# CROYDON SAFEGUARDING ADULTS BOARD

# SAFEGUARDING ADULT REVIEW MR HONG

2021

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**SAFEGUARDING ADULT REVIEW – Mr Hong**

**Croydon Safeguarding Adults Board**

## 1. INTRODUCTION

1.1. Mr Hong was 59 years old at the time of his death. He originated from the People's Republic of China and had been living on his own in the UK for over 17 years. His first language was Mandarin and he had limited use of English. He wife and two daughters lived in China and it appears that he was out of contact with them.

1.2. Mr Hong was a failed asylum seeker. He had entered the UK illegally from China in 1997 using a false passport. He was arrested as an immigration offender on 14/12/12. He also could not read or write in English and verbal communication in English was difficult for him. Mr Hong lived in a series of hostels and care homes funded by the Home Office.

1.3. Mr Hong came to the attention of the Health Wellbeing and Adults (HWA) department of London Borough of Croydon on 16/12/16 following a referral from his GP requesting a Care Act assessment. Mr Hong was described as living with complex health needs and struggling to maintain his independence.

1.4. Mr Hong had kidney failure and received regular kidney dialysis in hospital. Mr Hong was admitted to hospital on 31/01/17 with shortness of breath and pleural effusion (a build-up of fluid in the lungs). During this hospital admission, Mr Hong was also made homeless from the hostel in which he had been living. He was discharged on 22/06/17 to a nursing home funded by London Borough of Croydon and three weeks later, on 12/07/17, killed himself by hanging using the alarm pull cord in his room.

## 2. SAFEGUARDING ADULT REVIEWS

2.1. Section 44 of the Care Act 2014 places a statutory requirement on the Croydon Safeguarding Adults Board to commission and learn from SARs (Safeguarding Adult Reviews) in specific circumstances, as laid out below, and confers on Croydon Safeguarding Adults Board the power to commission a SAR into any other case:

*'A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –*

*a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and*

*b) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or*

*c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.*

*The SAB may also –*

> *Arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).*
>
> *…Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –*
>
> *a) identifying the lessons to be learnt from the adult's case, and*
> *b) applying those lessons to future cases.*

2.2. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons to the future (s44(5), Care Act 2014).

2.3. The purpose and underpinning principles of this SAR are set out in section 2.9 of the London Multi-Agency Safeguarding Adults Policy and Procedures: http://londonadass.org.uk/wp-content/uploads/2019/05/2019.04.23-Review-of-the-Multi-Agency-Adult-Safeguarding-policy-and-procedures-final-.pdf

2.4. All CSAB members and organisations involved in this SAR, and all SAR panel members, agreed to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

2.5. This case was referred to the SAR Sub-group of the CSAB in May 2019 and considered for a Safeguarding Adult Review at the meeting in June 2019.

2.6. The SAR Sub-group considered this case as meeting the criteria for a SAR, and the Independent SAB Char ratified this in September 2019.

2.7. Attempts were made to contact Mr Hong's relatives in Canada but no reply was received.

2.8. The CSAB agreed to use of the pseudonyms Mr Hong and Norbury Creek Nursing Home.

2.9. This review was commissioned in January 2020 but was delayed due to the response to the coronavirus pandemic and the need to reprioritise resources. It was further delayed by the London Borough of Croydon's s114 notice. These factors also impacted on the availability of the review writer.

## 3. BRIEF SUMMARY OF CHRONOLOGY AND CONCERNS

3.1. Mr Hong entered the UK illegally from China via the USA and Italy in mid-1997 using a false passport. Mr Hong left behind a wife and two daughters whom he did not have any contact with. The reason for this, according to Mr Hong, was because he was not able to send them any money. Mr Hong also had an 80-year-old sister and a nephew who lived in Canada. Although Mr Hong stated that he did not have any friends in the UK he did receive a visitor at the final care home in which he lived. Mr Hong stated that he had worked previously as a gardener for very little money. According to the Care Act assessment made by London Borough of Croydon in 2017, Mr Hong wished to remain in the UK and not to return to China since he was ill and would not receive the help that he needed there.

3.2. On 14/12/12, Mr Hong was arrested in Croydon, South London as an immigration offender but was released due to his health conditions. Mr Hong had been receiving treatment for his kidneys for the past 17 years. Mr Hong was described as living with complex health needs: ischaemic heart disease, pancytopenia (a blood disorder, one of the symptoms of which is a shortness of breath) atrial fibrillation (which again leads amongst other things to shortness of breath, feelings of anxiety and reduced ability to exercise), chronic pleural effusion (an accumulation of fluid in the lungs, with consequent shortness of breath) and end stage renal failure. He had been treated with haemodialysis since 1998 and attended hospital for dialysis three times a week. He had a chronic low BMI (Body Mass Index) and was on nutritional supplements.

3.3. Following his arrest and release, Mr Hong was required by the Home Office Asylum Operations team to report at Becket House, London from 11/01/13 onwards. Reporting to the Home Office is one of the conditions placed on asylum seekers who have been released following arrest. Mr Hong complied and reported again on 25/01/13 but did not report on 08/02/13. There is no information about why this was the case or how the Home Office responded to a reporting gap that was to last for the next 16 months. Mr Hong was recorded to have failed to report on 23/05/14 and again on 29/05/14 and latterly was sent a Failure to Report letter asking him to explain himself. Mr Hong did not and failed to report again on 23/06/14.

3.4. Mr Hong did not report to the Home Office in July 2014 since he was in hospital and because of this, his reporting conditions were briefly suspended. Mr Hong formally claimed asylum in the UK on 09/07/14. Mr Hong had little contact with any services other than when receiving kidney dialysis treatment in hospital and consequently little is known about this period of his life. On 24/10/14 the Home Office noted that Mr Hong was living in accommodation in Thornton Heath, which supports asylum seekers.

3.5. On 25/11/14 Mr Hong's asylum claim was rejected, and his appeal process began.

3.6. During 2015, Mr Hong was required to report to the Home Office at Lunar House, Croydon, which was closer to where he was living. Mr Hong's reporting

requirements were cancelled in August and September since Mr Hong was again in hospital. After this, Mr Hong continued to report to the Home Office irregularly.

3.7. On 07/10/15, Mr Hong was noted by the Home Office to be living in accommodation that provided short term housing and support but was reported to have already left this accommodation on 22/09/15. It appears that he had moved to another home in New Addington, Surrey.

3.8. On 07/12/16 a Home Office Immigration Officer, concerned about Mr Hong's health requested that further checks be made when Mr Hong next reported. Mr Hong, however, did not report to the Home Office again.

3.9. Mr Hong first came to the attention of the London Borough of Croydon on 16/12/16 when his GP requesting an assessment of Mr Hong's needs. This was delayed by waiting for the availability of a Mandarin speaking GP and due to internal council processes. An assessment was not undertaken until April 2017.

3.10. In the meantime, Mr Hong was admitted to St Helier Hospital, Sutton (where he regularly received dialysis treatment) on 31/01/17 with chest pains and shortness of breath. He was to remain there until 22/06/17.

3.11. On 10/02/17, St Helier Hospital notified the London Borough of Croydon to assess Mr Hong prior to discharge. Mr Hong's condition deteriorated, however, so he remained in hospital. This precipitated contact between the London Borough of Croydon and the Home Office regarding Mr Hong's immigration status and the financial support that he was receiving.

3.12. Despite having been at St Helier Hospital for almost two months, the home in New Addington in which Mr Hong had been living notified the Home Office on 21/03/17 that Mr Hong had "absconded" and by doing so had made himself intentionally homeless. In hospital, Mr Hong's health was improving but he was assessed to be unable to live independently. Mr Hong was also reported to be in a low mood, which was related to his increasing health needs.

3.13. The Home Office Asylum Support Team contacted St Helier Hospital on 24/03/17 and was notified that Mr Hong was likely to be discharged to a nursing home funded by London Borough of Croydon. Having completed its investigation into Mr Hong's absconding and finding that London Borough of Croydon would fund the next placement, the Asylum Support Team ended its involvement with Mr Hong.

3.14. In April 2017, members of the London Borough of Croydon's START team tried to identify where Mr Hong had lived prior to admission to hospital so that he might return there upon discharge. This process was delayed by a lack of interpreters and a lack of information about Mr Hong and where he had lived. A Croydon social worker also tried to find out where Mr Hong's belongings were since he had not brought anything with him to hospital. This appears to have been unsuccessful and not have been followed up further.

3.15. The London Borough of Croydon assessed Mr Hong's needs under the Care Act in April 2017 whilst he was still in hospital. This assessment recorded that Mr

Hong wanted to remain living in the UK and to receive support with his health and his care and support needs. Mr Hong stated “that without support I might get seriously unwell and not be able to breathe properly. It is important to me to remain in the UK and I need support to do this as I am not well enough”. Mr Hong wanted to be supported by someone who spoke Mandarin as he could not speak English. Mr Hong wanted reassurance that he would have the right amount of support and said that he did not feel safe in the community without support around him from nurses. The assessment also noted concerns about how much Mr Hong understood about his immigration status and about the legal support that he was receiving with this.

3.16. On 21/04/17 Mr Hong’s kidney function deteriorated, and rather than return to his previous accommodation, consideration of residential care for him began. When discharged from hospital the plan was for Mr Hong to go to a care home, which would be funded by London Borough of Croydon.

3.17. Since Mr Hong was seeking asylum, he was transferred to the London Borough of Croydon’s No Recourse to Public Funds (NRPF) team on 04/05/17.

3.18. On 21/06/17, Mr Hong’s right to appeal against his immigration status was dismissed.

3.19. On 22/06/17, Mr Hong was discharged from St Helier Hospital to Norbury Creek Nursing Home. He moved in with no belongings since these appear to have been lost at the point of his admission to hospital.

3.20. On 28/06/17. Mr Hong was visited at Norbury Creek Nursing Home by a friend who asked for money. Norbury Creek Nursing Home raised this as a safeguarding concern with the London Borough of Croydon.

3.21. On 04/07/17, a social worker from the NRPF team and a Home Office Immigration Officer visited Mr Hong. The Immigration Officer told Mr Hong about the dismissal of his right to appeal against his immigration status. Following this meeting, Mr Hong gestured to cut his throat. To reduce the opportunity for self-harm or suicide attempts, the alarm pull cord in his room was removed at the request of the social worker, and plastic cutlery was provided to Mr Hong.

3.22. The alarm pull cord was subsequently returned by staff at Norbury Creek Nursing Home. This was not reported to London Borough of Croydon social services or to Mr Hong’s GP.

3.23. On 05/07/17, Mr Hong was found by Norbury Creek Nursing Home staff trying to bang his head against the sink in his room.

3.24. On 06/07/17 Mr Hong was noted by Norbury Creek Nursing Home staff to be “displaying suicidal behaviour”, banging his head against his bed and the sink.

3.25. On Friday 07/07/17 Mr Hong stated, through a staff member at Norbury Creek Nursing Home who had a limited knowledge of Mandarin and who was interpreting for Mr Hong, that his self-harm was not because of his immigration situation but because of his complex health needs. Mr Hong expressed a desire to end his life and to want to “end it and return home”. Mr Hong said he had a

few health issues and was fed up. He denied that his behaviour was due to his immigration status or the recent issue regarding money (which had been reported as a safeguarding concern on 28/06/17). Mr Hong was on oxygen all the time despite it having been prescribed to be taken when necessary and had asked for the level of oxygen to be increased. There was, however, uncertainty about how much Mr Hong understood (and was understood) in these conversations due to translation difficulties.

3.26. A member of staff at Norbury Creek Nursing Home confirmed that Mr Hong had been referred to a psychiatrist for a full mental health assessment

3.27. Mr Hong's GP visited later that day and recommended that Norbury Creek Nursing Home provide 1:1 supervision of Mr Hong. This was not implemented. Mr Hong was referred to a psychiatrist for a full mental health assessment. It does not appear that this assessment took place. A risk management plan, however, was formulated as follows:

3.27.1. Mr Hong to be observed regularly, every hour at least

3.27.2. An ambulance should be called out immediately if Mr Hong bangs his head again or engages in any other self-harming behaviour

3.27.3. The Norbury Creek Nursing Home House Manager will send costings for one-to-one support for Mr Hong to be considered at the London Borough of Croydon funding panel, "…in case this continues for longer".

3.27.4. The Norbury Creek Nursing Home Manager to follow up the psychiatry assessment.

3.27.5. The Home Office Immigration officer to arrange an urgent visit from Mr Hong's solicitor with an interpreter.

3.28. On Saturday 08/07/17 and on Sunday 09/07/17 here was no contact between Norbury Creek Nursing Home and any of the other services involved with Mr Hong. There was not contact no contact between Norbury Creek Nursing Home and any of the other services on Monday 11/07/17.

3.29. On Tuesday 12/07/17 Mr Hong was found in his room at Norbury Creek Nursing Home, hanging from his bedroom window by the alarm pull cord. The Police and an ambulance were called. Mr Hong was taken to Croydon University Hospital where he died that night.

## 4. Analytical framework

4.1 Preston-Shoot (2019) argues that, "*Drawing on existing evidence about effective practice would mean that reviewers are not starting out with a blank canvas. What is proposed here is that SARs begin explicitly with the available evidence-base, using it as a lens with which to scrutinise case chronology and explore through panel meetings, interviews and learning events with practitioners and managers what facilitates good practice and what presents barriers to effective practice".*

4.2 The advantage of this approach is that, *"The emphasis then is less on description and more on immediate reflection and systemic analysis of facilitators and barriers, across nationally determined policy, legal and financial systems as well as local arrangements and staff values, knowledge and skills*" (Preston-Shoot, 2017).

4.3 Reinforcing this, The Local Government Association Analysis of Safeguarding Adult Reviews April 2017 – March 2019 section 3.4 "Type of Reviews" describes a number of "methodological" requirements and related shortcomings of SARs, which can be summarised as follows:

4.4 SARs should connect their findings and proposals to an evidence base. Few SARs compare actual practice with that suggested in guidance and few explore the reasons why there was a difference between the two.

4.5 SARs should be based on research. Over 50 Safeguarding Adults Boards have carried out SARs on the same set of circumstances on more than one occasion but have treated each discreetly. The SARs do not refer to each other, build on each other, or ask why it happened again.

4.6 SARs should be analytical. There is too much description and not enough analysis.

4.7 SARs should not shy away from difficult or sensitive topics. Few SARs engage in the legal and financial context of practice or decision making and should raise the impact of funding cuts, government strategy and reductions in services.

4.8 Consequently, a study was made of both the research evidence and practice evidence that provides insight and guidance when working with someone in Mr Hong's situation: experiencing a long-term, debilitating health condition; seeking asylum and experiencing communication difficulties.

## 5 Evidence from research and guidance

### 5.1 Chronic kidney disease, anxiety and depression

5.2 Chronic kidney disease is a recognised risk factor for heart disease, and is associated with high blood pressure and diabetes and also with economic deprivation (Bikbov, 2020).

5.3 There is evidence that people with chronic kidney disease have a higher prevalence of psychiatric disorders than the general population do, including higher levels of anxiety and depression (Egede, 2007). Mr Hong had anxieties related to his complex health needs and particularly when he became short of breath as this frightened him. Mr Hong was also anxious about his future as he was no longer able to live an independent life due to his restricted mobility resulting from his difficulty breathing and general weakness. He needed oxygen, which affected his ability to self-care.

5.4 People who receive dialysis treatment and who have a low Body Mass Index (BMI) are more likely to be depressed than those with a normal or high BMI (Egede, 2007). This correlation is increased further if there are other concurrent physical illnesses. A key factor in low BMI in people receiving dialysis appears to be a lack of appetite, which has been suggested to also be a manifestation of both depression and of other physical illnesses. Consistent with this, Mr Hong had a low BMI, several other physical illnesses and was depressed.

5.5 It appears (from a safeguarding adults enquiry made by the London Borough of Croydon following Mr Hong's death) that Mr Hong had a prognosis of six months to live but it was unclear whether or not he knew this. There was no evidence of any advance planning with Mr Hong to explain what this prognosis meant, how it was likely to affect him in the months ahead and about any preparations that he may have wanted to make, such as contacting his family.

### 5.6 Dialysis treatment and suicide.

5.7 There is evidence that the risk of suicide and self-harm is higher in people with kidney disease who are receiving dialysis than it is in the general population. This is especially so in those who are depressed and anxious, have a reduced quality of life and are socially isolated with little family contact (Pompili et al, 2013; Bohlke et al, 2008). Mr Hong shared this set of characteristics. Kidney dialysis can have both a physical and an emotional impact on quality of life and it has been estimated (in the USA; Pompili et al, 2013) that 21% of deaths from end stage kidney disease are the result of decisions to withdraw from dialysis. There is a significant body of research into predicting and intervening in decisions to end dialysis treatment.

5.8 Suicide by people receiving dialysis, however, appears to be a separate phenomenon from decisions to withdraw from treatment (Roy-Byrne et al, 2008). Again, the risk of suicide is increased when depression and anxiety are present (Bronisch and Wittchen, 1994) but there is evidence that people who receive dialysis and who kill themselves actually have fewer health problems, either associated with or in addition to kidney disease, than those who withdraw from dialysis. However, they appear to have more environmental and

psychosocial problems, which they have difficulty adapting to, and experience more stress than those who withdraw from dialysis (Kurella et al, 2005). Consequently, self-harm is more likely to be present in people who go on to actively take their own lives than in those who end their life by stopping treatment. Mr Hong does not appear to have decided to stop receiving dialysis but did make self-harm attempts and indicated that he wished to end his life prior to his suicide.

### 5.9 Reduced quality of life

5.10 In addition to the restrictions placed on him by the need to receive dialysis three times a week, Mr Hong was also anxious about the future as he was no longer able to live an independent life. Mr Hong had lost all his belongings (on or after 31/01/17 following his admission to hospital). Compounding this, there is extensive evidence that people who live in care and nursing homes have reduced quality of life compared to people who live in their own homes (Olsen et al, 2016).

**5.11** Mr Hong was also socially isolated. He lived in care homes, was a Mandarin speaker who faced difficulties being understood, had a very reduced social network (and his one friend was the subject of a safeguarding concern). He also had no contact with his family. During his five month stay at St Helier Hospital, Mr Hong was noted to be isolated due to his limited ability to speak English. He also did not have any visitors (except once when his sister and nephew from Canada came to see him). A visiting priest noted his isolation and asked staff to learn mandarin ‘for the sake of Mr Hong’.

5.12 In summary the research shows that anxiety, fatigue, depression, and reduced quality of life may occur in people who receive dialysis, and these may in turn contribute to increased suicide risk (Kring and Crane, 2009).

### 5.13 Asylum seeking and suicide

5.14 Mr Hong’s chronic kidney disease and dialysis treatment occurred within the context of his, ultimately failed, asylum claim, which took from 09/07/14 until 21/06/17 to resolve. There is some (non-statistically significant) evidence that failed asylum claimants exhibit more acute symptoms, such as suicidal ideation or suicide attempts, than people with asylum pending status do (Schoretsanitis, 2018). Mr Hong, however, appears to have been clear that his failed asylum claim was not the reason for his decision to end his life. Given the difficulties Mr Hong faced in communicating with non-Mandarin speakers (and it also seems with those who did not speak his dialect), his understanding, and the impact upon him of, his failed claim remains uncertain.

5.15 Viewed from the perspective of the research on chronic kidney disease and on asylum seeking, Mr Hong had several factors in his life which increased the likelihood that he would self-harm or attempt suicide. These factors had been present in Mr Hong’s life for a considerable period of time.

5.16 **Evidence from guidance**

The Royal College of Psychiatrists' Final report of the Patient Safety Group, Self-Harm and Suicide in Adults (CR229), published in June 2020 sets out a number of "Risk factors and red flag warning signs". The report states that "A red flag is a risk factor with special significance in that it indicates that a person is at heightened risk of attempting suicide at this particular moment in time. This imminent risk requires an urgent, clinically appropriate and personalised intervention with a Safety Plan". This report was published after the time period covered by this safeguarding adults review, but it still provides a useful framework for understanding the risk factors and warning signs in Mr Hong's life. The risk factors and "red flags" are divided into several themes and are as follows:

**5.17 Demographic and social**

5.18 The risk factors are:

- Perception of lack of social support, living alone, no confidants
- Males (may not disclose extent of distress or suicidal thoughts)
- Stressful life events (e.g. recently bereaved, debt/financial worries, loss of attachment/major relationship instability, job loss, moving house)
- LGBT
- Ethnic minority group.

5.19 Mr Hong had, and knew that he had, little social support, he was isolated and, due to this and not having someone to speak to, had no confidants. He was male, had experienced stressful life events (for example leaving his home, asylum seeking and having his claim rejected and being homeless) and was from an ethnic minority group.

**5.20 Personal background**

5.21 The risk factors are:

- Substance misuse: Alcohol and/or illicit drug misuse especially if precipitated by a recent loss of relationship
- Feeling close to someone who died by suicide (family or non-kin) or exposure to suicidal behaviour of key others (family, peers, favourite celebrity)
- Use of suicide-promoting websites or social media
- Access to lethal means; (If unable to remove lethal means ensure mitigation within a robust Safety Plan).

5.22 Less is known about Mr Hong's personal background but with the returned alarm pull cord in his room he had access to lethal means.

**5.23 Clinical factors in history**

5.24 The risk factors are:

- Previous self-harm or suicide attempt(s) (regardless of intent, including cutting)
- Mental illness, especially recent relapse or discharge from in-patient mental health care
- Disengagement from mental health services
- Impulsivity or diagnosis of personality disorder
- Long-term medical conditions; recent discharge from a general hospital; pain.

5.25 Mr Hong had previously self-harmed (he had banged his head against the sink and bed in his room). He was depressed and anxious but was not actively engaged with mental health services and had a long-term and debilitating medical condition. Mr Hong was diabetic and suffered with hip pain and back pain (the latter possibly related to his kidney problems). He had also recently been discharged following a prolonged stay in a general hospital.

**5.26 Mental state examination and suicidal thoughts**

5.27 The risk factors are:

- High degree of emotional pain and negative thoughts (hopelessness, helplessness, guilt – e.g. 'I'm a burden')
- Sense of being trapped / unable to escape (sense of entrapment) and/or a strong sense of shame
- Suicidal ideas becoming worse
- Suicidal ideas with a well-formed plan and/or preparation
- Psychotic phenomena, especially if distressing; persecutory and nihilistic delusions, command hallucinations perceived as omnipotent (pervasive).
- Suicidal ideas with a well-formed plan and/or preparation.

5.28 Mr Hong had negative thoughts, felt hopeless and unable to escape (on 07/0717 he is quoted to have said that he wanted to "end it return home" and was fed up. This was communicated through an informal interpreter: there is a risk that nuance, and meaning was lost in translation, perhaps compounded by his dialect and context). There is no evidence to suggest that Mr Hong experienced psychotic phenomena, but the lack of interpreting services may have meant that indicators of these were missed.

5.29 Mr Hong was suicidal. For example, on 07/07/17, Mr Hong said (via a member of staff at Norbury Creek Nursing Home who was interpreting for him but appears to have had a limited knowledge of Mandarin and of Mr Hong's dialect) that his self-harm was not because of his immigration situation but because of his complex health needs. Mr Hong was reported to have expressed a desire to end his life.

5.30 Consequently a number of the risk factors and red flags identified in the Royal College of Psychiatrists' report were also present in Mr Hong's life.

5.31 These risk factors and red flags were specifically formulated for use in primary care settings. The report cautions that risk should be assessed on an individual basis and that the absence of risk factors does not mean the absence of any risk of suicide: "*…a person may be imminently at risk of suicide even though*

*they are not a member of a 'high-risk' group. Conversely, not all members of 'high-risk' groups are equally vulnerable to suicide. Moreover, suicidal thoughts (and risk) can vary across a relatively short time period. The presence of red flag warning signs indicates that someone may be particularly at risk of suicide. Neither risk factors nor red flag warning signs can or should, however, be used to predict or rule out an individual suicide attempt*."

5.32 The report states that, "*…any patient with suicidal thoughts or following self-harm needs a Safety Plan. No one is ever ineligible for an intervention and Safety Plan*" and that, "*If there are red-flag warning signs/immediate risk of suicidal behaviour, the patient will require*":

- Immediate discussion with/referral to mental health services
- A robust Safety Plan
- Adequate support
- Removal of access to means

5.33 The components of a Safety Plan are:

- Reasons for living and/or ideas for getting through tough times
- Ways to make your situation safer
- Things to lift or calm mood
- Distractions
- Sources of support, to include anyone you trust

5.34 It is important that Safety Plans are co-created with patients and encourage communication with family and friends. There is little evidence that a Safety Plan of this type was developed or even considered with Mr Hong or that Norbury Creek Nursing Home would have been competent or consistent in its implementation. A risk management plan was created but was not complied with by Norbury Creek Nursing Home.

## 6 Practice and contextual factors

### 6.1 Dialysis at St Helier Hospital

6.2 Practitioners considered that Mr Hong had appeared reasonably settled and happy when at the St Helier Hospital Renal Unit for dialysis. This may have been because it was a familiar routine and Mr Hong knew the people there. On discharge to Norbury Creek Nursing Home, Mr Hong had been deemed medically fit and Mr Hong continued to attend dialysis three times a week. At an appointment with the Consultant Nephrologist at St Helier Hospital on 27/6/17, Mr Hong stated that he was not happy at Norbury Creek Nursing Home, that he was not being cared for adequately in that he was not eating or washing and dressing and that he was being left to be incontinent. Mr Hong said that he did not want to go to another nursing home but that he wanted to come back to hospital. The consultant wrote to Mr Hong's GP about these concerns, suggested that Mr Hong was lonely at Norbury Creek Nursing Home and asked for links to be made by the nursing home with the Mandarin speaking community.

6.3 Mr Hong attended six other dialysis appointments after this, the final one was on the day before his death. During appointments, there are no further references in the notes at St Helier Hospital to Mr Hong's discontent at the nursing home.

6.4 Mr Hong was reviewed by the dietician from St Helier Hospital on 31/06/2017 over the telephone. The dietician spoke to the staff at Norbury Creek Nursing Home, who provided details of what Mr Hong ate. The dietician concluded that Mr Hong was eating better than he had as an inpatient and that his weight was stable.

6.5 St Helier Hospital's notes included references to Mr Hong's low mood, resulting from his health and social situation. Mr Hong was seen by Psychiatric Liaison (a mental health service that assesses and supports patients in general hospitals) at St Helier Hospital and his low mood was judged to be a response to his situation and circumstances and not to be indicative of any mental illness.

6.6 It appears that Mr Hong's feelings were not explored further with him, possibly due to difficulties communicating with Mr Hong and the lack of access to and use of interpretation services. There may also have been difficulties in interpreting Mr Hong's ways of expressing his feelings. From the 1950's and into at least the 1990's mental health problems were considered to be political acts of counter-revolutionary subversion in mainland China (Parker et al, 2001; Wang et al, 2016). Inherent within this was extensive victim-blame. Depression, for example, was understood to be the result of weak revolutionary willpower (Desen, 1976). Consequently, people with depression were regularly diagnosed with "neurasthenia", a condition which emphasised physical rather than mental causation and thus lacked such seditious connotations or were given no diagnosis at all (Kleinman,1986). Mr Hong is likely to have grown up and lived in China during this period and these factors may have influenced his understanding and expression of how he felt.

6.7 Practitioners identified that support for communicating with Mr Hong relied on what they described as a "mixed bag" of resources, which often involved finding a staff member who could interpret for him. Improvements have since been reported to have been made with an interpreting service now provided by Language Line and Mandarin interpretation is now regularly requested and provided.

6.8 **Mr Hong's mental capacity**

6.9 There were concerns that at times Mr Hong did not appear to understand information, that he appeared confused and that his mental capacity to make decisions about his health needs appeared to be fluctuating. Mr Hong was tested for dementia, but no evidence was found, and he was not diagnosed. Mental capacity assessments, however, were not routinely carried out.

6.10 There was no definitive conclusion about the cause of Mr Hong's apparently non-lucid periods. These might have been due to pain, diabetes, Mr Hong's mental health state or could have been related to difficulties communicating with Mr Hong.

6.11 Advocacy for Mr Hong was considered but a decision was made by the London Borough of Croydon that Mr Hong had the mental capacity to understand the assessment process. Therefore, a formal advocate was not required.

6.12 Mr Hong was, however, an asylum seeker who was attempting to understand and to navigate his way through his immigration and appeal status. He did not speak English, was made homeless during his hospital admission, was socially isolated, had complex health needs. He is likely to have had 'substantial difficulty' in understanding the various assessments and discharge planning processes but was not supported with these. Consequently, Mr Hong could have been entitled to an independent advocate

6.13 **Asylum seeking and no recourse to public funds**

6.14 After Mr Hong began his appeal against the decision to reject his asylum claim in 2014, the Home Office Asylum Operations team had limited involvement with him. Mr Hong reported irregularly to the Home Office and there was inconsistent recording of where he was living. During the process of this review, the Home Office recognised that its co-operation with accommodation providers had been lacking.

6.15 There were occasions in which information could have been shared more effectively between the Home Office and providers. For example, the home in New Addington notified the Home Office on 21/03/17 that Mr Hong had "absconded" from his accommodation on 19/03/17. He had in fact been admitted to St Helier Hospital on 31/01/17, almost two months previously. The Home Office acknowledged this delay and apparent lack of oversight and the lacuna in the home's reporting and lack of action. This presents a need to improve communication between accommodation providers and the Home Office.

6.16 From the Home Office's perspective, all of Mr Hong's appeal determinations were served to Mr Hong's legal representatives and this should have allowed them to be explained to Mr Hong. There were concerns, however, about what Mr Hong knew and understood about his asylum status, compounded by communication difficulties. These were never adequately resolved. According to an OT assessment whilst Mr Hong was in hospital, for example, Mr Hong was not aware of his current immigration status and what his entitlement was. There was no indication that his solicitor was aware that Mr Hong was in hospital.

6.17 Mr Hong's solicitors confirmed that they had notified Mr Hong that his asylum claim was weak. Rather than appeal directly against this decision, Mr Hong's appeal was made based on Humanitarian Protection and Human Rights grounds due his physical health needs. The solicitors recognised that the threshold for success for this was very high. The solicitors stated that they were unaware that Mr Hong might have mental health needs.

6.18 The Home Office confirmed that safeguarding procedures within Asylum Operations have evolved since handling Mr Hong's asylum claim in 2014. Local safeguarding teams have now been introduced. As a result, all asylum decisions involving potentially vulnerable applicants are now signed off by local

safeguarding teams to ensure that they are served appropriately, based on the vulnerabilities and circumstances of each individual. This could involve asylum decisions being served to a support worker or support agency as well as to an applicant's legal representatives. In cases in which the applicant is deemed vulnerable but does not have the appropriate support in place, they are invited to a Home Office building so the decision can be served to them in person to ensure that both the decision and what this means for them is explained and understood. Effective interpretation services would still have been required for Mr Hong even if this process had been in place prior to his death.

6.19 The Home Office ended its asylum support for Mr Hong on 24/03/17 following London Borough of Croydon's involvement. Upon the dismissal of Mr Hong's asylum claim, and of his further right to appeal, Mr Hong was still liable for removal action from the UK. When NRPF team members asked Mr Hong whether the immigration issue was impacting on his low mood, Mr Hong said this was not the case. He said it was due to his health and his worries about not being able to lead an independent life anymore.

6.20 There was also limited information about Mr Hong's life in the UK. In addition to being due to limited contact with services, this was considered by practitioners to have been at least partly due to Mr Hong choosing not to disclose information since he was fearful of the impact that this might have on his application to stay in the UK.

6.21 **Interpretation services**

6.22 Mr Hong was described as having spoken a specific Mandarin dialect. Croydon's interpreting service had been contacted but no Mandarin interpreter was available. There were also delays in accessing adult social services in 2016 caused by waiting for a Mandarin speaking GP to be available. The Home Office confirmed that it uses security-cleared interpreters who may be aware (due to their experience, not special training) of issues in an individual's home country. These interpreters are not employed by the Home Office and may work also for other agencies including the police and local authorities.

6.23 Practitioners considered that it was possible that Mr Hong was reluctant to disclose information, for example about his family, because of his immigration situation. He may also have had concerns about the safety of his family back in China.

6.24 The use of informal interpreters was understood by practitioners to be problematic. They recognised that there may be conflicts of interest and that there are no contractual relationships with, or a professional code for, informal interpreters. Practitioners considered that Mr Hong might have felt uncomfortable or disinclined to trust such a person.

6.25 There were other perspectives on Mr Hong's communication needs and abilities, however. For example, the London Health Needs Assessment completed whilst Mr Hong was at St Helier Hospital noted that Mr Hong was able to communicate non-verbally. When he was in pain he pointed to where the pain was felt. He was described as always able to express himself, to

understand instructions and to be able to make his needs known verbally and non-verbally.

6.26 Despite this and despite clinical opinion to the contrary, when discharge was being discussed with Mr Hong he stated that his health had not improved since admission. On reflection practitioners recognised that it appeared that Mr Hong understood little about the treatment provided to him, its outcome, and the reasons why he would continue to feel unwell after his discharge. Mr Hong also appears to have not understood some of the restrictions, such as restricted fluid intake, placed on him.

6.27 **The placement at Norbury Creek Nursing Home**

6.28 Norbury Creek Nursing Home was not an ideal placement for Mr Hong for reasons of his age (he was younger that other residents there); language (no one could speak the same language as Mr Hong, although a member of staff did try to interpret for him) and Mr Hong's developing mental health needs. A care home for younger people was sought but was not available. There were vacancies, however, at Norbury Creek Nursing Home.

6.29 The Care Act assessment made whilst Mr Hong was in hospital had recommended that any placement should meet Mr Hong's cultural and communication needs. It is likely that such a placement would take some time to find. Despite Mr Hong spending a lengthy period of time in hospital, his placement at Norbury Creek Nursing Home was made as a matter of urgency. This meant that there was less choice of suitable homes available and less opportunity to plan for how Mr Hong's needs would be met. There is little evidence that Mr Hong's cultural and communication needs were met in Norbury Creek Nursing Home.

6.30 Practitioners considered that there should be a more diverse market of services so that specific needs could be accommodated more appropriately. Practitioners also recognised that much depends on the quality and competence of particular care or nursing homes and that skill levels vary across them. It was suggested that self-harm and suicide prevention training and Mental Health First Aider training for care and nursing home staff could be beneficial for people in Mr Hong's situation.

6.31 Mr Hong also moved to Norbury Creek Nursing Home with no belongings, and these were never found. It appears that he was admitted to St Helier Hospital without them but attempts to retrieve them from the home in New Addington seem to have been unsuccessful. It is not possible to determine what Mr Hong's belongings were but since he had lived in the UK for 17 years it is unlikely that he had acquired no possessions. He may also have kept items from China. The personal and sentimental significance of Mr Hong's lost belongings cannot be determined but it is easy to imagine that their loss would have had an emotional impact on him, further exacerbating his developing mental health needs.

6.32 Since Mr Hong's death, the London Borough of Croydon's commissioning team will introduce a Dynamic Purchasing System (DPS). This will allow more providers to be approached allow access to more providers including bespoke

ones who might be able to meet the more specific needs presented by Mr Hong. This implementation has, however, been delayed due to reprioritisation in response to Covid 19.

6.33 Consideration should be given to the effectiveness of one-to-one support for someone who is self-harming or at risk of suicide. Factors include the skill set required (for example awareness, knowledge and ability to understand and predict self-harm and suicide), the purpose (for example whether to physically intervene or to call for assistance) and the practicality (what happens during breaks, for instance) of the one-to-one support. There is a risk that one-to-one support might give a false assurance of how well risks are managed. It might also constitute a Deprivation of Liberty for someone who lacks the mental capacity to consent to it. Suitable safeguards would need to be put in place and a demonstration made that other less restrictive options had been considered.

6.34 **Mr Hong's mental health needs**

6.35 Whilst at St Helier Hospital, there were incidents when Mr Hong refused observations (on 11/2/17 and on 11/3/17), interventions (27/3/17) and care (8/3/17, 4/4/17) and when he became distressed (7/3/17), angry with the staff (26/3/17) and when he stated that he wanted to die (3/4/17). These incidents were not explored further. The depression and mental health measurement scales, which form part of the London Health Needs Assessment, were not used because of language difficulties.

6.36 There was also no further exploration of Mr Hong's mental health needs in response to incidents of self-harm and talk of, and demonstrating that he wanted to, end his life whilst at Norbury Creek Nursing Home. A recommendation for psychiatric assessment had been made but was not implemented.

6.37 **Risk management**

6.38 Norbury Creek Nursing Home reported to the London Borough of Croydon on 04/07/17 that Mr Hong was exhibiting self-harming behaviour (threatening to cut his throat). A social worker visited and recommended removing the alarm pull cord, which was done that day. Mr Hong should have been given a pendant alarm but these were not working. At this time, the pull cord was recognised, correctly, as a potential danger.

6.39 Mr Hong's self-harming continued, and he spoke about suicidal thoughts. As a result, on 07/07/17 a risk management plan was put in place based on a social worker's and Mr Hong's GP's recommendations. This was on a Friday evening and the social worker's plan was to make a formal risk assessment on the following Tuesday, 11/07/17 since they did not work on Monday).

6.40 The alarm pull cord was, however, returned to Mr Hong on Sunday 09/07/17. Three alternative explanations were given by Norbury Creek Nursing Home and understood by practitioners, for why the pull cord was returned. The first was that Mr Hong was agitated when it was removed. The second was that it gave Mr Hong a method for accessing emergency assistance if he required it. The third was that Mr Hong's mood had improved. Whilst none of these

explanations necessarily preclude any of the others, this does suggest an element of uncertainty and ambiguity about why the pull cord was returned. This may be related to the lack of communication with any of the agencies involved with Mr Hong about its return. The NRPF team were not aware that the cord had been returned until 12.07.17, following Mr Hong's death. The social worker recognised in hindsight that they had believed that the return of the pull cord was based on Norbury Creek Nursing Home implementing a check on Mr Hong every 30 minutes.

6.41 The GP's recommendation of 1-1 monitoring was not implemented. Norbury Creek Nursing Home awaited formal confirmation of funding for the 1-1 support but did not receive it. It was noted at the subsequent Coroner's Inquest following Mr Hong's death that mental health support was not put in place quickly.

6.42 Despite requests, Norbury Creek Nursing Home did not participate in this safeguarding adults review. Consequently, it is not possible to determine why Norbury Creek Nursing Home did not implement the risk management plan formulated on 07/07/17 or how the 30 minute check system had been devised and operated.

6.43 Changes have been made by the London Borough of Croydon following Mr Hong's death that enable social workers (where no manager is available) to authorise funding for a period of up to 72 hours so that emergency arrangements can be put in place (such as 1-1 support) until a manager can be informed and can approve this.

## 7 Findings

### 7.1 The risk of Mr Hong's suicide was not fully understood or responded to.

7.2 Despite escalation of risk from 4/07/17 onwards, when Mr Hong's behaviour and statements showed self-harm and suicidal intent, this does not appear to have been recognised and responded to with sufficient urgency. There was no referral for a mental health assessment, nor does it appear that Mr Hong's GP was contacted.

7.3 The social worker planned to complete a formal risk assessment on 11/07/17 since they were not at work the previous day. Given the evident risks, the visit to complete this risk assessment could have been allocated to another worker to complete on 10/07/17. Similarly, there does not appear to have been any contact with Norbury Creek Nursing Home by any out of hours services over the weekend of 8-9/07/17 or on Monday 10/07/17 to check on the implementation of the risk management plan.

7.4 There also does not appear to have clear consideration of other factors in Mr Hong's past and present which might have indicated an increased risk of suicide. Mr Hong had a chronic health condition that impacted on his quality of life, he had little social support, he was isolated. He was a man who had experienced stressful life events and was from an ethnic minority group. He was self-harming, was talking about suicide and had, in the form of the alarm pull cord, access to lethal means.

7.5 Further awareness, consideration, and exploration of these factors, all of which are associated with an increased risk of suicide, either with Mr Hong or by the different services in contact with him, might have helped to form a clearer picture of Mr Hong's circumstances and might have influenced the outcome of any risk assessments. In turn, these risk assessments might have led to additional actions to protect Mr Hong's life. History taking, spotting patterns and identifying escalation are essential activities in managing risks.

7.6 **There was insufficient action to keep Mr Hong safe**

7.7 Whilst the GP and the social worker provided instruction on risk management, this was not followed by Norbury Creek Nursing Home, and was, with the return of the alarm pull cord, actively subverted. There was confusion over the reasons why the alarm pull cord was returned and there was no evidence that alternative methods for Mr Hong to call for help were explored. The pendant alarms, which could have provided an alternative means for Mr Hong to call for assistance, do not appear to have been working at the time but no replacements were considered.

7.8 Norbury Creek Nursing Home does not appear to have provided additional monitoring of Mr Hong despite being requested to do so by the GP. Instead, Norbury Creek Nursing Home waited for confirmation of funding and does not appear to have considered whether its duty of care to Mr Hong meant that it should take protective action and then seek confirmation of funding. There was no process in place to obtain confirmation for funding at evenings and weekends.

7.9 **Suitability of placement for Mr Hong**

7.10 Despite seeming to be able to meet Mr Hong's physical needs, Norbury Creek Nursing Home does not appear to have been able to meet Mr Hong's cultural and mental health needs. It does not appear to have been able to implement the risk management plan requested by the GP on 07/07/17. The Coroner issued a Preventing Future Deaths Notice following the inquest into the death of Mr Hong, which stated the following:

7.11 The observation regime advised by the GP was not implemented; whilst awaiting a formal review of Mr Hong's mental state, no interpreter was sought in the meantime to assist with the assessment of Mr Hong's needs due to issues of confusion between the social work team and the care home over responsibility for funding; no risk assessment was carried out prior to making decisions to return the pull cord; no further advice was sought from the GP or other appropriate clinician and Mr Hong was left in social isolation without any means to express his distress and with no safety net and no therapeutic engagement. There was also evidence at the inquest was that the care home staff did not receive training in how to carry out risk assessments.

7.12 All of these factors represent service quality and commissioning challenges that need to be resolved.

7.13 **The lack of availability, and use of, interpretation services exacerbated Mr Hong's isolation and limited the assessment and understanding of his needs.**

7.14 Little use was made of interpretation services. Instead any Mandarin speaking staff member who was available in any of the organisations that Mr Hong was in contact with could be called upon in an ad hoc capacity to translate for him. There was limited availability of professional translation, and this was not addressed at the time. In consequence, Mr Hong was maintained in isolation. No attempts appear to have been made to support him to meet other Mandarin speakers or to access any Mandarin speaking community contacts.

7.15 **As a result, the extent of Mr Hong's understanding of his situation and of his mental capacity was limited.**

7.16 There were several concerns about the extent to which Mr Hong understood the information he received, and questions were considered about his mental capacity. This was not, however, formulated into mental capacity assessments and instead the extent of Mr Hong's mental capacity to understand and to make decisions about, for example, treatment options, planning or accessing support services was not explored.

7.17 **There was a lack of joint working between agencies to meet Mr Hong's needs.**

7.18 Mr Hong's physical health needs were identified by the Home Office in 2012 and had been treated by health services before this. Despite this, no referrals were made for an assessment of needs either under the NHS and Community Care Act 1990 or under the Care Act 2014 or under the Human Rights Act, since Mr Hong had no recourse to public funds. This was only resolved in 2017 when an assessment under the Care Act 2014 was requested by St Helier Hospital so that Mr Hong could be discharged after a prolonged stay in hospital.

7.19 Instead, Mr Hong had been placed in a series of hostels and care homes without ongoing monitoring of quality, effectiveness and suitability. This lack of monitoring and awareness led, for example, to Mr Hong being reported to have absconded and by doing so to have made himself intentionally homeless (and which may have meant that his belongings were disposed of) when in fact he had been admitted to hospital.

7.20 A consequence of this was that there appears to have been little knowledge of, for example, who Mr Hong was, what his life was like, what his ambitions were, who his friends were, what he enjoyed and what motivated him.

## 8 Conclusions

8.1 There were a number of factors in Mr Hong's life which might have predicted a risk of self-harm and suicide. These included chronic kidney disease, a condition that impacted on his quality of life, lack of social support, and isolated. Mr Hong was a man who had experienced stressful life events and was from an ethnic minority group. In the few weeks leading up to his death, Mr Hong was self-harming, was talking about suicide and had, in the form of the alarm pull cord, access to lethal means.

8.2 Whilst there were evident failings in the days immediately prior to Mr Hong's suicide, as identified by the South London Coroner, who issued a Preventing Future Deaths Notice, there were several longer-term factors which had exacerbated Mr Hong's situation. These included lack of use of interpreting services, lack of communication between Home Office Asylum Operations, NHS services and London Borough of Croydon and accommodation providers and a need to further develop the market for service provision that can meet cultural and communication needs as well as physical needs. A number of these have been and are being addressed and the following recommendations are made on this basis.

## 9 Recommendations

### 9.1 Direct practice with individuals

9.2 The CSAB, through its Voice of the People Sub-group should obtain assurance from NHS and local authority commissioners that a range of services for people from different linguistic and cultural backgrounds are available in Croydon and that links are made with community groups who might provide social support for people who are otherwise isolated. Advocates

9.3 Epsom and St Helier Trust should introduce a Safeguarding Resource Guide for staff which will include contact details of advocacy services, including IMCA and general advocacy. This should include contact details for befriending services and is an opportunity for joint working with Croydon University Hospital on safe discharge from hospital.

9.4 The CSAB should, in partnership with NHS and local authority commissioners and training departments, promote the Health Education England Self-harm and Suicide Prevention Competence Framework (October 2018) as a means of equipping staff with the skills necessary to identify and work with people who are at risk of self-harm and suicide.

9.5 The CSAB should, in partnership with NHS and local authority commissioners and training departments, promote the Royal College of Psychiatrists' Final report of the Patient Safety Group, Self-Harm and Suicide in Adults (CR229), published in June 2020 and the Department of Heath's "Information sharing and suicide prevention consensus statement". This could be done by inviting a representative from the Royal College of Psychiatrists to attend a safeguarding adults board meeting to present the report. With permission this could be recorded and distributed to staff in partner organisations.

9.6 London Borough of Croydon should check whether the current financial restraint arrangements in Croydon (post-S114, Challenge Panels etc.) have not impacted on the interim funding arrangements that allow social workers to approve 72 hours of additional funding without seeking managerial agreement. London Borough of Croydon should also consider the effectiveness of one-to-one support and the extent to which it might constitute a Deprivation of Liberty or provide a false assurance of safety.

9.7 **Agency and interagency cooperation**

9.8 The CSAB, through its Voice of the People Sub-group, should obtain assurance that translation services are available for Mandarin dialect speakers (and other languages) and that partner organisations, including care providers, know how to access these. There are opportunities for joint commissioning and the use of online translation aids (including those on smartphones and tablets) should also be considered.

9.9 The CSAB should obtain assurance that the Home Office safeguarding team and the safeguarding teams or leads in partner organisations are working together.

9.10 NHS and local authority commissioners in partnership with training departments should use established provider forums to promote the self-harm and suicide champion role and mental health first aider role in residential and nursing care homes. This should also include promoting the use of include interventions for all staff who have also been affected by suicide and joint working between agencies to share information and act together to support people who self-harm and are at risk of suicide.

## APPENDIX 1: Literature review

The literature review was conducted in November 2020 -July 2021 using the following resources:

1. An internet search using Google to find open access journals and articles
2. The Royal Society of Medicine's on-line journals and related sources
3. The British Psychological Society's on-line journals and related sources
4. The Athens on-line journals and related sources

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