Committee: Healthier Communities and Older People Overview and Scrutiny Panel

Date: 07 November 2017

Agenda item:

Wards: ALL

Subject: Services for people who have experienced brain Injury – Somerset Safeguarding Adults Board Serious Case Review.

Lead member: Councillor Peter McCabe, Chair of the Healthier Communities and Older People overview and scrutiny panel.

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Recommendations:

A. That Panel members comment on the Somerset Safeguarding Board Serious Case Review and the lessons to be learned in Merton.

B. That the Panel members take into consideration the factors outlined in paragraph 2.4 in this covering report.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. At the topic suggestion workshop in May 2017 this Panel decided to scrutinise services for people who have experienced brain injury. This topic summary is attached at **Appendix A.**

1.2. Somerset Safeguarding Adults Board published a "Death of Tom-Serious Case Review" Report in June 2016, this is attached at **Appendix B**. The report outlines the experience of someone with serious brain injury who did not receive they support they needed to manage the condition. This case study provides important lessons for the NHS, local authorities and the voluntary and community sectors. Colleagues from NHS and Merton Adult Safeguarding team will also attend the meeting to present reports and answer questions.

2 DETAILS

2.1. Somerset Safeguarding Adults Board report "Death of Tom-Serious Case Review" has been summarised below by Alisha Mahmood, Graduate Management Trainee whilst doing a placement in the democracy Services team.

2.2. **What happened to Tom?**

Tom was known to the NHS at an early age as he sustained a head injury when he was knocked down by a car. Throughout his early life he also had a number of minor head injuries (at 8 years old,14 years and 17 years old).

He struggled with alcohol and substance misuse throughout his life, and due to being intoxicated, he was involved in a road traffic accident at the age of 22. Tom sustained a significant brain injury and developed epilepsy, chronic

insomnia, depression and muscle/skeletal pain. He was involved in multiple accidents after this, due to his alcohol misuse.

Tom's case can be described as a "series of crisis" that would indicate that he was a vulnerable individual with complex needs , these include: Tom's brain injury, his substance and alcohol misuse; his bicycle accident (having been advised not to ride a bike), his association with particular drug users (who were known to target vulnerable people); his former status as an "intentionally homeless" man; the concern of Taunton Deane Borough Council that he felt that he could not suitably process information or understand consequences and was unable to identify his own risks."

On June 2014 at the age of 43, Tom took his own life.

2.3. **What failings in services were identified?**

Despite voicing their concerns about Tom's mental health and depression(he frequently asserted that his life was "not worth living" his families concern's were not prioritised or used to inform a risk or capability assessment.

- Somerset Partnership Trust states that, even now, he would remain ineligible for any mental health service if he were to be referred during 2016.Services do not easily respond to individuals whose lives appear chaotic and who are barely compliant.

- A professional-led, multi-agency approach was required, however this was absent as gatekeeping criteria and service "thresholds" meant that Tom remained in harm's way. Tom's family grieved for him throughout his post brain-injury circumstances – which came increasingly unsafe - and yet their requests for help did not result in integrated working.

- Although no single agency could address Tom's support needs, it appears that nothing impelled health and social care services to work collaboratively within and across their own provision to provide direction and resolution. Multiple assessments spanning many years, including risk assessments and plans did not enable professionals across disciplines to pool their knowledge, agree priorities and review progress.

2.4.**Recommendations of the Report:**

i. Somerset's Safeguarding Adults Board seeks reassurance that the "case study" of Tom's circumstances features in sector-led and multi-agency training and that multi-agency work with individuals with complex support needs is shaped by shared goals and clear leadership.

ii. The fact of a person's traumatic brain injury and mental capacity is foregrounded in professional assessments and referrals and that family involvement is prioritised.

iii Public Health, Somerset County Council and NHS commissioners should set out how local practice and priorities match good practice concerning the support of people

with brain injury, dual diagnoses (Department of Health 2002), and the expectations of the National Suicide Prevention Strategy for England (Department of Health 2012).

v. Homefinder Somerset and housing partners identify how tenants with extensive Support needs, including those with acquired brain injuries, may access supported Housing.

2.4. **Key things for Merton councillors to take into consideration :**

- The purpose of the Report was to inform but also encourage debate on this issue; Councillors could debate the recommendations of the report in relation to practice at Merton. This could involve looking at what measures Merton has in place to prevent this happening, as well as what else could be done at Merton Council to improve our ability to serve individuals with brain injuries.

- To have an awareness of the numerous organisations and individuals that a service user with brain injuries (especially with complex needs) will come into contact with, and to consider how, at Merton, we can promote and utilise an integrated and multi faceted approach to their problems.

- To consider the importance of family members and close relatives to local authorities when assessing the mental health and risk of an individual and to look at Merton's process for engaging with family members of service users.

3 ALTERNATIVE OPTIONS

The Healthier Communities and Older People Overview and Scrutiny Panel can select topics for scrutiny review and for other scrutiny work as it sees fit, taking into account views and suggestions from officers, partner organisations and the public.

Cabinet is constitutionally required to receive, consider and respond to scrutiny recommendations within two months of receiving them at a meeting.

3.1. Cabinet is not, however, required to agree and implement recommendations from Overview and Scrutiny. Cabinet could agree to implement some, or none, of the recommendations made in the scrutiny review final report.

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. The Panel will be consulted at the meeting

5 TIMETABLE

5.1. The Panel will consider important items as they arise as part of their work programme for 2017/18

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. None relating to this covering report

7 LEGAL AND STATUTORY IMPLICATIONS

7.1. None relating to this covering report. Scrutiny work involves consideration of the legal and statutory implications of the topic being scrutinised.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. It is a fundamental aim of the scrutiny process to ensure that there is full and equal access to the democratic process through public involvement and engaging with local partners in scrutiny reviews. Furthermore, the outcomes of reviews are intended to benefit all sections of the local community.

9 CRIME AND DISORDER IMPLICATIONS

9.1. None relating to this covering report. Scrutiny work involves consideration of the crime and disorder implications of the topic being scrutinised.

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. None relating to this covering report

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

- Appendix A: Brain Injury topic suggestion summary
- Appendix B: Somerset Safeguarding Adults Board report "Death of Tom-Serious Case Review, June 2016.

12 BACKGROUND PAPERS

12.1.