

June 2016



**SOMERSET
SAFEGUARDING
ADULTS BOARD**

The death of ‘Tom’

A Serious Case Review

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Introduction

The Circumstances that led to the review

1. Tom was born in 1971. He was the eldest of his mother's three children. Tom's parents separated when he was eight years old. As a young child he was "sweet natured and very protective of his siblings. He was very fond of animals...there was nothing nasty or aggressive about him...he was always anti-authority."
2. Tom became known to the NHS at an early age. In addition to the usual childhood illnesses and injuries, primary care services noted that, as a three-year-old, Tom sustained a head injury when he was knocked down by a car. He had a minor head injury as an eight-year-old; had concussion and a head injury when he was 14 (which his family attribute to school sport activities); and had a minor head injury and laceration when he was 17. Tom's family also recalled that he had "a number of motorbike accidents." It was during his teenage years that Tom began drinking. At 20, he was receiving help initially for alcohol abuse and subsequently for drug misuse. He had several convictions.¹
3. At the age of 22, Tom sustained a significant brain injury resulting from a road traffic accident. Even after this accident he sustained more head injuries during December 2011, June 2012, July 2012 and June 2013 - all of which were associated with his being intoxicated.
4. As a young teenager Tom had attended a Child Guidance Clinic. According to his family, he was abler than his examination results attested. He had won a scholarship to a prestigious school. It was membership of a particular group of his peers that was associated with his shoplifting and being expelled from this school, after which, "it went downhill from there...he did crazy things on motorbikes and was on and off drugs." His family were unable to divert him from his involvement in criminal activities which led to an appearance at a juvenile court plus a referral to social services.
5. Following his brain injury, Tom became known as a local character and was a familiar sight sporting a Mohican haircut, camouflage gear and listening to Classic FM at a high volume. He attached a horn to his electric wheelchair to warn pedestrians of his approach. Professionals who knew him considered Tom to be "intelligent, politically aware and anti-establishment."² After his brain injury Tom believed that his life was "not worth living." He developed epilepsy, chronic insomnia, depression and muscle/skeletal pain.
6. Tom lived with his partner, Liz, until 2013 when he was evicted. He had had a rolling tenancy agreement. Initially, Tom acted as her carer because Liz had herself sustained a brain injury. However, their relationship deteriorated when his substance misuse became so hazardous that he could no longer provide essential care-giving tasks. Liz became fearful of the people he allowed into her home. Tom became homeless. His final placement on an impoverished estate was calamitous.
7. Tom was 43 when he took his own life during June 2014.

¹ Avon and Somerset Police IMR

² Tom's family confirmed that he would "probably have appreciated being known as anti-establishment"

About this Serious Case Review

Terms of Reference

8. The following questions were asked of the services which had contact with Tom:
 - i. Did your agency follow its own policies and procedures and wider professional standards? Did it act in accordance with the terms of the multi-agency Safeguarding Adults Policy in respect of Tom at the relevant times?
 - ii. Was Tom's capacity assessed with regard to making decisions about his welfare and do your records demonstrate that his wishes and feelings were ascertained and considered in the decision-making process?
 - iii. Were assessments and decisions adequately recorded and did decisions and actions accord with assessments? Were appropriate services and support offered/ provided?
 - iv. Was information shared appropriately between agencies and at an appropriate level of seniority? Were there any issues in respect of communication, information sharing (including transfer of records where appropriate) or service delivery? Were relevant enquiries made in the light of information provided including, where appropriate, requests for records from other areas?
 - v. What impact, if any, did Tom's brain injury, cognitive ability, mental health and substance misuse have on proposed interventions and decision-making?
 - vi. Did your agency respond in a timely and appropriate manner to any concerns being raised by family members and carers?

Chronology

9. Pivotal events 1993 - 2003

During **1990**, Tom left the family home. He had "a very repetitive [desk] job...which he hated and later left, about 1991/2... [his family] didn't really know all he got up to, details emerged later, especially when he did a spell inside for begging in the street. Apparently, he had been involved in stealing cars, several police chases, ram-raiding shops, a few burglaries, then taking drugs and drinking."³

At the beginning of **1993**, Tom was drinking heavily. He was arrested; he was admitted to hospital with alcohol toxicity. He discharged himself from hospital, but continued to drink and was readmitted because he had had a "possible fit."

By mid-1993, Tom had been dry for several months during which time he became unmotivated and suicidal. His appearance deteriorated. He was described by primary care as "not amenable to medical help."

During **October 1993**, Tom stole a car, was arrested and during December appeared in court and was fined.

On **22 December 1993**, Tom's family recall that he had been working on a car which was neither taxed nor insured. However, he took it for a test-run and sustained traumatic brain

³ Information from Tom's family

injuries in a collision. The accident resulted in three weeks of intensive care treatment followed by acute treatment. Tom became hemiplegic, he had aphasia,⁴ he developed epilepsy and he developed insomnia.

During **February 1994**, Tom was transferred to a rehabilitation unit for a period of “extensive neuro-rehabilitation with comprehensive multi-professional and multi-agency support” including speech therapy and physiotherapy. Musgrove Park Hospital noted that he attended “many outpatient appointments where his various ongoing health needs were assessed.” However, it noted that “...some actions Tom agreed to were not followed through and also, it is not clear if...actions required by other agencies...were undertaken.”

During **May 1994**, Tom was discharged from the rehabilitation unit. He married his girlfriend⁵ who had shared the intensive care, bedside vigil with his family. She left him after two months.

Tom’s family recall that during 1994, Tom was subject to “rapid mood swings” and he became “irritable and aggressive” after his brain injury. It was difficult distinguishing the agitation caused by his brain injury from the irritability provoked by his profound awareness of his compromised abilities. In spite of the rehabilitation programme, his family accepted that “He couldn’t take things in - although socially, his manner suggested that he could...He could be volatile so you had to be careful what you said. It was like treading on eggshells.” He was referred for further physiotherapy due to his painful right hip and right knee.

Tom was now eligible for *inter alia*, the Disability Living Allowance.

Tom’s family can recall no occasion when they were invited, by either health or social care professionals to share with them his pre-brain-injury biography. Although the gap between the vibrant capability of his pre-brain-injury and his post-brain injury disability was most evident to his family, “we were never privy to any of the assessments...after the injury he didn’t see the point of living.”

During **1995 - 98**, Tom was prescribed various medications and his drug and alcohol abuse persisted. He trialled the use of an electric wheelchair;⁶ was issued with an Orange badge;⁷ and sustained a fall. Although he wanted to recover his driving licence, his GP and the DVLA decided that he should not drive.

Tom began to receive incapacity to work benefits. He sprained a knee and was referred to physiotherapy.

⁴ Loss of the ability to speak or understand spoken or written language

⁵ It has been speculated that, during this period, perhaps more information was disclosed to his girlfriend than to his family

⁶ Although *Tom used an electric wheelchair to cover longer distances he managed with an unsteady gait, to walk shorter distances...over time this caused wear on his hip and increased associated pain*

⁷ This became a Blue Badge, that is, a parking permit which permits disabled drivers and passengers to park nearer to where they are going

During **June 2000**, Tom referred himself to Headway.⁸ He disclosed a drug habit which he stated was “under control.” He attended Headway’s centre for one day a week. According to his family he spent the rest of his week, “pottering about. He was good at making things. He was good at woodwork. He made bird tables and planters and when he moved in with his girlfriend, he made a stand for her and adapted an exercise bike for her. He set up bird feeders and he enjoyed watching them and the badgers. He was good at calligraphy and he carved house names in 3D. Over time the physical aspect of woodworking became painful and he couldn’t stand easily. He listened to music – punk and classical – and he enjoyed the TV programme Countdown.” Tom’s mental arithmetic skills were unaffected by his brain injury.

Tom’s family cited Headway as the only specialist service which he received. It provided “a bridge between pottering and doing something rehabilitative.”

Tom sprained a knee once more and was referred to orthopaedics. He also sprained a shoulder, for which he was referred for physiotherapy.

Tom received a social care assessment during 13 June 2000 - 11 August 2000, although there are no apparently documents as evidence of this or its outcome.⁹

During **2001**, Tom continued to receive physiotherapy for his shoulder sprain. His drug and alcohol abuse persisted. Tom disclosed that he was not feeling himself due to his drug use and “stress” in his relationship with his partner Liz.¹⁰

During **2002**, Headway wrote to Tom informing him that he could not bring alcohol or drugs to the centre since this was contrary to policy. Within months it issued Tom with a “final warning” concerning his behaviour and outbursts at the centre.

During **2003**, Tom was a daily cannabis user; he was taking prescription medication for pain management to excess; he was drinking to excess; and he was having fits. He was referred to the neurology department, not least because of his depression and mood swings. He required reminding about his anti-social behaviour at the centre. He told centre staff that his life was “not worth living.” He agreed to be referred to a psychiatrist. He also disclosed concern about his home life.

10. From 2004 – 2012

During **2004**, Tom was known to be refusing help for his addictions.¹¹ Although subject to low moods he declined counselling. He was diagnosed¹² with post traumatic epilepsy. He

⁸ A UK - wide organisation, the mission of which is: *to promote understanding of all aspects of brain injury and provide information, support and services to survivors, their families and carers.*
See www.headway.org.uk/about-brain-injury/ (accessed on 3 January 2016)

⁹ Similarly, there are no documents evidencing assessments of 7 May 2008 and two during July 2008

¹⁰ Liz had sustained brain injury from an accident which left her wheelchair dependent. She was awarded compensation which enabled her family to purchase an adapted bungalow. Her relatives were Court Appointed Deputies

¹¹ Primary Care IMR

was warned of the risk of cycling, counselled on drug and alcohol use and his GP was advised to refer him to agencies for support. The Headway service was concerned about Tom's poor mental state and he was referred to neuropsychology. An MRI scan revealed that Tom had "bilateral temporal lobe atrophy, left more than right, and some left-sided atrophy in the upper brain stem."¹³

During **2005**, Tom sustained a wrist fracture and was prescribed medication for pain. His continuing shoulder pain resulted in a referral to physiotherapy.

Tom shared his misgivings about attending the Headway service since it made him "more upset." He acknowledged that he was taking recreational drugs and declined access to counselling and support.¹⁴ He reported to a clinical psychologist that he was "no good in life, would like help re-engaging...feels doesn't fit in. He was drinking alcohol, smoking cannabis and using diamorphine. Wants to change substance misuse...Liaise with mental health services. Send Tom record sheets for recording substance misuse."¹⁵ He attended an anger management session. His sister became his advocate.

During **October 2005**, Tom and his sister attended an outpatient appointment for his substance misuse. He explained to a clinical psychologist that he used drugs and alcohol "to numb" his mind. Contact was made with local drug and alcohol services and Tom was requested to record his substance use and mood. Tom's family were concerned that he was in contact with many professionals and yet "he could not take anything in." It is his family's perception that professionals believed they were engaging with a man who was mentally capable following his rehabilitation and processes of compensatory adaptation. However, Tom was experiencing chronic insomnia after his brain injury. He was plagued by depression¹⁶ and, unsupervised, his addictions compromised his cognitive abilities.

During **November 2005**, Tom met the clinical psychologist once more. It was noted that he had not completed the substance record sheets and was still using drugs and alcohol. "Not sure if he wants to change. Will consider reducing habit...low self-esteem and drug/alcohol problem coping strategy in stressful situations. To attend Turning Point. To work on self-esteem through setting long-term, medium-term and short-term goals."

¹² Taunton and Somerset NHS Foundation Trust

¹³ Temporal lobe injuries damage the brain's organisation and categorisation of verbal information, language comprehension, long term memory and affective behaviour for example. <http://www.neuroskills.com/brain-injury/temporal-lobes.php> (accessed 27 January 2016)

¹⁴ Headway IMR chronology

¹⁵ Musgrove Park Hospital IMR chronology

¹⁶ The Primary care IMR notes that during 1993 and 1994 Tom was treated with antidepressants, referred Tom to psychology (in 1995) neurology (in 2003 and 2004) arising from "depression and mood swings," neuropsychology (in 2005 and 2013)

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During **2006**,¹⁷ Tom moved in with Liz. He became Liz's carer; she paid him £100 per week in recognition of the support he provided to her. His family believe that caring for Liz "gave him a purpose."

Tom's sister, who is a psychologist, shared the family's concern about the combination of Tom's brain injury, his addictions and depression. Tom's biographical memory was compromised by his brain injury. His concentration and speed of processing had become limited, his attention to detail was ephemeral and "he had no complex problem solving ability." Information about appointments was sent directly to Tom even though his family asked if they could be involved. He was forgetful, and could be so incapacitated that he missed appointments.

During **2007**, Tom was admitted to hospital for five days for hip problem treatment. He had been overdosing as pain management. An MRI scan of his left hip was planned. His family recalled that Liz was left without assistance at this time.

A social worker and Tom's GP addressed a problem with his Disability Living Allowance.

During **2008**, Tom sustained a further knee sprain. Headway made contact with his sister because of his continuing drug use at the centre.

During **2009**, Tom was prescribed medication for the "stress" associated with caring for his partner. He disclosed to Headway that he was spending £50 a week on drugs.¹⁸

During **May 2009**, Tom attended A&E. He had fallen off his bike and fractured a shoulder.

During **2010**, Headway identified and assessed the risks associated with Tom bringing alcohol into the centre and his history of drug and alcohol dependency.

During **2011**, Tom was prescribed medication for his chronic insomnia.

A friend, who was himself a drug user and had been involved in some of the offences for which Tom had been convicted, was noted by the police to be a "regular visitor" to Liz's home.

At the end of the year, Tom arrived at the Headway service so inebriated that he had a fall. He explained that he was "trying to block out the memory of his accident" (18 years previously) and that "all the Christmas hoo-ha" reminded him of this.

Tom's alcohol and drug use presented additional challenges for the Headway centre during **2012**, not least since its driver was no longer willing to provide Tom and Liz with transport. During March 2012, Liz disclosed to Headway staff that Tom had not been sober for the last few days and had been unable to provide her with the support she required. Tom "had very

¹⁷ Email correspondence from Tom's family during October 2013, stated that Tom saw a neuropsychologist in 2006/2007 who felt he had depression but refused to work with him until he addressed his alcohol and drug issues...a cop out as the drug use and depression are too closely linked...can't fix one at a time – both need addressing in tandem

¹⁸ Tom's family believe that Tom could fund his drug addiction because he didn't eat adequately. One of the consequences of his brain injury was that he did not feel hungry and his sense of smell was compromised

little insight into the problem...he opted to go home straight after lunch after becoming verbally aggressive with staff and clients.”

During **May 2012**, adult social care decided that Tom was eligible “at substantial level for ongoing day centre support” but ineligible for transport or personal care. (Initially, Tom and Liz accessed the centre using public transport and, subsequently, Liz paid a private taxi.)

The social care assessment was “written from Tom’s own perspective.” It is acknowledged to be inadequate since there was “no holistic assessment of how Tom managed risk and the capacity assessment is very limited.” This and all preceding assessments did not take account of Tom’s role as Liz’s partner and carer. His family believes that professionals “missed the subtleties of his condition by dealing with bits – it’s just drugs, it’s drinking, it’s homelessness – no one put the whole picture together and saw him as a depressed, vulnerable man who was brain damaged with mental health problems exacerbated by drugs and alcohol.”

During **June 2012**, Tom sustained a head injury/laceration above his right eyebrow. The hospital noted that he had “fallen from his wheelchair after drinking alcohol.” According to Tom he had not been drinking “to excess.”

There were two occasions during **July 2012** when Tom arrived at the Headway service confused and disoriented. On the first occasion Tom was taken to hospital for observation. On the second, he fell and cut his head. He was allocated a social worker “to look at day services issues.”

During **August 2012**, police records state that: “found on stairs at the address was a mirror and a foil wrap containing burnt powder and an empty cling film wrap. There are concerns for Liz’s welfare.” This information was shared with adult social care.

During **October 2012**, Tom had a fit while in a café after which he informed the police that his phone had been stolen. This was not borne out by the CCTV coverage.

Tom was visiting primary care throughout 2012, requesting treatment for backache, and his hip and knee problems. At the end of the year he was prescribed antibiotics for food poisoning.

11. 2013

During **January 2013**, adult social care undertook a review of Tom’s day service support. Also, he was referred to orthopaedics, and then to rheumatology, because of his knee. He had a rheumatology review during February.

During **February 2013**, a police intelligence report stated that two drug users had moved into Liz’s home and a third was a frequent visitor. Liz was reported to be “afraid of them but because Tom is her primary carer and seems to have said it is OK for them to be there, she feels very vulnerable and unable to get rid of them...[she] has no other care package or involvement from Adult Social Care/Social Services.”

At the end of the month, social workers visited Tom and Liz. They declined help with personal care and domestic chores.

During **March 2013**, Headway contacted the Department of Work and Pensions on Tom's behalf. He was distressed because he could not access his benefits.

A member of the public advised the police that Tom was walking down the street wearing a top hat and black jacket with no footwear. A welfare-check established that Tom was "a little eccentric."¹⁹

During **April 2013**, Headway noted that Tom appeared to be taking a lot of painkillers. He spoke about "buying drugs to help with the [hip] pain." At Tom's rheumatology outpatient appointment, it was noted that his substance misuse was chronic and that he was drinking "a bottle or two of wine a few times a week." He was discharged from the clinic during May 2013.

A police intelligence report stated that Tom and Liz had been "targeted" by two people who had moved into Liz's home and taken money from them, one of whom had "bail conditions" not to enter the locality and specifically, not to enter Liz's home. Another drug user continued to associate with Tom.

Tom's family recall that there was a "case review" during **May 2013** at which it was concluded that "an emergency care plan" was required for Tom and Liz. It was noted that, "...over the past year there have been several instances when Tom has been incapable of caring for Liz, either due to alcohol or drug abuse or due to his own physical disabilities...nothing has ever been done about this."²⁰

On **5 June 2013**, an engineer carrying out checks at Liz's home heard a man "calling through his door saying he was unwell." The police and ambulance service gained entrance and found Tom in bed asleep.

Tom's social worker contacted Headway. Headway had alerted adult social care to Tom's deteriorating condition between **8 May** and **4 June**. It had become difficult for Headway staff to witness the trauma that the pain was causing Tom, since he "continues to be almost reduced to tears with the pain in his hip and has described his increasing use of 'street drugs' because the medicines he is prescribed don't touch the pain."

On **29 June 2013**, Tom fell out of his wheelchair, lacerated his chin and sustained a right, lower leg injury. He was taken to the Emergency Department by ambulance. He explained that he was "due for a left total hip replacement"²¹ on 1 July 2013 for osteoarthritis; he smokes heroin for pain relief, and denies intravenous drug use for last six months –

¹⁹ It is not known whether or not Tom made a deliberate and capacitated decision to live his life in an unconventional way or even if he considered himself to be eccentric. He had enjoyed wearing his top hat and his jacket from a morning suit which had brightly coloured buttons. He was buried wearing this jacket.

²⁰ Letter of complaint dated 18 November 2013

²¹ In correspondence, Tom's family assert that the hip replacement was *desperately required in part because he has been supporting and caring for Liz*

previously injected into left arm...says he drinks 8-12 units of alcohol a week...nothing abnormal detected." He was admitted to the Medical Admissions Unit to start intravenous antibiotics. Whilst there, he declined to wash and twice declined to have his pressure areas checked. He self-discharged.

In their complaint, Tom's family states that because Tom was admitted to hospital, Liz was "...left with no care arrangements in place. Liz had to call on her sister in the middle of the night for support as her emergency alarm people would not respond to the call."

On **1 July 2013**, Tom presented at Trauma and Orthopaedic Outpatients. He was wearing only a dressing gown. He "passed out in the waiting room with pinpoint pupils...was unarousable for some time. When he woke up he urinated on the floor and was unable to communicate." Although Tom was not due to have surgery on this date, the consultant decided that there were "major concerns about Tom's current state of mind. Surgery would require a degree of cooperation and compliance with treatment and post-operative rehabilitation. The evidence of today's consultation would seem to indicate other major health, psychiatric and psychological problems which would greatly increase the risks of surgery and the chances of a poor outcome...Would not be prepared to operate on him in his present state."²²

The following day adult social care was informed by primary care that Tom arrived at the hospital "stoned" and that his hip operation was cancelled. (Although the GP notes state that Tom had a "fit," the hospital notes state that he was intoxicated.) A relative rang Tom's GP to express concern that he was in bed having taken drugs and alcohol. The GP wrote back explaining that there would be "no operation" until Tom addressed his addictions.

On **3 July 2013**, the GP met Tom and his mother. Tom agreed to be referred to Turning Point.²³ He was told that he "must be stable prior to any hip surgery." The GP sent a referral letter on **8 July 2013**.

At the end of the month, Tom wrote to the Orthopaedic Consultant stating that he drank "to help him sleep...was sleep deprived when he spoke to the consultant and is not addicted to alcohol." He had made the decision to be free of drugs and requested hip surgery. A supporting letter from his girlfriend was included.

On **17 August 2013**, Tom locked the door of Liz's home when her carers were providing her with support. This and other concerning behaviour resulted in the care agency contacting his social worker.

In early **September 2013**, Tom called 111 because of the pain in his left hip and an arm. He explained that he had had a drink and he couldn't cope with the pain. He disclosed that he

²² In correspondence with an MP on 5 November 2013, Tom's family noted that surgery could not take place since *the amount of anaesthetic that would be needed to knock him out would kill him*. It is possible that this was Tom's understanding because it does not feature in any clinical records

²³ A social enterprise providing specialist services supporting people with learning disabilities, mental health problems and people who misuse substances. See <http://www.turning-point.co.uk/> (accessed 4 January 2016)

was using heroin six times a week but denied that he had a drug habit. He was given pain relief.

On **23 September 2013**, one of Liz's carers contacted the ambulance service to report that Tom had fallen again, hit his head and had a seizure. He was treated at the scene.

In their letter of complaint,²⁴ Tom's family state that on **4 October** "Tom was found out in the street naked, shouting and screaming at Liz and was reported to Liz's family by neighbours."²⁵ This was then followed up by him passing out and leaving Liz without care again."²⁶

On **5 October 2013**, Tom called 999. He had fallen and was intoxicated. He was treated at the scene. Two days later, the ambulance service made a safeguarding alert since Tom had been heavily intoxicated and concern was expressed about his "ability to care with his increasing alcoholism...would like them to receive alternative care and alcohol advice." It was proposed by adult social care that Tom should visit the GP weekly to address his need for pain relief and his drug use, that is, "it was not felt to be safeguarding." Primary care was informed that Tom had been intoxicated and naked in the street.

On **8 October 2013**, Tom's mother contacted primary care requesting enhanced pain control for Tom. The patch strength was increased on **10 October 2013**.

In their letter of complaint, Tom's family state that on **9 October** "a meeting was called by Liz's family and Tom's mother. At this meeting, social services offered no support or assistance to Tom. When rehabilitation services were suggested, a social worker stated that there were none available. Liz's family believed that Tom had been extorting money from Liz by threatening not to care for her if she didn't give him the money...why did social services not launch an investigation into this accusation? Liz is a vulnerable adult who requires protecting too...nothing at all was done."

In the same letter, the family state that on **18 October 2013**, "Tom passed out in his wheelchair outside the house, Liz had no care and nobody could get in to help her as Tom was in the doorway...his family ensured that he was moved back into the house and that Liz was safe until her brother-in-law could come and arrange for her to go to...residential care. Following this, Tom was issued with a one-week eviction notice²⁷ on **19 October**...Tom is a vulnerable adult...social services did not visit...to help him sort out accommodation."

On **19 October 2013**, Tom arrived at Headway in an inebriated state. He had been drinking heavily for a few days. When he arrived at the centre he was very tearful and expressing

²⁴ Dated 18 November 2013

²⁵ There were no safeguarding alerts concerning Liz

²⁶ Since Tom was no longer able to lift Liz properly because of his own physical problems, Liz's family called in a care firm...Tom continued to assist Liz into bed at night as this was 'outside' of core care provision hours. Tom's drug and alcohol use escalated as did the frequency and degree of incidents that placed Liz at risk. Their reliance on emergency services and care agency support increased and Liz's family raised concerns about Tom's ongoing role in her life. In addition, regular amounts of money were missing from Liz's bank account

²⁷ Tom had a six-month rolling tenancy agreement

suicidal ideas. He felt very unwell and couldn't see the point in carrying on. He was also threatening violence towards Liz's family in that he blamed them for him having to move out of Liz's home. He was very unsteady on his feet and quite volatile. Tom was allowed to remain at the centre and sleep. The social worker suggested contacting the GP and the latter suggested contacting the social worker. The GP also suggested phoning his sister.

On **25 October 2013**, Tom's family emailed social services asking about "a mental health assessment for him...he is no longer capable of caring for himself let alone Liz and...if he doesn't get help soon he will end up in the gutter or dead."

On **28 October 2013**, Tom's family received an emailed reply stating that any mental health assessment will need to be accessed through his GP.²⁸

On **30 October 2013**, Tom's mother informed primary care that Tom had been given notice to quit his accommodation.

On **31 October 2013**, a police intelligence report stated that Liz was seeking to remove Tom from her home due to his alleged use of illegal substances, heavy drinking and damage to the property.

A further eviction notice was issued.²⁹ Tom's family were unsuccessful in their attempts to engage social services by telephone on **31 October** and **1 November**.

In early **November 2013**, a carer from the support team working with Liz contacted the police "concerned for suicide attempt of Tom."³⁰ Tom had been distraught and had told the police that he planned to hang himself. It was noted too that Liz's home was unsafe due to used needles lying around.

"Police...feel Tom's physical disabilities may hinder him in any attempts to carry out his thoughts." The complaint³¹ from Tom's family states that on 2 November, Tom "became dangerously unstable and threatened to kill Liz's sister and brother-in-law and then himself."

The police referred Tom to the crisis mental health team which assessed him as being a "low risk" of deliberate self-harm, accidental self-harm and suicide. The community psychiatric nurse's assessment had concluded that he was not suffering from mental health issues but was "reacting to life events." He was advised to contact his social worker. The assessment also concluded that there was "no evidence of acute mental illness...needs may be better met through Drug and Alcohol services." It was noted that Tom had previously engaged with Turning Point but was reluctant to do so again.

²⁸ The letter of complaint of 18 November 2013, states that they followed this up with the community mental health team which advised, *that social services can indeed make a referral to them for assessment*

²⁹ There had been a query concerning the legality of the original one

³⁰ Tom's family were aware that Tom considered taking his own life after his accident. Also, they knew that he did not want to take an overdose because he did not want *to be more like a vegetable*

³¹ Dated 18 November 2013

The Trust's assessment excluded the knowledge and insight of Tom's relatives and professionals who had known him for many years. "Physical health and falls were identified as significant risks...no crisis plan detailed as level of risk was not assessed as sufficiently high to require this." Tom was advised "to contact his GP to sort out appropriate pain relief as he had missed scheduled appointments. A clear follow-up plan and review plan was established and actioned."

On **3 November 2013**, mental health professionals visited Tom to explain the rationale for not providing a service. His mother and a representative of the care agency supporting Liz were also present. Neither could understand the decision. The Trust's clinical risk assessment did not refer to (i) the *Somerset Partnership Dual Diagnosis Policy*, (ii) the protocol, *Joint Working with Specialist Drug and Alcohol Services (Turning Point)* or (iii) its *Safeguarding as a Vulnerable Adult Policy*, since Tom "was not assessed as having either, an acute or, severe and enduring mental illness and he was not identified as a vulnerable adult at the times of contact." Somerset Partnership Trust noted that there was "evidence from notes and staff interviews that additional discussions around processes for assessment of cognitive function had occurred." However, because these discussions were not recorded it seems unlikely that they were going to be acted upon.

Tom's mother referred to this experience in correspondence with her Member of Parliament. The family could not understand why neither adult social care nor mental health professionals perceived Tom as "a vulnerable adult." Tom had "expressed a wish to be sectioned so that he could dry out; have the replacement hip; and get back to something like a normal life." He had no morphine patches; he had not had heroin for two weeks because the money he was "unofficially being paid by Liz's Trust" had ceased; and he was due to be evicted from Liz's home on **9 November 2013**. Although Tom's social worker and social work manager were unavailable, the "council...advised Tom to present himself at the council offices on 9 November regarding his homelessness." Concern was expressed that his unsettled social situation "has resulted in deterioration of his mental health." The GP wrote a letter to support Tom's re-housing.

On **4 November 2013**, a police intelligence report noted Tom's intention to hang himself. "He was also making...comments about harming family members. Upon attendance Tom was sitting in his wheelchair and calm. He was drinking alcohol...said he did not intend to harm any [of Liz's] relatives...He is upset that he is due to be evicted...The care company supporting Liz was checking on him regularly...until the eviction."

Primary care expressed concern that Tom was "presenting as vulnerable and falling between services." It undertook to contact social services to request they offer a service that will meet his accommodation and physical needs "in the hope that this will improve his mental health."

The crisis team confirmed with adult social care that it had discharged Tom.

On **5 November 2013**, Tom attended the Headway centre where he appeared tired and lethargic.

On **6 November 2013**, Tom's family contacted primary care concerning Tom's referral to the pain clinic and neuropsychological help. A GP³² sought information from the mental health team concerning information and direction about a referral to psychology.

On **7 November 2013**, primary care made a safeguarding referral concerning Tom's impending homelessness. This was "not felt to be safeguarding as adult social care already referred Tom to Housing Department and was supporting him with re-housing."

The crisis team was seeking neuropsychological help for Tom.

On **8 November 2013**, Tom was placed in a hotel as temporary accommodation while homelessness duties were checked.³³ Tom disclosed to a housing officer that he had recently had suicidal ideation due to the eviction. On arrival at the hotel he had a grand mal seizure and was taken to hospital. The hotel later declined to accommodate Tom because of the perceived high medical risk.

Tom's mother contacted the Emergency Duty Team to report that her son was homeless. She explained that Tom had taken an overdose which had been followed by an epileptic seizure while at the hotel. The hospital assessed Tom as "medically fit" and in the absence of alternative accommodation she took him home.

On **11 November 2013**, the Housing Department had negotiated a placement at a unit for homeless people. However, no room was immediately available.

Tom's sister rang primary care concerning events of 8 November and the ongoing challenge of finding accommodation for Tom. He attended the GP practice with his mother. Although his alcohol intake was high, he said that he had had no heroin for two weeks.

On **18 November 2013**, Tom's sister wrote a letter of complaint to adult social care about the poor service her brother and his partner had received. Adult social care did not become aware of this letter until **October 2015**. It is not clear how it became "lost" in Tom's file.

Tom attended an appointment at Turning Point and disclosed that he was drinking a bottle of wine each day.

Primary care increased the patch strength of Tom's pain treatment.

On **20 November 2013**, Tom attended a pain management outpatients' appointment. He had left hip pain from osteoarthritis. "Not for consideration of surgery unless alcohol and drug (heroin) use is under control." It was noted that although Tom had been referred to Turning Point, it was unable to help since "he does not have an addiction due to ability to

³² Although Tom's family were concerned about the discontinuity of GPs and Tom's contact with locums, primary care did attend to such non-medical concerns as the crises surrounding his welfare benefits and his prospective homelessness

³³ Under the Housing Act 1996, local authorities must give priority to certain groups when they provide accommodation for unintentionally homeless people

abstain.”³⁴ It was noted that he was staying with his mother and that he was on a waiting list for accommodation. “Able to walk short distances but also uses an electronic wheelchair...says he stopped taking heroin a month ago. Trying to drink less...consider a TENS machine.”³⁵

On **21 November 2013**, Tom was placed at a guest house in Taunton.

Tom’s family recall that he was drinking throughout November.

December 2013

On **5 December 2013**, Somerset County Council concluded that Tom was not homeless. He moved to a service for homeless people because the hotel in which he had had a fit (see 8 November 2013) declined to admit him “due to risks from drink/drugs/others in his room.” Tom’s family believe that this transition was a significant watershed because “he was in contact with people who made him worse. In total he had five mobile phones stolen and because he gave people his bank card’s pin number, his account was cleaned out.”

On **10 December 2013**, social services contacted Turning Point. It was unable to assist since it did not have Tom’s signed consent.³⁶

On **11 December 2013**, Tom did not attend the pain management clinic. He was sent a letter stating that if he wished to re-engage his GP would have to re-refer him.

On **16 December 2013**, the GP informed adult social care that Tom was not keeping appointments.³⁷

On **17 December 2013**, Headway noted that “Tom took part in Christmas celebrations but was very preoccupied with issues relating to his homelessness...is requiring a lot of support when he attends Headway...his behaviour towards Liz causes concern, as do his drinking/drug habits.”

On **19 December 2013**, a social worker visited Tom at the unit for homeless people and reminded him of the importance of keeping to the “no drink or drugs” rule.

On **23 December 2013**, the unit for homeless people informed adult social care that Turning Point was visiting Tom.

12. 2014

January 2014

³⁴ It has been speculated that this conclusion is based solely on Tom’s description of his use of substances, that is, it is ahistorical and difficult to square with the experiential knowledge of his family, Headway, primary care and the police and contradicts Tom’s claim of 18 November

³⁵ A method of pain relief involving the use of a mild electrical current

³⁶ In the context of Tom’s deteriorating circumstances, this is unhelpful. His sister had sought to act as his advocate since 2005, with Tom’s agreement

³⁷ Primary care records indicate the following references to Tom’s *did not attend* clinical appointments: 1987x1; 1991x1; 1993x1; 1994x1; 1996x1; 1997x1; 1998x1; 1999x1; 2006x2; 2008x1; 2010x2; 2013x4; 2014x2

On **12 January 2014**, Tom attended Accident and Emergency which noted his “hip pain, alcohol and heroin use.” He requested pain relief and was low in mood. This was attributed to his recent court order, chronic pain and use of alcohol and heroin to top-up prescription medication for pain relief. He was very unhappy, requested psychological support and admitted to feeling “more psychological pain than physical.” Christmas was the anniversary of the Road Traffic Accident that permanently disabled him. “Not making threats to harm self. Now homeless...presenting problems sound much the same as when last assessed e.g. struggling with pain management...taking over prescribed dose (of pain relief medication), still misusing heroin and alcohol...A&E and unit for homeless people requesting mental health re-assessment...substance misuse issues would need to be addressed...will offer triage to ascertain whether a routine assessment appointment necessary or signposting to Turning Point the most appropriate course of action...no suicide ideation expressed.”

Tom was discharged from mental health because “it would be difficult to establish any underlying psychological issues relating to his mental health whilst experiencing physical symptoms and dependency.” Tom was “advised to engage with Turning Point...possible referral via GP to pain clinic...any future mental health concerns contact GP to discuss mental health referral.”³⁸

The Somerset Partnership Trust acknowledged that Tom had “longstanding...multiple complex difficulties...substance use was almost consistently problematic throughout Tom’s life and represented a barrier to accessing and remaining engaged with services and sometimes presented significant risks to Tom’s physical and mental health...he had difficulties with erratic mood and this may be part attributable to his head injury (and most likely further exacerbated by substance misuse). He experienced a number of historical losses, including family relationships and his identity as a physically intact being with a range of life choices, which continued to trouble him. During the time Tom had contact with the Somerset Partnership he was facing further significant loss, his relationship with Liz and his home and income. His presentation was that of a vulnerable adult with limited physical and psychological capacity to keep himself safe and avoid exploitation by others...his housing arrangement was not stable...his associations with drug users frequently alienated him from services who were unable to visit him at home due to the presence of drug users and drug paraphernalia...his exploitation by other drug users...further compromised the stability of his accommodation. Tom was known to multiple services and care providers...but there was no lead agency clearly identified to coordinate and oversee an appropriate and comprehensive programme of care...there was no defined multi-agency approach to try and meet his complex needs.”

On **17 January 2014**, Tom kept an appointment at Turning Point at which he stated that he had cut down his alcohol consumption to three times a week.

³⁸ Reference to 19 October 2013 underlines the disconnectedness of professionals’ responses

On **21 January 2014**, Headway was exercised by the dynamics between Tom and Liz. She did not understand that Tom was accessing Headway in his own right. The animosity between them, coupled with Tom's drinking, was troubling others using Headway's service.

On **28 January 2014**, Tom discussed his future support with Headway staff. He agreed to a referral being made to Turning Point and acknowledged that he required help to address his drinking in order to have the hip operation. A support plan was agreed with Tom involving a volunteer from Headway. This was shared with Tom's sister.

On **30 January 2014**, Tom met with a Turning Point recovery worker and discussed his drinking patterns.

February 2014

On **3 February 2014**, adult social care sought information from primary care about Tom's referral for a neurological assessment.

On **5 February 2014**, adult social care visited Tom. He was "in a good mood and settled in...no re-housing news yet. He had an appointment card for Turning Point. He was still using alcohol for pain." The service advised that Tom should be referred back to the pain management clinic.

On **11 February 2014**, Tom's sister visited Headway to discuss his circumstances.

On **14 February 2014**, Tom's sister took him to Headway. He was reported as being "happy to be supported in trying to get himself sorted out in readiness for a hip replacement sometime soon."

On **19 February 2014**, Tom was accompanied to Turning Point by the Headway volunteer. He received Hepatitis A and Hepatitis B injections while there. Tom advised the volunteer that he "had not drunk more than a bottle of wine...it was apparent that he was high...later he disclosed that he had smoked heroin on two occasions the night before."

On **21 February 2014**, messages were left with adult social care concerning transport to Headway. This was "still being provided by family."

On **25 February 2014**, Tom attended Headway. "Despite denial, he was clearly under the influence of some substance...he had enjoyed the support and attention but was fairly incoherent and did not join in with any activities."

On **28 February 2014**, Tom's mother transported him to Headway. He was "in a relatively good mood...did not seem under the influence of drugs although seemed that he had a drink."

March 2014

On **3 March 2014**, Tom sustained a head laceration.

On **4 March 2014**, adult social care agreed to fund Tom's transport to Headway.

On **7 March 2014**, Tom did not attend Headway and had not made any contact. Messages were left on his mobile.

On **11 March 2014**, Tom sent a text to the Headway volunteer.

On **14 March 2014**, "Tom attended Headway, brought by his mother. He had been depressed and suicidal in the previous week. Still wants support. New risk assessment carried out."

On **19 March 2014**, Tom was to have been supported to attend Turning Point but he did not attend.³⁹ He was "not compliant with their conditions of treatment and help." The Headway volunteer tracked Tom down to a park where he was waiting to purchase drugs. Tom was with another person with whom he had struck up friendship and upon whom he was reliant. His support package was described as "in jeopardy."

On **21 March 2014**, Tom was brought to Headway by his mother. Whilst there, he slept and appeared under the influence of drugs. He had been served notice by the unit for homeless people to remove himself in seven days due to his use of alcohol and drugs.

On **24 March 2014**, a police intelligence report noted that Tom was associating with a known drug user. They were stopped and searched.

On **25 March 2014**, Tom had an orthopaedic assessment. He had "osteoarthritis to left hip...was reviewed at hospital last year but was compromised by drug and alcohol use...so surgery was felt to be inappropriate...states free from drugs since orthopaedic review last year. Does have the odd alcoholic drink but does not abuse it. Keen for surgery to be reconsidered...refer to hospital for orthopaedic review."

On **27 March 2014**, the Taunton housing team was advised that due to concerns about Tom's "drinking and bringing people back to his room and his poor hygiene,"⁴⁰ he had been given a seven-day warning of possible eviction. A referral was made to adult social care for a "full independent living assessment with a view to living independently in social housing."

April 2014

On **3 April 2014**, the independent living assessment was declined because Tom "has no permanent accommodation. Tom was given another warning of eviction due to alcohol misuse."

On **4 April 2014**, it was noted that Tom's "community support package has been withdrawn...as risks involved and commitment issues...meant that support package proved unsafe for support staff. Tom's mother brought him to the new Headway premises. A risk assessment was prepared in anticipation of the move...spent most of his time asleep in his wheelchair not wanting to join in activities. His social worker has suggested registering with housing website." The new building was unsuitable for Tom since he could not be separated from his peers and staff when he was intoxicated.

³⁹ Tom *did not attend* appointments negotiated by Turning Point during August 2013; January 2014; March 2014; and May 2014. Tom cancelled an appointment with a recovery worker during March 2014

⁴⁰ Tom's family noted that *his self-neglect got worse towards the end*

On **8 April 2014**, Tom was suspended from Headway and volunteers had ceased accompanying him to Turning Point appointments. This was due to the risks from his drug and alcohol use and some aggressive behaviour with staff and other users [it is not clear whether or not these risks featured in risk assessments]. Tom had been increasingly under the influence of drugs when attending the centre recently. His sister was informed.

On **17 April 2014**, a referral was made to temporary accommodation for Tom, and a ground floor bedsit was identified. Adult social care assured housing of Tom's ability to live independently irrespective of concerns expressed by housing officers.

Tom ceased to attend the Headway service during **April 2014**.

May 2014

On **1 May 2014**, Tom was evicted from the unit for homeless people. A new homelessness application was created and he was placed in temporary accommodation while the council's homelessness duty was investigated.

On **7 May 2014**, a letter was hand-delivered to Tom's temporary accommodation "with regards to suspected breaches of tenancy, that is, he had a dog in the property and people were staying overnight. He was verbally advised of the letter's content."

On **19 May 2014**, Tom moved into a bedsit.⁴¹ His family helped to equip his new home.

On **21 May 2014**, it was accepted that Tom had a priority need due to his health status, his disabilities and homelessness.

On **23 May 2014**, because of a report received by local police, Tom was visited by a housing support officer in relation to anti-social behaviour. He was "continuing to allow others to stay at his address overnight...a potential tenancy breach...Tom presented as if he was under the influence of either drink or drugs" and there were other people at the address. He was given advice about (i) sustaining his tenancy and (ii) contacting his GP because he disclosed that he was feeling unwell. One of the men present "presented particularly aggressively to housing staff and the police." Another person expressed concern that Tom was "being exploited" by street drinkers. The housing support officer submitted a safeguarding referral and copied this to adult social care. This described Tom as being "spaced out" and friends "taking money from him."

Tom's risk of eviction was increased because of the non-payment of service charges which included electricity and water rates. He was offered support to ensure these payments were made and to carry out domestic chores.

June 2014

On **5 June 2014**, a multi-agency safeguarding strategy meeting was held. In spite of a number of absentees a "comprehensive multi-agency action plan resulted" which included

⁴¹ Taunton Deane Borough Council noted that it was assured by Adult Social Care of Tom's *ability to live independently although no formal assessment took place*

an ABC chart.⁴² Neither Tom nor his relatives were invited.⁴³ At the meeting the Headway service noted that “even when Tom is not under the influence he still has difficulty processing things due to his brain damage.” It was suggested that a neuropsychologist “may help to make some kind of decision as to whether Tom has the capacity to make decisions about his lifestyle and welfare...a suggestion was made around the possibility of [a relative] organising an appointeeship for Tom’s welfare benefits.”

The police advised that adult social care staff “should not visit without the police.”

On **9 June 2014**, adult social care discussed Tom’s mental capacity with a local authority solicitor.

On **13 June 2014**, adult social care noted that Tom was “tearful today...will now accept help...implementing ABC chart to help him control who comes into his home.”

Adult social care acknowledged that Tom “was particularly vulnerable to the influence and coercion of others and had limited ability to protect himself. Visitors to his home were well known drug/heroin users and Tom was vulnerable to financial abuse although continued to manage his own money.”⁴⁴

On **16 June 2014**, Tom did not attend an orthopaedic outpatient appointment. A letter was sent to Tom and his GP discharging him from care.

On **19 June 2014**, a police intelligence report noted that Tom was associating with known drug addicts.⁴⁵

Adult social care emailed Tom’s mother to invite her and Tom “to meet to discuss outcomes of the safeguarding meeting of **5 June**.”

On **20 June 2014**, Tom signed the Acceptable Behaviour Contract in the presence of his mother and a police officer.

A police intelligence report noted that one of the persons who was not allowed into Tom’s property was living there.

Tom’s family recall that his bank account had been “cleaned out 10 days before his death.”

On **25 June 2014**, adult social care completed the “risk assessment document as agreed at the safeguarding meeting. This identified Tom to be at significant risk of: health damage from alcohol abuse...drug abuse combining prescribed and illegal drugs...and poor nutrition; involvement with organised drug crime; financial abuse; eviction from his temporary

⁴² An Acceptable Behaviour Contract specifying three conditions: Tom should not allow, (i) *overnight visitors* (ii) *people to access the property in his absence* and (iii) *two named individuals into the property*

⁴³ It is noted that towards the end of his life the communication between Tom’s family and other professionals became *more frequent and intense*. However, there was *little evidence to demonstrate clear information sharing to move forward actions or outcomes*

⁴⁴ At the strategy meeting of 5 June 2014, it was noted that Tom was *in control of his bank card and has willingly given out his pin number to people*

⁴⁵ These people were *known to prey on vulnerable people*.

accommodation and becoming homeless; mobility limitations compromising the control of his own front door.”⁴⁶

On **26 June 2014**, a police intelligence report noted that Tom was obtaining drugs and owed a drug debt to the person who was not allowed into the accommodation.

On **30 June 2014**, Tom’s mother emailed a friend. She wrote “I am increasingly feeling that I am banging my head against a brick wall and that...he is going to be found dead one day having overdosed accidentally or otherwise.”

On the same day the police summoned the ambulance service to Tom’s property. He had taken his own life.

Analysis

13. Trauma to the brain has a profound impact on a person’s life course, family and interpersonal dynamics. The crisis of brain injury arising from road traffic accidents and the long term medical and rehabilitation interventions associated with such accidents transform lives (see Spinney 2016)
14. Personality change is well documented (Hubert, 1995; Knechel Johansen, 2002; and Daisley *et al* 2009). Tom’s brain injury was associated with rapid mood swings and irritability which arguably impacted on his relationship with his girlfriend at the time of his accident. Their marriage lasted only weeks after his discharge from rehabilitation.
15. During the rehabilitative aftermath of Tom’s accident, it became evident that he had lost the full range of movement on one side of his body. This compromised his mobility and inhibited his ability to consciously perform actions. Although his impaired language skills were short term, his writing skills (as reflected in correspondence with an orthopaedic consultant during July 2013) were suggestive of cognitive impairment in terms of ordering his ideas and the points he wanted to make.
16. Tom lacked insight into his post brain-injury support needs and his abilities as he sought to negotiate his former world. Driving is a symbol of independence and although it was the cause of criminal convictions and his brain injury Tom wanted to drive again and he believed that he could.
17. Prior to Tom moving into Liz’s home, her family had taken the precaution of securing a lasting power of attorney. Liz had received compensation and her family’s actions gave expression to the concern that her compensation might attract individuals who would not be engaged by her best interests. However, it was after Tom became her live-in partner and carer that his behaviour changed and he was known to be dependent on Liz for such matters as financing his alcohol, drugs and transport costs to get to Headway for example. Ultimately Liz’s best interests became remote from Tom’s concerns as he ceased to provide the care she required and, *inter alia*, allowed known drug users into her home. Because Liz’s family assumed responsibility for managing her finances and her support, and she had a social worker, she was perhaps less visible than she should have been to adult social care. **There was neither a local authority Community Care Assessment nor an assessment of**

⁴⁶ There was no reference to the risk of suicide. See 2 and 4 November 2013

Tom as a carer in his own right [emphasis added], irrespective of his deteriorating circumstances and growing concern about the mutuality of his relationship with Liz. Once the couple became known to an array of services, not least because of Tom's addictions, the local authority acknowledge that Tom's role should have been assessed.

18. Over-drinking and intoxication were features of Tom's life before his brain injury. During the years following his accident these addictions escalated. On a single occasion during December 2011, Tom attributed his drinking to an attempt to obliterate the memory of his accident (which is the only glimpse professionals had of Tom's perception of his post-accident circumstances) and he ascribed his drug use to his means of relieving physical pain. Yet Tom's brain injury is likely to have reduced his tolerance to drugs and alcohol and to have interacted adversely with his prescribed medication.
19. Tom did not follow the professional advice he received – most particularly the advice of clinicians. He had chronic conditions and yet the attention he received from health and social care was dispersed and consisted simply of a series of discrete interventions in particular settings. If he did not cooperate or keep appointments he was discharged.
20. During 2003, Tom was referred to neurology. He was subject to depression and mood swings. During 2004, he declined counselling and he was referred to neuropsychology. During 2009, Tom was prescribed medication for the stress he associated with caring for his partner. During 2011, he was prescribed medication for chronic insomnia. During July 2013 an orthopaedic consultant declined to consider Tom for hip surgery due to, inter alia, "psychiatric and psychological problems which would greatly increase the risks of surgery and the chances of a poor outcome." Although Tom's family were acutely aware of Tom's deteriorating mental health and the incongruities between his pre and post brain-injured self, Somerset Partnership NHS Trust's clinical assessment was ahistorical and took no account of their experiential knowledge. His family remain bewildered that mental health professionals declined to pay necessary attention to Tom's post brain-injury despair and enduring depression. They question the merit of service responses which do not build on an interdisciplinary and competent assessment of a person with a brain injury – who frequently asserted that his life was "not worth living."
21. Avon and Somerset Police gathered information about Tom from the Halcon One Team⁴⁷ which includes representatives from partner agencies such as housing and the local authority and seeks to address the underlying causes of crime with bespoke support packages for individuals. Tom's address at the end of his life was well known to the Halcon One Team, not least because of its proximity to a police station. Police officers were instrumental in "offering ongoing support...by way of regular attendance at the address with a view to encouraging him to access the support available for his drug use." Tom advised these officers that he chose to use illegal drugs and would decline any support "to aid him with becoming abstinent." This was not known to the clinicians who were concerned that

⁴⁷ <http://www.avonandsomerset-pcc.gov.uk/News-and-Events/News-Archive/2014/July/Ground-breaking-crime-reduction-project-to-be-rolled-out-further-after-major-funding-boost.aspx> (accessed 7 February 2016)

Tom's drug use was compromising his prescribed medication and the likelihood of orthopaedic surgery being carried out.

22. Headway had a high tolerance of Tom's behaviour and remained a constant in his life until he was suspended during April 2014. However, Headway did not follow its policy insofar as it allowed Tom to continue attending when he was intoxicated and long after he had been given a final warning. For example, he was allowed to rest in a part of the service where he did not distract or cause distress to others. Since he was receiving no other service input, Headway provided health promotion advice and it undertook "relevant risk and general assessments, most particularly concerning his use of drugs and the bringing of alcohol into the centre."
23. **Tom's mental capacity was assumed** [emphasis added] notwithstanding the limited references to his capacity and discussions concerning neuropsychology and neurological assessments. Although a discussion with the County's solicitor is noted during June 2014, the outcome of the discussion was not documented. Over time, it would have been prudent for assessments to have been carried out in the light of 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; his failure to comply with the terms and conditions of his tenancies; the concern of Taunton Deane Borough Council that Tom had begun to self-neglect; and acknowledgement that Tom "was making decisions and was felt that he could not suitably process information or understand the consequences because of his acquired brain injury...had difficulties in complying with expectations and was unable to identify his own risks."⁴⁸ Although adult social care might have assumed responsibility for initiating a mental capacity assessment, health services might also have initiated a capacity assessment, perhaps when he refused medical interventions such as checking for pressure ulcers (during June 2013), refusing to wash and discharging himself from hospital. The Safeguarding Strategy Meeting Minutes of 5 June 2014 confirmed that a mental capacity assessment was required and it was determined that adult social care should "contact GP re the possibility of a referral being made to the neuropsychologist" – who, it was envisaged, would undertake the assessment.
24. The Somerset Partnership Trust came to the conclusion that "Tom had capacity when assessed by Mental Health Services in November 2013." The extent to which this was an in-depth and contextualised assessment is not known. There is no information about what information Tom was offered and whether or how he retained it, weighed it and used it to make a judgement. This assessment was not shared with Tom's family or other agencies. Musgrove Park Hospital noted that "Tom was identified as having a number of factors that may have impacted on his capacity for some decision-making. This included brain damage from his previous head injury, epilepsy and drug/alcohol use."
25. The police attended Tom's address during November 2013 "following his comments...about taking his own life and/or harming others...Tom clarified to officers that he did not intend to

⁴⁸ Headway IMR

harm others given his limited capacity...due to his physical disability. Officers subsequently made the necessary arrangements to have Tom appropriately assessed by a qualified mental health nurse...Tom was referred by police to the Crisis Team at Musgrove Park Hospital.”

26. The South Western Ambulance Service noted that Tom “was aware” that the safeguarding referral was being made.
27. More generally, **the assessment processes experienced by Tom were not integrated and had no impact on inter-professional working** [emphasis added]. Adult social care’s assessments were scant, unfocused, barely documented and disconnected from professional judgement and decision-making. It follows that it is not possible to determine either the purpose of these assessments or the social work goals which informed them. The basis for Adult Social Care assuring Taunton Deane Borough Council of Tom’s ability to manage a placement in independent living accommodation during 2014 is not known because no documented assessment took place.
28. Although three events (of 10 July 2012; 7 October 2013; and 7 November 2013) were not considered to be sufficient to meet the criteria for requiring a safeguarding assessment, adult social care attribute this to staff adopting an ahistorical approach which did not take account of the changing nature of Tom’s circumstances.
29. Taunton Deane Borough Council investigated Tom’s circumstances and his priority in terms of re-housing following his evictions from Liz’s home and then from the unit for homeless people. A tenancy agreement sought to isolate him from two drug dealers who were known to target vulnerable people. Numerous visits characterised its contact with Tom when he was in independent living accommodation which were triggered by breaches of his tenancy agreement (as required by procedures for addressing anti-social behaviour). These led to a safeguarding referral to adult social care during May 2014. Although Taunton Deane Borough Council acknowledge that information raised via the Halcon One Team was inconsistently recorded on its own system, this did not impact on the support it provided to Tom in terms of trying to sustain his tenancy. However, Tom was not believed to be an “adult at risk” by adult social care. The latter was responsible for two thirds of the resulting actions required at the Strategy Meeting of 5 June 2014. It is not certain that these were undertaken. This was in breach of its policy and procedures.
30. Adult social care acknowledges that its recorded evidence concerning Tom’s circumstances was scant. Headway, Tom’s partner and his family were in regular contact with his social workers and raised concerns and yet these were not reflected in adult social care records.
31. In terms of information sharing, Musgrove Park Hospital noted that **information seems to have been shared appropriately**, “but the communication with mental health services is not clearly documented.” Headway observed that all services managing Tom’s needs “were not totally linked up enough to fully understand how his general health and wellbeing was [impacting]...on his day to day challenges such as his drug and alcohol abuse and his anxieties.”

32. At a locality level, when Tom was re-housed within the Halcon One team area, information was shared about his circumstances during regular meetings. However, no skilled practitioner was identified to work with Tom to clarify his perspective and determine the options which made sense to him. Although information from the South Western Ambulance Service and Avon and Somerset Police was shared appropriately and at the appropriate level of seniority, as Tom's relative noted to an MP, "nobody will take responsibility for helping him."
33. The Somerset Partnership Trust acknowledges that generally, there was a lack of a coordinated proactive approach to follow-up and interagency communication. However, it did liaise with the care agency supporting Liz, Tom's GP and the unit for homeless people after its contact with Tom during November 2013 and January 2014. The Trust acknowledges that there were no discussions with drug and alcohol services or "proactive attempts to engage Tom with the specialist drug and alcohol service (Turning Point) despite his complex physical health problems and needs and accommodation and financial difficulties, which would most likely act as a barrier to his accessing treatment independently."
34. The police and the Halcon One Team were "aware of Tom's **vulnerabilities** [emphasis added] and raised concerns" about the targeting and exploitation of these vulnerabilities. The support of the Halcon One Team included engaging with drug support agencies and voluntary work, despite the fact that he ostensibly declined such support. Also, Avon and Somerset Police took action to safeguard Tom by imposing bail conditions on his peers when he was sharing Liz's home. Taunton Deane Borough Council's Housing Options service reasonably questioned adult social care's assertion that Tom could "manage independently." Given its misgivings concerning Tom's mental health, cognitive ability and substance misuse, Housing Options involved Tom's family, with his consent, to ensure that he had an advocate on his behalf. It appreciated that the voluntary Acceptable Behaviour Contract, which served to try and protect Tom from those who were minded to exploit him, would potentially isolate him from two of the four people he perceived to be his friends.
35. The responses of Adult social care were wanting prior to and at the time of recording that Tom's brain injury "did appear to affect his mental health...his substance misuse...appeared to dominate his life in a more uncontrolled, unprotected and vulnerable way once he lost his home with his partner. He was subjected to abuse and coercion from people he believed were his friends." The Somerset Partnership Trust acknowledged that Tom's A&E attendance during January 2014 was a "missed opportunity."
36. Musgrove Park Hospital acknowledged that it was "difficult to determine how much Tom's behaviour and cognition were affected by his head injury as he was identified as having problems with substance use and having a non-conformist personality prior to the injury. It seems likely that there was some ongoing impact but this is difficult to quantify."
37. Even though different professionals and agencies acknowledged that Tom was "**at risk**," [emphasis added] there is no clarity about Tom's perspective on the risks in his life and what he believed should be done about them. It does not appear that the risks of not eating,

living in unhygienic conditions, the risks of self-neglecting, the risks of tolerating discarded needles in his home, the risks of combining prescribed and street drugs, the risks associated with being with exploitative peers, and of suicide, for example, were considered individually or collectively. It does not appear that these assessments took account of the possible outcomes, their likelihood and how mitigation efforts were to be managed. This would have required explicit collaborative enterprise, rather than embarking on, yet another, disconnected assessment. They should have involved Tom and his family, which had provided long-term support, transport services and default accommodation. Although his sister had been a willing advocate since 2005, she could not understand the activities of professionals and recalled being advised on one occasion that Tom was “not eligible for an assessment.” Her overall sense was that “Everyone seemed to buck pass.”

38. Tom’s family sought the engagement of a Member of Parliament during November 2013 because they could not comprehend a single mental health assessment which determined that he had no mental illness, asserting that he was “merely reacting to life’s problems;” they wanted adult social care to “help by getting Tom into rehab;” and to deal with his prospective homelessness.
39. Housing Options engaged positively with Tom’s family since it recognised that his relatives were extremely concerned about the consequences of his deteriorating circumstances. Tom’s family was encouraged that a housing officer “knew it was ridiculous to describe him as intentionally homeless.”
40. Somerset Partnership Trust state that they liaised with Butterfield Care (which was commissioned by Liz’s family to support her) and with Tom’s mother as part of its assessment and follow up process. This was not experienced as liaison since both parties learned that Tom was ineligible for its assistance. They could not make a dent in professionals’ misunderstanding concerning Tom’s mental capacity.
41. The association of substance misuse with traumatic brain injury and suicide is well documented (Harris and Barraclough, 1997; Leon-Carrion 2001; Teasdale and Engberg 2001). It was Tom’s family which correctly anticipated that he would take his own life. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness showed that there were 4,799 male suicides in the general population during 2013. The National Confidential Inquiry noted:
*“Suicide in men is sometimes blamed on a reluctance to ask for help...our findings suggest the drivers of these increases [that is in terms of numbers of male suicides] may be risk factors such as (a) alcohol misuse is a common antecedent but most patients are not in contact with alcohol services (b) economic pressures...”*⁴⁹ [para 6].
Our findings make it clear that working more closely with families could improve suicide prevention [para 12].

⁴⁹ Patient suicides are those that occur within 12 months of mental health service contact

One example of how services can improve contact with families...how [do] services respond when a patient does not attend an appointment. In only 22% the service contacted the family when the patient missed the final appointment before the suicide occurred [para 13]. Our findings suggest that good physical health care may help reduce suicide risk in mental health patients:

- *Physical health needs, especially long term needs, should be reflected in mental health care plans*
- *Mental health staff should regularly review care with GPs or specialist clinics” [para 26].*

Lessons

- 42.** 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. Certainly Tom was situationally incapacitated by exploitative and drug using peers - a fact that was known to many professionals who did not question the absence of mental capacity assessments.
- 43.** In Somerset, the Mental Capacity Act 2005 is not meeting the higher standards than were expected when the need for such legislation was identified. Reference only to Appointeeship for Tom’s welfare benefits, as the legislation was approaching its 10th anniversary, confirms the concern of the House of Lords (2014) that “the Act has suffered from a lack of awareness and a lack of understanding.”
- 44.** Little was known about Tom’s life before he sustained his brain injury. Although his family was an obvious source of information, and his mother provided him with emergency accommodation during November 2013, their role as reflected in contacts with services became one of pleading for engagement and help. Butterfields, which was supporting Tom’s former partner, became knowledgeable about Tom’s deteriorating circumstances by default. It experienced frustration that his detrimental and harmful decisions merited no credible response. Headway had bent its own rules for over 13 years to support Tom; Housing Options officers had sought to protect him from harmful relationships; and the police had sought, *inter alia*, to protect visiting professionals from his hazardous living circumstances. So although no single agency could address Tom’s support needs, it appears that nothing impelled or even required health and social care services to work collaboratively within and across their own provision to provide direction and resolution. There was, and there remains, a strong sense that a man with a brain injury, depression and addictions requires the sustained assistance of mental health services - and yet Tom was deemed ineligible.
- 45.** It remains to be determined where brain injury, depression and addictions reside in terms of service provision in Somerset. Brain injuries transform people’s lives and their relationships. As the intensity of life-saving medical interventions discontinue, the slow processes of rehabilitation begin, which are experienced by families as seemingly less-urgent. The

continuities and discontinuities spanning Tom's brain injury were not known to professionals who became known to Tom. He frequently stated that his life was "not worth living." Addictions are harmful. They are known to devastate relationships and the ability to function. They are a significant factor in domestic and public violence. Not even the final risk assessment took account of Tom's known wish to take his own life.

46. During October 2013, primary care and adult social care appear to have run out of options when Headway sought assistance, that is, the social worker suggested contacting the GP and the latter suggested contacting the social worker. The GP also suggested phoning Tom's sister. What is the point of multiple assessments spanning many years, including risk assessments, and plans if they do not enable professionals across disciplines to pool their knowledge, agree priorities and targets and review their progress? It is not known why Turning Point prioritised Tom's "consent" over the necessity of engaging with colleagues across sectors, at a time when these sectors failed to identify any credible intervention.
47. Carrot and stick approaches had zero impact in persuading Tom to curtail his appetite for alcohol and drugs. His long term substance misuse and depression meant that he was at greater risk of non-compliance. There is a gap between knowing that these are excessive and harmful and changing behaviour. After Tom's death, and following contact with his family, it would appear that degree of agency and freedom of choice that Tom had after his brain injury was more severely compromised than professionals (with the exception of Headway) had appreciated.

Conclusions

48. *Most patients who commit suicide suffer major psychiatric illness, most commonly depression or alcoholism* (Black and Winokur, 1990).
49. Somerset County Council's adult social care, Somerset Partnership Trust and Turning Point did not provide a service to a man who was brain injured, who was depressed, who could not sleep, who abused alcohol and drugs and who had expressed his intention to take his own life. Somerset Partnership Trust states that, even now, he would remain ineligible for any mental health service if he were to be referred during 2016.⁵⁰ Services do not easily respond to individuals whose lives appear chaotic and who are barely compliant.
50. 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. Tom's family grieved for him throughout his post brain-injury circumstances – which became increasingly unsafe - and yet their requests for help did not result in integrated working. In part, he became a stranger to his family: he became indifferent to his diet and self-care and he developed severe, generalised depression. Tom did not benefit from

⁵⁰ During April 2016, Somerset Partnership Trust requested that this review should "incorporate" the findings of a report "...compiled following a review of our Independent Management Review submission, Significant Incident Requiring Investigation and the draft...review." Also, it hinged on the disquiet of all contributors to this SCR process that Tom was ineligible for assistance from mental health services. The Trust has subsequently reviewed this position and now asserts that Tom was indeed eligible and that he should have received a Trust service

credible social work input since meetings and actions arising from these were inadequately documented. Social work did not even address the many “for now” concerns, which was the principal reason that Tom’s family wrote a letter of complaint. The purpose of the social work input is unknown. He did not receive mental health input since he declined to address his addictions (see October 2005). Turning Point did not proactively engage with Tom’s family or primary care and the risk assessments which were undertaken were compromised by inattention to the principal risk of suicide. A professional-led, multi-agency approach was required and this was entirely absent as gatekeeping criteria and service “thresholds” meant that he was placed in remained “in harm’s way.”

- 51.** Tom’s circumstances may be viewed as a series of crises. For example, although threatened eviction from the home with his partner and subsequently from a unit for homeless people were significant events, neither resulted in any professional or agency willing to assume a lead role in determining a multi-agency resolution. Significantly, Tom threatened to take his life and yet it appears that the practices and cultures of organisations and professional groups got in the way of grounded decision-making and the provision of collaborative support. Some professional decision-making was frankly bizarre. For example, during April 2013 the independent living assessment was declined because Tom had “no permanent accommodation.” Also, during November 2013, it was noted that although Tom had been referred to Turning Point, it was unable to help because “he did not have an addiction due to ability to abstain.” It is unlikely that the basis for these positions is known to the commissioners of services in Somerset.

Recommendations

- 52.** It is recommended that:
- i. Somerset’s Safeguarding Adults Board seeks reassurance that the “case study” of Tom’s circumstances features in sector-led and multi-agency training for Somerset Adult Social Care, Somerset Partnership Trust, Turning Point, Avon and Somerset Police, NHS England/Somerset, Primary Care, South Western Ambulance Service and the acute hospitals; 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 all professional assessments and referrals and that family involvement is prioritised with a view to understanding the continuities, the discontinuities and the unpredictable and complex process of reconstructing the self which arise from such a critical injury;
 - iii. Even accepting some basic similarities in brain injury and the fact that not two injuries will be alike, a learning event should be hosted concerning Tom and others currently known to Headway Somerset. The event should involve (i) service commissioners, including Public Health, and (ii) practitioners, with a view to identifying a purposeful, strongly led and multi-disciplinary response. It is possible

that Headway and Tom's family may be willing to assist in designing and contributing to such events;

- iv. 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;
- vi. This review is shared with Headway UK for dissemination beyond Somerset to stimulate debate.

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