Norfolk Safeguarding Adults Board

Safeguarding Adults Review: Eric

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Please note that this document has been anonymised by the use of pseudonyms to protect the identity of those concerned

Contents

1. Eric

1.1. 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 ago. Eric had 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.

1.2. 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.

1.3. 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.

1.4. 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.

1.5. 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.

1.6. Eric's daughter was provided with the completed overview report and provided feedback to the Independent Chair regarding the difficulties Eric posed to professionals trying to care for him. Eric's daughter stressed that although Eric was not permitted to return home, which was against his wishes, she believes he would not have survived at home and so professionals had an impossible situation to navigate.

1.7. A Safeguarding Adults Review (SAR) referral was submitted by Adult Social Services Department (ASSD)[1] in June 2022, citing that the placement at Care Home C was inappropriate for Eric, care plans were not documented, a lack of joint working by ASSD and GP Practice A, and a lack of provider checks made by ASSD prior to Eric starting his placement at Care Home C.

2. Methodology

2.1. This SAR is commissioned under Section 44 (1) of the Care Act 2014. In accordance with the Care Act 2014 and accompanying statutory guidance, SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so lessons can be learned from the case and applied to prevent similar harm occurring again in the future.

2.2. Eric had care and support needs and was unable to protect himself from harm, there were concerns identified that agencies could have worked better together to respond to Eric's needs prior to his death. Therefore, the criteria for a SAR were met.

2.3. A traditional SAR methodology was planned. This includes gathering Independent Management Reports (IMRs) and chronologies from all partner agencies involved with Eric prior to his death.

2.4. The Norfolk Safeguarding Adults Board (NSAB) initially commissioned a Chair and Author for the review following receipt of the referral in summer 2022. This appointment did not progress due to unforeseen circumstances.

2.5. Dr Liza Thompson was appointed in September 2023 to Chair and Author the SAR, the initial meeting was held with the panel on 19th September 2023. At this meeting it was agreed that due to the delay in commencing the review, a more flexible methodology would be followed. This involved the Independent Chair meeting with panel representatives, and where possible practitioners who had direct involvement with Eric. These meetings took the form of discussions around the following terms of reference and replaced the traditional method of written IMRs.

2.6. These meetings took place in October 2023. The scoping period covered by the review was 1st September 2019 until Eric's death on 27th November 2021. Information was also gathered from prior to this scoping period, to allow context to Eric's experiences, which supported the learning from the review.

[1] In Norfolk, ASSD operate an Integrated Older People and Physical Disability Service with NCH&C and integrated management – which operates under a s.75 legal agreement.

Terms of Reference

a. 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.

b. Were the responses to the safeguarding concerns while Eric was at the residential care unit effective?

c. 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.

d. The understanding, assessment and management of risks associated with self-neglecting behaviour both in the community and in residential services.

e. 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.

f. 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?

g. How confident are staff from different agencies in identifying and understanding the complex condition of Korsakoff's dementia, how it presents and the associated risks?

h. The suitability of service provision in Norfolk to meet the needs of adults with Korsakoff's 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.

i. 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.

j. 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?

k. An analysis of Eric's mental capacity at each key decision-making point.

Contributing agencies

Agency	Nature of contribution	Panel member
Adult Social Services	Triage form Meeting with Chair Chronology	Dawn Whing
Norfolk Constabulary	Triage form Meeting with Chair Chronology	Matt Stuart
Care Home C	Triage form Meeting with Chair Chronology	Anne-Marie Prothero
Norfolk and Waveney Integrated Care Board – for Primary Care	Triage form GP Practice A met with Chair Chronology	Kate Brolly
East of England Ambulance Service	Triage form Meeting with Chair Chronology	Elaine Joyce
Hospital A	Triage form Meeting with Chair Chronology	Tracey Denny
Norfolk and Suffolk Foundation Trust	Triage form Meeting with Chair Chronology	Christine Hodby
Norfolk Community Health & Care NHS Trust	Triage form Meeting with Chair Chronology	Victoria Aspinall
Change, Grow, Live[2]	Triage form	n/a
Social Housing Provider A	Triage form Chronology	n/a
Hospital E	Triage form	n/a

[2] This is the commissioned alcohol and drug behaviour service in Norfolk

3. Significant Incidents

3.1. The following sections will be presented as three distinct periods, detailing an overview of the circumstances, findings and learning for each specific period. This will be followed by an analysis of systems learning emerging from the review.

3.2. Period one: Eric Living Independently - October 2016 to January 2021

3.2.1. Eric's adult children told the Independent Chair that Eric had separated from their mother when they were young, over twenty years before his death. Eric lived in a busy town, which was centrally located. Despite having a problematic relationship with alcohol throughout, he worked and would visit pubs and socialise with friends.

3.2.2. In 2016, Eric moved to the rural area of Town A. By this point Eric was no longer working and his alcohol use had become problematic. In the UK, average weekly consumption is highest amongst midlife men, and they are disproportionately affected by alcohol harm.[3] Eric's children stated that Eric's motivation for the move was to live close to a woman he was in a relationship with – and who also had problematic alcohol use. Eric moved to a bungalow opposite her, in a quiet cul de sac.

3.2.3. Norfolk Swift Response is a 24-hour service that provides practical help to adults with an urgent, unplanned need at home. During the period that Eric lived in the bungalow in Town A, the service was contacted by Eric or other professionals on 59 occasions, to assist Eric, mostly with falls.

3.2.4. Eric was registered with the same GP Practice throughout the period that he was living in the bungalow in Town A. They had very little contact with him, and the majority of the information held by them was shared by other areas of health. He has recorded diagnoses of alcohol dependency syndrome[4] and chronic cholecystitis.[5]

3.2.5. The rural setting became problematic as Eric did not drive, and when the relationship ended sometime towards the end of 2018, Eric became very isolated; at this point his alcohol misuse became more problematic.

[3] Parke, H et al "Understanding Drinking Among Midlife Men in the United Kingdom: A Systematic Review of Qualitative Studies" *Addictive Behaviours Report* (2018) pp.85-94

[4] A chronic disease characterised by uncontrolled dependence on alcohol.

[5] Inflammation of the gall bladder

3.2.6. During 2018 Eric was involved with police on two occasions. In June 2018, he reported his wallet and phone stolen from a bedside cubicle at Hospital A ED. In September 2018, he reported common assault – through fear of immediate violence – by a male known to Eric, who walked into Eric's home, threatened him and threw some of Eric's items around the property.

3.2.7. Following a fall which resulted in a fractured shoulder, Eric spent some time in a residential home between June and August 2018. It is noted that he returned home through his own choice, stating that he wanted to go home and "drink himself to death". He was not happy about his alcohol consumption being curtailed while in the residential care home. Four days later, he was readmitted to Hospital A with coffee ground vomit[6] and stated he had been drinking two bottles of wine a day and had been vomiting for two days.

3.2.8. Between January 2019 and January 2021, Eric called East of England Ambulance Service NHS Trust (EEAST) ambulance control via 999 on 396 occasions. This resulted in Eric being conveyed to Hospital A on approximately 40 occasions, 19 of these occasions resulted in an inpatient admission for at least one night; often longer.

3.2.9. In January 2019, Eric fell and broke his femur, he was admitted to Hospital A, where he told staff that he was lonely, that his ex-partner had financially abused him and that she had a Lasting Power of Attorney[7] for him but was not helping him.

3.2.10. Following this disclosure, Eric was not considered as a victim of domestic abuse or responded to as such. A thematic analysis of twenty-two DHRs where the victim was male, found that professionals and systems were often dismissive of women's abusive acts against men.[8]

3.2.11. Eric took an overdose on 30th January 2019 and remained in Hospital A until 15th February 2019. He was discharged with a care package which included personal care, meals and medication prompts. Eric told his social worker that he could not leave the house. The social worker challenged this as he had an electric scooter.

[6] This is vomit which looks like coffee grounds due to the presence of clotted blood. It is a serious symptom of gastrointestinal bleeding.

[7] This is a legal document that lets a person appoint one or more people to help make decisions, or make decisions on the person's behalf, if they no longer have mental capacity.

[8] Hope, K et al "What we can Learn from DHRs with Male Victims" *Partner Abuse* (2) (4) (2021)

3.2.12. During the next few months, Eric continued to have falls in the home, EEAST were called on several occasions and made safeguarding alerts on 10th and 20th April 2019. There was a mention of self-neglect in April 2019, however the social worker identified this as a lifestyle choice and stated that there were no care and support needs beyond what had already been provided to Eric.

3.2.13. Mental health services indicated they could not support Eric until his alcohol issues were resolved.

3.2.14. At the time of Eric's death, there were no pathways in place regarding mental health and substance misuse/alcohol dependency. However, Norfolk and Waveney Integrated Care System's Joint Forward Plan[9] includes an objective to develop "pathways that support engagement, treatment and promote recovery for people living with multiple and complex needs, with a focus on dual diagnosis and Complex Emotional Needs (CEN)"

3.2.15. Progress has been made regarding a pathway for co-existing conditions. At the time of writing, NSFT, Change Grow Live (CGL) and Experts by Experience have been working together to develop a clear pathway, which will be rolled out during 2024. NSFT and CGL are also working together to look at staff competencies and training to ensure that each provider has appropriate knowledge to support patients experiencing these conditions.

3.2.16. From April 2019, Eric's calls to 999 escalated. The calls were for mental health issues, alcohol related issues, physical health problems – for example Eric stating he could not walk. Ongoing safeguarding alerts were made, and the ASSD narrative continued to be that Eric was choosing to live this way.

3.2.17. When in Hospital A, Eric would engage with CGL and mental health services. The Independent Chair spoke to the practitioners based at the hospital, who had a lot of contact with Eric. They felt that he received the care and attention he needed when he was an inpatient at Hospital A, he stated he had intentions to engage with services once he left the hospital, however, did not take up any of the services in the community. Eric may have had a mental barrier to engagement with services in the community, however he certainly had a physical barrier, due to the rural location of his property.

[9] Norfolk and Waveney 5-Year Joint Forward Plan - Norfolk & Waveney Integrated Care System (ICS (improvinglivesnw.org.uk)

3.2.18. Each time Eric was admitted to Hospital A, he would detox. He would then order alcohol to his bungalow to arrive as he returned home. In October 2019, a large supermarket chain refused to deliver anymore alcohol to Eric. He had been seen naked and covered in vomit and faeces when the delivery driver arrived. There is no indication that the supermarket chain submitted a safeguarding concern following this incident. At this point, Eric started to order alcohol from the local convenience store, and they would deliver to his home.

3.2.19. It is recorded that each time Eric detoxed, he was able to make sound decisions, had better care for himself and would engage with services. This positive behaviour would then stop as soon as he used alcohol again. There is no indication that professionals seized upon this well-established pattern to stage an intervention, arrange a multi-disciplinary team meeting or follow the self-neglect process during the small windows of clarity for Eric.

3.2.20. During 2018-2019 Norfolk Safeguarding Adults Board undertook a lot of work raising awareness of self-neglect and the multi-agency self-neglect and hoarding strategy which was launched in 2016.[10] The strategy includes a practitioner guide which was revised in September 2021, and more recently in March 2023.

3.2.21. During 2019, Eric also had some involvement with Hospital E. On one occasion, he had self-discharged from Hospital A but when his condition had worsened, Hospital A had been at capacity, so the ambulance conveyed him to Hospital E, where he was admitted to the Acute Medical Unit. Whilst in Hospital E, who were not familiar with Eric, he raised a concern regarding his care package and stated he wanted carers to attend more often. After speaking to Eric's allocated social worker, it was established that care packages had broken down on five or six occasions, due to Eric's behaviour following his alcohol consumption. Hospital E submitted a safeguarding referral, with the request for three times a day package of care. There were also concerns raised that a friend had his mobile phone and bank card, and therefore professionals could not contact him to organise any care. Eric chose to discharge himself against medical advice, as the staff had wanted him to remain until the package of care was organised, he had also stated he felt suicidal as he wanted to go home. He was in Hospital E for six days.

[10] Self-neglect and hoarding | Norfolk Safeguarding Adults Board

3.2.22. In September 2019 Eric had indicated to his social worker that he would like to move back to the town he had lived in before, which would have been central and easier for him to access services. A move was agreed by the Social Housing Provider; however it was left to Eric to follow this up with calls, which he was not able to make, and this move therefore did not progress.

3.2.23. Eric's daughter reflected at this point in the chronology that a move away from the rural area, and back to the town centre may have changed the outcome for Eric, as none of the family could visit while he was living rurally – due to their lack of transport, and the lack of public transport locally. Eric's daughter thought that help for him at this stage, specifically with a move back to the town, may have made an impact on his welfare.

3.2.24. In March 2020 an EEAST safeguarding referral led to a Norfolk Community Health and Care NHS Trust (NCHC) Community Health Care Assistant[11] being allocated to Eric twice per day. They were faced with bowls full of urine and faeces to empty. Eric declined any additional support with continence pads. The HCA would tidy up the house and remind Eric to take his medication.

3.2.25. The Covid-19 national restrictions began on 23rd March 2020. Eric continued to have visits by the Health Care Assistant, Eric began to open up to her, and managed short periods of sobriety. However, he did also continue to overdose on his medication and continued to use emergency services for his health care.

3.2.26. An MDT was called in May 2020, a package of care was agreed and in July 2020 the High Intensity User Service (HIUS)[12] started working with Eric. Eric engaged well with the HIUS, who supported him with a lot of practical matters such as having a charge point installed for his electric scooter, taking him out in his wheelchair, assisting with plans for a move back to the town, and liaison with the carers to undertake specific duties. There appeared to be a rapport built with Eric, and it is recorded that during her support, he was interested in making plans.

[11] This role works with people in their own homes rather than in care settings, like nursing homes or hospitals.
[12] Project introduced to reduce ED attendance.

3.2.27. In November 2020, the house was in a poor state with faeces around the house, this led to the HIUS making a complaint to the care agency and speaking to the social worker. The HIUS provided photos, and the care provider sent a quality assurance officer. Eric would refuse entry to the carers and would be obstructive to them completing their tasks. Eric was re-admitted to Hospital A during this time and could not be discharged until the issue with his care package was rectified.

3.2.28. From October 2020 until October 2021, there continued to be calls to the ambulance service due to Eric's falls, yet no issues were identified upon EEAST crew arrival at the property. No further issues arose subsequently, however this appeared to be due to the level of support provided by the HIUS, who also cleaned the property as Eric continued to refuse entry to the carers.

3.3. Period two: Eric Hospitalised - January 2021 – June 2021

3.3.1. By January 2021, Eric had lost a lot of weight, when he became unwell at the end of the month, he was too weak to recover at home and was kept in Hospital A. During this time his mental capacity is recorded as fluctuating and his mobility was very poor. Eric also contracted Covid-19 which further exacerbated his poor physical health.

3.3.2. Eric consented to a short-term in-patient placement whilst he became stronger. He was admitted to a rehabilitation ward at Hospital B - which was taking Covid-19 positive patients - on 31st January 2021. Eric started to request a return home two days later. He was transferred to Hospital C, another rehabilitation ward – on 3rd February 2021 following a negative Covid-19 test.

3.3.3. Eric continued to request a return home during the coming week. The Independent Chair had sight of a "hospital discharge conversation" form completed on 6th February 2021, which did not appear to include discussions with Eric, and indicated that the assessment was carried out in consultation with the hospital ward MDT team, rather than with Eric "due to the Covid-19 arrangements in the hospital". There is a further comment regarding Eric's home address reportedly being in a poor state, however there is no further information on this form to indicate what decision was made regarding a discharge from hospital, or indeed any decision-making rationale. Eric's voice is completely absent from this form.

3.3.4. On 10th February 2021 Eric self-harmed by eating a tube of hand cream, stating his actions were because he wanted to return home. It is from this point, until Eric's death that he consistently requested to return home. Also from this point on, a range of mental capacity decisions and processes were considered, assessed and utilised, which were confusing to review in hindsight, and the panel can recognise how confusing and frustrating this must have been for Eric, who was often not involved in conversations about his own care.

3.3.5. At this point, Eric's daughter voiced her concerns about Eric's ability to care for himself at home.

3.3.6. On 11th February 2021 Hospital C completed a DoLS standard authorisation request as Eric was requesting to leave the hospital. Case notes indicated that Eric was awaiting a short term "discharge to assess"[13] bed, and discharge planning had commenced.

3.3.7. On 12th February 2021, hospital staff began to search for suitable care homes for Eric to continue his recovery. Care Home A was sourced on 16th February 2021. Eric was deemed as lacking the capacity to make decisions about where he would live. There is little to no evidence of discussions with Eric about his wish to go home, he does not appear to have been asked his views at this point, and no record of any discussions with him about why it would not be safe for him to go home. This lack of engagement with Eric, may have made him feel helpless, with no control over his own life, and exacerbated his behaviours. At this point his behaviours are recorded as becoming more erratic; for example, he is recorded as seeing things, and urinating around the ward.

3.3.8. On 22nd February 2021, Eric was admitted to Care Home A. The DoLs request from Hospital C was cancelled due to the move.

[13] When someone is ready to leave hospital but not well enough to return to their previous place of residence. In this situation, patients will be discharged through the Discharge to Assess pathway into a nursing care home so they can receive additional support and further assessment.

3.3.9. Two days later it is recorded in Eric's care notes that a DoLS request had been submitted to withhold Eric's alcohol and cigarettes. This is not an appropriate use of a DoLS, which has the purpose of safeguarding those individuals who lack capacity to understand their care and support arrangements, and those arrangements deprive them of their liberty. Information gathered from the NCC DoLS team indicates that the DoLS request had been received from Care Home A. The DoLS team were monitoring the situation as Care Home A was a short-term bed, and Eric was awaiting further assessments to determine longer term care arrangements.

3.3.10. Eric was recorded in ASSD notes as presenting with "significant cognitive impairment" by Care Home A. He was observed crawling around the floor, telling people that he had broken his heels and could not walk. He is recorded as believing he was in hospital for an operation on his legs. An MCA was arranged by ASSD.

3.3.11. The MCA assessment was undertaken on 18th March and completed on 20th March 2021. The decision to be made was whether Eric would make decisions around his care and support needs, and where these needs should be met. It is recorded that Eric had an impairment of the mind, due to "alcohol induced brain damage" although there is no record of the source of this diagnosis. It was considered that Eric was able to understand and report his current, and his previous circumstances. He was able to recall difficulties with carers at his home address, and that he had overused emergency services for his care. He recalled that alcohol had been an issue, that he had not been eating properly; however, he also recalled a positive relationship with his High Intensity Practitioner, and stated that things had been getting better, albeit slowly. He was also considered able to retain information, although stated that each day felt like the other, so he had lost track of specific days. Eric was considered able to weigh up information. Eric felt he was too young to be in a care home, that everyone else was much older than him and had dementia. He was able to weigh up that he was healthier than at home, that he was eating and not drinking alcohol, and he had his toenails cut and had a haircut. He did not believe that his drinking was an issue, as he had not experienced physical side effects from withdrawing from alcohol, even when this had been without a detox.

3.3.12. It was recorded that during the MCA interview Eric was very good at detracting from the conversation, when asked about this by the social worker, he accepted this and admitted he was a “chatterbox”. Eric was not able to state his decision regarding where he would live and receive care. The social worker left Eric for a few days to consider the pros and cons of staying in care or returning home. She revisited this decision with Eric on 20th March 2021 and stated it was clear that Eric struggled to make a decision and had resorted to distraction techniques to avoid giving an answer. He was recorded as being fixated on having two broken ankles and not being able to engage in the meeting, or make a decision, as he needed an immediate operation, which was not true. The social worker summarised that Eric was not able to make an informed decision at that time, that although he understood the information and could retain and weigh up the information, he struggled to make a decision and appeared delusional about his own health status, which would impact on his making a decision around his care needs, and the ability to remain safe at home.

3.3.13. The manager of Care Home A advised the social worker that Eric had a strange presentation, in that he could sound very rational at times, but this was interspersed with delusional thoughts and behaviours.

3.3.14. The social worker completed a reassessment conversation on 31st March 2021, and assessed that managing and maintaining nutrition, maintaining personal hygiene, managing toilet needs, making use of the home safely, and being appropriately clothes were ongoing relevant Care Act outcome categories for Eric. The outcome of the reassessment was 24-hour care to continue.

3.3.15. Care Home A had been intended as a short-term option, and the enhanced funding provided for this due to Covid was due to end. A best interests assessment was therefore undertaken the following day to determine the next steps. It was recorded that it was difficult to ascertain if Eric was likely to regain his capacity to make the decision about where he resides. It was recorded that his current presentation was markedly different to when he had been at home, and may have been due to infections, and temporary delirium, or a new level of presentation. It was also recorded in the assessment that Eric had not indicated whether he wanted to remain at the Care Home or return home – however this is not consistent with the information held which indicates he requested to return home on occasions and had given his reason for self-harming as wanting to go home.

3.3.16. Within this best interests assessment, the burdens of returning home outweighed the benefits, and the benefits of remaining in a 24hour care establishment were identified as allowing more time to determine if the cognitive impairment was temporary or Eric's new level of functioning, and that he would be safer in terms of mobilisation. The best interest decision was made for Eric to have a temporary placement in a secure environment to determine if his current level of functioning would improve. It was deemed that this would allow time for future planning in terms of appropriate care and support for Eric to return home if deemed appropriate – this decision was to be reviewed in six months.

3.3.17. Care Home B was identified for Eric, and he moved there on 1st April 2021. This was due to the Covid funding ending, and Care Home A was outside of budgetary restrictions. The DoLS request from 24th February 2021 was cancelled on 6th April 2021, due to this move.

3.3.18. At this point Eric had experienced four moves in three months, he had left his home at the end of January 2021 in an ambulance, as he had many times, but on this occasion, he had not returned home again. He had very quickly lost all control of his own life. There is little evidence to show that, apart from the MCA in March 2021, Eric was involved in discussions about his future. It is identified that his presentation had changed, and research shows that when people are placed in increasingly restrictive environments, they begin to act out. Indeed, at this point, Eric started to behave more erratically.

3.3.19. On 12th April 2021, whilst in Care Home B, Korsakoff's Dementia was first mentioned. Eric's social worker told the Independent Chair that she had identified the symptoms of Korsakoff's as being like Eric's behaviours.

3.3.20. Wernicke-Korsakoff Syndrome is a neurodegenerative disorder that is caused by a severe thiamine deficiency. Parts of the brain may be damaged because of this deficiency, causing increased difficulty in memory, movement, vision, and coordination. Excessive alcohol consumption can lead to thiamine deficiency.

3.3.21. The steps to diagnose Korsakoff's include a clinical evaluation, where health care professionals evaluate the patient's symptoms, their medical history and undertake a physical examination. This is followed by laboratory tests, to screen out other disorders, and examine B1 and thiamine levels, as well as undertaking a liver function test. Finally, the patient would be observed and monitored.

3.3.22. There is mention in Eric's notes, that Eric would be assessed for Korsakoff's while at Care Home B. However, there are no records of any of the above assessment steps being taken at this point. The social worker asked the GP about this diagnosis, the GP stated it was possible due to Eric's behaviours. At this point a diagnosis of Korsakoff's was added to Eric's records and remained on his records until he passed away.

3.3.23. Practitioners must ensure that notes are clear when an opinion is recorded, as opposed to a diagnosis. Following this recording of an opinion of possible Korsakoff's, Eric's notes indicated this was a diagnosis, and all future professionals coming into contact with Eric assumed this to be the case and made decisions about his life based upon this as a diagnosis.

3.3.24. Care Home B made a DoLS request on 19th April 2921. This was prioritised as high for monitoring of Eric's new placement. The case notes indicated that Eric had expressed a wish to return home to the GP, and the social worker was in the process of undertaking further assessments.

3.3.25. On 6th May 2021, Eric stated that he wanted to leave Care Home B, and there is a record of him attempting to "abscond" on 10th May 2021. Eric threatened to harm himself, and Eric's social worker discussed the possibility of moving him to a more suitable placement in her supervision; following this, she spoke to Eric. He stated that he wanted to go home, not to another placement. There is no record of a discussion with Eric about why going home may not be suitable for him. There is a sense that Eric's voice was not being heard, and there is no understanding of his wishes for the future.

3.3.26. On 30th May 2021, Eric set fire to a book in his room at Care Home B. He was moved immediately to a s.136 suite[14] situated at Hospital D, to be assessed under the MHA. Eric was assessed by the Cambridge AMHP service the following day, and he agreed to voluntary admission to a psychiatric bed.

[14] S.136 of the Mental Health Act – emergency police powers to take a person from a public place to a place of safety.

3.3.27. At this point, a multi-agency meeting would have been appropriate. This could have been a joint agency group supervision session, to discuss how to move on in Eric's situation. This is a process which Children's Services utilise on a regular basis. ASSD do not generally use this process to progress "stuck" cases, however since summer 2024 the Adult Social Work team have been holding monthly "stuck cases" peer supervision to work through cases like Eric's.

3.3.28. On 1st June 2021, Eric's social worker attended Hospital D to undertake a reassessment conversation with Care Home B and Hospital D staff. Eric was not present. It is recorded in the reassessment that Eric had set light to some paper as he wanted to return home. It is recorded that Eric had demonstrated that he "says he wants what he does not or cannot have." It is also recorded that "it appears that whatever Eric is offered he is not satisfied." It is recorded in the reassessment, that Eric has the potential to exaggerate or make up events about his life, and that his daughter had confirmed this was something he had always done. However, the social worker considered this to be confabulation, and due to an un-diagnosed cognitive problem.

3.3.29. The reassessment identified the following Care Act outcome categories; maintaining person hygiene, managing and maintaining nutrition, being appropriately clothed, maintaining a habitable home environment, being able to make use of the home safely, developing and maintaining family and other personal relationships, and making use of necessary facilities or services in the local community. Ongoing residential care was identified as being required, with the need for the next provider to be fully aware of the risks with the ability to adapt to issues as they presented themselves. Whilst at Care Home B, Eric had been found with a call bell, and also a belt around his neck; therefore Eric's access to ligatures, and lighters were also to be eliminated.

3.3.30. Whilst an inpatient at Hospital D on a S.2[15] Eric's social worker tried to find him a suitable placement. Due to the fire setting and his problematic behaviour, five care homes turned down the applications. Also, during this time, Eric's social worker spoke to the psychiatrist at Hospital D about Korsakoff's, the psychiatrist agreed that Eric's confabulation[16] became clear after speaking to Eric for some time, and this was one of Korsakoff's symptoms. The social worker requested that the Psychiatrist write this diagnosis in Eric's notes to assist with finding the "right" placement for Eric's needs. As above, this then led to the "diagnosis" following Eric within his notes, without this ever formally being assessed.

3.3.31. A theme which runs through this period is a lack of legal literacy, and incorrect application of the MCA assessments. There was a general confusion about MCA assessments and decisions throughout this period. The powers of the legislation were incorrectly applied on a number of occasions, and often multi-layered with decisions and assessments contradicting themselves. This would have rendered the circumstances unclear for professionals, but also for Eric, whose liberties were being deprived, and whose voice appears lost amongst all of the decisions being made.

3.3.32. Challenging behaviour is known to increase in institutional settings with restrictive practices.[17] Research indicates that there may be features of a particular environment that contribute to the occurrence of particular behaviours, and it is therefore possible that by changing a person's environment, the likelihood of that behaviour occurring can be reduced.[18]

3.4. Period three: Care Home C – 30th June 2021 – 27th November 2021.

3.4.1. On 17th June 2021, Care Home C accepted Eric's application. During gathering the information for this SAR, the Independent Chair spoke with the care home, and they stated that they were not fully cognisant of the risks Eric posed to himself, and at the point of accepting him as a resident they believed they were able to manage the risks he did pose.

3.4.2. Eric moved to Care Home C on 30th June 2021, this was on a voluntary basis as there were no legal restrictions in place at this time. The DoLS

[15] Mental Health Act 2005 - this is an admission to hospital for an assessment
[16] The generation of a false memory without the intention of deceit
[17] NICE Guideline, No. 11 *Challenging Behaviour and Learning Disabilities: Prevention and Interventions of People with Learning Disabilities Whose Behaviour Challenges* (2015)
[18] Department of Health *Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs* (2007)

request from 19th April 2021 was cancelled.

3.4.3. Eric's social worker was the only professional who had been constantly in contact with Eric since he had left his home in January 2021. She had seen Eric's changing behaviour and made it clear to Care Home C that his behaviour would change once he had moved into the home. She predicted that he may decide he did not want to be in the placement, and then he would display problematic behaviours.

3.4.4. The day after Eric moved to Care Home C, he stated he was not happy with the placement. On 4th July 2021, Eric climbed over the fencing on the boundary of the care home and was located by police at the pub across the road. The following day, the care home staff tell the social worker that they cannot cope with Eric.

3.4.5. This would have been a suitable juncture to undertake a formal MCA assessment to determine his capacity to decide to remain or go home. It would have also been a suitable juncture to call a multi-disciplinary team meeting, or joint supervision meeting, to complete and discuss a risk assessment regarding the placement.

3.4.6. Over the coming days, staff find a noose made from a blanket, and another made from a pair of trousers, in Eric's room. Again, a risk assessment should have been completed by the care home staff and social worker at this point.

3.4.7. A DoLS request was completed by Care Home C on 16th July 2021, this was prioritised as high for allocation. The referral indicated Eric's attempts to leave the care home. The case was allocated to a mental health assessor on 28th July, and to the best interest assessor on 3rd August 2021.

3.4.8. During this time two further care homes were identified which would have been more appropriate placements for Eric. He was on waiting lists for both.

3.4.9. The GP linked to Care Home C attended to visit Eric on 4th August 2021. Eric spoke about losing the phone number for his daughter and feeling frustrated that he could not contact her. Eric also declined some of his medication. He was assessed as having the capacity to decline his medication. Eric did not take his sertraline medication for seven days and was demanding morphine from his GP. There was a further missed opportunity during this time for a multi-disciplinary meeting to discuss Eric's refusal to take medication, and assess the risks associated with

this change of circumstances.

3.4.10. During this time Eric is also noted to have left the care home on six occasions, often the police were called to assist with locating him and bringing him back to the care home. Eric also called police on one occasion stating his liberties had been deprived and his human rights were not being met as he wanted to go back to his bungalow.

3.4.11. The DoLS request from 16th July 2021, was granted on 16th August 2021, keeping Eric at Care Home C. There were conditions attached, which included keeping the DoLS team updated with changes, and for the care home to review whether Eric needed to be accompanied when he went into the community. A "paid representative"[19] was also recommended. Eric was informed of this decision by the social worker, which meant he would not be permitted to go home, and the social worker was looking for a more appropriate placement for him. Eric's daughter was also consulted about this decision. Eric stated he would not eat and would take his own life if he could not return to his own home. On 21st August 2021, a suicide note was found. This escalation in behaviour should have triggered a risk assessment and a multi-disciplinary team meeting to develop a safety plan.

3.4.12. On 25th August 2021, Care Home D indicated they had a space for Eric. This placement was deemed to be more suitable to Eric's needs and the risk he presented to himself. A plan was made for Eric to move to Care Home D on 23rd September 2021, however on this date Eric declined the move stating that he was now happy with his placement at Care Home C. There is no evidence that his capacity to make this decision was assessed. And no further action was taken regarding moving Eric to a more appropriate placement, despite staff continuing to state they could not cope with Eric's needs and risks to himself.

3.4.13. There was an MCA decision on 29th September 2021, regarding Eric consuming alcohol, whereupon Eric was found to lack capacity to make this decision. He was no longer permitted to have alcohol in the care home. There does not appear to have been any plans regarding detoxing or support for him withdrawing from alcohol either medically or mentally.

[19] The role of a Relevant Person's Representative is to maintain contact with the person and to represent and support them in all matters relating to the Deprivation of Liberty Safeguards.

3.4.14. On 29th September 2021, the social worker completed a Mental Capacity Assessment. The question posed as *What support would be needed to meet needs if Eric were to return home*. This was completed as Eric had been asking to leave Care Home C and to return home. It is stated on the form that:

> *"Eric has historically been recorded in his notes as having a cognitive problem due to alcohol, no definite professional who diagnosed this. Recently I have gained the agreement Eric has Korsakoff psychosis. Eric does have short and longer-term memory problems. Eric also presents very well for a time then during conversation will ' confabulate' which is more obvious when you know him well. Eric also has said total untruths, for example that he was waiting for surgery on his feet which are broken."*

3.4.15. As described above, a diagnosis of Korsakoff requires a series of assessments, which had not occurred, therefore it is incorrect to state that Eric had this condition. Once a person is framed as having a certain condition or diagnosis, it is difficult for assessments – such as MCA assessments – to be completed objectively, as the person will be viewed through the lens of the condition.

3.4.16. This MCA assessment was completed on 29th September 2021, although the information was gathered over several calls and visits to Eric. Within the assessment, Eric's reason for wanting to return home is recorded as: "*I have considered that as an alcoholic Eric may just be driven by his wish to have access to alcohol although this has not been voiced as part of his rationale.*

3.4.17. Within this MCA, it is considered that Eric was not able to understand the information relevant to the decision, as he was unable to remember how his physical health and poor mobility affected him while he had lived at home. It is recorded that he either denied these issues or was unrealistic about the impact of these issues. It was also considered that Eric could not retain the information to make a decision, for example he stated he had been about to get a cleaner in at the point he went into hospital in January 2021, which the social worker did not believe to be true. Eric was also considered to not be able to weigh up or use the information, as he was not able to say how all of his care needs could be met if he returned home, and it is stated that he was in denial about the extent of his needs. It was therefore assessed that Eric lacked capacity to decide about what support would be needed if he returned home.

3.4.18. A best interests assessment was made the same day. It is stated on the assessment form that Eric's wishes were to return home, and also that the social worker had consulted with Eric's daughter who was in full agreement that Eric should not return home. Within the best interest decision outcome, the burdens outweighed the benefits of Eric returning home, and the social worker listed many risks associated with Eric returning home. The benefits of remaining in a secure residential unit outweighed the burdens. The burdens identified included the effect on Eric's behaviours which were disruptive to others and challenging for staff, and that ethically this was against Eric's wishes, and that Eric felt he had lost his autonomy. The best interest decision was for Eric to remain in residential care to manage his needs.

3.4.19. On 6th October 2021, police were called to the local acute hospital where Eric had undergone two ultrasounds, and was subsequently refusing to return to Care Home C.

3.4.20. On 17th October 2021, Eric was found to be attempting to cut his wrist.

3.4.21. Following this a risk assessment was completed. The safety plan was put in place to remove any sharp objects, or objects which could become sharp, from Eric's room.

3.4.22. On 22nd October 2021, Eric was found in his room with a plastic bag over his head. Following this incident, a requirement for Eric to be observed every hour was included on the Care Home C care plan. All bags were to be removed from his room.

3.4.23. It was clear at this point that the staff at Care Home C could not manage his behaviours. However, at this point there were no other options for residential homes, as the mental health inpatient spaces were not allocated for the Older People's Social Work Team. There was another missed opportunity at this point for a multi-disciplinary team meeting, for a robust risk assessment, and a safety plan for Eric.

3.4.24. There is a national issue regarding a lack of inpatient or residential provision for Eric's demographic. This is compounded by an increase in older men with the compound needs of mental health and alcohol misuse. Drug and alcohol support provider CGL have identified a significant number of cases like Eric's, with male using alcohol excessively to suppress emotions brought in by loneliness and isolation.

3.4.25. Eric had been referred to the Crisis Team for an assessment which may have enabled a mental health bed space. On 25th October 2021, he had been assessed as not suitable for the crisis team. They determined, via a Microsoft Teams assessment, that his issues were situational and linked to wanting to return home, and not linked to his mental health. He had told the psychiatrist during the assessment that he would take his medication and would eat, so that he could go home. The social worker reflected that Eric presented to different professionals, at different times, in very different ways.

3.4.26. A Mental Capacity Assessment was completed by the social worker on 21st October 2021. The assessment was regarding the question "*to drink alcohol while living at Care Home C".* Within the assessment form, the social worker had indicated that Eric had an impairment of the brain due to "suspected Korsakoff's, and records show memory loss dating back several years. Eric is known to confabulate to cover his gaps in memory and is insistent that certain events took place when the evidence shows otherwise" – the date for the assessment of this diagnosis was given as 28th September 2021, however there is no evidence of an assessment or progress towards an assessment for Korsakoff's on that date.

3.4.27. The social worker recorded on the assessment form that Eric had ordered a case of wine and a bottle of brandy to the care home, and this highlighted the need for an exploration of his capacity around drinking alcohol. The assessment was completed remotely, via the speaker phone in Eric's bedroom. It is recorded on the assessment that Eric was "stubborn and was able to manipulate a situation to suit his own outcome." Risks identified when Eric drank alcohol included falls, vomiting and diarrhoea – however these were risks when Eric was living at home alone and there does not appear to be any consideration of any current risks linked to Eric consuming alcohol.

3.4.28. Eric was considered not to be able to understand the information relevant to the decision to drink alcohol, namely Eric did not accept that using a wheelchair increased his risks of falls, he argued that being in a wheelchair kept him safe from falls. Eric was unable to accept that he had bouts of vomiting and diarrhoea due to his alcohol use whilst living at home. He denied being abusive or aggressive with alcohol, and the care home manager agreed that whilst at Care Home C he had not acted this way despite consuming alcohol at Care Home C. Eric was able to state that consuming alcohol was detrimental to his health but was not able to give example of how it was a risk to his health, aside from saying he did not mind dying.

During the interview, Eric stated that he was being detained against his will, and that the social worker had said he had dementia which he did not and had put him in a home. Eric was also considered not to be able to retain information for long enough to make the decision, and unable to use or weigh the information as part of the process of decision making. It is stated that although the social worker and care home manager repeatedly described the risk of falls, Eric failed to understand these risks. At one point Eric stated, "I have considered the risk of a fall, there isn't one." It is stated that Eric was provided with historical examples of the consequences of his drinking however Eric denied the evidence or gave his own version of events.

3.4.29. Eric was assessed as not having the capacity to decide whether to consume alcohol, and a best interests decision was made the same day. With the best interests assessment form, it is stated that although Eric was told of the risks of him drinking whilst in Care Home C, he was not able to retain these or weigh them up. The social worker also recorded that *"I have also considered that as a self-confessed alcoholic, Eric would struggle to have any other opinion on this decision despite his long period of sobriety, nine months or more."* Both the care home manager and Eric's daughter were consulted, and both agreed that using alcohol had negative effects on Eric. The burdens of allowing Eric to consume the alcohol which he had ordered online far outweighed the benefits – the one benefit being that it was Eric's wish to consume alcohol. The burdens and risks of allowing Eric to consume alcohol in the home were mostly based upon his time living alone at home, namely self-neglect, incontinence, living in an unclean environment, overuse of emergency services, and falls. It was also recorded that using alcohol may lead to deterioration of his behaviours, and physical health. The benefits of Eric being denied access to alcohol could have also been viewed as being the benefits of him remaining in residential care, and the contents of the assessment form appear to be very similar to the best interests form completed in September 2021 – including the dates which have not been changed. A best interest decision was made to not allow Eric access to alcohol while he was living in a residential setting, the review for this was set for February 2022.

3.4.30. Eric continued to refuse food and medication, and on 5th November 2021 a multi-disciplinary team meeting was held at Care Home C. However, the social worker was not invited to this meeting, which is an omission as the social worker had been the only constant since Eric had been living in his bungalow.

3.4.31. Eric told a GP during a visit to the care home on 23rd November 2021 that he had a plastic bag and wanted to use this to suffocate himself. He continued to refuse food and medication. The Care Home Manager was updated. The safety plan from October 2021 continued, this was that Eric would be checked each hour. There does not appear to have been any additional elements put in place to reduce the risk.

3.4.32. The following day Eric told the care home staff that it was his dying wish to have wine with his dinner. He told the staff this was his last night before he would die. This should have triggered a risk assessment, and actions to mitigate the risk of Eric taking his own life.

3.4.33. The GP discussed this concern at a clinical meeting at the practice. Within these notes it is stated that Eric was not at Care Home C under a section, indicating an ongoing confusion regarding the legal basis by which Eric was being kept at the care home.

3.4.34. The same day there is a record of a Multi-Disciplinary Team (MDT) meeting being held, although on review of the meeting notes it would not appear that only the social worker, NSFT and the care home manager were present, and there was a lack of formal actions - indicating it was more of an informal catch-up meeting than an MDT. The issue of the lack of access to mental health beds was highlighted. Care Home C's lack of expertise to support Eric was also reiterated. There was also a discussion about Eric being within the incorrect ASSD team – as he was under sixty-five with mental health as his presenting needs. Within this meeting there was a discussion about possible 1:1 care, which Care Home C did not have the capacity to put in place. There was a discussion regarding the funding of additional care, which the social worker stated was not a social care issue as it was linked to Eric's mental health, and NSFT stated they would be unlikely to fund. It was again stated that Eric had a diagnosis of Korsakoff's, which is not accurate. The meeting ended with an agreement to monitor the situation and a statement that "there seems not to be anything effective that any of us can do".

3.4.35. On 27th November 2021, Eric was checked throughout the night. He was recorded as having a cigarette at 6.02am, then recorded as being asleep at 6.30am. When staff went to check on him at 8.30am, he was found in his room deceased.

4. Systems Findings

4.1. The following sections detail the overarching learning themes emerging from the review.

4.2. Legal literacy

4.2.1. The use of term legal literacy in this report covers all areas of legislation and process related to health and social care, and particularly to adult safeguarding.

4.2.2. 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.

4.2.3. A recent publication[20] providing advice and support to practitioners faced with dependent[21] and chronic[22] drinkers who are also highly vulnerable[23], highlights the need to use existing legal powers wherever possible and not to allow the person's denial and refusal to stop intervening if they are at risk.[24]

4.2.4. The view that people are "entitled to make unwise decisions" is often taken out of context. The Mental Capacity Act Code of Practice states that "People have the right to make decisions that others might think are unwise."[25] The Mental Capacity Act has a more measured statement: "The following principles apply for the purposes of this Act… A person is not to be treated as unable to make a decision merely because he makes an unwise decision."[26] However, "For the purposes of this Act" is a critical caveat. This is not a general statement about the right to make unwise decisions in all contexts.

[20] Safeguarding-guide-final-August-2021.pdf
[21] Alcohol addicted drinking at levels that make them physically dependent
[22] Alcohol dependent for a long time – usually decades
[23] People who present a high level of risk to themselves and suffer long term negative effects. One indicator is a high use of emergency services.
[24] Safeguarding-guide-final-August-2021.pdf p.8
[25] Department for Constitutional Affairs, Mental Capacity Act 2005 Code of Practice (London, 2007) p.19
[26] Mental Capacity Act 2005 in Practice (publishing.service.gov.uk)

Also, the word “merely” is relevant, the fact that the decision is unwise is not sufficient to conclude that the person lacks capacity, however it may be a relevant consideration to consider in determining whether a person is unable to make a capacitous decision,[27] for example if there are many repeated unwise decisions, taking in specific circumstances, a consideration of executive capacity[28] may be appropriate.

4.2.5. A Plymouth Safeguarding Adults Board SAR stated the following:
“Whilst capacitated Adults are considered self-determining, and in law have the right to make unwise decisions, a duty of care still exists on professionals to explore why the Adult is making an unwise choice and what can be done to support them in caring for themselves… In order to be able to work with a person who is self-neglecting and very reluctant to engage with support, it is necessary to create a relationship with them.”[29]

4.2.6. The Blue Light Project has developed a Guidance manual[30] for professionals who may encounter people with problematic alcohol issues, who also have complex needs and who are not currently engaged with specialist alcohol services. The manual provides guidance on how to provide assertive outreach[31], along with details of the legal powers available to intervene when a person’s chronic alcohol issues may be putting them at high risk.

4.2.7. Throughout periods two and three, from January 2021 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.

4.2.8. From a review of the MCA assessment details, it appeared that the Act was used to force Eric to act (or not to act) in certain ways, as opposed to the purpose of the Act which is to support people to do certain things. There were also examples of decisions and actions taken which were not the least restrictive options, for example the decision to remove alcohol from Eric without any therapeutic follow up, or detox process.

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[27] Jenkinson, A. and Chamberlain, J., ‘How misinterpretation of ‘unwise decisions’ principle illustrates value of legal literacy for social workers’ Community Care, (28 June 2019)
[28] Executive capacity is the ability to carry out a decision.
[29] SAR Ruth Mitchell - safeguarding_adult_review_ruth_mitchell.pdf (plymouth.gov.uk) p.30
[30] The-Blue-Light-Manual.pdf
[31] This is a proactive approach to delivering support and interventions. It is used with people who have difficulties engaging with services. It is a way of organising services to provide an intensive, assertive and comprehensive service, and challenges the idea that a client is always responsible for engaging with services and showing that they want support.

4.2.9. The MCA assessment regarding whether Eric had capacity to decide whether to drink alcohol was problematic, because the assessment hinged on whether Eric was able to recognise the risks of consuming alcohol based on his experiences of when he was living independently at home. The social worker presented the effects of alcohol on his self-neglecting behaviours, and on mobility – citing falls when he was intoxicated. Eric was not able to recognise these risks within the care home environment – where he was intending to consume alcohol. Part of his care plan was daily support with his self-care, to reduce self-neglecting behaviours, which he did not have when he lived at home. He also argued that whilst he was in the care home environment he was using a wheelchair, so he believed he was less likely to fall. The best interests decision was made to stop his use of alcohol, however this decision could have been to monitor or restrict a sensible amount of alcohol, which would have been less restrictive, and also in line with national guidance around alcohol use in care homes.[32]

4.2.10. The MCA assessment was also problematic, as throughout the narrative with Eric, he was presented with a set of circumstances - purported to have occurred when he was residing at a respite placement in 2018 – which are at odds with the information in the casefiles, and therefore presumably at odds with Eric's recollection of events. This would have exacerbated his feelings of not being heard, and being badged as having dementia, when he was adamant that he did not have issues with his long-term memory. He stated to a care worker in Care Home C, a little while before his death that "he keeps being told he had dementia and feels he doesn't…. he says only his short term memory is affected." This must have been incredibly frustrating for him and is not conducive with professionals taking the least restrictive route.

4.2.11. The MCA is intended to protect and empower individuals over the age of 16, who may lack mental capacity to make their own decisions about their care and treatment. The legislation stipulates five main principles to follow when working with people who may experience difficulty making decisions:

- **Presumption of capacity:** Every person is assumed to have capacity unless proven otherwise.

- **Support to make a decision:** Every person should be given all the help and support they need to make a decision.

[32] care-home-guide-for-staff-final.pdf (beds.ac.uk)

- **Ability to make unwise decisions:** Every person has the right to make their own choices, even if they seem unwise to others.

- **Best interest:** Any decisions made on behalf of a person who lacks capacity must be in their best interest.

- **Least restrictive:** Any intervention or restriction on a person's freedom must be the least possible to achieve the desired outcome.

4.2.12. A reminder of the purposes of the Act should be shared with practitioners, and in particular the first three principles.

4.2.13. Although on analysis of the DoLS requests, they all appear appropriate, the language used regarding the DoLS in some of Eric's papers were not appropriate. For example, the statements regarding the DoLS being in place to remove the cigarettes and alcohol from Eric is incorrect.

4.2.14. The Independent Chair also spoke with the DoLS Team manager, who indicated that often DoLS were requested and then circumstances changed and the DoLS team were not informed of the changes of circumstance, for example when Eric moved from one setting to another, the team were only aware due to their own monitoring, and the DoLS requests were then cancelled on each occasion.

4.2.15. A deprivation of liberty is defined as three elements:

- Objective element: a confinement to a restricted space for a non-negligible period of time. This was defined as the 'acid test' in the Cheshire West (2014) which was brought to the Supreme Court; the person is under continuous supervision and control, and not free to leave.

- Subjective element: the person either cannot or will not give valid consent.

- Imputable to the state: the state is aware, or should be aware, of the deprivation.

4.2.16. A Deprivation of Liberties Safeguard (DoLS) is the process which aims to provide legal protection for those vulnerable people who are deprived of their liberty as part of their care, and to prevent arbitrary decisions about deprivations of liberty being taken. In order to achieve this, the following four safeguards were developed:

- Organisations wishing to deprive someone of their liberty must seek authorisation to do so.
- Where authorisations are granted, they must be reviewed regularly.
- The individual being deprived should be provided with a representative.
- The individual being deprived has the right to challenge authorisation.

4.2.17. The care home or hospital must complete the DoLS application to seek authorisation for the deprivation. Where the criteria is met, the application is granted and the person can be legally deprived of their liberty by the hospital or care home. The safeguards should be about ensuring the care and support is necessary and proportionate to the person's needs and in their best interests.

4.2.18. Conversely, at the point that Eric declined to move to the more suitable care setting, on the day he was meant to move, an assessment under the Mental Capacity Act should have been completed regarding the decision, and if found to lack capacity, Eric could have been moved in his best interests.

4.2.19. The NCHC Safeguarding Team have recently been exploring different ways in which their staff can be supported in relation to considering the MCA.

- They have introduced the use of the "Deciding Right" app which was created by Northern England Clinical Networks and is readily available to download for smart phones. The App supports practitioners to ensure they are complying with the MCA legislation, whilst keeping the patient at the centre of all decision making.

- There has been an MCA "lunch and learn" completed as a drop-in for staff at one of the community hospitals. The session presented the opportunity for staff to ask questions regarding MCA in general or to discuss cases. The Safeguarding Team have also offered regular MCA drop-in sessions for staff on all community inpatient wards.

- The Safeguarding Team are working with the ICB to offer some train the trainer style MCA training – to enable in-patient wards to strengthen their legal literacy. This is in the process of being rolled out to identified MCA Champions.

4.2.20. During period one, and period three, there appeared to be a lack of understanding or knowledge of the NSAB escalation processes,[33] for professionals to follow when either a decision has been made, or an action hasn't been taken, which they do not agree with.

4.3. Use of Multiagency Meetings

4.3.1. Throughout all of the periods upon review, there was a distinct lack of joined up, multiagency working when responding to Eric.

4.3.2. During period one, there were missed opportunities for practitioners to work together, to monopolise on the short periods of abstinence when Eric was able to function and appeared to want to change his lifestyle. This could have included CGL and mental health services, alongside ASSD and the High Dependency Service Worker.

4.3.3. 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.

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

4.3.5. By bringing together the various agencies working with Eric, for a discussion about their concerns and also the parameters of support which each agency can provide; information can be triangulated, and a robust plan can be made.

4.3.6. Professionals responding to Eric reported feeling "stuck" and not knowing where to go and what to do. Within Children's Services a process called Joint Agency Group Supervisions (JAGS)[34] has been introduced, which assists with this issue for social workers supporting families. ASSD do not generally adopt a similar process, however the principle, of bringing together professionals working with an adult to collaborate through formal joint supervision, would be of benefit to cases such as Eric where it was difficult for professionals working alone to identify how to become "unstuck."

[33] Professional-Difficulties-V2FINALDEC-2020.pdf (norfolksafeguardingadultsboard.info)
[34] Joint Agency Group Supervision Procedure | NSCP (norfolklscp.org.uk)

4.3.7. As reference above, since Summer 2024, Adult Social Work teams have been holding monthly group peer support sessions to work through cases similar to Eric's which are "stuck". This is a development which was generated directly from the learning for this review.

4.4. High Frequency Users

4.4.1. During period one, Eric has 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.

4.4.2. 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. The hospital appeared to provide comfort and human contact for Eric.

4.4.3. Eric's behaviours may have stemmed from feelings of loneliness. Recent work by Norfolk County Council[35] had identified that loneliness can impact on physical and mental health, including cognitive decline.[36] This work is developing into a "Proactive Interventions" workstream, which looks to identify risk groups early and direct people towards targeted support based on their individual circumstances.

4.4.4. Whilst in hospital, Eric would engage with the mental health liaison team, and CGL. He would indicate his intention to engage with the equivalent community teams when he was discharged, however this did not happen possibly due to Eric's inability to travel to meetings – as CGL and NSFT were not providing home visits. Eric would begin drinking again as soon as he returned home, and the whole process would begin again until Eric was again admitted to hospital.

[35] Briefing_paper_Loneliness_approved_and_accessible_v4.pdf (norfolkinsight.org.uk)

[36] HM Government (2018) 'A connected society, A strategy for tackling loneliness – laying the foundations for change'. Department for Digital, Culture, Media and Sport, London.

4.4.5. The High Intensity Support Practitioner's involvement reduced Eric's accessing acute care for a short period, however overall, his hospital attendance did not reduce significantly. The High Intensity Support Practitioner role was well received by Eric, and her presence may have reduced his loneliness for a short period. The High Intensity Support remit appears to be very broad, and at times it seems that the Practitioner was carrying out tasks which overlapped into a Carer's remit. The role did not appear to have a planned ending, with overall goals to achieve – and ended due to Eric being hospitalised in January 2021. This lack of firm end-goal may have led to increased dependency on Eric's part, as there did not appear to be any progress with reducing his self-neglecting behaviours and his hospital admittances.

4.5. Risk Assessments

4.5.1. 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.

4.5.2. 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.

4.5.3. Care Home providers in Norfolk do not have access to suicide prevention training, and 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 AgeUK have recently raised the issue of a hidden mental health crisis in older people,[37] 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.

4.6. Suitable Placements

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

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

4.6.2. 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 similar to this.

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

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

4.6.5. His placement was unsuitable, and not risk assessed, however there were little to no other options for him.

4.7. Safeguarding Adults Review Methodology

4.7.1. The methodology used for this review encouraged an exploration of practitioner experiences and responses, which enhanced the learning.

4.7.2. The Independent Chair was able to gain 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.

4.7.3. 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.

4.7.4. The methodology enabled Eric to be central to the learning, in a way which would not have been possible through use of the traditional methodology. The materials gathered were raw, unfiltered and unrestricted, enabling a truly independent analysis by the Independent Chair and the SAR panel.

5. Recommendations

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

5.2. **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

5.3. **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

5.4. **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

5.5. **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

5.6. **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

6. Reflective Practice

Please see below a series of recommendations and some reflective questions that you can use as part of group reflective sessions or as individual practitioners.

Theme – Using multiagency meetings

Throughout the scoping period there were many missed opportunities to organise a meeting between all of the professionals linked to Eric. On some occasions, the multiagency meeting which did take place were not focused, with specific actions and reviews of decisions made. Practitioners across all services should be encouraged to coordinate and facilitate multi-agency meetings – it should not be assumed that only ASSD will lead on these.

Reflective Questions	Useful Resources
• Do you feel confident in coordinating and facilitating a multi-agency meeting? • What do you need to help you feel more confident with coordinating and facilitating a multi-agency meeting? • What are the main elements of a successful multi-agency meeting?	NSAB Complex Case Management - Multi-agency Guidance

Theme – High Frequency Hospital Users

Eric appeared to use the Emergency Department at Hospital A in the place of primary care. Hospitals in Norfolk and Waveney operate a High Frequency User Meetings; however all practitioners should be aware of the use of emergency and non-planned care in place of primary care.

Reflective Questions	Useful Resources
• Have you ever supported an adult who used EDs in place of primary care? Think about the reason why they may have acted in this way. • How can you, in your particular role, respond to either encourage GP Practice engagement/attendance – or identify the underlying reason for high frequency use of ED? • What projects or services do you know about which may reduce the underlying reasons for high frequency use of EDs? For example, projects which reduce loneliness.	BW2066-supporting-high-frequency-users-october-22.pdf (england.nhs.uk)