# Merton Council

# Healthier Communities and Older People Overview and Scrutiny Panel

## 7 November 2017

## Supplementary agenda


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# Healthier Communities and Older People Overview and Scrutiny Panel

## Date: 07 November 2017

Agenda item:

## Subject: Serious Case Review The death of 'Tom', from Somerset Adults Safeguarding Board

Lead officer: John Morgan – Assistant Director of Community and Housing

Lead member: Councillor Tobin Buyers - Cabinet Member for Adult Social Care and Health

Contact officer: Gemma Blunt – Safeguarding Adults and DOLS Manager, gemma.blunt@merton.gov.uk

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**1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY**

1.1. The purpose of this report is to consider the findings from a Serious Case Review commissioned by Somerset Adult Safeguarding Board regarding a Somerset resident residing in their area. The review highlights a number of failings within services from someone who experienced Traumatic Brain Injury (TBI).

1.2. The Scrutiny Panel requested the report as it wants to be reassured "there is adequate provision in Merton and services are provided to brain injury survivors on discharge to smooth their transition from hospital to home".

1.3. Whilst the report finds that Merton and it's partner agencies have practices in place which comply with the relevant legislation and seek to ensure individuals at risk are properly identified and there is a process in place for discharge, it makes two recommendations to ensure all partners are aware of this case and best practice around safeguarding for those with TBI's.

**2 A BRIEF OVIERVIEW OF THE SOMERSET CASE**

2.1. Tom was 43 when he took his own life during June 2014. Tom suffered a significant brain injury resulting from a road traffic accident. He had a number of convictions, issues with drug and alcohol, homelessness and illness that required ongoing health care and pain control.

**3 SOMERSET SAFEGUARDING ADULT REVIEW (SAR) FINDINGS - PREVIOUSLY KNOWN AS SERIOUS CASE REVIEW (SCR)**

3.1. The SAR found the following:

- There was neither a local authority community care assessment nor carer assessment.
- Tom's mental capacity was assumed and not assessed.
- Assessment processes were not integrated or coordinated between agencies.

- There was no clarity about Tom's perspective on risks in his life and what he believed should be done about them.

**4 ADULT SOCIAL CARE LEGISLATION: ASESSMENT AND SAFEGUARING**

4.1. This paper documents the key areas of legislation that local authorities work to and is now present since this case presented in 2014:

4.2. Section 9 of Care Act 2014 – assessing needs

- Needs assessment: This would take place within First Response and Initial assessment including consultation with Mental Health services.
- Carer Assessment: This is done locally by Carers Support Merton

4.3. Section 42-44 of Care Act 2014 – Safeguarding adults at risk

- Tom would be seen as an 'adult at risk', enquiries would made to determine if Tom is at risk of or suffering from abuse, Tom's views would be sought and capacity considered when safety planning.
- The Safeguarding Adults Board in Merton is chaired by an independent chair and represented by core agencies such as Police, CCG and London Fire Brigade that coordinate and lead the strategy of protecting adults at risk in Merton.
- Safeguarding Adult Reviews (SAR), this has a process to independently review a case when an adult has died or suffered abuse. There is a board protocol in place and sub group to manage the referrals for a SAR.

**5 REFERRAL PATHWAYS IN MERTON**

5.1. Children

- Individuals known to services as a child would be flagged through to transition services. If they did not meet the eligibility criteria under the Care Act 2014 at that point, mechanisms are in place in adult services that would capture the individual presenting at risk in the community which is discussed further in the report in section 6.

5.2. Adults

- St Georges Hospital hosts the regional head injury unit for the area.
- Referral into adult social care from them in a person's recovery will ensure planning begins promptly. Resources and pathway options for neuro rehab can be limited particularly for people with TBI that drink alcohol. In 2 local cases in particular, issues have been raised via Mental Capacity Act legislation processes which can be an added safeguard for someone that lacks capacity due to TBI.
- Mechanisms are in place in adult services that would capture the individual presenting at risk in the community which is discussed further in the report in section 6.

**6 PARTNERSHIP MEETINGS THAT MANGE RISK TO INDIVIDUALS IN THE COMMUNITY**

6.1. The Community Risk Assessment Conference (CMARAC) has been operational for over a year and is held monthly. It's a multi agency meeting that brings together key agencies such as Health, Police, London Fire Brigade and housing to discuss residents at risk in Merton that are referred to it. Children's services attend when appropriate. A holistic action plan would be actioned once an understanding of how a person engages with partners was known to all.

6.2. The local policing team and the police ASB team has a mental health link worker who is based in Safer Merton that communicates with services in the Trust and Adult Social Care in order to manage individuals presenting with similar needs. They also facilitate referrals to Adult Social Care and CMARAC.

6.3. The ASB case conference which likes CMARAC is a monthly meeting which looks at lower level ASB. This can then feed up to CMARAC where required.

**7 CASE STUDY**

7.1. The following case example can evidence good outcomes via CMARAC process:

7.2. *D was known to the Merton Drug and Alcohol Team and Engage Merton. D had a dog, which was extremely important to him. There had been 8 Merlin Police reports (vulnerable adult notifications) sent to the Merton First Response Team in Adult Social Care. The reports detailed mental health episodes, suicidal attempts/threats and rough sleeping. D was being targeted by a gang of drug dealers who had also attacked him. A referral was made to CMARAC in January 2017. At the point of the referral to CMARAC, D had been served with a repossession notice from the landlord. It was reported that D was being exploited by the gang of drug dealers and they were using D's property to take drugs and was also assaulted by this gang.*

*Actions taken as a result of the referral to CMARAC: Agency visits to D continued. Merton Housing wrote to the court due to problems with the paperwork for eviction, which gave D more time and for services to work with him. A Needs Assessment completed for funding for rehabilitation. Police gathered information to support funding for rehab and assessment for rehab was completed. Rehab identified so that D could take his dog. D went to rehab, and extra funding obtained for extension of rehab. D is reported to be doing well.*

7.3. This case demonstrates the strength of this process when all agencies work together to assess needs, manage risk and safeguarding a Merton resident from abuse.

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**Recommendations for Merton:**

A. The Safeguarding and MCA Learning Forum to hold a traumatic brain injury themed forum to ensure practitioner learning from this case involving staff from partner agencies.

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B. St George's Hospital to use this SAR as learning for the TBI team and feedback discussions to Merton via the Merton Safeguarding Adults Board (MSAB).

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**8 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT**

- Somerset Safeguarding Adults Board – The death of Tom, A serious Case Review. Flynn, 2016.

**GEMMA BLUNT – SAFEGUARDING ADULTS AND DOLS MANAGER**

Gemma Blunt