Executive Summary and composite action plan

Safeguarding Adult's Review on L.P

Executive Summary

The Richmond and Wandsworth Safeguarding Adults Board decided on 23/2/17 to commission a Care Act Section 44 Safeguarding Adults Review, following the death of LP (not real initials) in February 2017. The review was undertaken between June and November 2018, following on from a Section 42 Safeguarding Adults Enquiry and overlapping with a Coroners' Inquest and Independent Office for Police Conduct (IOPC) investigation. This executive summary corresponds with an overview report and composite action plan.

LP, a Richmond resident, presented at Kingston Hospital Accident & Emergency Department on 06/02/17 at 15.38 with mental health concerns. At 21.00 he was placed under Section 136 of the Mental Health Act by Richmond Police and at 23.59 was taken by ambulance to the 136 Suite at Springfield Hospital in Wandsworth, a service provided by South West London & St George's Mental Health Trust (SWL&STG). After waiting outside in an ambulance for over three hours for a vacancy to arise, he was admitted to the unit on 07/02/17 at 03.33. A Mental Health Act Assessment was requested at 04.10 but was not undertaken. LP was transferred to the adjacent Lotus Suite on a step-down basis at approximately 09.30 and absconded from the unit at approximately 12.25. Following a Police pursuit on 08/02/17, LP was involved in a fatal car crash at 04.38.

The review panel reached the following findings:

1 – There was a lack of sufficient 136 bed capacity, when LP required this resource, which led to a prolonged period waiting outside the unit for admission and was a contributory factor in the decision to transfer to the less secure Lotus Suite. This reflected a wider concern about the local and national availability of 136 beds.

2 - It was the general panel view that the step-down risk assessment reflected the presenting circumstances and was proportionate. The Reviewer held a different view, that the decision to transfer LP to an unlocked unit did not give sufficient weight to the risk presented by a history of fluctuating mood, previous withdrawals from support and previous attempts at absconding. The panel recognised that the assessment tool did not include the risk of absconding and, for LP, was not signed by an appropriate level manager. The risk had been addressed following the incident by the immediate provision of locks to the exit doors on the unit, the inclusion of absconding in the assessment tool and an escalation policy.

3 - The delay and ultimately the omission in conducting a Mental Health Act Assessment, when LP required this resource, was due to a combination of the unavailability of medical support and system and human errors. This reflected a wider local issue about staffing availability for out of hours Mental Health Act Assessments and was an apparent factor in the increased anxiety level experienced by LP.

4 - The completion of a full Section 42 Safeguarding Adults Enquiry, prior to the commencement of a Section 44 Safeguarding Adults Review, was considered to be inappropriate in the circumstances presented as the outcome did not provide added value to other statutory interventions.

The review panel endorsed the following recommendations, based on shared learning:

1 - Kingston and Richmond Clinical Commissioning Group, in partnership with the South West London and St George's Mental Health Trust, were tasked to provide ongoing assurance to the SAB that there are sufficient local resources; including regular reporting on the number of admissions and the waiting times for access to the 136 Suite.

2 - Kingston and Richmond Clinical Commissioning Group, in partnership with the South West London and St George's Mental Health Trust, were tasked to review the impact of policy changes to ensure the safety of patients on the 136 and Lotus Suites. It was agreed that there should be specific regard to the impact of the locked door, to the step-down risk assessment, and to critical decisions based on information received on service users' mental health history.

3 – Richmond and Wandsworth Councils were tasked to review the effectiveness of a round the clock Mental Health Act referral and assessment process. It was agreed that there should be specific regard to the prompt communication of clear risk information to ensure effective prioritisation and the provision of timely round the clock access to assessment.

4 - Richmond and Wandsworth Councils were tasked to clarify the circumstances in which both a Section 42 Safeguarding Adults Enquiry and a Section 44 Safeguarding Adults Review would be undertaken on the same case.

An agreed action plan to deliver these recommendations will be monitored by the Richmond and Wandsworth Safeguarding Adults Board to minimise the risk of a similar incident occurring in the future and to promote the safety and wellbeing of adults at risk in Richmond and Wandsworth boroughs.

Clive Simmons

Independent Reviewer

09/12/18

Composite Action Plan – LP

Finding	Recommendation	Action	Lead agency and person	Completion date
1 – The lack of sufficient 136 bed capacity, when LP required this resource, led to a prolonged period waiting outside the unit for admission and was a contributory factor in the step-down decision. This reflected a wider concern about the local and national availability of 136 beds.	**1 -** The Kingston and Richmond Clinical Commissioning Group, in partnership with the South West London and St George's Mental Health Trust, to provide ongoing assurance to the SAB that there are sufficient local resources; including regular reporting on the number of admissions and the waiting times for access to the 136 Suite; and that safe waiting and handover spaces are provided.	1. Regularly monitor and report to the SAB on the number of admissions and the waiting times for access to the 136 Suite.	Kingston and Richmond Clinical Commissioning Group	June 2019
		2. Consider arrangements for patients waiting outside on admission and whether a separate handover area can be provided for the Police.	Kingston and Richmond Clinical Commissioning Group	June 2019
2 – It is the general panel view that the step-down risk assessment reflected the presenting circumstances and was proportionate. The Reviewer takes a different view, that the decision to transfer LP to an unlocked unit did not give sufficient weight to the risk presented by his history of fluctuating mood, previous withdrawals from support and previous attempts at absconding. The panel	**2 -** The Kingston and Richmond Clinical Commissioning Group, in partnership with the South West London and St George's Mental Health Trust, to review the impact of policy changes to ensure the safety of patients on the 136 and Lotus Suites. There should be specific regard to the impact of the locked door, to the step-down risk assessment, and to critical decisions based on information received on service users' mental health history.	3. Provision of a locked exit door to the Lotus Suite, inclusion of absconding in the step-down risk assessment, and introduction of an escalation policy.	Kingston and Richmond Clinical Commissioning Group	Completed

Finding	Recommendation	Action	Lead agency and person	Completion date
recognised that the assessment tool did not include the risk of absconding and, for LP, was not signed by an appropriate level manager. The risk has been addressed by the immediate provision of locks to the exit doors on the unit, the inclusion of absconding in the assessment tool and an escalation policy.		4. Audit and report to the SAB on the impact of the revised step-down risk assessment procedure on the safety of patients admitted to the 136 and Lotus Suites; including consideration of mental health history in completing risk assessments.	Kingston and Richmond Clinical Commissioning Group	April 2019
3 - The delay and ultimately the omission in conducting a Mental Health Act Assessment, when LP required this resource, was due to a combination of the unavailability of medical support and system and human errors. This reflected a wider local issue about staffing resource availability for out of hours Mental Health Act Assessments and was an apparent factor in the	**3 –** Richmond and Wandsworth Councils to review the effectiveness of a round the clock Mental Health Act referral and assessment process. There should be specific regard to the prompt communication of clear risk information to ensure effective prioritisation and timely assessment; and twenty-four-hour availability of AMHPs and Section 12 doctors, including the morning 'handover' period.	5. Monitor, audit and report to the SAB on the of timely completion of round the clock Mental Health Act Assessments, including the morning 'handover' period.	Richmond and Wandsworth Councils	April 2019

Finding	Recommendation	Action	Lead agency and person	Completion date
increased anxiety level experienced by LP.				
4 - The completion of a full Section 42 Safeguarding Adults Enquiry, prior to the commencement of a Section 44 Safeguarding Adults Review, was not appropriate in these circumstances as the outcome did not provide added value to other statutory interventions.	**4 -** Richmond and Wandsworth Councils to clarify the circumstances in which both a Section 42 Safeguarding Adults Enquiry and a Section 44 Safeguarding Adults Review will be undertaken on the same case.	6. Provide clear guidance to Council staff, and to partner agencies, on circumstances in which both a Safeguarding Adults Enquiry and Review will be undertaken in the same case.	Richmond and Wandsworth Councils	April 2019