NHS Digital

[33] https://thriveldn.co.uk/resources/londoners-mental-health-and-wellbeing/

[34] https://www.gov.uk/government/publications/lammy-review-final-report

[35] https://www.supremecourt.uk/docs/speech-150410.pdf

6.6.13 It appears that the impact of disproportionality and racial disparity was also experienced by the supported living provider. The service manager shared at our learning conversation that there was a stigma attached to their service as a whole, in that forensic patients were stereotyped.

6.6.14 The LCFT staff have found that their patients are more marginalised because of the intersection between their severe mental health problems, their risk of violence and, if from a minoritised ethnic group, their racial background.

6.7 Resourcing of local mental health facilities to accommodate and respond to people with acute mental health needs.

6.7.1 It was acknowledged by all partners at the learning workshop of 10/01/2023 that there was a lack of resourcing for local partnership responses for people with acute mental health needs at the time of the review period.

6.7.2 Despite the known history of potential rapid decline of Joshua's mental health, the formulation of his crisis plan did not include pre-crisis liaison with the police and the LAS about their key role in providing an emergency response.

6.7.3 At the time of the incident, Joshua had relapsed acutely and was out on the street and in urgent need of care. This was the case for the use of S136 as a last resort.

6.7.4 The focus became one of speed over safety. In the absence of a pro-active and planned approach to managing crises for people with acute mental health needs, the statutory principle of promoting the least restrictive options could not be applied.

6.7.5 All partners at the learning workshop shared the same concern that there is now more pressure on resourcing in health and social care, as well as for the police, LAS, and provider services. Whilst learning has been progressed since the death of Joshua, partners are not confident that the resourcing gap has been adequately improved.

6.8 The way organisations worked together in this case

6.8.1 The supported living provider service had a good working relationship with the LCFT. However, recording appears to be largely limited to procedural functions of Joshua's review meetings, notification of alerts and following the crisis plan in case of relapse.

6.8.2 The reviewer challenged partners at the learning workshop to think about when and how they 'talked to each other.' The 'rules of communication' were heavily governed by the crisis plan, i.e., they talked to each other when things went wrong. It was recognised that meaningful communication needs to be extended to the care and support of the person and the involvement of their family.

6.8.3 It was shared at learning conversations and at the learning workshop, that the supported living provider service was expected by partners to be the first to observe and pick up changes in Joshua's behaviours as they were involved in the day-to-day management of his care and support. This forms part of the commissioned contractual agreement.

6.8.4 Partners agreed there should be one collaborative care and support plan, and one risk management plan, between the provider and mental health. In this case,

however, these essential documents had not been reviewed and updated for some time. There was an absence of clear leadership and ownership of care and support planning for Joshua.

6.8.5 A more holistic approach would be based on a model that includes options of person-centred support and review, individual strengths and wider circumstances of the person, and regular communication between all relevant agencies. Working together in this case should also have included Joshua himself and his mother. Whilst it was reported that this was done at CPA meetings with both Joshua and his mother present, this was not well documented on his care and crisis plans.

6.8.6 The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in mental health crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

6.8.7 'We commit to work together to improve the system of care and support so people in crisis because of a mental health condition are kept safe and helped to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first. We will work together, and with local organisations, to prevent crises happening whenever possible through prevention and early intervention. We will make sure we meet the needs of vulnerable people in urgent situations. We will strive to make sure that all relevant public services support someone who appears to have a mental health problem to move towards Recovery. Jointly, we hold ourselves accountable for enabling this commitment to be delivered across England.'[36]

6.8.8 What happened in the case of Joshua did not support the vision and aspirations of the Concordat statement.

6.9 Model of restraint.

6.9.1 Nearly ten years ago, the findings of the Independent Commission on Mental Health and Policing (May 2013) highlighted the disproportionate use of force and restraint, discriminatory attitudes, and failures.[37]

6.9.2 The Coronial Inquest jury recorded the medical cause of death as Acute Behavioural Disturbance (ABD) (in a relapse of schizophrenia) leading to exhaustion and cardiac arrest, contributed by restraint struggle, and being walked.

6.9.3 Statistics clearly show that Black people are disproportionately assessed as having ABD and are more likely to be subjected to coercive practices such as restraint.

6.9.4 Black Thrive #NoPlace4ABD maintains that 'the label ABD is costing Black people their lives'. ABD is not a formal psychiatric diagnosis but has been used to justify the use of excessive physical force, causing significant health risks including restricting a

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[36] https://www.crisiscareconcordat.org.uk/about/

[37] https://amhp.org.uk/app/uploads/2017/08/independent_commission_on_mental_health_and_policing_main_report.pdf

person's ability to breathe. 'A person's natural response to stress is pathologised.' Black Thrive believes that the label ABD explains 'why Black people will continue to be harmed by the criminal justice and healthcare system.'[38]

6.9.5 In their IMR, LAS stated that 'ABD is a high-risk clinical condition with an associated mortality risk.'

6.9.6 Inquest shares concerns that ABD is often framed as a diagnosis to explain away the role of restraint and deny the responsibility of those involved. 'There is a longstanding pattern of dangerous and disproportionate use of fatal restraint and neglect against people from racialised groups, particularly Black men and those in mental health crisis.'[39]

6.9.7 The LAS IMR noted on review that a potential opportunity was missed for the ambulance clinicians to undertake a more in-depth clinical assessment of Joshua when they arrived. Another potential opportunity was missed to consider an alternative method to the police walking Joshua from the field and for the ambulance clinicians to advocate for him on this matter.

6.9.8 The LAS made the decision not to progress with a Serious Incident (SI) as it was agreed that ambulance staff did not impact on Joshua's outcome and reference was drawn between ABD and his cardiac arrest.

6.9.9 The position statement (September 2022) of the Royal College of Psychiatrists (RCP)[40] highlighted the significant variation in how ABD is defined and understood across professions. This causes unhelpful confusion for frontline staff, those delivering training and those working in the coronial system. A consensus is urgently needed across stakeholders.

6.9.10 The publication of this statement, following extensive consultation and research, emphasised that ABD is not a diagnosis or cause of death. Discussion at the learning workshop appears to indicate that training continues to reinforce this misunderstanding.

6.9.11 LAS confirmed at the learning workshop that ABD is now treated as the highest prioritisation category on request from the police. Advanced practitioners are involved to give more appropriate treatment.

6.9.12 While a shorthand such as 'ABD' can facilitate effective triaging and rapid health-based responses, alternative terminology which does not infer a diagnostic category, and which is more humanising, should be sought.

6.9.13 The reviewer has been assured that mental health services do not use this term, despite continuing use by the police and the LAS.

6.9.14 Specialist mental health input should be sought and made available at the earliest opportunity when responding to extremely agitated and distressed patients, to

[38] https://blackthrive.org/no-place-for-abd/
[39] https://www.inquest.org.uk/news-bbc-panorama-2021
[40] https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps02_22.pdf

support effective de-escalation, reduce unnecessary restrictive interventions and support safe restraint and appropriate follow-up. Verbal and environmental de-escalation, with a trauma-informed approach, should be applied.

6.9.15 A patient's ethnic background can have an enormous impact on their experience of interacting with emergency services. Previous negative experiences with police and health services will shape a patient's behaviour, while ingrained racial biases can affect the behaviour of staff. This was the case in this review.

6.9.16 This statement of the RCP ends with the conclusion that 'people working across police services, ambulance services, in emergency departments, acute hospitals and mental health services must work together to ensure the safety and wellbeing of people who become severely agitated and distressed.'

6.9.17 People who experience these episodes of severe agitation are often very distressed and frightened. When services are supported in recognising and responding to their needs appropriately, many can recover without the need for physical or chemical intervention. Where physical or chemical restraint must be used to keep them safe, doing this in an evidence-based, compassionate, and controlled manner is critical to improving patient outcomes.

6.10 A whole-person and whole-system approach.

6.10.1 The Discussion Paper 'Mental Health and Wellbeing Plan (updated 26/09/2022) starts with a statement from the Lived Experience Advisory Network at NHS England and Improvement. 'A new mental health plan needs to shift how we approach the subject of "mental health"… if we are going to truly change things for the better, we need to think about people as a whole – what makes up their lives, and their needs, wants and ambitions.'[41]

6.10.2 It is important to acknowledge that 'race' was a core part of Joshua's identity and is a key element of this review. The SLaM records noted Joshua's own comments about being black, that people were 'scared' of him because of his 'colour and size,' but there was no evidence this was explored or followed up by his care team with him. It is important to look behind the 'big, Black man' to find and work with the whole person.

6.10.3 Professor Leslie Thomas QC referred to 'that age-old trope against Black men.' Joshua was a victim of the 'big, strong Black man trope.' 'That he was some big, Black, superhuman powerful man.'[42]

6.10.4 A SAR is not about apportioning blame on individuals who were involved with the person who suffered abuse or harm. It is important to look beyond specific responses of organisations to explore racialised perceptions in the wider systems.

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[41] https://www.gov.uk/government/consultations/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence/mental-health-and-wellbeing-plan-discussion-paper - statement-from-the-lived-experience-advisory-network-at-nhs-england-and-improvement

[42] https://www.huffingtonpost.co.uk/entry/kevin-clarke-leslie-thomas-charges_uk_5f8478e4c5b6e6d033a5e54e

6.10.5 That 'trope' plays into 'white fear, which Inquest believes explained the responses of the police and the ambulance service.

6.10.6 The LCFT highlighted that this was in contrast to the way that mental health services and the provider, who knew and worked with Joshua for many years, understood him as a whole person and worked to support him because of his severe mental illness.

6.10.7 'We are all simultaneously positioned within multiple social identities including gender, social class, (dis)ability and racialisation, among others. These categories, forming qualitatively different meanings and experiences that are situated in different contexts, times, and power relations.'[43]

6.10.8 Changes in training or education could appear to be focused on individual wrongdoing rather than broader structural issues. Macpherson's understanding of institutional racism as a more pervasive issue, a product of how that institution 'normally' functions, supports his argument that racism cannot be addressed with responses targeted at extracting or educating individuals.[44]

6.10.9 'You can't train away bias.' Two common features of diversity training, mandatory participation, and legal curriculum, tend to make participants feel that an external power is trying to control their behaviour. Some have argued that anti-bias training activates stereotypes. The key to improving the effects of training is to make it part of a wider programme of change, developing multipronged diversity initiatives that tackle structural discrimination.[45]

6.10.10 Macpherson's definition highlights that the operation of an organisation systematically disadvantages certain groups of people. Organisational discrimination is borne from 'unwitting prejudice, ignorance, thoughtlessness and racist stereotyping.'[46] Harm is done regardless of intent. An institution is racist when it does not proactively ensure that its agents do not cause harm (wittingly or not) by discriminating against certain people based on their colour, culture, or ethnic origin.

7. Learning and Improvement

7.1 Partnership working.

7.1.1 There has been improvement in information sharing, liaison and joint working between mental health services and the police since 2018. SLaM now has a joint crisis team which works closely with the police as part of their street triage team.

7.1.2 Following the outcome of the Inquest, the supported living provider has worked collaboratively with the LCFT to enhance partnership working. They have introduced a Mental Health Crisis Management Policy and Relapse Prevention Policy across the organisation, including input from the Mental Health Team, on how to prevent and effectively manage crisis situations. The crisis management process includes the involvement of family members and provides guidance to staff where the police

[43] https://www.thebritishacademy.ac.uk/blog/what-is-intersectionality/
[44] https://www.gov.uk/government/publications/the-stephen-lawrence-inquiry
[45] https://scholar.harvard.edu/files/dobbin/files/an2018.pdf
[46] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277111/4262.pdf

decide not to exercise S136, and how to safely engage and proactively intervene with a service user in crisis. A flowchart is used to demonstrate their improved escalation process and related reporting mechanisms.

7.1.3 A joint crisis planning committee with the LCFT has been set up to agree joint working protocols and improve communication.

7.1.4 The provider has reached out to their local neighbourhood police team to foster collaborative working around monitoring of concerning activities and support in times of crisis. Meetings take place every month.

7.1.5 LAS confirmed that they can access a patient's National Care Record (NCR) on route if they have the relevant patient information (name and DOB and/or NHS number), which would give them access to patient demographics only. Once on scene, they would need to seek consent from the person to access the clinical information held with NCR. There is the option to override consent for those who lack capacity or under emergency circumstances.

7.1.6 Whilst the police hold information of vulnerable adults in the public protection field of their systems, there would have to be a rationale for holding specific information where the risk to the individual is clinical.

7.1.7 The police shared there is an understanding and acknowledgement that S136 is a power of last resort. Officers will only use it if they have to, but partners recognised the continuing lack of alternative options resourced by mental health.

7.1.8 The LCFT pointed out that, in the event of a crisis, there are limited options available to manage someone who has a history of violence that do not involve police support.

7.1.9 The LCFT team leader shared the change in practice, since the death of Joshua, that they made all attempts to be present when the police were called, to provide mediation and to promote a caring approach.

7.1.10 There is pilot work going on across the country on crisis assessment teams and mental health ambulances, as well as mental health staff accompanying police officers to S136 callouts to offer support if there is suspicion of a person in a public place with a mental health problem. These are experimental and currently not widely available.

7.1.11 General practice continues to aim for continuity of care which facilitates relationship building. The provider shared at the learning workshop about the potential benefits to residents of in-house physical health care support and advice, to promote trust and engagement. It is acknowledged that GPs are only able to do this for housebound people due to a general lack of resources, and it is not possible for some health checks to be undertaken at home.

7.1.12 The reviewer has been informed that the question about Lewisham's position statement in response to the Mental Health Crisis Care Concordat was raised from a previous SAR. SLaM confirmed that the Crisis Concordat work was superseded by the Trusts crisis response which includes the establishment of the acute referral centre, a single point of access for crisis and acute concerns/referrals. This includes 'one place' for police and all other agencies to make referrals.

7.2 Training and Learning.

7.2.1 Since July 2022, SLaM has developed an enhanced mandatory Promoting Safe and Therapeutic Services awareness training course, known as Seni Lewis Training. This is co-produced and delivered by people who have lived experience of psychiatric services and their family members. The training covers primary prevention techniques, de-escalation and person-centred responses to people using a trauma informed approach. It includes cultural diversity aspects of care, using the case study of Seni Lewis who died following restraint on a SLaM ward by the police. The course also emphasises Human Rights legislation and includes a learning log for staff to record how they implement the learning.

7.2.2 SLaM is currently working to develop training and a methodology to introduce Advance Choice Documents to all patients who have ever been detained under the MHA.

7.2.3 The supported living provider has appointed an Equality, Diversity, and Inclusion (EDI) Programme Manager and established 6 EDI Ambassadors who are on-hand to shape resident/staff workshops primarily around EDI matters.

7.2.4 The supported living provider also holds monthly local service review meetings with staff to discuss and reflect on learning from incidents.

7.2.5 LAS confirmed that there has been considerable learning since the death of Joshua, including training on ABD.

7.3 Co-production.

7.3.1 SLaM shared that there has been a greater focus within the Trust to engage with service users with lived experiences and involve them and their families. SLaM's Changing Lives strategy seeks to routinely involve service users and carers in all aspects of service design, improvement and governance, and all aspects of planning and delivery of individuals' care.

7.3.2 SLaM holds regular meetings of the Reducing Restrictive Practice forum. This is in recognition that physical restraint is unlikely to achieve positive outcomes. Service users and their carers/families and ward staff are involved, with the aim of promoting safe and therapeutic services.

7.3.3 SLaM is a national pilot site for PRCREF (Patient and Carer Race Equality Framework), bringing together local Black communities, Black service users and their carers with staff to work together in partnership, to look at how PCREF competencies are implemented within SLaM and develop local competencies as needed, with the aim of identifying priority actions that will help eliminate disparity in AEO (access, experience, outcomes). The competency framework is to be implemented and supported by an outcome's framework.

7.3.4 The supported living provider works with residents to develop their own crisis management plan. The format of support plans has been changed so they are now written from the first person's perspective.

7.3.5 The supported living provider has in place a single support plan and a clear protocol on family involvement in support or crisis. These are reviewed every six months during CPA by the multi-agency team.

7.3.6 The LCFT now makes sure that their documentation reflects the conversations and discussion they have with the person, their family and the relevant provider, and everyone has copies as appropriate.

7.3.7 The LCFT confirmed it is now planned in advance when and how people want their families involved should there be a crisis. Families are helped to understand the processes and signposted to appropriate resources.

7.3.8 The potential development of a person's crisis plan between mental health and the police may need to be further explored. In a research project on Advance Choice Documents, people with lived experience were not in favour of police involvement in the development of their crisis plans as they did not trust how the police might use their information.

7.3.9 The reality is that both mental health services and the police are very under resourced.

7.4 Police engagement.

7.4.1 The police have been unable to take part in the review due to an ongoing IOPC investigation.

7.4.2 The reviewer has put to the police representative on the LSAB Case Review Sub-group specific questions inviting an organisational response. It is accepted that any questions and further conversations would not be focused on the subject of this specific Safeguarding Adults Review.

7.4.3 A response was received from an Inspector of the MPS who works in Public Powers and Encounters, and Public and Personal Safety Training Policy.

7.4.3.1 There has been a change of terminology from Acute Behaviour Disorder to Acute Behavioural Disturbance following advice from the Clinical Practitioners who in turn advise the National Police Chiefs Council's Self Defence Arrest & Restraint Strategic Committee (NPCC SDAR). The previous term 'condition' incorrectly indicates a diagnosis, and this is not the case at initial presentation.

7.4.3.2 A national ABD package is now in place which outlines how to recognise ABD, how it causes death, the risk of physical restraint in people with ABD and an outline of the expected response and information for the ambulance service. This package was produced by the MPS with clinical oversight and endorsed by the College of Policing.

7.4.3.3 Part of the National ABD package is the 'CAMERAS' mnemonic to assist officers where ABD is suspected.

C – contain, avoid/minimise restraint where possible
A – ambulance, Cat 1 call – prompting immediate response
M – monitor vital signs

E – explain (and listen) about what you are doing to person and family, use friends/family to reassure
R – relay information to ambulance and from family
A – ABD = A&E (never custody or 136 suite)
S – sedation, healthcare sedation to reduce overdrive and restraint

7.4.3.4 The MPS have introduced scenario-based training to Public and Personal Safety Training (PPST) at both recruit and refresher levels. This allows officers to train in start-to-finish scenarios rather than practicing one skill in isolation. Officers are debriefed following the physical scenario and are asked to justify their actions both legally and ethically. Encompassed in these training sessions are Trauma Informed Policing practices where the officers are asked to consider alternative options to deal with that 'incident.' The training promotes a pedagogical learning style and includes stress inoculation circuits. An expansion of this scenario-based training will also feature in the new nationally directed PPST from the College of Policing which is expected to be implemented in 2024.

7.4.3.5 All MPS police recruits now receive an additional whole day's training which includes Fundamental Behaviour Intervention (FBI) and Trauma Informed Policing to build on their communication and de-escalation skills. This day includes discussions and inputs from community members.

7.4.3.6 The MPS have introduced the Post Incident Officer and Staff Support (PIOSS) program. This serves as a means of de-briefing and learning from incidents, as well as feeding back into various MPS Boards where organisational learning has been identified. The success of PIOSS has led to it being adopted by other police forces and agencies both nationally and internationally.

7.4.3.7 The Police Powers and Encounters Unit (PPEU) scrutinises all incidents where officers are assaulted, every incident involving the use of baton or pelargonic acid vanillylamide (PAVA) and dip samples a large number of incidents across the MPS looking for any learning.

7.4.3.8 The Police are trained and expected to de-escalate situations wherever possible using good communication skills, often referred to as Tactical Communications (though now more broadly referred to as Fundamental Behaviour Intervention).

7.4.3.9 The term restraint covers a plethora of techniques within police training, ranging from a single officer taking hold of a person's arm in an 'ordinary police hold' to multi-officer prone restraint and the use of handcuffs.

7.4.3.10 As to which form of restraint is required falls to the officer to decide based on the information available to them at the time whilst considering the mnemonic PLANE – Proportionate, Legal, Accountable, Necessary and Ethical. The use of force must be justified by the officer applying it.

7.4.3.11 Should a restraint be necessary, then officers are expected to select the least intrusive option to achieve the desired outcome, with the officer continually assessing the situation and removing the restraint if or when possible.

7.4.3.12 Should a person be restrained by multiple officers, then a single officer should take on the role of Safety Officer, who is usually the officer positioned by the

subject's head. The Safety Officer's role is to provide effective leadership of the restraint and is irrespective of rank. The Safety Officer is responsible for the care of the subject, control of the situation and communication with all concerned.

- Control by protecting and restraining the head
- Care by monitoring the condition/behaviour of the person restrained
- Communication with the person restrained
- Communication with colleagues

7.4.3.13 All officers involved in the restraint have a duty of care to the person being restrained. Officers are encouraged to say something if they notice any changes in the medical condition of the person being restrained.

7.4.3.14 Officers should record in their evidence when they are the safety officers and what action they took.

7.4.3.15 Should there be sufficient officers on scene, they are encouraged to use a second Safety Officer to step back and observe the restraint without being physically involved.

7.4.3.16 Officers must consider the impact of their chosen tactical option against the possible medical implications to any person and the overall aim of any interaction.

7.4.3.17 Following the inquest of Joshua, the role of the Safety Officer was further enhanced with the requirement of 'verbalisation.' Verbal commentary on decision making by both Safety Officer and Supervisor is recommended for future use of Body Worn Video (BWV).

7.4.3.18 In response to the reviewer's question on the challenges for frontline policing, the MPS explained 'the reality' that 'restraints are extremely difficult even when the officers in question are fit, strong and well trained.'

7.4.4 The MPS response demonstrates changes in the management of restraint, the adoption of different approaches and the provision of relevant training. It is unclear from the information provided how these address the specific issues of working with Black people with an enduring mental health condition.

7.4.5 As the police were not able to participate in the SAR process, the fundamental question remains unanswered of the potential role of racism in the police's treatment of Black men in general and of Joshua in particular, where restraint was used.

7.4.6 In February 2023, Inquest published their new report, 'I can't breathe: Race, death & British policing'[47]. The report highlighted that Black men are seven times more likely to die following police restraint, but racism is not being addressed. Joshua, alongside other Black men, are named in this report.

7.4.7 Despite the stark racial disproportionality evidenced in data, it is the position of Inquest, following interviews with expert human rights lawyers and bereaved family

[47] https://www.inquest.org.uk/police-racism-report-2023

members, that the accountability processes expected from the IOPC, and the coronial system do not effectively or substantially consider the potential role of racism in deaths.

7.4.8 *'Investigation and oversight bodies are failing to examine the potential role of race and racism in deaths involving police. This renders racism invisible in the official narratives and prevents justice, accountability, and change.' (Deborah Coles, Director of Inquest)*[48]

7.4.9 In the case of this SAR, the commencement of the review following Joshua's death in March 2018 was delayed due to parallel enquiries. The review started in April 2021, was paused in June 2021 due to the IOPC investigation and re-started in August 2022. The IOPC investigation is still ongoing. This must continue to cause distress for the bereaved family and reinforce their mistrust in the systems and processes which are expected to tell the truth, deliver justice, and promote accountability.

7.4.10 *'When accountability never comes, and people continue to die in comparable circumstances, the trauma never ends.'*[49]

8. Conclusions

8.1 Joshua's care plan was lacking in evidence of direct engagement with him in his care and support within the wider context of his identity. There is room for improvement in considering how professionals capture the lived experiences of those who use mental health services to ensure, wherever possible, we do things with people and not to people.

8.2 The person's mental health issues need to be understood within the context of race, their family, cultural and/or community setting, and wider wellbeing outcomes. To enable meaningful communication and relationship building with the individual, professionals must find time and courage to be curious and ask challenging questions, especially when it comes to sensitive issues relating to race and culture.

8.3 Oversight and regular review of care and support planning, including CPA and CTO reviews, risk assessment and contingency planning, must be maintained. These need to be person-centred, and person led wherever possible. A shift of focus from a medicalised model (whilst acknowledging the importance of medication in maintaining Joshua's mental health) to a psycho-social model would include therapeutic and less restrictive options, earlier intervention, and an anticipatory planning approach.

8.4 Learning from this SAR highlights the importance of reviewing the S136 pathway in particular and the care planning process in general which includes a planned approach to managing deterioration of mental health and crisis situations. Changes have already been made locally (7.1.9) and pilot work has been initiated in other

[48] https://www.inquest.org.uk/police-racism-report-2023
[49] https://www.inquest.org.uk/police-racism-report-2023

parts of the country between the police and mental health teams (7.1.10). However, sustainable improvements have to be directed and resourced at strategic levels.

8.5 The continuing challenge of Mental Health Act assessment delays is very real to people with severe mental illness and their families, and people from minoritised ethnic communities in particular, and all professionals in relevant services. This must be debated and tackled at a central government and local commissioning level.

8.6 The ownership and management of care plans and crisis plans should happen at a partnership level, including the person and their family, the GP, mental health, the provider and other services, the police, and the LAS.

8.7 There is a fundamental question of building the trust between the police and people with lived experience and their families, and people from minoritised ethnic communities in particular.

8.8 Improving regular communication and shared learning must continue to inform emergency care planning and joint working between mental health, primary health, the police, LAS, and relevant providers.

8.9 To learn the lessons from this SAR and many other similar SARs, all agencies must have a commitment to improving practice through regular communication, case discussion and reflection, shared risk assessment and risk management and shared decision making.

8.10 The 'big issues' which are identified in this review, of the intersectionality of discrimination around race and mental health, are systemic and therefore require policy and system-wide changes.

8.11 'Mental ill health is a public health issue, not a criminal justice issue.'[50] Person-centred responses to Black people in mental health crisis must be focused on de-escalation, care, and compassion. [51] '(We) must decrease reliance on policing and investment in the criminal justice system.'[52]

8.12 Where the police become involved in responding to a mental health crisis through an absolute necessity, the priority of de-escalation and care must be maintained.

8.13 *It is essential for all organisations to note and respond to the findings and recommendations of the Inquest report.*[53]

9. Recommendations

9.1 It is recommended for all partners of the LSAB (the national organisations that are signatories to the Concordat in particular) to review (as soon as practically possible

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[50] https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps02_22.pdf
[51] https://www.inquest.org.uk/police-racism-report-2023
[52] https://www.inquest.org.uk/police-racism-report-2023
[53] https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps02_22.pdf

and annually) their joint position to the Mental Health Crisis Care Concordat, and renew their commitment to a joint declaration statement, as a whole system response. A shared action plan should be agreed to ensure effective emergency response systems are in place, including detailed coordination arrangements, locally agreed roles and responsibilities, and locally agreed timescales for health and social care and all partners' responses. Respect, compassion, and dignity must be at the heart of person-centred care, taking into consideration the differences and needs of people from black and minoritised ethnic communities.

9.2 It is recommended for all relevant partners of the LSAB to review training and strengthen guidance at a cross-disciplinary level, in line with the Position Statement published by the Royal College of Psychiatrists on 'Acute behavioural disturbance' and 'excited delirium'[53]. Taking into account the confusion and the disproportionate use of this term by the police and the ambulance services, it is recommended for the MPS, LAS and SLaM to discuss further and agree on a joint position on this, in response to this review.

9.3 It is recommended for all partners of the LSAB to review relevant training and policies, so as to strengthen anti-racist perspectives and to include the involvement of people with lived experience and their families and third sector organisations. Training needs to be part of a wider programme of change, developing multipronged diversity initiatives that tackle structural discrimination.

9.4 Multi-agency training on the application of MCA in practice for complex mental health cases, with anti-racist perspectives, is recommended. The learning should be facilitated at a partnership level, so as to promote discussion and dialogue across organisations.

9.5 It is recommended for SLaM to review (and update if required) their care and support plan template, including risk assessment, crisis plan and contingency plan, taking into full consideration the lessons learned from this case. (The reviewer has been made aware that some changes have already been made.) A more holistic approach is to be adopted that integrates mental health, physical health, race and culture.

9.6 It is recommended that the LSAB consider with MPS its response to all the issues raised by this report.

9.7 It is recommended for the LSAB Chair to highlight and escalate via the National Chairs Network the 'big issues' relating to the chronic lack of resourcing to sustain emergency responses and improve outcomes for people experiencing mental health crises, and for people from black and minoritised ethnic communities in particular. The local challenges identified in this review are magnified at a national level, so debate and assurance about meaningful changes is required moving forward.

10. Glossary

ABD	Acute Behavioural Disturbance
CBT	Cognitive Behavioural Therapy
CPA	Care Programme Approach
CTO	Community Treatment Order (Section 17A MHA 1983)
DHR	Domestic Homicide Review
DHSC	Department of Health and Social Care
EDI	Equality, Diversity, and Inclusion
IAPT	Improving Access to Psychological Therapies
IOPC	Independent Office for Police Conduct
LAS	London Ambulance Service
LCFT	Lewisham Community Forensic Team
LSAB	Lewisham Safeguarding Adults Board
MCA	Mental Capacity Act (2005)
MPS	Metropolitan Police Service
RCP	Royal College of Psychiatrists
SEL ICS	South East London Integrated Care System
SAR	Safeguarding Adults Review
SI	Serious Incident
SLaM	South London and Maudsley NHS Foundation Trust
SOAD	Second Opinion Appointed Doctor