7-minute briefing on Safeguarding Adults Review - Eric

Background to the review

Eric was a white British male in his early sixties when he died by suicide in November 2021. Eric had a long history of problematic alcohol use, self-harm, self-neglecting behaviours and suicide attempts. Prior to his death, Eric was living in a care home and had been continuously expressing a wish to return home to independent living. This had been deemed unsuitable due to his inability to care for himself.

Legal literacy

Throughout the period of the review there was a lack of legal literacy demonstrated by health and social care professionals. Practitioners are reminded to access the support MCA leads within their organisation, where available. There was also a lack of understanding or knowledge of the Norfolk Safeguarding Adults Board (NSAB) escalation processes,[1] for professionals to follow when either a decision has been made, or an action hasn't been taken, which they do not agree with.

Use of Multiagency meetings

Throughout all of the periods upon review, there was a distinct lack of joined up, multiagency working when responding to Eric. Practitioners are reminded that bringing various agencies together, allows discussion of concerns and sharing of the different parameters of support which each agency provides; information can be triangulated, and robust plans can be made.[2]

High-Frequency Users

Whilst Eric lived in his own bungalow he had many hospital attendances, and even more 999 and 111 calls where an ambulance either did not convey him to hospital or advice was given over the phone and a crew was not deployed to his property. It is possible that Eric was lonely and was using hospital admissions for human contact. Practitioners are reminded to consider loneliness when developing support plans.

Risk Assessments

Eric posed a risk to himself, from self-neglect, self-harm and latterly from suicide, however there is little to no evidence of robust risk assessments, resulting in a comprehensive safety plan, to reduce the risk of harm from Eric towards himself. It is vital that risk assessments are completed, and then reviewed regularly, as risk is fluid.

Practitioners are also reminded of the availability of suicide prevention training, which Norfolk and Waveney Mind deliver, and which is commissioned by Norfolk County Council.[3]

Suitable Placements

The review highlighted the lack of suitable residential accommodation for younger people with complex needs such as Eric. He was placed at Care Home C with a "diagnosis" of Korsakoff's dementia. Eric was not diagnosed with this, instead it was a condition which his social worker had identified as possibly fitting his behaviour and symptoms.

It is important that the source of a diagnosis is noted, and that anecdotal information or opinion becomes assumed as a diagnosis over time.

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[1] Professional-Difficulties-V2FINALDEC-2020.pdf (norfolksafeguardingadultsboard.info)

[2] Complex Case guidance

[3] Norfolk and Waveney Mind - Suicide Prevention & Awareness