Mr X

Safeguarding Adults Review

Executive Summary

Prepared by the Safeguarding Adults Board

July 2017

1. INTRODUCTION

1.1. In June 2015, the Safeguarding Partnership Board (SAB) agreed that the circumstances surrounding Mr X's care and support prior to his death in May 2015, met the criteria for a Safeguarding Adult Review (SAR). The SAR commenced in September 2016.

1.2. There was a delay in commencing the SAR until September 2016, as the SAB had been advised by the Borough Police Commander at the time, to await the completion of the Independent Police Complaints' Commission (IPCC) enquiry and Police Professional Standards Review before commencing the SAR. The completion of the SAR was also impacted upon by an Article 2 Inquest at the Royal Courts of Justice which was originally listed for March 2017 and subsequently deferred to September 2017, to enable the SAR to be concluded before the enquiry.

1.3. Independent Safeguarding Adults Reviewers were appointed in September 2016 and their independent review report was presented to the SAB in June 2017. The SAR Panel considered in detail, the multiagency involvement with Mr X during the period of 31 May 2015 to 6 June 2015.

1.4. This document, which has been prepared by the SAR Sub Group (which had governance oversight of the SAR Panel) summarises the independent SAR panel report. It also presents the SAR Panel's recommendations (Appendix 1) and sets out supplementary commentary and proposed actions.

2. INVOLVED AGENCIES

2.1. The following agencies were involved in the SAR Panel contributing to the information considered and to the final SAR Panel report and recommendations:

- South West London and St George's Mental Health NHS Trust (SWLSG MH Trust) including Springfield Hospital and the Community Mental Health Team (CMHT);
- St George's University Hospitals NHS Foundation Trust Accident & Emergency Department;
- GP Services, NHS Richmond Clinical Commissioning Group;
- Chelsea and Westminster Hospital NHS Foundation Trust through West Middlesex University Hospital Accident & Emergency Department;
- London Ambulance Service (LAS);
- Metropolitan Police Service (MPS);
- London Borough of Richmond upon Thames Adult Social Care, including Social Work professionals (integrated with SWLSG MH Trust) and Approved Mental Health Practitioner (AMHP) Service;
- London Borough of Hounslow Home Treatment Team (HTT).

2.2. Mr X's mother was contacted and invited to contribute directly to the SAR process. Initially, dialogue between the family and the Lead Reviewers was conducted via the family solicitor and the police Family Liaison Officer. One of the Lead Reviewers met

with Mr X's mother, older sister and brother-in-law once. The family did not wish to discuss the review period in question as this had been covered in Mr X's mother's statement provided for the purpose of the police investigation. Mr X's mother provided the Lead Reviewers with a copy of her statement. The family's wishes were respected. The content and statements made to the Lead Reviewer during her meeting with the family were fully considered as part of the review.

3. REVIEW PROCESS

3.1. At the outset of the process the Lead Reviewers planned to use a methodology which involved collating an integrated chronology, identifying key areas for review, meeting with involved practitioners from the identified agencies to understand their actions and to engage with the SAR Panel to consider the findings and use this to inform the final report. As a result of the Coroner's Inquest due to be held at the Royal Courts of Justice, which involved statements from the same core participants, it was not possible to follow this methodology.

3.2. Agencies were asked to supply chronologies and Independent Management Reports (IMR's) and these together with reports compiled for other process including IPCC and SWLSTG (MH Trust) Serious Incident (SI) report were used to inform the final report.

4. REVIEW FINDINGS

4.1. Changes in Mr X's care from Care Programme Approach (CPA) to standard care in 2011 reduced the level of involvement both Mr X and his mother had with mental health professionals. The relapse he experienced in May 2015 was the first following these changes. During a period of 6 days leading up to Mr X's death, a number of issues appeared to complicate the situation and impacted on his optimal care.

4.2. There were numerous delays across a range of agencies which undoubtedly led to Mr X's mental health deteriorating and led to a prolonged period where, although he was being contained, he received no treatment.

4.3. These delays were due in part to a lack of resources, including available 'Section 136 beds', 'Section 12' doctors[1] and Approved Mental Health Professionals (AMPHs) at significant times when they were required by Mr X.

4.4. Delays were compounded by the design of the service arrangements at the time and the lack of accuracy and timeliness of communication between different components of the mental health services and between agencies.

4.5. The death of Mr X could not have been predicted by the professionals working with Mr. X and his mother.

[1] Section 12 and Section 136 refers to the Mental Health Act 1983 (MHA)

5. FULL LIST OF RECOMMENDATIONS AS SET OUT IN INDEPENDENT SAR PANEL REPORT

5.1 The recommendations set out below in paragraph 5.3 below are taken exactly as worded from the full SAR Panel Report. These have been extensively discussed in relation to their focus, intention and achievability. The Composite Action Plan (Appendix 1) provides a multi-agency response via the SAR Sub Group as to the intended way to address the recommendations. The Composite Action Plan will be both dynamic and the key reference document through which the SAB will ensure oversight and assurance of the required actions.

5.2 The SAB will require subsequent progress reporting on the Composite Action Plan. The SAR Sub Group, acting on behalf of the SAB, will have oversight of this Composite Action Plan and will seek regular updates from partners on the implementation of the actions in order to provide that assurance. The SAR Sub Group will regularly update the SAB.

5.3 The Recommendations are as follows:

- **Recommendation 1:**
  SWLSTG (MH Trust) to ensure that all patients with histories of violence during relapses, receive coordinated care, support and monitoring on a monthly basis to enhance relationship building.

- **Recommendation 2:**
  Mental Health Service Care Coordinators to ensure all care plans are holistic and dynamic in nature, and interface with partner agency plans, taking account of the patients support network needs including their Carer's assessments the support required, any children who may need support, and partner agency involvement. Care plans must demonstrate consent to share information with Carers has been sought and, provision for if the patient becomes unwell and their judgement is impaired, has been discussed. The decision regarding consent must be regularly revisited and documented in both the care plan and the crisis plan; arrangements for this to be shared with relevant professionals in times of crisis must be demonstrated. Where consent is not obtained, an advance statement should be requested.

- **Recommendation 3:**
  Assessment tools used by Medical and Psychiatric staff in A&E and PICU to be reviewed, to ensure they include the need to demonstrate that all aspects of both mental and physical health in patients with mental health issues, in receipt of acute or emergency care, have been assessed. Guidance on the use of the tool must direct the assessor to record reasons for any none completion of part of the assessment tool.

- **Recommendation 4:**
  LAS to devise a risk assessment tool, to be completed on all occasions that Police presence is requested; that prompts the assessor to note all areas of risk. The outcome of this risk assessment is to be shared with the Police prior to the Police Grading a call.

- **Recommendation 5:**
  The scope of the out-of-hours Home Treatment Team Service review to be revisited to ensure the review is focused on the outcome and experience for patients whilst considering the co-ordination of its' services, its' recording systems and practice, and its onward referral process.

- **Recommendation 6:**
  A process to be developed by Health professionals within Emergency Care and Mental Health Services (health and social care), to ensure a robust plan of care, which includes administration of already prescribed medication, is put in place by the named professional in A&E and the allocated mental health worker, including which service has overall responsibility for the care of the patient.

- **Recommendation 7:**
  SWLSTG (MH Trust) to review the pathway for patients entering A&E with Mental Health issues to ensure smooth and timely navigation through the services to treatment is achievable.
- **Recommendation 8:**
  The SAB to be assured by its partners that:

  - Staff regularly receive information and training on communication and information sharing based on national and local guidance that directs staff to focus on the outcome they are aiming to achieve
  - That examples of what is and is not effective communication are provided in training and,
  - That staff are supported to challenge each other's actions/inactions
  - That staff know they maintain a level of responsibility to ensure requested actions have been completed.

- **Recommendation 9:**
  The SAB to hold a practitioner's event, following Mr X's inquest, to explore the themes arising from this SAR and review any additional learning.

- **Recommendation 10:**
  SWLSTG (MH Trust) to develop a pathway that gives clear direction to all staff working in PICU, as to which policy to follow in each circumstance. The Seclusion and RT policies to be revised to include a requirement that rationales for non-adherence to policy must be recorded and reviewed by the Nurse in Charge or treating Psychiatrist.

- **Recommendation 11:**
  SWLSTG (MH Trust) to provide training to all staff working in-patient areas regarding the pathway and the application/interface between the Rapid Tranquilisation policy and the Seclusion Policy.

- **Recommendation 12:**
  The SAB to be assured by partner agencies that the learning from the earlier SCR has been incorporated into training and shared across services in Richmond, and that agreed actions have been completed.

- **Recommendation 13:**
  The SAB to seek assurance through regular progress reports from partners that they are effectively addressing the resource issues raised in this SAR.

- **Recommendation 14:**
  The Police to review its information sharing protocols, devise and introduce a form to be completed in situations where they are transferring the care of a person detained under Section 136 of the Mental Health Act to a health facility.

- **Recommendation 15:**
  Chelsea and Westminster Hospitals NHS Foundation Trust to explore further the underlying factors for the lack of documentation with the professionals involved and produce an appropriate action plan.

- **Recommendation 16:**
  SWLSTG (MH Trust) to ensure a mental health practitioner is assigned to advocate, and take responsibility for overseeing and monitoring a patient's mental health, including ensuring prescribed medication is administered when there are delays in admitting/transferring them into Hospital.

APPENDIX 1: MR X COMPOSITE ACTION PLAN

Including a commentary for each recommendation and implementation proposals

RECOMMENDATION 1: SWLSTG (MH Trust) to ensure that all patients with histories of violence during relapses, receive coordinated care, support and monitoring on a monthly basis to enhance relationship building.			
SUB GROUP CLARIFICATION AND COMMENTARY	**PROPOSED IMPLEMENTATION**	**ASSIGNED LEAD AGENCY AND LEAD OFFICER**	**TARGET DATE**
Many issues highlighted have already been reported as addressed by SWLSTG (MH Trust) in recommendations arising from their Root Cause Analysis report. These include clarification around criteria for assessment and informal hospitalisation as well as increasing the number of care coordinators to monitor severely mentally ill patients. The recommendations do not however include a requirement for all patients where "*violence during illness is known*" as contained in NICE guidelines.	SWLSTG (MH Trust) to review their policy and check that it is in alignment with the NICE guidance on Schizophrenia management in relation to situation where "*violence during illness is known*". SWLSTG (MH Trust) will undertake robust care planning and risk management on a minimum of a monthly basis to enhance relationship building	Safeguarding Lead - SWLSTG (MH Trust)	October 2017

RECOMMENDATION 2: Mental Health Service Care Coordinators to ensure all care plans are holistic and dynamic in nature, and interface with partner agency plans, taking account of the patients support network needs including their Carer's assessments the support required, any children who may need support, and partner agency involvement. Care plans must demonstrate consent to share information with Carers has been sought and, provision for if the patient becomes unwell and their judgment is impaired, has been discussed. The decision regarding consent must be regularly revisited and documented in both the care plan and the crisis plan; arrangements for this to be shared with relevant professionals in times of crisis must be demonstrated. Where consent is not obtained, an advance statement should be requested.			
SUB GROUP CLARIFICATION AND COMMENTARY	**PROPOSED IMPLEMENTATION**	**ASSIGNED LEAD AGENCY AND LEAD OFFICER**	**TARGET DATE**
Contingency and crisis planning should be a usual practice in care planning; it did not work well in this case. The issue of consent is critical and it is unclear whether consent was sought from Mr. X to share the details of his support plan with his mother. It is probable, given the significant role his mother played in supporting Mr. X, that he would have consented to sharing information if asked.	It is recommended that SWLSTG (MH Trust) review the process of developing and documenting care plans to ensure crisis management arrangements are routinely included in the care plan, discussed with the service user and their support network so any worker knows what to do should a crisis situation emerge.	Safeguarding Lead - SWLSTG (MH Trust)	November 2017
The division of work between agencies for the completion of the Carer's Assessment and the care plan review impacted on the documentation in this case and possibly also the level of support offered to Mr. X and his mother. There is a need to reinforce the importance of joint working and information sharing both between agencies and with service users and their Carers, within the context of explicit consent.	Also, to ensure that the issue of consent to share information is fully explored with the service user during the care planning process and this is clearly documented and recorded. Where it is likely that they may become unwell and will not have capacity to consent, consideration should be given to an Advanced Directive which enables decisions about how contact with their carer is made and ensures this is in line with their best wishes. Where a service user declines to share information with carers, the Trust (and any other organisation) should ensure that the carer is supported and their concerns are heard.	Safeguarding Lead - SWLSTG (MH Trust)	November 2017

RECOMMENDATION 2: Mental Health Service Care Coordinators to ensure all care plans are holistic and dynamic in nature, and interface with partner agency plans, taking account of the patients support network needs including their Carer's assessments the support required, any children who may need support, and partner agency involvement. Care plans must demonstrate consent to share information with Carers has been sought and, provision for if the patient becomes unwell and their judgment is impaired, has been discussed. The decision regarding consent must be regularly revisited and documented in both the care plan and the crisis plan; arrangements for this to be shared with relevant professionals in times of crisis must be demonstrated. Where consent is not obtained, an advance statement should be requested.			
SUB GROUP CLARIFICATION AND COMMENTARY	**PROPOSED IMPLEMENTATION**	**ASSIGNED LEAD AGENCY AND LEAD OFFICER**	**TARGET DATE**
	The Council to review the process of undertaking Carer's Assessments to ensure that there is good communication and information sharing between the different agencies, especially those undertaking any part of the assessment and the agency reviewing the service user care plan but to ensure this is undertaken in the context of explicit or implied consent. The Council to ensure that feedback is given to other professionals, including mental health professionals after a Carer's Assessment has been completed.	Head of Safeguarding and Quality Standards Richmond and Wandsworth Councils	November 2017

RECOMMENDATION 3: Assessment tools used by Medical and Psychiatric staff in A&E and PICU to be reviewed, to ensure they include the need to demonstrate that all aspects of both mental and physical health in patients with mental health issues, in receipt of acute or emergency care, have been assessed. Guidance on the use of the tool must direct the assessor to record reasons for any none completion of part of the assessment tool.			
SUB GROUP CLARIFICATION AND COMMENTARY	**PROPOSED IMPLEMENTATION**	**ASSIGNED LEAD AGENCY AND LEAD OFFICER**	**TARGET DATE**
It is noted that monitoring of vital physical signs was regularly attempted and undertaken in West Middlesex and in St Georges A and E departments and by the police FME. It appears however that none of the staff were sufficiently professionally curious about the persistent higher than average heart rate Mr. X experienced over 6 days. All professionals assumed it was due to his agitated state and did not confirm this by measuring his heart when he was calmer. Nobody recognized the length of time the high blood pressure continued. In addition, there was no documentation of Mr. X's last PRN dosage of Olanzapine or of when it was administered. There was also no consideration documented of whether the Olanzapine which Mr. X had in his home was still in date.	Patient recording protocols are reviewed in the acute hospitals to include detailing professional reasoning for not responding to any anomalous recording and to ensure that the information is transferred with the patient. Richmond and Kingston CCG should consider with their GP partners how vulnerable patients prescribed PRN medication are supported to ensure there is oversight of the medication being in date SWLSTG (MH TRUST) guidance and patient information should be amended to encourage patients to check all their medication before it is used, particularly PRN where it is used infrequently to ensure it is in date. The guidance update to include a reference to carers also being made aware of this requirement	Safeguarding Leads - Chelsea and Westminster Hospital/ St. Georges Hospital. Safeguarding Lead - Richmond & Kingston CCG (on behalf of CCG commissioners) Safeguarding Lead - SWLSTG (MH Trust)	ASAP but no later than March 2018 November 2017 November 2017

RECOMMENDATION 4: LAS to devise a risk assessment tool, to be completed on all occasions that Police presence is requested; that prompts the assessor to note all areas of risk. The outcome of this risk assessment is to be shared with the Police prior to the Police Grading a call.			
SUB GROUP CLARIFICATION AND COMMENTARY	**PROPOSED IMPLEMENTATION**	**ASSIGNED LEAD AGENCY AND LEAD OFFICER**	**TARGET DATE**
The London Ambulance Service (LAS) requested assistance from the police when responding to Mr. X's mother's call to convey him to hospital. It appears when the police requested clarification that this was not forthcoming on this occasion. As a result, the police response time was based on the information available. Had the LAS clarified that the call was in response to a Domestic Incident it would have been graded higher and elicited a quicker Police response.	It is recommended that **the** LAS and Metropolitan Police (MPS) review the response protocol in place across London that addresses such issues. It is proposed that the Metropolitan Police share the overview report with MPS Central Communication Command (CCC) and Territorial Policing (TP) Mental Health.	Metropolitan Police (MPS) London Ambulance Service	ASAP but no later than March 2018

RECOMMENDATION 5: The scope of the out-of-hours Home Treatment Team Service review to be revisited to ensure the review is focused on the outcome and experience for patients whilst considering the co-ordination of its' services, its' recording systems and practice, and its onward referral process.			
SUB GROUP CLARIFICATION AND COMMENTARY	**PROPOSED IMPLEMENTATION**	**ASSIGNED LEAD AGENCY AND LEAD OFFICER**	**TARGET DATE**
The Hounslow Home Treatment Team (HTT) was responsible for providing an out of hours' service for people with mental health issues between 17:00 and 09:00 each day, to the locality in question. The decision of the HTT to request that Mr. X's referral was made to the oncoming day service created a significant delay for Mr. X. It appears this was due to the person being busy on another assessment and not able to assess Mr. X. There should be an escalation procedure for the duty worker to get support from a colleague when simultaneous involvement is required in 2 cases.	The Hounslow Home Treatment Team to review its escalation procedures and offer assurance that there are sufficient resources available to cover peaks in demand. This to include discussions with the CCG about the commissioning arrangements for this service provision.	Service Manager - West London Mental Health Trust Safeguarding Lead - Hounslow Home Treatment Team	December 2017

RECOMMENDATION 6: A process to be developed by Health professionals within Emergency Care and Mental Health Services (health and social care), to ensure a robust plan of care, which includes administration of already prescribed medication, is put in place by the named professional in A&E and the allocated mental health worker, including which service has overall responsibility for the care of the patient.			
SUB GROUP CLARIFICATION AND COMMENTARY	**PROPOSED IMPLEMENTATION**	**ASSIGNED LEAD AGENCY AND LEAD OFFICER**	**TARGET DATE**
	This is covered by the proposed implementation responses under recommendation 3		

Recommendation 7: SWLSTG (MH Trust) to review the pathway for patients entering A&E with Mental Health issues to ensure smooth and timely navigation through the services to treatment is achievable.			
SUB GROUP CLARIFICATION AND COMMENTARY	**PROPOSED IMPLEMENTATION**	**ASSIGNED LEAD AGENCY AND LEAD OFFICER**	**TARGET DATE**
There was a lack of availability in an AMPH; Section 12 doctor and Section 136 beds which impacted on the level of service Mr. X received at a heighted time of crisis. Mental health assessments cannot be undertaken unless and AMPH and Section 12 doctor are available at the same time, as required in law.	Richmond and Kingston CCG through their partnership with Wandsworth and Merton CCG, are undertaking a review of AMPHs, Section 12 doctors and Section 136 beds and will report back to the SAB on their findings. As AMHPs services are delivered by the local authority, the Council should be involved in this review.	Director of Quality & Governance NHS Wandsworth & Merton CCG's	December 2017
		Director of Adult Social Services – Richmond and Wandsworth Councils	December 2017
	The CCG with the full support of SWLSTG (MH TRUST) and the general acute hospitals to review the pathway for patients entering A&E with mental health issues to ensure smooth and timely navigation through the services to treatment is achievable.	Director of Quality and Governance Richmond and Kingston CCG	December 2017

RECOMMENDATION 8: The SAB to be assured by its partners that: • Staff regularly receive information and training on communication and information sharing based on national and local guidance that directs staff to focus on the outcome they are aiming to achieve • That examples of what is and is not effective communication are provided in training and, • That staff are supported to challenge each other's actions/inactions • That staff know they maintain a level of responsibility to ensure requested actions have been completed. •			
SUB GROUP CLARIFICATION AND COMMENTARY	**PROPOSED IMPLEMENTATION**	**ASSIGNED LEAD AGENCY AND LEAD OFFICER**	**TARGET DATE**
Although much of the communication was appropriate in this case, there were instances where it was hampered by miscommunication, misinterpretations, lack of accuracy and a lack of follow through.	Assurances need to be made to the SAB by all agencies but especially from SWL&SG MH Trust, St George's Hospital, West Middlesex Hospital, LAS and Police that communication strategies and plans are up to date and that communication is included in routine refresher training for all staff.	SAB Board Coordinator - Richmond and Wandsworth Councils	Sept 2017

RECOMMENDATION 9: The SAB to hold a practitioner's event, following JP's inquest, to explore the themes arising from this SAR and review any additional learning.			
SUB GROUP CLARIFICATION AND COMMENTARY	**PROPOSED IMPLEMENTATION**	**ASSIGNED LEAD AGENCY AND LEAD OFFICER**	**TARGET DATE**
It is recognised that this was the preferred methodology of the Lead Reviewers as part of the SAR Panel process, but they were prevented from undertaking this given that many of the staff were already 'warned' as witnesses as part of the Coroner's Inquest. Given the would have been unable to fully be involved, this approach did not progress, so a learning event, under the stewardship of the SAB is appropriate	The SAB will look to hold a practitioner's event as soon as is practical, following JP's inquest, to explore the themes arising from this SAR and review any additional learning. The SAB will also look to produce a simple 'practitioners' briefing' for each and every SAR that is undertaken	Safeguarding Manager - Richmond and Wandsworth Councils	February 2018

RECOMMENDATION 10: SWLSTG (MH Trust) to develop a pathway that gives clear direction to all staff working in PICU, as to which policy to follow in each circumstance. The Seclusion and RT policies to be revised to include a requirement that rationales for non-adherence to policy must be recorded and reviewed by the Nurse in Charge or treating Psychiatrist.			
SUB GROUP CLARIFICATION AND COMMENTARY	**PROPOSED IMPLEMENTATION**	**ASSIGNED LEAD AGENCY AND LEAD OFFICER**	**TARGET DATE**
The situation with Mr. X on admission to the S136 suite was a dynamic and changing one. It is evident that the staff did not always adjust their actions to suit changes in the situation and as a consequence followed incorrect procedures. There was an interface between two policies (Rapid Tranquilisation and the Seclusion Policy) which created a professional complexity and confusing situation. SWLSTG (MH Trust) has identified that it will be holding a learning event on restrictive practices.	SWLSTG (MH Trust) to advise the SAB of the details of the learning event, when it has been undertaken and what the outcomes for staff practice are/will be and how they will be measured in practice.	Safeguarding Lead – SWLSTG (MH Trust)	Sept 2017

RECOMMENDATION 11: SWLSTG (MH Trust) to provide training to all staff working in-patient areas regarding the pathway and the application/interface between the Rapid Tranquilisation policy and the Seclusion Policy.			
SUB GROUP CLARIFICATION AND COMMENTARY	**PROPOSED IMPLEMENTATION**	**ASSIGNED LEAD AGENCY AND LEAD OFFICER**	**TARGET DATE**
	This is covered in Recommendation 11 detailed above.		

RECOMMENDATION 12: The SAB to be assured by partner agencies that the learning from the earlier SCR has been incorporated into training and shared across services in Richmond, and that agreed actions have been completed.			
SUB GROUP CLARIFICATION AND COMMENTARY	**PROPOSED IMPLEMENTATION**	**ASSIGNED LEAD AGENCY AND LEAD OFFICER**	**TARGET DATE**
A Serious Case Review was undertaken in 2012 and the findings were presented to the SAB in March 2013. During 2013/14 and again in 2015/16 the SAB checked that agreed actions had been completed. All organisations involved provided assurance they had with the exception of SWL&SG. On checking past records this assurance remains outstanding	SAB to get assurance of the completion of actions by SWLSTG (MH Trust) in the case of AB.	Chief Executive- SWLSTG (MH Trust)	Sept 2017

RECOMMENDATION 13: The SAB to seek assurance through regular progress reports from partners that they are effectively addressing the resource issues raised in this SAR.			
SUB GROUP CLARIFICATION AND COMMENTARY	**PROPOSED IMPLEMENTATION**	**ASSIGNED LEAD AGENCY AND LEAD OFFICER**	**TARGET DATE**
There is clear evidence that resource issues impacted in part to delays Mr. X experienced over this period. This issue is covered in Final Recommendation 7.	It is prudent that not only resource issues, but all agencies adopting a review of service arrangements ensure that they have learnt from the issue of Mr X's case and they reflect this in their annual SAB Self-Assessment process. The SAB Chair uses the face to face sessions to seek assurance in this regard as well	All SAB Partners	March 2018

RECOMMENDATION 14: The Police to review its information sharing protocols, devise and introduce a form to be completed in situations where they are transferring the care of a person detained under Section 136 of the Mental Health Act to a health facility.			
SUB GROUP CLARIFICATION AND COMMENTARY	**PROPOSED IMPLEMENTATION**	**ASSIGNED LEAD AGENCY AND LEAD OFFICER**	**TARGET DATE**
This recommendation came from a specific issue with the medical aspects of the handover from police custody to [health professionals]. In-custody lead for health assessment is the Force Medical Examiner (FME), a qualified doctor. The custody suite is managed by a police inspector.	It is recommended that the Metropolitan Police Service share the Overview Report and relevant documents with the Metropolitan Detention, Territorial Policing – Mental Health and SCO22 Public Order (Officer Safety Unit). A review of Information Sharing Protocols, at handover to health professionals, following police detention under the Mental Health Act, should be considered. Auditable processes that capture what information was shared, when and with whom should be designed to increase accountability, reduce organisational risk and improve compliance with the principles of information management (Management of Police Information – MoPI).	Metropolitan Police (MPS)	March 2018

RECOMMENDATION 15: Chelsea and Westminster Hospitals NHS Foundation Trust to explore further the underlying factors for the lack of documentation with the professionals involved and produce an appropriate action plan.			
SUB GROUP CLARIFICATION AND COMMENTARY	**PROPOSED IMPLEMENTATION**	**ASSIGNED LEAD AGENCY AND LEAD OFFICER**	**TARGET DATE**
	The review highlighted variable standards of record keeping across agencies. Documentation in A and E departments can be challenging. This issue is covered off in the proposed implementation in Recommendation 3.		

RECOMMENDATION 16: SWLSTG (MH Trust) to ensure a mental health practitioner is assigned to advocate, and take responsibility for overseeing and monitoring a patient's mental health, including ensuring prescribed medication is administered when there are delays in admitting/transferring them into Hospital.			
SUB GROUP CLARIFICATION AND COMMENTARY	**PROPOSED IMPLEMENTATION**	**ASSIGNED LEAD AGENCY AND LEAD OFFICER**	**TARGET DATE**
Multi-agency working and the delivery of services to Mr. X during his relapse were not effective. There was evidence of good practice but a lack of overall co-ordination and support to Mr. X and his mother. It is noted that SWLSTG (MH Trust) have introduced an acute care coordination centre which manages all request for inpatient services and could address some of the delays Mr. X experienced. The issue of developing good crisis plans is outlined in proposed implementation of Recommendation 2 above. It will not be possible for a mental health practitioner to take full responsibility if they are not present when the patient has contact with other organisations (i.e. an acute hospital). At all times they can advise and ensure the plan is known, but ensuring that prescribed medication, for example, is administered is difficult if it is a non-mental health prescriber who is administering it.	SWLSTG (MH Trust) to ensure that mental health practitioners who have contact with a person in a non-mental health setting, advocate for and ensure that the plan for addressing mental health concerns through an agreed plan is put in place and is known to others who become involved in their care. The plan will make it clear who is responsible for each part. The SAB recommends that SWLSTG (MH Trust) report back to the SAB on the impact of the acute care co-ordination centre.	Safeguarding Lead SWLSTG (MH Trust) Safeguarding Lead SWLSTG (MH Trust)	October 2017 December 2017