Merton Safeguarding Adults Board

Noah - 7 Minute Learning Safeguarding Adults Review

Noah came to the attention of the Bexley Safeguarding Adults Board (BSAB) in May 2022. The BSAB decided that the case met the criteria for a Safeguarding Adults Review (SAR) and commissioned a review with support from the Merton Safeguarding Adults Board. The SAR looked at the involvement of agencies across boroughs in support and care of Noah from childhood to adulthood and what lessons need to be learned.

Full report: Noah SAR Executive Summary

Who was Noah?

Noah was a young Black Caribbean man with diagnosed Severe Learning Disability and Attention Deficit Hyperactivity Disorder (ADHD) who sadly died at the age of 22 in March 2022.

Noah had been accommodated since he was eight years old and received support from Merton's Children and Families Service during childhood. He had complex health and social care needs with all his residential placements outside the borough of Merton.

Transitions

As Noah approached18, there was little preparation for his transition to adult hood and a late referral to adult services. Earlier referral and joint preparation work would have helped the family understand what is involved in the change from children to adult services and ensured that robust placement planning and mental capacity assessment would have been undertaken at the right time.

Mental Capacity Act and Deputyship

The review found concerns about the level of legal literacy on the Mental Capacity Act across services and providers. While there were examples of good practice, there was inconsistency in the application and documentation. The family were not made aware of the legal channels available to ensure they could take decisions on behalf of Noah who did not have capacity. A Community DOLs also should have been applied for in Noah's circumstances as he was being placed in a setting with a high level of restrictions.

Hospital Passports and Discharge

Noah had several admissions to hospital as an adult and prior to his death. Despite his known complex health and care needs and lack of capacity, there was no hospital passport in place to support him when admitted to hospital. There were concerns about the response by the provider when Noah was in hospital and lack of inclusion of all relevant professionals in discharge planning.

Holistic assessment and attention to cultural needs

The review identified a lack of focus on the cultural needs of Noah that would have enhanced his support and ensured a more personalised approach to his care. It found that assessments did not consider his requirements in relation to personal care and support from a cultural perspective, such as lack of attention to spiritual needs in relation to his faith.

Health and social care responsibilities

A lot of people were involved in support of Noah however this was not well coordinated. There was confusion about who was responsible for which areas of support which meant that some actions were duplicated unnecessarily or missed. This resulted in a lack of clarity for the family in understanding the different responsibilities of teams when a young adult is being provided with Continuing Health Care.

Out of borough placements

The review identified issues with the standard of care and quality assurance of placements, as well as the severe structural challenges in securing appropriate placements for individuals with high levels of need. The review highlighted the importance of effective quality assurance processes around placements, including the assurance of the host authority where placements are commissioned out of borough.

What has changed?

Better transitions processes have been developed between children, adults and education services with the introduction of a specific Transition team and protocol. Young people are referred to the service at an earlier and more appropriate time after 14 years.

A more holistic approach to the individual needs of young people through improved transition planning, ensuring there is time to build a more comprehensive picture of the young person including their needs in relation to their culture.

Closer working between Adult Social Care and Continuing Health Care (CHC) to support better joint working and greater clarity in relation to placements.

Improved quality assurance processes when making placements such as checks using intelligence from the local authority and Care Quality Commission and notifying the relevant local authority. The clinical side of the CHC has been brought in-house by the Integrated Care Board since the period of the review.

More training provided on the Mental Capacity Act (MCA) for people working with young people with complex needs in children services and in adult services.

Further multi-agency training and awareness around the MCA across the partnership is being explored by the SAB . This will address the concerns about the levels of legal literacy in relation to the MCA in agencies and providers.

Questions for services and practitioners to consider

- Are my team and I confident in our understanding and application of the Mental Capacity Act ?
- Are people who do not have capacity protected when they cannot consent to restrictions in the community or in a placement?
- Are we identifying the primary health need at the earliest point possible to ensure people receive support when they are eligible?
- How well are we preparing young people and their families for the transition between child and adult services?
- Are my team and I confident that assessments of care and support needs are holistic and consider the ethnic and cultural identity of the individual? Do we always consider young people's needs in relation to their culture or faith?