

07/01/2026

PRIVATE AND CONFIDENTIAL

Dear HM Senior Coroner Alison Hewitt,

Re: Tony Montana Duncan

Date of birth: 20/08/1989

Date of death: 04/07/2024

Thank you for your Regulation 28 Report dated 15th October 2025, setting out your concerns to be addressed. I would like to begin by expressing our deepest condolences to the family and friends of Mr Duncan on their loss.

The concerns set out in your PFD report were as follows:

1. The Deceased presented to the South London and Maudsley NHS Foundation Trust's psychiatric liaison team which was operating within the Accident and Emergency Department of King's College Hospital, with a referral letter from his General Practitioner which sought possible admission and medication review. The Deceased was known to the Trust, and he had been the subject of a safeguarding referral and a self-referral shortly before his attendance at the hospital. From the information available to the psychiatric liaison team, it was apparent that:

(i) The Deceased had a chronic and persisting mental health condition which was usually controlled by medication but which, when not controlled, could give rise to suicidal ideation; he had previously been helped by periods of detention / voluntary admission to hospital,

(ii) By May 2024, there was evidence that he was suffering an acute deterioration in his mental health which he subsequently reported was because he had not been properly compliant with his prescribed medication for a number of weeks, and

(iii) The Deceased recognised the deterioration in his mental health, that he was suffering specific suicidal ideation relating to jumping from London Bridge, and that he needed help from mental health services, including by voluntary admission to hospital; he sought help by making a self-referral to the Trust via the Single Point of Access service and by attending his GP and the hospital.

2. When the Deceased attended the hospital, the Accident and Emergency team's triage notes included express reference to his specific suicide plan and attached the GP's letter of referral. The Deceased was then assessed by a psychiatric liaison nurse who concluded that his presentation was as a result of psycho-social stressors rather than mental illness; she was not concerned about the risk of suicide because he had no plan or intent; and she referred the Deceased to the homelessness team and discharged him back to the care of his GP. The nurse did not take any steps to review the Deceased's medication or consider admission, or escalate these matters to a doctor, nor did she involve the Crisis or Home Treatment teams for follow up / immediate safeguarding. Despite there being a recognised risk to self and to others, both of which the Deceased himself said he could not control, there is no evidence of any risk assessment documentation being completed.

3. The Deceased was subsequently seen in the Accident and Emergency Department by a Social Worker from the homelessness team. The Deceased insisted that he was not homeless and that he had attended the hospital for help with his mental health, without which he would jump from London Bridge. The Social Worker immediately passed this information to members of the psychiatric liaison team who he found, together, in their office. Subsequently, whilst still in the department, the Deceased became agitated and abusive, which behaviour was a recognised aspect of his behaviour when he was unwell. It seems he later left the department and/or was escorted out as he was being abusive; the records show that at least one member of the psychiatric liaison team was aware of this development but took no action to prevent the Deceased from leaving or to encourage him to stay in order to re-assess him, nor to alert the Crisis and/or Home Treatment teams, the GP, or the Deceased's family as to the situation.

4. Following the report of the Deceased's death, South London and Maudsley NHS Foundation Trust's own review highlighted various concerns about the operation of its Single Point of Access service but neither that review, nor the evidence provided to the inquest from the Consultant Psychiatrist who was responsible for the psychiatric liaison team in King's College Hospital, identified any concerns about the management of the Deceased by the psychiatric liaison team on the 4th July 2024. This may suggest that there were systemic as well as operational factors which led to the Deceased not receiving the help and support, he needed on the 4th July 2024.

Before we address the concerns you have raised, I would like to apologise that there was no review available at inquest into the care and treatment provided by King's

College Hospital Liaison Psychiatry. In accordance with Trust mortality processes, a mortality review had been carried out, and the incident had been referred for an After-Action Review (AAR), which is the Trust's main investigatory response to a patient safety incident. However, the AAR spanned two boroughs and was taken forward by Lambeth Governance Team with no representation from Southwark. This was an oversight and meant that the AAR did not focus on learning from the parts of Mr Duncan's care which had been provided by the King's College Hospital (KCH) Liaison Psychiatry team, which is a service in the Southwark Directorate. Governance arrangements for AARs have been discussed at the Trust Patient Safety Committee on 13th November 2025 and are being reviewed.

Therefore, an AAR into the care and treatment provided by KCH Liaison Psychiatry was carried out retrospectively, on 19 November 2025, and is attached. The review identified several areas of learning and improvement, and it has also established facts that the Trust did not put forward at the inquest, which is regrettable. Although the Trust appreciates that the coroner has made findings of fact based on the evidence heard at the inquest, the Trust still considers it important to set out its position. The Consultant Psychiatrist covering KCH Liaison Psychiatry on the day of the incident may have been able to put forward some of these points during his verbal evidence at the inquest but unfortunately became seriously ill days before the inquest and was unable to attend.

In response to the concerns raised:

1. Mr Duncan had a diagnosis of personality disorder (Type B, emotionally unstable traits, also referred to as borderline personality disorder or EUPD). This is a chronic and persistent mental health condition and had been diagnosed following a two-week admission to hospital in 2016. He had been stable since then and managed by his GP in primary care, except for a brief review by a SLAM community team in 2022. Since 2016, his GP had prescribed his medication, namely the antipsychotic olanzapine. Olanzapine can be helpful for sleep and agitation as well as psychotic symptoms and whilst sometimes used in the treatment of emotionally unstable/borderline personality disorder, it is not a strongly evidence-based treatment; NICE guidelines recommend that medication is used in the treatment of personality disorder on a short-term basis only, or for the treatment of co-morbidity. It is not clear discontinuation of medication was the main causative factor in Mr Duncan's relapse as one might suspect in a psychotic illness. During the Psychiatric Liaison Nurse's (PLN) assessment in KCH Emergency Department (ED), Mr Duncan did not present with signs or symptoms of psychotic or mood disorder, or with agitation or sleep disturbance which might indicate the need for medication. We acknowledge the GP requested a medication review in the referral letter and that the PLN did not address this. Medication review is often more usefully carried out with a full treatment history, and this is more suitable for the Community Mental

Health Team (CMHT) setting; this was another important reason to ensure community follow up.

We acknowledge the safeguarding referral and self-referral to Lambeth Single Point of Access prior to presentation at the ED provide further evidence that Mr Duncan was experiencing significant and persistent need/distress. The safeguarding referral contains information suggesting possible paranoia; if the assessing PLN had access to this, an exploration of the reasons behind the presentation to the police could have elicited important information about his mental state. The referral was uploaded to an unusual part of the electronic notes which is not always routinely checked, nor was it referenced in the main body of the notes; recommendations for managing such information have been made by the AAR as it is crucial staff have easy access to it.

Mr Duncan had last been admitted to hospital in 2016; this was initially a voluntary admission, subsequently an emergency Section 5(2) was used to detain him until a full Mental Health Act assessment could be organised. He was found not to be detainable and self-discharged against medical advice. Shortly after this he requested to be readmitted and when this could not be accommodated, he caused damage to Trust property by smashing the windows of the ward. When in the community, he was less agitated than on the ward and was subsequently managed by a CMHT and then primary care without further intervention from acute services. It is therefore not clear admission had been helpful, and this is not uncommon in patients with personality disorder and one of the reasons why the benefits of admission should be weighed against potential harms of admission to hospital. NICE guidelines state alternatives to admission must be considered and likely harms resulting from admission ought to be discussed with the patient. Mr Duncan initially seemed to be able to engage with community treatment and therefore this would have been an appropriate plan. These principles likely shaped some of the decision making by the PLN.

2. The AAR found that on review of the SLAM electronic record, the PLN considered admission but concluded this was not indicated. NICE guidelines mandate the consideration of alternatives to admission in the treatment of borderline/emotionally unstable personality disorder. She discussed her opinion that admission was not indicated with Mr Duncan who, according to the record, seemed initially in agreement. However, the PLN did not document any exploration of the discrepancy between the presentation to the GP and the presentation to her. Whilst this change in presentation is not unusual in itself - as suicidal ideation is dynamic and can fluctuate rapidly, particularly in response to emotional containment - exploration of this could have been helpful in formulating a better understanding of the triggers and mitigating factors for suicidal ideation. Training needs around assessing suicidal ideation are discussed below.

Addressing social stressors, as the PLN did through referral to the homeless team, is an important aspect of holistic mental health care, and Mr Duncan was also in agreement with this plan initially. The PLN's plan was to refer to a CMHT after review by the homeless team.

Referral by the PLN to a doctor was not clearly indicated, as this pathway is for those who may require admission under the Mental Health Act, or changes to their medication, or for other complexities as deemed by the assessing clinician. The AAR explored onward referral to doctors by PLNs and this was thought to be working well, with senior psychiatric doctors available 24 hours a day. Mr Duncan initially presented as calm and without signs or symptoms of affective disorder or psychosis. Later, when Mr Duncan became agitated, referral to a doctor to consider next steps (including potential referral to a crisis team) may have been indicated, and his self-discharge without further review or discussion was a lost opportunity to review the assessment and offer further support. Had Mr Duncan been found to have capacity to make decisions around treatment and care, as he was in the initial assessment, there would have been no grounds to detain him and stop him if he insisted on leaving. However, it would have been useful to review his mental state again, given that his presentation appeared to change while he was in the ED. It does not appear that the Liaison Psychiatry team were informed by the ED team that Mr Duncan was trying to leave the ED and self-discharge, until such time as he was being escorted out by security. The AAR recommends that potential self-discharges must be flagged to the Liaison Psychiatry Team by Emergency Department colleagues early and there must be consideration whether further assessment is warranted to ensure self-discharge is safe.

Ideally, the PLN would have sought Mr Duncan's consent to contact a named person/carer, ideally his mother with whom he lived, but did not do this; the AAR has made a recommendation to address this omission by embedding 'carer contact' in the Liaison Psychiatry departmental handover board; this must be done and documented before patients can be discharged. The Trust is accredited under the Triangle of Care initiative led by the Carers Trust and endorsed by NHS England, which seeks to implement six key standards required to achieve better collaboration and partnership with carers, including identification of carers at first contact; the implementation of this in the ED can be difficult for reasons outlined in the AAR, and this extra flag is intended to provide further operational support for future patient cases. The AAR did note that adult patients with mental capacity to make the relevant decision may well decline or refuse a request to contact their family, but in this case there is no documentation that this discussion took place. Family members are often able to provide useful collateral information which can assist in care planning, even if the patient does not permit the clinician to share information about them. However, if a patient refuses to allow contact, it may not be possible to make this contact. This should be noted in the electronic record.

The AAR reviewed the electronic record which showed the PLN did complete the risk assessment tool and documented a brief risk assessment in the 'Events' section of the SLAM electronic record. However, she did not explore the discrepancy in suicidal intent and planning, especially such that was evident in the difference between her and the GP's assessment, and there is not sufficient evidence in the notes that she carried out safety planning with Mr Duncan. It is possible that she intended to do this following review by the homeless team, as what they can offer often might affect what can be discussed around a safety and crisis care plan. Although it is impossible to accurately predict suicide in an individual, modifiable risk factors for suicide should be identified and addressed and safety planning should be carried out. Furthermore, risk assessment should involve a carer, if possible. Training on personalised risk assessment and management was released by NHSE in September 2025, and the AAR recommends that such training should be mandatory for clinicians. The Trust is one of ten mental health organisations taking part in a national pilot through the NHS England and Royal College of Psychiatrists Culture of Care Programme – Personalised Approach to Risk. The pilot aims to enhance how we approach, assess, and manage the risk of suicide. This work aligns with the NICE guidance for Self-harm, which states that risk assessment tools should not be used to predict suicide. Further information can be found here: [Culture of Care Programme](#) and here: [NCISH | Implementing a personalised approach to risk](#).

3. The AAR found that Mr Duncan was ambivalent about whether he wanted help with his housing. At some points during his treatment episode at KCH, he said he wanted to be seen by the homeless team, at others he did not. His mental distress increased after he was seen by the homeless team and he then stated he would jump into the Thames if he were not admitted to a psychiatric ward. A recommendation made by the AAR is that the Liaison Psychiatry team and KCH homeless team should consider seeing patients together, especially patients with complex emotional needs/borderline/emotionally unstable personality disorder where differences of opinion between different teams can be marked due to the phenomenon of 'splitting' of affective states.

When Mr Duncan became abusive and was escorted out of the department, the PLN team seemed to be of the opinion, perhaps on the basis of the information provided to them by the ED team, that this was also a self-discharge made with mental capacity. The original plans to refer on to a CMHT and finalise the management plans around discharge were then lost. This was a missed opportunity to offer further support. The AAR recommends that any Liaison Psychiatry patient wishing to self-discharge from the ED must be flagged to the Liaison Psychiatry team at the earliest opportunity and the Liaison team must then consider further assessment and whether the decision to self-discharge is appropriate. The Trust endorses the Triangle of Care, as discussed earlier, and the PLN should have

requested consent to contact Mr Duncan's named person/carer as discussed above.

4. The Trust would like to reiterate that we are sorry there was no review of the care and treatment provided by the KCH Liaison Psychiatry team available at inquest. A Mortality Review had been completed, and the plan had been to carry out an AAR. Governance arrangements for AARs that involve multiple directorates are under review by the Trust's Patient Safety Committee. The Consultant Psychiatrist for Liaison Psychiatry provided a witness statement for the inquest, but this was not an investigatory review of this incident.

Since Mr Duncan's death the Trust has introduced several new systems to address the challenges raised by patients presenting to ED. The Liaison Psychiatry team carries out multiple clinical safety huddles in ED each day. These are brief, daily, multi-disciplinary team meetings to quickly review patient safety, share urgent information, identify risks (like high-risk behaviour or medication issues), plan care, improve teamwork, and resolve problems. This follows the team handover which facilitates rapid risk review and shared decision making between ED and Liaison Psychiatry teams.

The AAR recognises the difficulties of providing optimum mental health care in the ED environment and makes a recommendation around the development and opening of a dedicated mental health urgent & emergency care (UEC) centre at The Maudsley Hospital. This had already been planned for June 2026. The model is designed around time, space, privacy, and dignity, permitting clinicians to formulate care and treatment plans collaboratively with patients and carers. A growing evidence base supports the model. The available evidence shows these deliver improved patient and staff experience; reduce 12-hour breaches in ED; and alleviate wider ED activity. SLAM has therefore developed this service with support from South East London Integrated Care Board (SEL ICB).

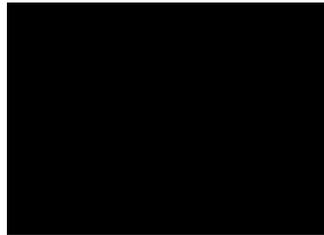
KCH has also launched a new ED Low Intensity Area (LIA) in partnership with SLAM. The LIA space offers a calm and supportive environment for suitable patients who would otherwise wait in the busy environment of the main ED. Operating 24/7, it currently has capacity for six patients. The LIA is a continuum of the ED, but patients are kept in a less stimulating environment. Patients who are moved into LIA have already been assessed and have a plan in place, but they need to wait to have it enacted. These plans may include referral for a psychiatric admission, referral to an associated team such as the homeless team or addictions care team, with ongoing care planning following the assessment, or referral to Recovery House in Lewisham, where they can be offered a maximum of 7 nights stay, as an alternative to admission for people who feel unable to return home. However, the Recovery House is not suitable for people who are homeless so would not have been an option for Mr Duncan.

5. It is our sincere hope that this response letter and the accompanying AAR provide sufficient reassurance that the Trust has taken appropriate action to address your concerns in order to prevent future deaths. The Trust is committed to improving its systems and processes in the interests of patient safety wherever possible and we are grateful for this opportunity to reflect on the service we deliver and how it can be improved for patients like Mr Duncan to prevent such a tragic event occurring again.

Yours sincerely



Chief Nurse



Chief Medical Officer