



Safeguarding Adults Review: Eric Briefing Paper for Practitioners

1. Background

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.

1.1 The key lines of enquiry for the review

- 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.

2. The purpose of the review

The overall purpose of a Safeguarding Adults review (SAR) is to promote learning and improve practice, not to re-investigate or to apportion blame.

The objectives include establishing:

- Lessons that can be learnt from how professionals and their agencies work together.
- The effectiveness of safeguarding procedures.
- Good practice.
- How to improve local inter-agency practice.

The SAR Panel included relevant agencies involved in the care and treatment of Eric.

3. Recommendations and areas for learning and improvement

The themes, and corresponding recommendations are detailed below.

3.1 Legal literacy

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.

Recommendation: 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: NSAB, working in conjunction with the NCC, Working Age Adults Commissioning Team, 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

3.2 Risk Assessments

There were a lack of robust risk assessments undertaken during the time when Eric was accommodated in Care Home C. 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.

The recommendation says: 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.

3.3 Suitable Placements

The review identified a lack of residential accommodation for younger people with complex needs such as Eric throughout Norfolk.

The recommendation says - 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: Norfolk County Council.

3.5 Safeguarding Adult Review Methodology

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

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