Board Statement on the Publication of the Safeguarding Adult Review concerning Mr Michael Thompson

Lewisham Safeguarding Adults Board has today published a Safeguarding Adult Review that has scrutinised the circumstances surrounding the tragic death of Michael Thompson.

First and foremost all members of the Board wish to extend their sincerest condolences to Michael's family and to express their determination that lessons will be learned from this review. The Board is also very grateful for the way in which Michael's family has engaged with the review. This has enabled us to gain a very clear picture of Michael, the person, and the circumstances surrounding his death.

Lewisham Safeguarding Adults Board is under a statutory duty to commission a Safeguarding Adult Review where an adult has died as a result of abuse and neglect and there is concern about how agencies worked together. The review includes the terms of reference and details the findings concerning the circumstances surrounding a mental health crisis. In such circumstances the Mental Health Act 1983 and the Mental Capacity Act 2005 provide a clear framework for the roles and responsibilities of police officers, ambulance crews, social workers and doctors, working alongside the individual and their relatives.

There are 18 learning points that have emerged from an analysis of the available evidence, covering mental health assessment, mental capacity, risk assessment, record keeping, knowledge of relevant legal rules and liaison between different agencies with roles and responsibilities during mental health crises. Implementation of the learning points will be designed to ensure that professionals involved in mental health crisis situations are fully aware of their roles and responsibilities.

Lewisham Safeguarding Adults Board has required each organisation that had some involvement with Michael at the time to prepare and submit an improvement action plan. These action plans have been scrutinised and approved by the Board, which will monitor implementation at its subsequent meetings to ensure that the necessary policy and practice changes are achieved.

The Board will also ensure that a briefing summary is circulated to all staff members within the organisations involved to ensure that the learning from this case is disseminated widely. The review report will also be the focus of forthcoming learning and service development seminars, again to ensure that the learning is circulated widely and that the outcome of implementation of the learning points gives reassurance about how organisations will respond to mental health crises in future.

Professor Michael Preston-Shoot
Independent Chair
Lewisham Safeguarding Adults Board
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