Norfolk Safeguarding Adults Board

Safeguarding Adults Review: Eric

Executive Summary

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1. Background to the review

Eric was a white British male in his early sixties when he died by suicide in November 2021. At the time of his death, Eric was living in a care home in Town B, Norfolk. Eric had a long history of problematic alcohol use, self-harm, self-neglecting behaviours and suicide attempts. Eric's adult children told the Independent Chair that Eric's poor self-care and self-harming behaviours started when he separated from their mother more than twenty years prior. Eric had then been in a relationship with a woman who also had alcohol and mental health issues, and when this relationship had ended Eric's behaviours escalated.

Eric lived independently in a bungalow in Town A until January 2021. During this time, he was a frequent attender at Hospital A, due to self-harming, falls, and poor physical health linked to alcohol use. During his final admission to Hospital A in January 2021, he contracted Covid-19 which rendered him weak with poor mobility. While he was an inpatient, rehabilitating from Covid-19, his adult daughter raised a concern that he would be unable to care for himself back at his bungalow; Eric was also deemed to lack capacity to decide where he should live, a best interests decision was made, and Eric was accommodated in a series of care homes and inpatient beds. At the end of June 2021, Eric was accommodated at Care Home C, where he passed away.

From January 2021 when Eric left his bungalow, until his death, Eric constantly requested to return home. There were numerous mental capacity assessments, his capacity fluctuated, and it was considered that he would be unable to care for himself if he returned to independent living.

A diagnosis of Korsakoff Dementia was recorded on Eric's records, however there is no evidence that this was officially diagnosed. The care homes identified for Eric were specifically for dementia patients, Eric did not fit into the environment, and they were not equipped to deal with his specific behaviours.

Whilst at Care Home C, Eric refused to take medication for his mental health, the NSFT psychiatrist assessed that Eric's presentation was a protest regarding his desire to return home and assessed that there was no requirement for mental health support. He attempted suicide in October 2021, and in November 2021, care home staff found him deceased, having taken his own life.

2. Key Lines of Enquiry

- The management of Eric's move from the mental health hospital to Care Home C (the residential care unit) including pre-assessment and decision making on the suitability of the service to meet his needs and the ongoing support to staff at Care Home C to provide the required care.
- Were the responses to the safeguarding concerns while Eric was at the residential care unit effective?

- The voice of Eric and his wishes to return home and the extent to which these were recognised, acknowledged, explored, and validated. Including an understanding of his mental capacity to make these decisions. Mental health medical assessment was that Eric's presentation was down to a protest regarding wanting to return home to the community which is not something the mental health team could treat.
- The understanding, assessment and management of risks associated with self-neglecting behaviour both in the community and in residential services.
- Was there an effective multi-agency response to Eric's mental health concerns raised about his safety? In particular, threats to harm himself, and following a suicide attempt in October 2021.
- In what ways were professionals responding to Eric aware of the links between Eric's condition, problematic alcohol use, self-harm, and suicide. How was their safety planning reflective of this link?
- How confident are staff from different agencies in identifying and understanding the complex condition of Korsakoff dementia, how it presents and the associated risks?
- The suitability of service provision in Norfolk to meet the needs of adults with Korsakoff dementia and the complexities and risks they present. It was acknowledged by the mental health team, GP surgery, and residential care provider that Care Home C was not an appropriate placement for Eric.
- The assessment of Eric's mental capacity/best interest decision for a move to a more suitable placement when this was found. On the day he was due to move Eric declined to go.
- Eric did not engage with the community mental health team, did not want therapies they offered and often declined to take his mental health medication. How effective were agency and multi-agency responses to Eric, and was consideration given to his possible lack of understanding of his condition, and how services were intended to help him with his condition?
- An analysis of Eric's mental capacity at each key decision-making point.

This review looked at the period 1st September 2019 to Eric's death on 27th November 2021.

The chronology of the review and subsequent findings were grouped into three distinct time periods:

- Period one – Eric Living Independently – October 2016 to January 2021.
- Period two – Eric Hospitalised – January 2021 to June 2021
- Period three – Care Home C – 30th June 2021 – 27th November 2021.

3. The multi-agency review panel for this review

The SAR Panel met five times for this review. The panel was made up of representatives from Norfolk County Council (NCC), Adult Social Services (ASSD), Norfolk Constabulary, East of England Ambulance Service, the Integrated Care Board (representing the GP), Norfolk and Suffolks NHS Foundation Trust (NSFT), Care Home C, Hospital A, and Norfolk Community Health and Care NHS Trust (NHCC).

The panel extend their condolences to Eric's family and friends. During the review process, Independent Reviewer met with Eric's daughter and son. They provided valuable insights and were very generous with their time and their memories of Eric. They also provided the pseudonym for their father. The panel would like to thank Eric's children for their support of the review.

4. Summary of Findings

Legal literacy

The use of term legal literacy in the review covered areas of legislation and process related to health and social care, and particularly to adult safeguarding.

During period one, there appeared to be a lack of understanding of the links between alcohol addiction and executive functioning. Eric would agree to stop drinking whilst in hospital, however, would arrange for alcohol to be delivered to his home in time for his return home. Professionals identified that working with Eric was much easier during the brief periods where he abstained from alcohol. However, ASSD decision making was based predominantly upon the narrative that Eric chose to drink alcohol and so could similarly choose not to drink alcohol.

From January 2021 onwards, when Eric was taken into hospital and did not return to his home address, there were a complex web of decisions assessed under the Mental Capacity Act, often overlapping. Some of these lacked defensible decision making, with a lack of circumstances, assessment process, and rationale recorded.

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.

During period one, there were missed opportunities for practitioners to work together, in order to monopolise on the short periods of abstinence when Eric was motivated, and more able, to change his lifestyle. These conversations could have included CGL and mental health services, alongside ASSD and the High Dependency Service Worker.

During period two, professionals within the hospital and care home settings could have been brought together to discuss Erics needs, to ensure the correct use of the

MCA was in place, and to assist with risk assessing ahead of Eric moving to a more permanent setting.

During period three, the first multiagency meeting was not held until just before Eric passed away, and ASSD were not invited to this meeting.

High Frequency Users

During period one, Eric had many hospital attendances, admittances, and even more 999 and 111 calls which did not result in hospital attendance.

When speaking to the staff at Hospital A, it was clear that Eric utilised the acute hospital for his medical care, in the way that most people would utilise their GP. It is possible that Eric was lonely and hospital admissions provide him with comfort and human contact.

Risk Assessments

There is a lack of robust risk assessments available from periods two and three. 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.

This was particularly evident in the lack of risk assessment completed by Care Home C, before accepting Eric as a resident. A few days after Eric had moved to Care Home C, they stated they were unequipped to manage the risk he posed towards himself. The placement was unsuitable, and as a risk assessment had not been completed prior to the care beginning, the unsuitability of the placement was not identified.

The panel representative from Care Home C shared with the Independent Chair that suicide is not something that is on their radar as a provision for older people. This is problematic, as Age UK have recently raised the issue of a hidden mental health crisis in older people,[1] and as will be discussed further below, the lack of mental health placements for younger people is leading to a changing demographic in care homes.

Suitable Placements

Linked to the lack of risk assessments, was the lack of suitable residential accommodation for younger people with complex needs such as Eric.

Care Home C is a residential home for older people with dementia. Most of the in-patient bed spaces available to the ASSD Older Person's Team, are like this.

[1] AGE UK Press Release: New Research shows a "hidden" mental health crisis is debilitating older people

Before Care Home C accepted Eric's application, numerous other care homes had declined Eric's applications. This was due to his self-harming behaviours, but also due to a fire he had set in his bedroom at Care Home B.

Eric would have benefited from a mental health placement.

Eric was placed at Care Home C with a "diagnosis" of Korsakoff's dementia. Eric had not been formally diagnosed with this, instead it was a condition which his social worker had identified as possibly fitting his behaviour and symptoms.

Eric's final placement was unsuitable for his needs, however there were little to no other options for him.

Safeguarding Adult Review Methodology

The methodology used for this review involved the Independent Reviewer meeting with practitioners. Employing this methodology, enabled an understanding of the difficulties practitioners faced when responding to Eric, including frustrations around lack of options for bed spaces and funding for care specific to Eric's needs.

Meeting face to face with practitioners, in place of written IMRs allowed exploration of the "so what" questions, which are pivotal to the learning within a review. The Chair was also able to learn more about Eric's presentation, personality and traits from speaking to the practitioners tasked with responding to his complex needs.

This methodology also ensured Eric was central to the learning, in a way which may not have been possible through the use of a more traditional methodology. The materials gathered were raw, unfiltered and unrestricted, enabling a truly independent analysis by the Reviewer and the SAR panel.

5. Recommendations

Recommendation One: The Safeguarding Adults Board Manager will share the methodology used in this review with the National Board Managers' Network. Lead agency: NSAB

Recommendation Two: Eric's age and needs did not fit neatly into the criteria which would have enabled more options for an appropriate placement. Norfolk County Council, Working Age Adults Commissioning Team, with assistance from the Integrated Care Board and other relevant agencies, will conduct a joint scoping exercise to understand the impact of the lack of placements for adults – of all ages – presenting with complex needs. This should include a thematic study of national SARs where this was a factor and will be linked to NSAB's upcoming thematic SAR; which will analyse the direct and indirect impact - including system issues - linked to the lack of mental health beds, and the resulting implications for care. Lead agency: NCC

Recommendation Three: The review raises concerns about the use of Mental Capacity Act assessments, and practitioners' understanding of available legislation. The introduction of a single point of access role across the system, for agencies without an MCA, or DoLs specialist, would reduce the confusion and possibly inappropriate use of the MCA assessments. The Safeguarding Adults Review Group (SARG) will undertake a cost/benefit analysis of the implications of introducing this role, making a recommendation to NSAB for implementation. Lead agency: NSAB

Recommendation Four – NSAB, working in conjunction with the NCC, Head of Social Care - Adult Mental Health, Norfolk and Waveney ICB All Age Safeguarding Team and NSFT, Deputy Director of Safer Care to produce a learning briefing tool with terminology and criteria for various Mental Health Act and Mental Capacity Act terms, to assist with the legal literacy of professionals. Lead agency: NSAB, NCC, N&W ICB and NSFT

Recommendation Five - The SAR author, working with the NSAB board manager, to produce a briefing video, sharing Eric's story and reminding practitioners of the importance of recording the source of diagnosis and the availability of suicide prevention training commissioned by Norfolk County Council and available via Norfolk and Waveney Mind. Lead agency: NSAB

Recommendation Six - Care Home C to review their processes regarding intake of residents, including training for staff on the risk assessment process, both at intake and throughout the placement. Lead agency: Care Home C.