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For the attention of Ian Potter
Assistant Coroner for Inner North London

7 July 2025

Dear Sir/Madam,

I, [redacted], Chief Care and Support Officer, write in response to the Regulation 28 Report to Prevent Future Deaths that was issued following the tragic death of Mr Paul Reeves.

Please find below our response to the (numbered) matters of concern raised by the Coroner:

1. Maygrove Road, the supported accommodation, is not a care home and there is no expectation that staff at the accommodation will administer or supervise medication. Despite this, staff at the accommodation documented that they had collected Mr Reeves' medication 'for daily supervision'. Staff were aware that it was an expectation, from the mental health unit, that the accommodation staff should supervise Mr Reeves' compliance with his medication. There is no suggestion that the accommodation provider contacted the mental health unit to advise that this was something that they were unable to facilitate.

The concerns here are twofold. First, there appeared to be a lack of awareness from staff at Maygrove Road about the nature and extent of what they could/should do to support residents. Second, there was a lack of communication with the treating mental health team.

Medication and Support Officers duties

We acknowledge the concern raised regarding the remit of support staff in relation to the supervision of medication within supported accommodation. As correctly stated, supported accommodation is not a care home and there is no expectation for staff to administer or supervise medication.

Support staff collecting medication on behalf of Mr Reeves for 'daily supervision' does not imply a clinical responsibility to oversee compliance. The role of support staff, as outlined in our policies and consistent with the Medicines Act 1968, is to support residents by:

- Being present when residents take medication (if appropriate), prompting or reminding residents to take their medication, offering guidance on the safe storage, ordering and disposal of medication.
- Staff cannot administer medication or enforce compliance and their role remains supportive, not supervisory in a clinical context. That said, we recognise the need to strengthen awareness of this boundary.

To address the above, the following action has been taken:

- All staff at Maygrove have received mandatory refresher training on medication procedures, completed in January 2025, which reinforces their responsibilities, the remit of their role as set out above and communicating with partner agencies such as GPs, hospitals and care co-ordinators where necessary to ensure that they are aware of the remit of Support Officer roles and informing them if there are any issues with a resident taking medication prescribed to them (it is relevant to note that during the inquest, the hospital's consultant psychiatrist indicated that he had "little faith" in Mr Reeves complying with his medication but wanted to offer him an opportunity in any event as a long term plan with his therapeutic engagement was required).
- A three-month improvement plan was completed in May 2025 with support staff, focusing on strengthening key areas such as internal and external communication, medication handling, record keeping of daily concerns, resident activity and conducting a monthly medication audit to ensure safe practices and compliance.
- Our Quality and Improvement Team is currently developing a guidance document, due for completion by the end of September 2025, for staff working with specialist mental health services. This document will reinforce keeping in touch arrangements, ensuring that support teams are informed in advance when a customer is due for discharge from hospital or other clinical settings. It will also establish procedures to ensure that we receive up-to-date information about a customer's support needs, including medication, legal status and any other known risks, prior to their return to supported accommodation and allow for concerns to be raised where we are unable to facilitate the level of support required, particularly around medication.
- Staff have been reminded of the organisational medication policy which refers to staff responsibilities and the importance of adhering strictly to this policy. This reminder was provided verbally during a staff team meeting on 29 April 2025 and followed up in writing on 11 May 2025. Maygrove is scheduled to be audited in October 2025 as part of our national programme of quality audits – this will ensure that a full review of activity in relation to medication support is undertaken and any further gaps in colleague knowledge or practice are addressed.

2. During a welfare check on Mr Reeves on the morning of 26 March 2024, it was noted that Mr Reeves was 'agitated' and that 'there were broken glasses and pulled electrical panel in his flat'. It was also noted that Mr Reeves 'didn't know what had happened'. The mental health unit contacted staff at Maygrove Road on 27 March 2024 and it was accepted in evidence that the concerns about Mr Reeves' behaviour and the damage caused to his flat were not mentioned to the mental health staff. In the circumstances, these matters not having been raised with the mental health staff deprived the mental health team of an opportunity to assess Mr Reeves' mental state and leave status and to

consider whether or not he should have remained on leave. The manager at Maygrove Road told me in evidence that they would not expect staff to raise these matters with the mental health team; something which I found to be 'irrational'.

While I found that there was insufficient evidence to suggest that this would have altered the outcome for Mr Reeves, it raises serious concerns about communication that would enable mental health professionals properly to assess the needs and status of patients in the community, particularly given that the accommodation 'generally supports residents with mental health needs.

Missed communication

We acknowledge the concern regarding the lack of communication with the mental health unit following the welfare check on 26 March 2024. Although, as confirmed above, this did not make a material contribution to Mr Reeves' death, we recognise the incident highlighted a breakdown in expected information-sharing protocols.

To address this, we have taken the following actions:

- We have reviewed our national Support Planning Procedure. The procedure now specifically states that:
    - Where a customer is on leave to the service from hospital, for example, Section 17 leave, the hospital ward details must be held on the customer record as a key contact.
    - Safety Plans must detail which external agencies or clinical teams must be contacted if concerns arise regarding customers who are on Section 17 leave, Community Treatment Orders or under other legal restrictions (e.g. Section 41).
    - Where a customer is admitted to hospital, particularly where this is a stay of more than 1-2 nights, the Support plan must be reviewed. The procedure asks that where possible, this should take place prior to the customers return but as a minimum this should happen within 24 hours of their return to the service.

- Staff have been reminded of the importance of sharing behavioural changes, environmental damage or unusual incidents with the relevant mental health team — not only for safeguarding, but to ensure a collaborative, well-informed approach to care. The Senior Team Manager, [redacted], held a Maygrove Service Improvement Meeting with the staff team on 4 February 2025 and a follow up via email was shared on 27 May 2025. This was addressed and completed within our three-month improvement plan completed in May 2025.

- Our Quality and Improvement Team is currently reviewing and updating our approach to welfare checks, including our national Welfare Checks Procedure, due for completion by the end of September 2025. This will set out circumstances in which colleagues should also contact the Duty Team where they have concerns about a customer's welfare and are unable to contact their Social Worker/Care Coordinator.

3. Although concerns regarding Mr Reeves' presentation (para 2 above) were not raised during the telephone call from mental health staff, the manager of Maygrove Road did send an email to Mr Reeves' care co-ordinator. That email raised health and safety concerns relating to the damage caused by Mr Reeves to his room/flat. However, it did contain phrases such as, 'he is not doing well' and he appears 'very unwell'. I found that an email (essentially headed as a health and safety

matter) essentially raised concerns about escalation and communication of a deteriorating patient.

We acknowledge the concern raised regarding the email communication sent by the accommodation manager to Mr Reeves' care coordinator. While the intent of the message was to report health and safety risks following damage caused in the flat, we recognise that the email included phrasing such as "he is not doing well" and "he appears very unwell," which could reasonably indicate a deteriorating mental health presentation.

Although this email was framed as a property-related issue, it indirectly communicated clinical concerns and as such, may not have prompted the appropriate clinical response or escalation. We recognise the importance of ensuring that concerns about a customer's mental state are clearly and unambiguously communicated to the relevant professionals.

In response, we have taken the following steps:

- Staff have been reminded and trained to separate and appropriately escalate clinical vs. operational concerns, ensuring that communications referencing mental health deterioration are directed through the correct clinical escalation channels (i.e. mental health professionals, crisis teams or the responsible care coordinator). This was addressed and completed within our three-month improvement plan completed in May 2025.
- The Team Manager of Maygrove Road, [redacted], sent an email to the staff team on 27 May 2025 advising them that if they observe any changes in a customer while they are on leave from hospital, that this needs to be communicated to the hospital and care team by phone and followed up with an email. The Maygrove Road Improvement plan states the following: Any concerns regarding a customer's mental or physical health should be reported to the appropriate teams, including management, without delay within 24 hours
- We already audit Support Plans and verify that local arrangements are in place to monitor customer welfare as part of the quality audit process. However, we will now include specific guidance in the audit tool to ensure that auditors check that: Safety Plans clearly detail which external agencies or teams must be contacted when colleagues have concerns about a customer who is on Section 17 leave from hospital, under a Community Treatment Order or subject to other legal restrictions (e.g. Section 41). The audit tool will also check that any concerns regarding customer welfare have been escalated appropriately, for example, by ensuring teams make direct contact with the Social Worker or Duty Team.
- As detailed above, this has also now been embedded into our national Support Planning Procedure which outlines the expectation that customer Safety Plans will cover when external agencies or clinical teams must be contacted to escalate concerns regarding customers who are on Section 17 leave, are subject to a Community Treatment Order or under other legal restrictions (e.g. Section 41).
- These measures will be reinforced in monthly team meetings, within our four supervision check-ins per year and training to ensure clarity and consistency of communication across all services.

4. In the early morning of 28 March 2024 (approximately 07:13), the CCTV footage showed Mr Reeves crawling out of the front entrance to Maygrove Road, initially into the bin area and, a few minutes later, into the road. A support worker from Maygrove Road can be observed walking towards Mr Reeves. However, from the CCTV footage, the support worker appears to make limited attempts, if any, to engage Mr Reeves or block his path into the carriageway of the road. I heard evidence that staff members would not be permitted to restrain Mr Reeves; however, the CCTV footage raises concerns that staff may lack the knowledge, skills or training in handling or attempting de-escalate a situation such as this. For the avoidance of doubt, there was no evidence that an improved response would have altered the outcome for Mr Reeves, but that does not diminish the future risks to others.

We acknowledge the concern raised following CCTV footage of Mr Reeves exiting the premises in the early hours of 28 March 2024 and entering the road. While the support worker in question was not called to give evidence at the inquest, we recognise the importance of reflecting on staff actions in situations involving potential risk.

Support Officers are not authorised or trained to restrain residents. Their remit is supportive and non-clinical. Although this was an isolated incident and the coroner confirmed that it did not alter the outcome for Mr Reeves, we have used it as a learning opportunity. On 4 February 2025, Support Officers were reminded of their responsibilities in responding to residents in visible distress or potential danger. Further to the above, this included a reminder that any concerns regarding a customer's mental or physical health should be reported to the appropriate teams, including management, without delay within 24 hours and that any issues or concerns related to assigned customers should be escalated to management and the clinical team for appropriate action. The team manager also advises staff during handovers that if there are any concerns that any customers are deteriorating in their mental or physical health, the clinical team needs to be contacted immediately.

Current Safeguarding and Support Measures

We are confident in the strength of our wider training and operational systems. The following are either already in place or are being enhanced as part of our ongoing quality improvement efforts:

- Mandatory induction and refresher training, covering mental health awareness, health and safety and incident management (this was completed in April 2025).
- We provide a Mental Health training programme that includes our training in Basic Therapeutic Skills which covers communication (including how to have difficult conversations with clients), self-awareness, boundaries and case formulation. All staff will have completed this by the end of 2025.
- We are working with our Learning and Development Partner in reviewing our training offer for colleagues working in mental health services to ensure that both mandatory and role required training continues to be appropriate for the needs of colleagues working in these services. This will be complete by the end of 2025.
- We offer 24-hour on-call management support, available to all staff for escalation and decision-making support during high-risk incidents.

- Regular 1:1 supervisions (minimum of four per year). We also provide reflective case discussions held every 2–3 months or more frequently as needed.
- Monthly team meetings to review incidents, medication concerns, resident concerns, safeguarding concerns, reinforce procedures and identify emerging training needs.
- A performance management and quality assurance framework to monitor service standards and ensure residents are supported safely.
- Audit programme conducted at least every two years, or sooner where quality issues are identified.

To conclude, our Quality and Improvement Team have reviewed or are in the process of reviewing the following procedures quoted within this report:

1) **Complete: Review of the Support Planning Procedure to specifically reference:**

    - Where a customer is on leave to the service from hospital, for example, Section 17 leave, the hospital ward details must be held on the customer record as a key contact.
    - Safety Plans must detail which external agencies or clinical teams must be contacted if concerns arise regarding customers who are on Section 17 leave, are subject to a Community Treatment Order or under other legal restrictions (e.g. Section 41).
    - Where a customer is admitted to hospital, particularly where this is a stay of more than 1-2 nights, the Support plan must be reviewed. The procedure asks that where possible, this should take place prior to the customers return but as a minimum, this should happen within 24 hours of their return to the service.

2) **By the end of September 2025: Produce a guidance document for specialist mental health services setting out what they should do where a customer is admitted to hospital, covering guidance on:**

- Keeping in touch arrangements to help ensure that we are aware where there are plans for the customer to be discharged and that we have up to date information about the customers' support needs e.g. medication, legal status, other risks before the customer returns. This will help to improve multidisciplinary collaboration and ensure that the customer receives the right level of support upon discharge.
- Action to take where a customer is discharged and returns to a supported service without prior notification to or knowledge of the support team.

3) **By the end of September 2025: Include information in our national Welfare Checks Procedure:**

- Setting out circumstances in which colleagues should also contact the Duty Team where they have concerns about a customer's welfare and are unable to contact their social worker, care co-ordinator or other relevant professional.

4) **By Mid-July 2025:** Include specific guidance in the Quality Audit Tool used across services to ensure that auditors check that:

    i. Safety Plans clearly detail which external agencies or teams must be contacted when colleagues have concerns about a customer who is on Section 17 leave from

hospital, under a Community Treatment Order or subject to other legal restrictions (e.g. Section 41).

ii. Any concerns regarding customer welfare have been escalated appropriately, for example, by ensuring teams make direct contact with the Social Worker or Duty Team.

While this was an isolated event, it highlighted the need for continual reinforcement of safe engagement techniques. We are satisfied that our current systems provide a solid foundation and that actions led by the Quality and Improvement Team will further enhance staff capability and response consistency across services.

We are committed to ensuring that staff fully understand their role boundaries and work collaboratively with healthcare professionals to support residents in a way that is safe, lawful and consistent with best practice.

We trust that the above deals with the Coroner's concerns. If, however, any concerns or queries remain, please do not hesitate to contact [redacted], Regional Operations Manager (London Mental Health), via email [redacted] or by calling [redacted].

Yours Faithfully,

[redacted]

[redacted]
Chief Care & Support Officer