Learning Review - Mr D

Background
Mr D was deemed to be at serious risk of harm as a result of a series of missing person episodes, culminating in an incident when he was traced 2 days later in a remote area, requiring medical assistance and subsequent treatment at hospital. He had been deemed to have capacity and significant support in place at the time of this incident.

Multi-agency Info Sharing
The review found good evidence throughout agency recording systems and files of good information sharing. This was particularly evident in the multi-agency discussions and planning which took place before Mr D's discharge from hospital. It is clear from the information recorded that professionals had worked collaboratively to support Mr D and mitigate risk.

'Screening out' of the ASP process
Longer term solutions to Mr D's support using different legislation was considered and thorough discharge planning took place by all involved in Mr D's care, from the staged process by staff at RCH which would ultimately lead to him becoming more independent, to the use of staff known to him.

Appropriate placements of individuals on discharge from hospital
There was good practice by the care provider regarding the Care at Home package put in place for Mr D for 6 weeks following his discharge and it was felt that the provider had gone 'above and beyond' by ensuring the staff involved were already known to Mr D and it was recognised that having familiar faces around him would have had a positive impact on Mr D. Detailed and thorough planning in place.

Multi-agency working – assessment of risk and subsequent risk management
There was good evidence of a lot of discussion between relevant professionals, the information sharing with care provider was also good, allowing them to put in place an appropriate support package, particularly around his first 6 weeks, with practitioners directly involved in his care feeling fully apprised of his care needs and concerns.

Awareness raising and practice relating to Missing Adults, including revisiting local protocols
Mr D had a very singular presentation. During the review knowledge and awareness of missing persons protocols was clear. The **Herbert Protocol** was used well.

What does this mean for you as a practitioner, your team and your service?
Bring this to a team meeting or development session and identify actions or strategies from this review that you can implement to improve practice.

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