Learning Lessons Practice Briefing Note

'Tom' Case Review, June 2016

From the Somerset Safeguarding Adults Board (SSAB)

Thank you for taking the time to read this briefing sheet. It is one way by which we are supporting multi-agency professionals working with adults at risk, or families to learn from practice.

This briefing sheet pulls together key messages arising from local case reviews.

We ask that you take time to reflect on these issues and consider, together with your team/s, how you can challenge your own thinking and practice in order to continuously learn and develop and work together to improve outcomes for adults. This document includes a feedback sheet to capture how you have used this learning.

The practice briefing will also be disseminated to training providers to ensure content is included within or informs safeguarding adults training.

What is a Safeguarding Adults Review?

The SSAB, as part of its Learning and Improvement Policy, undertakes a range of reviews and audits of practice aimed at driving improvements to safeguard and promote the welfare of adults at risk. A key duty is for Boards to commission Safeguarding Adults Reviews (SARs), when:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult
- an adult in its area has not died, but the Board knows or suspects that the adult has experienced significant abuse or neglect.

SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again.

'Tom' Case Review

A recent case review (which pre-dated the introduction of SARs) concerned a man who in his early twenties sustained a traumatic brain injury in a road traffic accident. He took his own life in 2014. The case was presented to the Board and informed a multi-agency learning event in June 2016.

How you can make a difference

Take some time to think about what these key messages mean for your practice. Ask yourself:

- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?

Key considerations for practice arising from the review

Supporting people with brain injuries: capacity assessment

'Tom's circumstances highlight the fraught boundaries between personal responsibility, public obligation and the assumption of mental capacity. Mantell (2010) has argued that an assumption of mental capacity is risky because a person's severe brain injury usually results in a degree of cognitive impairment'

- Frontline professionals have crucial roles in identifying people who may have sustained brain injuries in terms of providing support, information and advice. People's presenting problems/ requests for help may *not* indicate that they have brain injuries. Too often, brain injuries are not identified.
- Acquired brain injuries may result from trauma such as a blow to the head or a road traffic accident, or can be acquired from an infection, such as encephalitis. Although there are some unexpected causes of brain injury, such as a cardiac arrest which deprives the brain of oxygen, typically brain injuries interrupt people's lives without warning.
- Brain injuries nearly always result in long-term symptoms, for example, people may need to remain on anti-seizure medication. Brain injuries are complex and those occurring during childhood differ from those sustained in adulthood.
- Practice Guidance (*see further reading below*) highlights the importance of thorough assessment and post-assessment support. The Mental Capacity Act 2005 protects all of us from having the fundamental right of making decisions being taken from us. It empowers us by enshrining the principle that capacity should be assumed. Tom's mental capacity was assumed by too many decision-making professionals.
- The fact of a brain injury is so critical it is essential that it features in assessments. Case notes may reveal a diagnosed brain injury.
- Tom made decisions which made him vulnerable to significant harm. For example, he was known to associate with individuals who targeted vulnerable adults. It was assumed that Tom had the mental capacity to decide to associate with exploitative individuals.
- Families who have helped to restore their loved ones from comas and through rehabilitation have a great deal of knowledge about their relative's pre-brain-injury life as well as many concerns about the range of possible outcomes. It is essential that professionals' decisions are negotiated and made in the context of a person's biography.
- Advocacy is crucial since people with brain injuries may lack insight into their circumstances and their capacity, and claim, for example, that they do not need any assistance. By default, this role is typically assumed by people's relatives.

Further reading:

- Practice Guidance for Social Workers working with people with an Acquired Brain Injury, February 2016
- Headway is the UK-wide charity working to improve life after brain injury. Visit www.headway.org.uk to find out more about brain injury and its effects
- Mantell, A. (2010) Traumatic brain injury and potential safeguarding concerns *The Journal of Adult Protection,* 12 (4) 31-42

Working with people with multiple and complex needs

'Working with people with multiple and complex needs, across agencies, has to hinge on coordinated assessment, care management and working with the risk of harm together'

- People with support needs arising from mental health problems, homelessness and substances misuse are likely to be in contact with a wide range of services. However, public services may exclude people if they do not meet rigid or complicated access thresholds. Also, individuals may be vulnerable to being excluded for disruptive behaviour, for example. Chaotic lifestyles and inconsistent compliance can result in people being described 'hard to reach' or perceived as 'someone else's problem' – neither of which are relevant to the urgency of people's deteriorating circumstances.
- Although no single agency could address Tom's support needs, it appears that nothing impelled or required health and social care services to work collaboratively within and across their provision to provide direction and resolution.
- The assessment processes experienced by Tom were not integrated and had no impact on inter-professional working. The review asks: what is the point of multiple assessments spanning many years if they do not enable professionals across disciplines to pool their knowledge, agree priorities and targets and review progress?
- Decisions about Tom's mental health were made prematurely without assessing his mental capacity or gathering information from family members, significant others and the range of agencies involved in his care, most particularly Headway Somerset. There were missed opportunities to initiate a coordinated, multi-agency approach. As a result, Tom's difficulties were perceived in a fragmented way.
- Tom required a professional-led, multi-agency approach. Gatekeeping criteria or service 'thresholds' should not allow a vulnerable man to remain "in harm's way". Negotiating shared solutions has to be actively facilitated.
- Without effective help, we know that some clients and patients inadvertently take up a phenomenal amount of professionals' time over long periods of time. Commissioners and public services are not currently thinking creatively and ambitiously enough about delivering credible support to people with long-term, complex support needs.

Think Family

'Little was known about Tom's life before he sustained his brain injury. Although his family was an obvious source of information, their role as reflected in contacts with services became one of pleading for engagement and help'

- Family involvement and that of significant others should be prioritised. Professionals require help in understanding the continuities, the discontinuities and the unpredictable and complex process of restructuring the self which results from a traumatic brain injury. Tom's family could recall no occasion when they were invited, by either health or social care professionals, to share with them his pre-brain injury biography.
- The association of substance misuse with traumatic brain injury and suicide is well documented. It was Tom's family who correctly anticipated that he would take his own life. The review's findings make it clear that working more closely with families could improve suicide prevention.
- Tom had acted as carer for his partner, Liz, who had herself sustained a brain injury. When their relationship deteriorated and Tom's substance misuse became hazardous, he could no longer provide essential care-giving tasks. Professional assessments did not take account of Tom's role as Liz's partner and primary carer. There was no assessment of Tom as a carer in his own right.
- The Care Act 2014 places a legal duty on Council's to assess a carer's need for support. Although requirements for privacy and trust shield the care-giving tasks from the gaze of others, the same conditions may also provide the context for abuse and neglect. Tom's family, Liz's family and the South West Ambulance Service were attuned to the fact that Tom's circumstances meant that he ceased to be a dependable carer.
- Services should understand the motivations and goals of caregiving. Although it is accepted that caregiving by partners and relatives is not unilaterally burdensome, despite its associated demands, it changes over time. How it changes and what is significant about the changes has important implications for professional practice. It should not have required visible crises to alert professionals to the fact that Tom's caregiving had ceased to be an outlet for expressing his love for Liz.

SOMERSET SAFEGUARDING ADULTS BOARD

Learning Lessons - Feedback Sheet

Please return completed feedback to: ssab@somerset.gov.uk

Your name	
Agency	
Date	

This briefing was cascaded to: (e.g. all district nurses; duty social workers etc.)
This briefing was used in: (e.g. supervision with X number of staff; team meeting; development event etc.)
Action taken as a result of the learning:
Other feedback / discussion points