Nottingham City Safeguarding Adults Board Safeguarding Adults Review 'Billy'

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Contents

1. Executive Summary

1.1. This Safeguarding Adult Review (SAR) relates to a man 'Billy' who died from starvation in 2018. Billy was a single man in his fifties of Black African Caribbean heritage, who lived alone in his flat as a tenant of Nottingham City Homes (NCH).

1.2. Eight months before his death, the Department for Work and Pensions (DWP) had stopped Billy's Employment Support Allowance (ESA) as Billy had not responded to requirements to review his entitlement. When his ESA ended, this meant his Housing Benefit was not paid. Billy quickly fell into arrears. Billy did not respond to NCH attempts to resolve this.

1.3. At the time of his death, Billy was at point of eviction, his gas supply had been cut off, so he had no heating or hot water, and he had no income for basic essentials of food and utilities.

1.4. Billy had struggled for many years with his mental health as well as problems with an under-active thyroid. He had been diagnosed with depression and had been treated by his GP on anti-depressant medication for many years. Billy had a son, daughter-in-law and grandchildren who were very supportive of him, but Billy was very independent, kept to himself and declined help.

1.5. In 2015, Billy's mental health deteriorated, and he experienced an acute episode of psychotic depression. He had shut himself away, was not eating or drinking and had suicidal thoughts. Billy's family alerted services and Billy was detained under the section 2 of the Mental Health Act 1983. Billy recovered from his acute phase of illness but declined any support from mental health services. Soon after, Billy also reduced his contact with his GP and stopped taking medication for his mental, or physical health. Billy also stopped contact with his family.

1.6. When DWP wrote to Billy's GP requesting the GP complete a form about his fitness for work, the GP had not seen Billy since 2013 and not had regular prescription since 2015. The GP Practice provided basic information confirming his diagnosis of depression and the medication he had been prescribed. The form, although giving the option for additional information, was focused on Billy's fitness to work rather than wider considerations of any barriers to securing benefits, risks posed by his mental health when in acute relapse or by the removal of benefits. DWP had no detail regarding the nature of Billy's mental health, specifically the risks when in an acute phase of illness.

1.7. DWP did have a 'mental health indicator' in their medical records to indicate Billy was vulnerable due to his depression. DWP made several attempts to engage with Billy, including home visits. However, their attempts did not extend to contacting any other agencies or speaking directly to his GP to gather more information for their decision making i.e. potential reasons for non-engagement, further information about Billy's health needs.

1.8. DWP did inform Housing Benefit that Billy's ESA had ended but this was through an automated system that did not include information from the medical report system regarding Billy's vulnerability due to his mental health. This lack of multi-agency information sharing was key to the actions that followed by NCH.

1.9. NCH had some historic information about Billy's depression, pre-dating his latest tenancy. Billy had not disclosed his depression when he had completed the new lettings process and NCH had not been informed by Health services of Billy's episode of acute psychotic depression in 2015. When Billy did not engage with requirements for gas safety checks, NCH made attempts to engage with him. When Billy built up arrears, NCH also made many attempts to talk with him. However, NCH were reliant on their internal records which were based on self-report from their tenants. This perpetuated the mistaken belief that Billy had no vulnerabilities. Their perception was that Billy was choosing not to engage or had simply abandoned his property. NCH acted accordingly.

1.10. Very sadly, we now know from a letter that Billy wrote, but never sent, that he had been in extreme mental health distress. He was debilitated by his depression and unable to function. Had there been improved communication between agencies, this may have mobilised the help and support he needed. Tragically, the interventions by agencies added to his problems by cutting off vital services.

1.11. The Coroner referenced a series of missed opportunities but ultimately did not find a direct causal connection between Billy's death and any of those missed opportunities when considered alone. A Judicial Review also judged that the DWP had met their duties under the Equality Act 2010. However, as with many SAR's, there is learning about the effectiveness of multi-agency working, bringing together information to reveal the full picture to enable a joint, supportive response.

1.12. This review endeavoured to examine those aspects of multi-agency learning and what measures were needed to strengthen the safety net that should have been in place for Billy:

Summary of Learning Points	
Opportunities for Early Intervention to Support Billy's Mental Health	
i	Research indicates that Black people are less likely to receive the psychological services that offer effective treatment and may reduce longer term mental health needs. Mental Health commissioners, service providers and referring agencies (such as GP Practices) need to be mindful of this research; understand the local take up of services by BAME communities and consider strategies for pro-active outreach.
ii	The involvement of family and carers in mental health care is a crucial element of understanding the person's mental health needs and risks, recognising relapse indicators and engaging family in discharge support planning.
iii	Primary Care and Secondary Care mental health services records need to highlight signs and risks associated with a person's mental health relapse as well as current mental health presentation i.e. the nature and degree of their mental health. These records need to be accessible to practitioners to facilitate information sharing with other agencies in line with Safeguarding Adult duties and with due regard to the Data Protection Act 2018.

iv	Housing provides an essential component of a person's care. Housing services can offer a wide range of support services for people with additional needs. Housing services need to be viewed as key partners in multi-agency care and support.
Interactions by Agencies leading up to Billy's Death	
v	NCSAB partner agencies need to ensure front line staff are confident in their application of the Data Protection Act 2018, specifically the lawful sharing of information that is necessary and proportionate to meet the needs of adults who may be at risk.
vi	There was a missed opportunity for DWP to inform Housing of Billy's mental health vulnerabilities when notifying them that his benefits had ended. Robust systems are required to review any concerns in ending a person's claim and that there is appropriate communication with relevant agencies such as Health, Social Care and Housing.
vii	NCH were reliant on the tenant self-reporting and their internal records. There is a need to make additional, enquiries from other agencies where actions are likely to have a significant adverse impact on the person's wellbeing (where justifiable under the Data Protection Act). *[Recommendation Arising]*
viii	NCH had limited records of key contacts such as for family and for Billy's GP. This created a barrier to checking his circumstances and alerting others to risk from his imminent eviction. Agencies should routinely ask the person's permission to share information with other services involved, and to understand when information may be shared without consent. *[Recommendation Arising]*
ix	A key message from the review is that non-engagement does not negate the fact that a person may be vulnerable. Agencies need to understand indicators of self-neglect and be aware of NCSAB self-neglect guidance, including considerations of capacity. Agencies need to take additional steps, as reasonable and proportionate to the risks of harm, to proactively engage adults who may be at risk. Multi-agency working is a key component of this. *[Recommendation Arising]*

1.13. Since Billy's death, the GP Practice, NCH and DWP have all made significant changes and improvements. The review was provided with information about the outcomes achieved through these improvements, as detailed within the main report.

Conclusion

1.14. The circumstances of Billy's death are shocking and disturbing. The Coroner in their Inquest Report referenced*. 'The safety net that should surround vulnerable people like [Billy] in our society had holes within it.'*

1.15. This review has considered those essential components of multi-agency working that should have formed Billy's safety net. The benefits of multi-agency working are a recurring theme in Safeguarding Adult Reviews[1] and this review is no exception.

1.16. There were a series of missed opportunities to share information between services. Had information been shared, this may have revealed the true nature of Billy's mental distress and mobilised the care and treatment he needed.

1.17. There has been significant learning for the agencies involved. Many improvements have been made since Billy died. There is evidence that these changes are making a difference to people in similar circumstances to Billy. However, the review has also identified further measures that will build on these improvements, strengthening the multi-agency response to people like Billy and reducing the risk of such a tragedy occurring again.

Recommendations
Recommendation 1: Procedural Change NCH to review their systems to strengthen the checks and balances when taking high impact actions such as cutting off gas supply without consent or seeking eviction. This should include a protocol that is compliant with the Data Protection Act (DPA), to liaise with relevant Health and Social Care agencies to check any unknown mitigating circumstances or vulnerabilities, and alert those services of any risks arising to the tenant from NCH's intended actions (where justifiable in line with the DPA)
Recommendation 2: Procedural Change NCH to review their processes for recording information on tenants' contacts, specifically: i) Requesting contact information for GP (and any other relevant agencies) ii) Requesting contact information for families or representatives (to include two means of contact)

[1] Local Government Association 2020 Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019 [Accessed October 2021]

iii) Seeking consent to share relevant information with named agencies and families or representatives

Recommendation 3: Procedural Change

The NCSAB needs to review and revise:

i) Nottingham and Nottinghamshire Multi-Agency Safeguarding Adults at Risk Self-Neglect Advice and Toolkit and

ii) Failure to engage service users framework: Supporting adults who experience difficulties engaging with services in Nottingham City

This guidance needs to set out agencies' responsibilities to take additional steps, as reasonable and proportionate to the risks of harm, to proactively engage adults who may be at risk. Non-engagement of a capacitous adult does not negate the fact that a person may be vulnerable.

Recommendation 4: Procedural Change

National Recommendation – Develop a protocol between DWP and Safeguarding Adult Boards

The NCSAB Chair should escalate the recommendations from this SAR, using the agreed national escalation protocol, to the National SAB Chairs network.[2] The aim of the escalation is to ensure that a protocol is developed to achieve the following outcomes:

i) The DWP to consider whether any case under internal review, may meet criteria under the Care Act section 44 for a Safeguarding Adult Review and make referral to the relevant Safeguarding Adult Board

ii) Chairs of Safeguarding Adult Boards should identify where any SARs they have commissioned, indicate learning relevant to DWP. This should be referred through the relevant DWP channels so that the DWP Internal Process Review Group are sighted on that learning and themes can be considered by the DWP Serious Case Panel to inform organisational change

iii) The protocol should be evaluated within 12 months of implementation to understand effectiveness of application and outcomes achieved.

DWP representatives contributing to this SAR, should share findings with the DWP Serious Case Panel.

Recommendation 5: Staff Support

Training and development:

i) The NCSAB partner agencies should disseminate the learning raised within this report and use in the agencies' staff training and ongoing quality improvement work.

[2] National Network of Safeguarding Adults Board Chairs National Escalation Protocol for Issues from Safeguarding Adults Reviews (SARs) from Safeguarding Adult Boards (SABs) July 2021

ii) NCH should share the report with the wider Nottingham City Housing sector so that this learning can be applied across Housing partners.

Safeguarding Adult Review: Main Report

2. Context of Safeguarding Adults Reviews

2.1 The Care Act 2014 requires Safeguarding Adults Boards (SABs) to arrange a Safeguarding Adults Review (SAR) if an adult (for whom safeguarding duties apply) dies or experiences serious harm as a result of abuse or neglect and there is cause for concern about how agencies worked together.

2.2. This SAR explores the death of 'Billy.' Billy had Care Act eligible needs relating to his mental health. Billy died from starvation. The NCSAB believed that there was learning about how agencies had worked together and through understanding more about the neglectful circumstances of Billy's death.

2.3. The purpose of SARs is '[to] *promote as to effective learning and improvement action to prevent future deaths or serious harm occurring again'*.[3]

2.4. The Care Act stipulates that Safeguarding Adults Reviews should be completed within 6 months of initiating it, unless there are good reasons for a longer period being required. This review was considerably delayed due to legal proceedings and the Covid pandemic. The terms of reference recognised the passage of time since Billy's death and learning focused on changes that have occurred since that time.

2.5. Nottingham City Safeguarding Adults Board (NCSAB) commissioned an independent author to carry out this review. The author is an experienced chair and author of reviews, holding a professional background in mental health social work and safeguarding adults. The author is independent of NCSAB and its partner agencies.

2.6. The Department of Health's six principles for adult safeguarding should be applied across all safeguarding activity[4]. The principles apply to the review as follows:

Empowerment:	Understanding how Billy was involved in his care and supported in decision making. Reflecting Billy's family's views within the review and communicating his experience.
Prevention:	The learning will be used to consider prevention of future harm to others.

[3] Department of Health, (2016) *Care and Support Statutory Guidance Issued under the Care Act 2014*
[4] Ibid

Proportionality:	Understanding whether least restrictive practice was used; being proportionate in carrying out our review.
Protection:	The learning will be used to protect others from harm.
Partnership:	Partners will seek to understand how well they worked together and use learning to improve partnership working.
Accountability:	Accountability and transparency within the learning process

3. Billy and the Background for This Review

3.1. Billy was a black man of African Caribbean ethnicity. He was in his fifties when he died in 2018. Billy was emaciated, weighing 30 kg (four and a half stone). The Coroner found that Billy had died from starvation.

3.2. Billy had lived on his own in a Housing Association flat as a tenant of Nottingham City Homes (NCH). His body was found by bailiffs who had entered his property to evict him as he had not paid his rent for seven months.

3.3. Billy's Employment Support Allowance (ESA) had been stopped eight months earlier as he had not responded to repeated requests from DWP for information required to review his entitlement. Billy's Housing Benefit was paid directly to NCH so when his benefits stopped, his rent was not paid. Billy's gas had also been capped off as he had not responded to requests from NCH to carry out statutory safety checks. Billy had no heating or hot water through the winter.

3.4. At the time of Billy's death, he had no income for essentials of food and utilities and was about to be made homeless.

3.5. Billy had a long history of depression and was prescribed anti-depressants. He had struggled to come to terms with the death of his father in 2003. He had taken a deliberate overdose in 2006 and was referred to Adult Mental Health Services (AMHS) but did not follow this up.

3.6. Billy had a son, daughter-in-law, and grandchildren. His family recalled that when well, Billy could be outgoing, enjoying spending time with his grandchildren and going out on his bike. His family described Billy's continuous struggles with his mental health and that he was a proud man, who could be stubborn and found it very difficult to ask for help. Billy would tend to shut himself away. If his family tried to persuade him to get help from services, Billy would close himself off further from them.

3.7. Billy's GP confirmed Billy was always reluctant to engage with services. At the time of Billy's death, his GP had not seen him in the last five years. He was not on treatment for depression and hypothyroidism as had been necessary previously. The extent of Billy's struggles with his mental health were not identified by any agency.

3.8. This SAR considers the interactions by agencies with Billy and the learning arising from this. The review also considers the changes that have been put in place after Billy's death and makes recommendations for further improvements.

4 Terms of Reference and Methodology

4.1. Terms of Reference

4.1.1. The review has focused on the period June 2017, the date Billy's benefit review process began - until June 2018, the date when sadly, Billy died. Agencies were asked to also provide information of relevance to the terms of reference before that date. The specific areas of enquiry are as follows:

Terms of Reference

1. Were opportunities missed by agencies involved in the care, treatment, support and housing of Billy to act sooner than they actually did in respect of safeguarding an adult at risk?

2. Did all agencies concerned have adequate policies and procedures for safeguarding adults and acting on concerns in place? Specifically, did they make adequate reference to the need to consult widely and work in a multi-disciplinary and multi-agency way?

3. Were professionals adequately trained and competent in the relevant aspects of safeguarding, including understanding of mental ill health, and able to adhere effectively to adult safeguarding policy?

4. Were there organisational or multi-agency blockages that prevented or delayed a timely and effective response by agencies (single or multi-agency) in respect of supporting Billy? If so, at what point(s) did these occur and what were the reasons?

5. Was the quality of risk assessment and subsequent decisions and actions arising from those assessments satisfactory?

6. Did assessments consider whether decision-making may be impaired due to mental capacity and/or mental ill health and did appropriate actions follow?

7. What factors enabled and empowered Billy to self-protect or acted as a barrier to him doing so?

8. How well did agencies consider equality and diversity and adapt intervention accordingly?

9. Was there evidence of positive practice by the agencies involved?

10. What are the learning points from this review? What changes have already been made in organisational practice, and what further recommendations for single agencies and the partnership will strengthen multi-agency working and reduce the likelihood of a similar situation occurring in the future?

4.2. Methodology

4.2.1 NCSAB's approach to this SAR was to ensure full exploration of learning while making the most efficient use of existing information and resources. The SAR reviewed the extensive information from the Coroner's inquest and the findings from Judicial Review. Agencies were asked to provide additional information as relevant to the TOR.

4.2.2. A Learning Event with agencies involved used structured discussion to explore good practice and learning points. Given the passage of time, the Learning Event focused on exploring what changes had been put in place and what assurance could be given that those changes have improved outcomes for people in similar circumstances to Billy.

4.2.3. Understanding the experiences of those receiving support from agencies is central to learning. Billy's family have been actively involved throughout the Coronial, and subsequent legal proceedings. Continually revisiting painful memories is understandably distressing for family. However, they wished to contribute to this review so that learning could be used to reduce risks to others. The Independent Author and NCSAB are grateful to Billy's son and daughter-in-law for the time given to share their views and to give us insights into Billy's life.

4.2.4. Pseudonyms have been used throughout to protect privacy. Billy's son and daughter-in-law chose the pseudonym that we have adopted for this review. Dates have been deliberately generalised and identify of professionals and smaller agencies protected.

4.2.5. The role of the contributing agencies is outlined in the table below:

Participating Agencies and Context of Involvement	
Department for Work and Pensions (DWP)	Billy was in receipt of Employment Support Allowance
NHS Nottingham and Nottinghamshire Clinical Commissioning Group (NNCCG) + GP Practice	Provided information relating to the GP's care and treatment of Billy
Nottingham and Nottinghamshire Coroner	Billy's death was subject to an inquest. The SAR accessed the Coroner's findings.
Nottinghamshire Healthcare NHS Foundation Trust (NHCT)	Adult Mental Health Services were provided to Billy during 2015 – inpatient admission along with an offer of community services
Nottingham City Homes	Billy was a long-term tenant of NCH

Nottingham City Council Adult Social Care	Adult Social Care had limited involvement. Assessed Billy under the Mental Health Act in 2015

4.3. • Structure of Report

The report is structured as follows:

- Section 5 provides a chronology of key events
- Section 6 offers analysis of those events and learning arising
- Section 7 explores what changes have occurred since Billy's death
- Section 8 gives a conclusion
- Section 9 sets out recommendations to improve future practice

5. Summary of Key Events

5.1. In **2010,** Billy completed an application for a new tenancy with NCH and was allocated a property. The form that Billy completed at that time included a vulnerability assessment that had questions relating to mental health. Billy's self-assessment scored zero. An NCH letting officer completed a follow up face-to-face visit, as was standard practice with a new tenancy. The vulnerabilities assessment completed with Billy, again scored zero.

5.2. In **2013** Billy attended his GP for blood test and treatment for an under active thyroid, low mood and anxiety. His weight at that time was 56.4 kg. He continued to have blood tests in **2014** and into **2015.** His thyroid results were normal, and he was maintained on medication for this and his mood.

5.3. **In 2015** Billy's mental health deteriorated following the death of a close friend. He became withdrawn and anxious and was acting out of character. His ex-partner and his son were worried about him. Billy was not caring for himself and he had no food in his flat and was not eating or hydrating adequately. Billy was also behaving oddly. He had cut cables off electric equipment and hung them around the flat and had no light bulbs. Billy was detained under section 2 of the Mental Health Act 1983 (revised 2007). The psychiatric assessment concluded that Billy may have had an acute and transient psychosis due to psycho-social stress factors.

5.4. Billy's mental health improved with medication. While still detained under section 2, he was given leave to visit home but refused to return. Adult Mental Health Service (AMHS) eventually were able to see him and as he agreed to engage with community services, he was discharged from inpatient detention. However, two weeks later, Billy declined any further involvement. He had stopped his anti-psychotic medication but continued with his anti-depressant and thyroid medication. He was discharged from mental health services to his GP's care.

5.5. Three weeks later, a friend of Billy's contacted the AMHS Crisis Team, concerned about his behaviour in public. She was advised to either make an appointment with Billy's GP or take him to Accident and Emergency.

5.6. Billy's GP sent him a letter, asking him to make an appointment. Billy did not make an appointment but did contact the Practice to arrange repeat prescriptions for depression and thyroid. The GP Practice wrote again later in 2015, asking him to make an appointment for a health review. Billy did not respond and also did not arrange for repeat prescriptions of his medications.

5.7. In **January 2017**, the GP Practice sent a text message to Billy to ask he make an appointment for a blood pressure check but Billy did not follow this up. The GP practice sent further texts in **March 2017**, offering advice on stopping smoking but with no response.

5.8. In **June 2017** DWP requested that Billy's GP complete the Employment Allowance form (ESA 113). The GP reviewed Billy's records of depression and hypothyroidism. The GP noted that Billy had not been seen since 2013 and not had regular prescription since 2015. The GP Practice completed the form to this effect without offering Billy a follow up appointment.

5.9. In **August 2017**, Billy's entitlement to ESA was reviewed by DWP. The nurse carrying out the review had historical reports until 2013 and the GP's ESA113 form from June 2017. The nurse assessor recorded a need for a face-to-face assessment as the DWP did not have a recent questionnaire and Billy's GP had not seen him since 2013. DWP sent Billy an appointment, but he did not attend. DWP sent two reminder letters asking him to provide reasons for non-attendance. DWP also tried to call and text but got no response.

5.10. In **October 2017**, the DWP Decision Maker phoned Billy to discuss the Work Capability Assessment; there was no response. They sent a text message to him. The Decision Maker phoned Billy again the next day but got no response. The worker referred Billy's case to the DWP Visiting Team for a safeguarding visit as he hadn't responded, and because their records indicated a history of depression.

5.11. The DWP Visiting Team tried to call Billy but got no response. They sent him a letter arranging for a visit. However, when the Visiting Officer visited, they got no response. They left a letter arranging to visit again the next day. Again, there was no answer to the home visit or to a phone call.

5.12. DWP then stopped Billy's ESA, subject to the mandatory reconsideration which was communicated to Billy in writing. As Billy's ESA also incorporated Housing Benefit, this too ended. No rent was paid from October 2017. The NCH rent arrears team sent Billy a letter and texted him, advising that the Housing Benefit had stopped. They also informed Housing Benefit who in turn, informed NCH.

5.13. In **October 2017**, the NCH gas team attempted to visit Billy, having sent letters advising of the safety risk and that the gas supply would be capped if not safety checked. An NCH officer also attempted to contact Billy by phone. The gas team left cards after each attempted visit. After three failed attempts, the gas supply was capped off. This meant that Billy had no hot water or heating.

5.14. NCH wrote to Billy in **November 2017**, advising he now had rent arrears. By **January 2018**, his arrears were mounting. The Rent Account Manager attempted to phone and then sent a letter

advising of a planned visit to serve a notice of seeking possession. There was no answer when they visited so the notice was posted through Billy's letter box along with a letter giving information about various support and advice services.

5.15. In **February 2018**, the Rent Account Manager tried to phone Billy again but got no answer. A letter, warning Billy of court action was sent to his property. The manager then visited Billy at home and spoke to Billy through his front door. Billy was upset and shouted and punched the front door. A warning letter related to Court action was sent to Billy. The NCH worker then tried to phone Billy, but his number was not in service. Billy's NCH records had his son listed as his next of kin. The NCH worker tried to phone Billy's listed next-of-kin but the number was not in service. Later that month, NCH carried out a further fire safety event and tried to visit Billy but got no response.

5.16. By **March 2018**, Billy's rent arrears had increased to over £1000. The Rent Arrears Manager again attempted to visit Billy to advise him of the date of a Court Hearing. He had no answer so posted a card requesting Billy call back. The NCH fire safety officer also attempted a further visit but without success.

5.17. NCH sent Billy an enforcement letter in **April 2018**, to inform him they would be asking the Court to grant NCH possession of Billy's flat. A further offer of a home visit was made. Two weeks later, the case was heard at Court. Billy did not attend. The Judge gave NCH the right to re-possess their property in two weeks' time. NCH wrote again to Billy to advice of this.

5.18. In **May 2018**, NCH hand delivered a letter to inform Billy of the Court decision and the intent to seek a warrant for his eviction, requesting urgent contact. NCH were of the belief that Billy had abandoned his property. NCH made a further hand delivered card to inform of the eviction date

5.19. Very sadly, Billy died in **June 2018**. He was found by bailiffs who had broken down the front door of his flat with the purpose of evicting Billy. The Coroner found that Billy had died of starvation.

6. Analysis and Learning

The analysis of these events is considered through two aspects:

1. Opportunities for early intervention to support Billy's mental health
2. Interactions by agencies leading up to Billy's death

6.1. Opportunities for Early Intervention to Support Billy's Mental Health

6.1.1. The review considered whether there were earlier opportunities to support Billy's recovery from depression.

6.1.2. Billy had struggled with depression for many years. His mental health deteriorated significantly when triggered by stressful life events. The death of his father in 2004 and then of a close friend in 2015, were particularly difficult for him.

6.1.3. Billy's family also shared how anxious Billy would become if he had to sort out financial matters. Billy's vulnerability to stress and self-harm became apparent when he took an overdose in 2006 but declined follow up by mental health services.

6.1.4. Billy had received Citalopram[5] medication for his depression for many years. While medication provides one aspect of treatment, national guidelines recognise the impact of biological, psychological and social factors on the course of depression.[6] This guidance promotes the use of psychological and psychosocial interventions as the first treatment response, with medication only being used in addition, where more moderate or severe symptoms are evident.

6.1.5. Billy may well have benefitted from psychological interventions such as Cognitive Behavioural Therapy, stress management and bereavement counselling. He may also have benefitted from social inclusion measures aimed at enhancing his social functioning and overall wellbeing. Historically, (2005) Billy's GP had discussed psychological therapies with him but at the time, he had declined those treatment options. He was also reluctant to engage in therapies, or any mental health support, following his discharge from hospital in 2015.

6.1.6. Billy had been challenging for services to engage. Billy's family highlighted how important it is for people with needs such as Billy's, to be able to access their GP and for appointments to be available – Billy had expressed some frustration in this. Services also need to be alive to other potential under-lying causes of apparent difficulties to engagement. As far back as 2002, a well-publicised report 'Breaking the Circles of Fear,'[7] examined the experiences of Black African Caribbean Communities in mental health services and that their experiences led to '*a strongly grounded fear and mistrust of services (which they perceive as inhumane), resist seeking help and only present in the most aversive of care pathways at the point of crisis*.' Sadly, it appears little has changed.[8] Black people are less likely to receive psychological services[9] and four times as likely as White people to be detained under the Mental Health Act with Black Caribbean people having the highest rate of detention out of all ethnic groups. [10]

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[5] Citalopram is a type of antidepressant often used to treat depression and panic attacks. Citalopram has fewer unwanted side effects than older antidepressants. https://www.nhs.uk/medicines/sertraline/ [Accessed October 2021]

[6] National Institute for Health and Social Care Excellence: Depression in adults: recognition and management Clinical guideline [CG90]Published: 28 October 2009 https://www.nice.org.uk/guidance/cg90/chapter/Key-priorities-for-implementation [Accessed 2021]

[7] The Sainsbury Centre for Mental Health 2002: Breaking the Circles of Fear A review of the relationship between mental health services and African and Caribbean communities https://www.centreformentalhealth.org.uk/sites/default/files/breaking_the_circles_of_fear.pdf

[8] Department of Health and Social Care Independent report Modernising the Mental Health Act – final report from the independent review 2018 https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

[9] Section 136 Mental health Act – powers of police to detain a person for purposes of psychiatric assessment

[10] H M Government: March 2021 Detentions under the Mental Health Act https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest

6.1.7. This is not to suggest that Billy's detention in hospital in 2015 was not necessary. However, there may have been earlier opportunities to engage Billy in treatment to recover his mental health. Research indicates that services need to work harder to try and engage people from Black Asian Minority Ethnic communities in psychological therapies, for example, through proactive outreach and targeted, culturally sensitive services.[11]

Learning Point 1:
Research indicates that Black people are less likely to receive the psychological services that offer effective treatment and may reduce longer term mental health needs.

Mental Health commissioners, service providers and referring agencies (such as GP Practices) need to be mindful of this research; understand the local take up of services by BAME communities and consider strategies for pro-active outreach.

6.1.8. Billy had short term involvement with secondary mental health services in 2015 when he was assessed and detained in hospital. The evidence available indicates that Billy's inpatient care was good. He improved following treatment of his psychotic depression and within two weeks, while still under detention, was offered community leave. Leave is a crucial aspect of a person's care. It is important in terms of the person's freedoms, keeps them connected to their families and community and allows the person and their clinical team, to test out a step toward discharge.

6.1.9. Billy's family believe he was offered leave too early on in his admission – they '*could see the illness in his eyes*.' They also believe that more assertive steps should have been taken to return him to hospital when he refused to return from leave. They felt that if Billy had made a fuller recovery while in hospital, he may have been more open to ongoing support from mental health services. Family also felt that Billy was not followed up sufficiently when he then disengaged from community services.

6.1.10. Mental health law and statutory guidance requires practitioners to work in a way which is the least restrictive of the person's rights and freedoms.[12] Mental health care can entail constant balancing of competing factors. Practitioners must work in partnership with the person, respecting their rights to make decisions and building a relationship to engage the person in care. However, services must also manage risks arising from mental health needs, risks that the person may not see or accept.

[11] NICE Innovative ways of engaging with Black and Minority Ethnic (BME) communities to improve access to psychological therapies 2017 https://www.nice.org.uk/sharedlearning/innovative-ways-of-engaging-with-black-and-minority-ethnic-bme-communities-to-improve-access-to-psychological-therapies

[12] Department of Health: Mental Health Act 1983 Code of Practice 2015 (updated 2017) h14ttps://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983 [Accessed October 2021]

6.1.11. NHCT did take reasonable steps to assess Billy when he failed to return from leave. They attempted to obtain a warrant[13] though their application to the Magistrate was declined. However, with family help, they located Billy at a friend's house. Although Billy remained subject to the Mental Health Act, his clinical team would still need to consider whether enforced return to hospital was justifiable. They would also need to weigh the impact of this action on Billy's likely future engagement with mental health services. Billy's safety to remain at home was assessed. He was saying he would engage with community services and take medication. On balance, this decision to respect his views and wishes and not compulsorily return him to hospital, was reasonable.

6.1.12. Billy was offered support from AMHS Crisis Resolution Home Treatment and Community Assessment Team. Unfortunately, Billy dis-engaged soon after. The assessment by community AMHS at that time, found no evidence of psychosis, or concerns about suicidal intent. Billy was sleeping well, managing his self-care and the stress factors that had triggered his mental health relapse appeared reduced. Billy said he had seen his family recently but was not seeing them so much as they had their own lives to get on with. He confirmed he would contact his GP if needed. There were no concerns about Billy's mental capacity. Given this picture, risks did not warrant reconsideration of the Mental Health Act. However, NHCT accepted that there should have been more assertive follow up particularly when three weeks later, Billy's friend contacted the mental health crisis team expressing concern about his behaviour.

6.1.13. The role of families/carers is a key aspect of mental health care. Families are often best placed to give insights into the person's history, the factors surrounding their illness and knowledge of relapse indicators. Billy's family's description of '*still seeing the illness in his eyes'* is a good example of this.

6.1.14. The NICE guidance[14] references good practice in involving families and carers. Where the person is willing for a carer and family to be involved this includes:

- Asking at regular intervals about involvement of others
- Negotiating sharing information on a regular basis
- Advising families and carers about how to contribute to treatment plans
- Giving information about diagnosis and treatment
- Offering information about support to family and carers
- Offering an assessment of their needs

6.1.15. It can be challenging where the person does not wish their family to be involved. However, information can be received from family, without disclosing information about the person without their consent.

[13] Mental Health Act 1983 (2007) Section 135 (2)
[14] NICE Guidance (2011) Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services https://www.nice.org.uk/guidance/CG136/chapter/1-Guidance#care-and-support-across-all-points-on-the-care-pathway [Accessed Nov 2017

6.1.16. Billy's family believe they needed to be involved and consulted more in relation to Billy's discharge. NHCT records note a multi-disciplinary meeting where it was agreed to override Billy's consent to inform his family that he had disengaged from mental health services. This decision recognised the potential risks to his mental and physical wellbeing should his mental health deteriorate again. The plan was to also offer the family education on signs of deterioration and how to access crisis services if concerned. This was good practice. NHCT records note phoning Billy's son to inform him that Billy was being discharged from community services and to confirm he knew how to access mental health services. There is no reference to discussing signs of relapse. Billy's family have no recall of this contact.

Learning Point 2:
The involvement of family and carers in mental health care is a crucial element of understanding the person's mental health needs and risks, recognising relapse indicators and engaging family in discharge support plan.

6.1.17. Sadly, Billy disengaged from his family. They believe this was because of the role they took in involving mental health services. They had very limited contact with Billy thereafter and were not able to provide a safety net to alert services to his relapse.

6.1.18. Records indicate that there was good communication between NHCT AMHS and Billy's GP. The GP had information from Billy's Mental Health Act assessment, detailing his presentation and risks at that time. The GP also had information about Billy's contacts with community AMHS and his improved presentation at point of discharge from them.

6.1.19. The chronology documents the attempts by the GP Practice to follow up Billy, both in relation to his mental health, his underactive thyroid and for health promotion. Billy's sporadic engagement with health services was not uncommon. Like many of the population, Billy did not necessarily follow up on all aspects of his health care although initially was proactive in getting repeat prescription for his thyroid and depression.

6.1.20. However, over time, there was less and less contact with Billy. The GP Practice accepted that at the time, the Practice did not have a robust system in place to recall patients for face- to- face appointments, nor for regular blood tests necessitated for long-term conditions.

6.1.21. The GP Practice did have a system to flag vulnerable patients so that additional steps could be provided to support their health care. However, Billy was not classed as a vulnerable patient because at the time, the GP Practice classified an adult patient as vulnerable if they were frail, elderly, learning disabled or lacking in capacity.

6.1.22. The GP Practice agree, that with the benefit of hindsight, Billy should have been classed as vulnerable. Whilst Billy's mental health was much improved at point of hand-over from AMHS, greater account needed to be taken of Billy's risks when he relapsed. The records needed to highlight Billy's signs of relapse, his risks, and the contingency plan. As will be discussed in section 7.2, flagging these risks was not only important for the GP's interactions with Billy, but to alert other agencies.

Learning Point 3:
Primary Care and Secondary Care mental health services records need to highlight signs and risks associated with a person's mental health relapse as well as current mental health presentation i.e. the degree *and* nature of their mental health. These records need to be accessible to practitioners to facilitate information sharing with other agencies in line with Safeguarding Adult duties and with due regard of the Data Protection Act 2018.

6.1.23. Contact with Billy's GP was an important safety net to assess any deterioration, particularly as Billy had stopped contact with his family. NCH's tenant support services could potentially have offered a further safety net and support to Billy. There is no record that mental health services or Billy's GP considered the involvement of Housing.

6.1.24. It is questionable whether Billy would have given consent to share information about his mental health with NCH and at the time, there were no grounds to share information without consent. NCH expressed a view that Health and Social Care agencies may overlook the contribution that Housing can make in supporting people with additional needs. Other contributors to the review questioned this, noting some positive examples of collaboration between agencies such as a Hoarding Panel. Housing sector involvement in multi-agency adult safeguarding may be an area the NCSAB will wish to seek further assurance about. In this situation, NCH remained unaware of Billy's circumstances. The relevance of this is considered further in the following section.

Learning Point 4:
Housing provides an essential component of a person's care. Housing services can offer a wide range of support services for people with additional needs. Housing services need to be viewed as key partners in multi-agency care and support.

6.2. Interactions by Agencies in the Period Leading up to Billy's Death

6.2.1. The chronology of events from October 2017, documents a series of actions taken by DWP and NCH that led to Billy having no heating, no money for essentials, and being at point of eviction from his flat. Both agencies were following their processes. However, the procedural route that had been taken was based on partial information and misconceptions about Billy.

6.2.2. What we now know is that Billy was a man in acute mental distress, who had shut himself away from the world. This section of the report begins by trying to understand Billy's experience.

6.2.3. A letter written by Billy was read out at his inquest. His family believed that Billy intended to take it along to the Work Capability Assessment that would decide whether he would remain eligible for his Employment Support Allowance. However, this is not known as the letter was undated and never sent. Whatever, the intended purpose, it is a very eloquent, but poignant

and troubling insight into Billy's world and the challenges he faced every day due to his mental illness.

> *Dear Sir/Madam,*
> *I've had to put in writing how I feel as I find it hard to express myself. I wish I could feel and function normally like anyone else, but I find this very hard.*
>
> *I can't say I have a typical day because some are good, not many, clouded by very bad days. I get up as late as I can so that the day doesn't seem too long. On a good day I open my curtains, but mostly they stay shut.*
>
> *I find it hard to leave the house on bad days. I don't want to see anyone or talk to anyone. It's not nice living this way.*
>
> *I'm afraid to put my heating on and sit with a quilt around me to keep me warm. I dread any mail coming, frightened of what it might be because I don't have the means to pay, and this is very distressing. Most days I go to bed hungry, and I feel I'm not even surviving how I should be. Little things that people brush off are big things to me.*
>
> *I have come on my own today because I have been unable to share how I feel with anyone because I don't think they would understand. It has made me ill to come here today. It is a big ordeal for me.*
>
> *My nerves are terrible and coping with this lifestyle wears me out. Sometimes I can't stand to even hear the washing machine and I wish I knew why. Being locked away in my flat I feel I don't have to face anyone. At the same time, it drives me insane. I think I feel more secure on my own with my own company, but wish it wasn't like that.*
>
> *I'm not a drinker and have never been so don't think that I'm here to abuse the system. Please judge me fairly. I am a good person but overshadowed by depression. All I want in life is to live normally. That would be the answer to my prayers.*
>
> *Thank you to all for taking the time to read this letter, I really appreciate it. I don't know how I'll cope when I see you all. I hope I will be OK*.

6.2.4. Reviews must be cautious of hindsight bias. Billy's lived experience that he documented so well, was not known to either his family, or to agencies. DWP had some information about historic depression but were not aware of the Billy's acute episode in 2015, nor of his current mental health needs. NCH's information about a mental health need dated back to 2006 through a letter from his GP that referenced depression.

6.2.5. The Coroner noted a series of missed opportunities to better support Billy. However, ultimately their finding was:

> *'I cannot however say that there is a direct causal connection between any of these missed opportunities when considered alone, and [Billy's] death. As is so common sadly with*

hindsight at an Inquest, a number of agencies had pointers suggesting his deteriorating health, but these were not put together into the full and very worrying picture until after his death.'

6.2.6. The focus of this review is to consider those opportunities for multi-agency working that may have uncovered the full extent of Billy's mental distress. Had the combined information been known, it should have set DWP and NCH onto a different procedural route. This could have mobilised a multi-agency response providing Billy with the vital social, physical and mental health support he needed.

6.2.7. There were many contributory factors that were identified through the Inquest, interviews with Billy's family and the additional information agencies provided for this review.

6.2.8. One of the missed opportunities appeared to be the request by DWP to Billy's GP to complete the ESA113 form when his entitlement to ESA was under review. The GP Practice accepts that completion of the ESA113 form should have prompted further enquiries to be made into Billy's welfare, particularly given the lack of contact and that he had stopped medication for his depression and hypothyroidism. It is not known whether Billy would have accepted an appointment given his intermittent contact with his GP over the years, but the GP Practice recognised that attempts should have been made.

6.2.9. The notes for completing the ESA113 form guided that the process was to assess the claimant's ability to work and that completion of the form would help DWP medical staff decide whether a face-to-face medical assessment was required. Although there was provision within the form to detail '*past, present and planned interventions and management, including medication, where relevant*' and space for additional information, this related to current conditions affecting ability to work. The form did not request information relating to wider considerations of Billy's mental health such as any barriers to him securing his benefits, risks posed by his mental health when in acute relapse or the impact on his mental health of discontinuing his claim. This limited the amount of information the GP was i)) prompted to share and ii) may have been able to share in the absence of consent from Billy. Furthermore, the context of the request for information did not encourage a more detailed, analytic response from the GP - the form had to be returned within five days, there was no payment to the GP Practice for the task and the notes stated it was possible to send in a computer print-out of the relevant section of the patient record.

6.2.10. The information that was provided by the GP Practice was limited to Billy's diagnosis, the date he was last seen and medication at that time. It did not include information relevant to the risks of a failure by Billy to engage with the DWP. This may have signalled the fluctuating nature of his mental health as well as the severity of his condition when in relapse. This knowledge *may* have proved invaluable to the decisions made by DWP and the actions that followed.

6.2.11. The subsequent decisions made by DWP regarding whether there was good cause for Billy's failure to engage in the review process, needed to take account of the limited nature of the GP background information available, and the purpose for which it had been provided i.e. whether the answer to the question about Billy's fitness to work was sufficient to answer the question about Billy having 'good cause' not to engage in the review process. The GP had not been asked

a view regarding any mental health barriers to accessing/securing benefits or reasonable adjustments required by DWP in relation to this. DWP did make many attempts to try and contact Billy when he failed to respond to the Work Capability Assessment request: four letters; four phone calls and texts and two attempted home visits.

6.2.12. Billy's DWP record had a 'mental health indicator'. To a degree, this was recognised, as evidenced by the decision to ask their team for a safeguarding visit. However, when those safeguarding visits were not successful, no further inquiries were attempted.

6.2.13. At the time there was no guidance for DWP staff following a home visit under their Advanced Customer Support Processes where no contact was made. The author's view is this was an omission.

6.2.14. DWP's guidance did facilitate the DWP Decision Maker being able to seek additional multi-agency information.

'DMs are reminded that the nature of the claimant's disability is a factor that must be taken into account when considering whether good cause is shown (see DMG 42500). The DM should make every effort to ensure that all sources of evidence are considered before making a determination on good cause" – and at paragraph 01405 – "*where the information is available to* [decision makers] *rather than the claimant, then they must make the necessary steps to enable it to be traced*"

6.2.15. In Billy's case, the Decision Maker reviewed the information available and decided seeking additional information was not warranted. The DWP's view is that this decision was justifiable. Due to the limited information shared by the GP Practice within the ESA113, the DWP Decision Maker was not aware of how Billy's depression could affect him. From their perspective, there were no concerns that would lead them to seek further information.

6.2.16. Billy's family questioned the knowledge the Decision Maker had in relation to mental health. ESA is a benefit for people who have an illness, health condition or disability which limits their capability for work. It is reasonable to expect a Decision Maker in that role to understand symptoms of depression. Symptoms such as lack of interest, decreased energy, loss of confidence, guilt, indecisiveness, agitation, sleeplessness.[15] All this can impact on the person's ability to interact with others, make decisions and meet the day-to-day demands of life, such as completing forms and attending appointments.

6.2.17. Decision makers need to understand the potential impact of depression and other mental illnesses, for *all* claimants and use this knowledge to make reasonable adjustments. DWP Decision Makers need to have adequate training in mental health to meet the competence requirements of their role.

[15] World Health Organisation The ICD-10 Classification of Mental and Behavioural Disorders Diagnostic criteria for research https://www.who.int/classifications/icd/en/GRNBOOK.pdf [Accessed October 2021]

6.2.18. DWP state that they had relevant training in place to support decision makers but have taken steps to improve training in mental health. This is described in section 7.

6.2.19. Billy's case was subject to Judicial Review in March 2021. The High Court Judge examined arguments regarding whether duties under the Equality Act 2010 had been met, including whether DWP were bound to make further inquiries. The Judge reiterated that the standard of reasonableness is to be judged in context, including the gravity of the potential effects of an adverse decision.

6.2.20. Ultimately, the High Court judgement was that the DWP had complied with their duty. The Judge referenced the benchmark being that '*no reasonable authority could have been satisfied on the basis of the enquiries made that it possessed the information necessary for its decision*'

6.2.21. This review's aim is to understand what can improve future multi-agency practice. Indeed, the Judge commented on the distinction between what is sensible or desirable and what is a duty. A national analysis of Safeguarding Adult Reviews has reiterated the importance of multi-agency working. Lack of information sharing, and collaborative working was a recurring theme in SARs – this review is no exception.[16]

6.2.22. At the time, there were not robust structures to support the DWP Decision Makers to trigger further inquiries of key agencies, in circumstances where there were concerns about a claimant's vulnerability and an intent to end a claim.

6.2.23. The DWP's role in safeguarding vulnerable claimants, including learning lessons from case reviews, has been scrutinised through Parliamentary process.[17] In July 2020, the Work and Pensions Secretary of State acknowledged that '*some things weren't working as they should*.' The Work and Pensions Permanent Secretary referenced the DWP wanting to improve how it engages with other agencies; to understand more about the circumstances of vulnerable claimants when decisions are being made about ending benefits.[18] Section 7 details the mechanisms that DWP has now put in place to engage with other agencies, for example case conferences.

6.2.24. The lack of information sharing between agencies was a key issue for what followed. The DWP was unaware of Billy's significant risk factors when acutely unwell, shutting himself away, disordered thoughts, not eating, not drinking and with suicidal ideation. Had this been known, it should have alerted personnel that his lack of engagement may be due to a further relapse of acute mental illness.

6.2.25. In summary, effective multi-agency communication required a two-way process i.e.

i) Recording of risks and relapse indicators within Health records as noted in 6.1.22. above.

[16] Local Government Association 2020 Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019 [Accessed October 2021]
[17] House of Commons Evidence Session Work and Pensions Committee July 2020 https://www.parliamentlive.tv/Event/Index/2d0d9a4b-4da3-449d-9f03-245c56f8e727
[18] Note: these references were not attributable to any specific case

ii) GP Practice providing salient information regarding both the nature and degree of depression to DWP to enable appraisal of fitness to work and the need for medical assessment

iii) DWP Decision Maker understanding the potential impact of depression on Billy's engagement in the process (and gaps in information to enable this understanding)

iv) DWP having an escalation process (based on context and the potential effects of an adverse decision) to gather additional information from other agencies and make those agencies aware of concerns

6.2.26. DWP did notify the Council Housing Benefit services that they were ending Billy's ESA. This was an automated system, and the information was duly relayed to NCH.

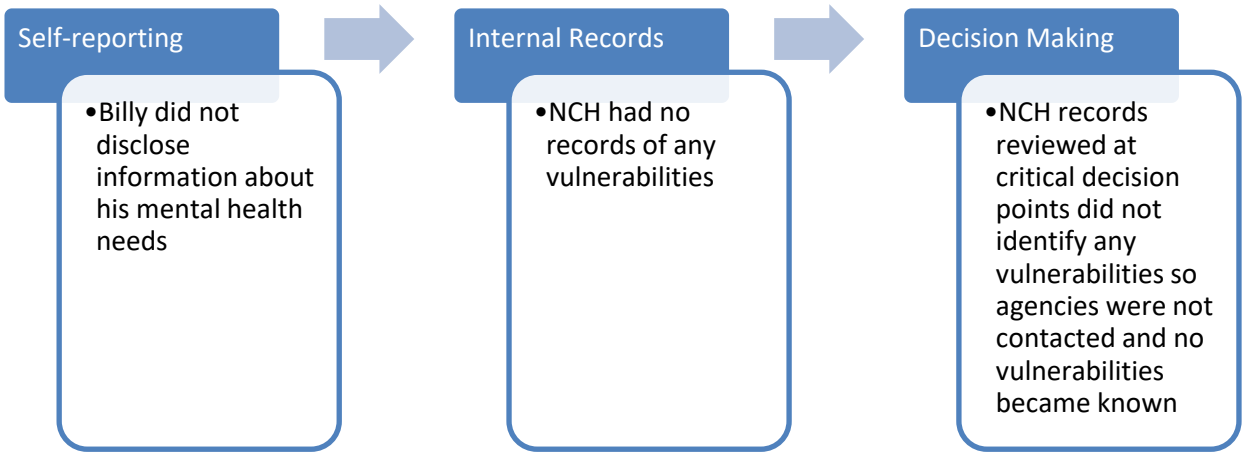
6.2.27. This was a further opportunity where DWP could have informed Housing that Billy had a 'mental health indicator' due to his depression and therefore could be vulnerable. This was a key factor because NCH had no record that Billy had any *current* mental health needs. Their perception that he had no vulnerabilities then drove their interactions with him.

6.2.28. Section 7 details changes put in place by DWP to strengthen multi-agency working and mitigate these risks.

Learning Point 5:
There was a missed opportunity for DWP to inform Housing of Billy's mental health vulnerabilities when notifying them that his benefits had ended.

Robust systems are required to review any concerns in ending a person's claim and that there is appropriate communication with relevant agencies such as Health, Social Care and Housing.

6.2.29. The decisions that NCH then made, appeared to be caught up in something of a paradoxical, 'catch -22' situation. There was a reliance on tenants self-reporting and NCH's internal records which was based on that self-report. The NCH records perpetuated the impression that Billy had no vulnerabilities and this in turn justified not involving other agencies. This meant that information that other agencies held about Billy's vulnerabilities remained hidden.



6.2.30. The effect of this could be seen at key points when NCH were interacting with Billy.

6.2.31. When Billy applied for his tenancy, he did not disclose any mental health needs. When his lettings manager carried out their initial face-to-face meeting, Billy was asked about any vulnerabilities. Again, Billy did not disclose.

6.2.32. NCH recognise that their form used for these assessments at the time, could have been more comprehensive. Nonetheless, given Billy's reticence, he may still not have disclosed any mental health needs.

6.2.33. It would be untenable, dis-proportionate, and intrusive to expect NCH to routinely make further enquiries from other agencies for all new tenancies. However, as Billy's family pointed out, it was not unreasonable for NCH to make additional enquiries at critical points when actions would have a significant impact on the person's wellbeing. For Billy those critical points were:

1. Having his gas supply capped without consent – impact was having no heating or hot water
2. Eviction with the consequent risk of street homelessness

6.2.34. Contributors to the review recognised that there remain barriers to information sharing. The permissive provisions of the Data Protection Act 2018 and safeguarding responsibilities are not always understood i.e. where the processing of information is necessary to protect an adult at risk, or where the adult is not defined as 'at risk' information may still be shared where there is substantial public interest or to protect the vital interests of the subject or another individual.[19] This was not tested in relation to Billy but remains a challenge for the NCSAB to ensure clarity across partner agencies.

> **Learning Point 6:**
> NCSAB partner agencies need to ensure front line staff are confident in their application of Data Protection Act 2018, specifically the lawful sharing of information that is necessary and proportionate to meet the needs of adults who may be at risk.

6.2.35. NCH did make significant attempts to engage with Billy. There were approximately ten letters; six attempts to visit and five phone calls or texts. NCH were duty bound to carry out safety checks on the gas and ultimately would need to disconnect where safety could not be assured. However, in the absence of a tenant's consent, or clear explanation, it is reasonable to expect additional steps. Checks with key agencies may identify mitigating circumstances and vulnerabilities such as mental health needs and alert those services that the person was at risk of having an essential utility cut off. It is recognised those checks and communications need to be justifiable in line with the Data Protection Act 2018.

6.2.36. The need for additional steps also applies to the eviction process. As NCH pointed out, the fact of a person being in arrears of itself, does not make the person vulnerable. It is also not unusual to find a tenant abandoned their property and not informed NCH.

[19] Data Protection Act 2018 schedule 8
http://www.legislation.gov.uk/ukpga/2018/12/schedule/8/enacted

6.2.37. NCH policies did require some additional steps to be taken. When referring a tenancy to Court, the Rent Accounts Manager completes a vulnerability assessment for the tenant. If the tenant is considered vulnerable through a scoring system, a referral to a Tenancy Sustainment Officer is made. The information NCH held about Billy's vulnerability scored zero so a referral to a Tenancy Sustainment Officer was not made.

6.2.38. Billy's family questioned whether the earlier interactions that Housing had had with Billy should have alerted them to his mental health needs. NCH follow a 'eyes wide open' policy, expecting all their personnel to be safeguarding minded and to report anything of concern. NCH confirmed that all their staff receive annual training in safeguarding. Their Patch Managers also have a higher-level awareness and there are safeguarding leads within their organisation. Partner agencies at the review's learning event confirmed NCH's 'eyes wide open' policy does work. They were able to confirm examples of good practice where NCH staff had demonstrated vigilance to safeguarding concerns and alerted other agencies.

6.2.39. NCH acknowledge that it is reasonable to make additional enquiries at critical points where their actions are likely to have a significant impact on their tenant's wellbeing.
NCH had limited information about other contacts for Billy. NCH did try and phone Billy's son, but his phone was not in operation. They had no other contact details. NCH also noted that even had they decided to contact Billy's GP, they had no information about which Practice he was registered with.

6.2.40. The CCG Safeguarding lead confirmed they can provide information about a GP registration, subject to data protection requirements such as safeguarding concerns. NCH also identified a need to strengthen their systems to enable improved multi-agency working i.e., requesting new tenants provide information about GP contacts and additional contact information for next-of-kin.

6.2.41. Agencies contributing to this review confirmed that there should be an expectation for all safeguarding partner agencies to routinely ask the person's permission to share relevant information with other services involved.

Learning Point 7:
NCH were reliant on the tenant self-reporting and their internal records. There is a need to make additional, enquiries from other agencies where actions are likely to have a significant adverse impact on the person's wellbeing (where justifiable under the Data Protection Act).

Recommendation Arising

NCH to review their systems to strengthen the checks and balances when taking high impact actions such as cutting off gas supply without consent or seeking eviction. This should include a protocol that is compliant with the Data Protection Act, to liaise with relevant Health and Social Care agencies to check any unknown mitigating circumstances or vulnerabilities, and

alert those services of any risks arising to the tenant from NCH's intended actions (where justifiable in line with the DPA)

Learning Point 8:
NCH had limited records of key contacts such as for family and for Billy's GP. This created a barrier to checking his circumstances and alerting others to risk from his imminent eviction.

Agencies should routinely ask the person's permission to share information with other services involved, and to understand when information may be shared without consent.

Recommendation Arising

NCH to review their processes for recording information on tenants' contacts, specifically:
i) Requesting contact information for GP (and any other relevant agencies)
ii) Requesting contact information for next-of-kin (to include two means of contact)
iii) Seeking consent to share relevant information with named agencies and their families or representative

6.2.42. Billy's difficulties in engaging with services, could be defined as self-neglecting behaviours.[20] However, his family would not wish his death to be framed as being a consequence of self-neglect. As they pointed out, though Billy's quality of life had been poor, he was existing. The final detrimental impact on his wellbeing was through the responses by agencies, cutting off access to those basic physical requirements that were essential to his life.[21]

6.2.43. Attendees at the Learning Event agreed that a key message for all agencies is that non-engagement does not negate vulnerability. Indeed, non-engagement may be a sign of increased vulnerability.

6.2.44. It is not possible to say what Billy's capacity was to be able to make decisions or the degree to which his executive functioning was impaired. What does seem clear is that further assessment was required and, as is cited within self-neglect guidance

'*…..a series of unwise decisions should raise sufficient concern to justify an assessment of their mental capacity for certain decisions…. A conclusion that an adult has capacity to make relevant*

[20] Definition: 'Self-Neglect', SCIE (2014), *Self-neglect Policy and Practice: Building an Evidence Base for Adult Social Care*, Available from: http://www.scie.org.uk/publications/reports/69-self-neglect-policy-practice-building-an-evidence-base-for-adult-social-care/ [Accessed: October 2021]
[21] The 5 Levels of Maslow's Hierarchy of Needs

decisions does not mean that professionals do not still have a duty of care and should not be used for a justification for inaction.'[22]

Learning Point 9:
A key message from the review is that non-engagement does not negate the fact that a person may be vulnerable. Agencies need to understand indicators of self-neglect and be aware of NCSAB self-neglect guidance, including considerations of capacity.

Agencies need to take additional steps, as reasonable and proportionate to the risks of harm, to proactively engage adults who may be at risk. Multi-agency working is a key component of this.

Recommendation Arising

The NCSAB needs to review and revise:

i) Nottingham and Nottinghamshire Multi-Agency Safeguarding Adults at Risk Self-Neglect Advice and Toolkit and

ii) Failure to engage service users framework: Supporting adults who experience difficulties engaging with services in Nottingham City

This guidance needs to set out agencies' responsibilities to take additional steps, as reasonable and proportionate to the risks of harm, to proactively engage adults who may be at risk. Non-engagement of a capacitous adult does not negate the fact that a person may be vulnerable.

6.2.45. The learning within this section has highlighted key process that should be in place, to support safeguarding minded practice. The following section examines what changes have been put in place toward this.

7. What's Changed?

7.1. Billy's GP Practice carried out a significant incident learning review following Billy's death. The GP Practice has revised their policy for flagging patients classed as vulnerable and now classify anyone in a similar position to Billy as being vulnerable.

7.2. The GP Practice has also strengthened their arrangements for call/recall patients that is used in conjunction with a new non responders monitoring policy. The aim is to ensure that all patients with long term health conditions are encouraged to attend an annual review at least once per year. Had Billy attended an annual medication review, it would have been noted that he had stopped collecting his repeat prescriptions. This then could have provided a trigger to encourage further engagement.

[22] Nottingham and Nottinghamshire Multi-Agency Safeguarding Adults at Risk Self-Neglect Advice and Toolkit 2019
https://nsab.nottinghamshire.gov.uk/media/er1jskhb/selfneglectadviceandtoolkit.pdf

7.3. The Practice has appointed a trained person responsible for reviewing patients' records. In addition to the standard call/recall procedures the Practice now checks records for:

- When was the patient last reviewed?
- Has the patient had an appropriate number of repeat medications since that time?

Where there are any discrepancies in review times and/or issues of any repeats then the patient's case should be referred to a GP in the Practice to review and make appropriate action plans.

7.4. The GP Practice has also emphasised to their team, the importance of using a records review (such as for a benefits review request) as an opportunity to consider the patient's records beyond the mere task at hand.

7.5. The GP Practice completed an audit into patients receiving levothyroxine to ensure that they are having annual blood tests and a face-to-face assessment. The results noted good uptake (both over 80%) and the audit will be repeated in 12 months to confirm improvement.

7.6. Nationally, there has been a drive to extend access to Psychological Therapies. NHS England reports '*Plans set out in the NHS Long Term Plan build on the ambitions of the Five Year Forward View for Mental Health*[23]*, and will see the number of people with anxiety disorders or depression who can access talking therapies through IAPT increase by an additional 380,000 per year to reach 1.9 million by 2023/24*.'[24]

7.7. GP Practices are also increasingly using 'Social Prescribing' to provide a more holistic approach to people's health and wellbeing. Link workers are able to give people time and connect them to their local services for practical and emotional support. This can be particularly helpful for people such as Billy who have long-term conditions, mental health needs, isolated and have complex social needs.[25]

7.8. NCH has also used learning to make changes. The information that is provided at sign-up to a new tenancy is now recorded on the person electronic notepad, making the information available across all departments. NCH plan to also enhance their housing management systems with the implementation of 'Every Contact Counts,' where key information is highlighted, including vulnerabilities, and is visible to all. NCH carry out audits and spot checks on the quality of sign-ups.

7.9. NCH has also amended their procedures where a single vulnerable adult is at risk of eviction. In addition to the involvement of their Tenancy Sustainment Team, NCH now make a referral to

[23] The Five Year Forward View for Mental Health A report from the independent Mental Health Taskforce to the NHS in England February 2016 https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf [Accessed October 2021]
[24] NHS England Adult Improving Access to Psychological Therapies programme https://www.england.nhs.uk/mental-health/adults/iapt/ [Accessed October 2021]

[25] NHS England Social Prescribing https://www.england.nhs.uk/personalisedcare/social-prescribing/ [Accessed October 2021]

their Eviction Prevention Panel. This collates the recent recorded contacts companywide and involves a multi-agency approach with statutory agencies.

7.10. While these initiatives are positive, they relate to a tenant with known vulnerabilities. This would not have made a difference to Billy. NCH recognised this and at the review Learning Event, agreed that at points of high impact decisions (such as eviction or capping off gas without consent) they would enhance their multi-agency information gathering to check for any unknown vulnerabilities.

Recommendations Arising

7.11. NCH also agreed to revise their tenancy sign-up forms to ask for additional information regarding contacts for GP/other relevant involved services and additional contact information for next-of-kin. This will need to be accompanied by consent to share relevant information with agencies and explanation of when information could be shared by NCH without consent.

Recommendations Arising

7.12. NCH is reviewing data sharing protocols with DWP. They have also introduced a new process if they are informed by the Council or DWP that Housing Benefit or Universal Credit Housing Payments Direct to NCH have been cancelled. This now triggers additional interventions by NCH to identify reasons so that appropriate support can be provided.

7.13. DWP has also made significant changes following the death of Billy and learning from other serious incidents involving their customers.

7.14. DWP has recruited Advance Customer Support Senior Leaders (ACSSLs). Their role is work with local communities and the agencies that provide support to claimants. ACSSL's help frontline staff to support vulnerable customers, and work in collaboration with those involved in local safeguarding arrangements.

7.15. DWP has strengthened the training provided to their staff so that they have greater understanding of how mental health may impact on the ability of people to make a claim or provide evidence for a review of a claim. A learning 'routeway' is in place for Decision Makers (and specifically for ESA Decision Makers) which includes standalone and ongoing training covering mental health. This has been in place since 2019 and is regularly updated. The Work and Health Decision Making Team also introduced a Compassion Agenda, with sessions delivered to Decision Makers to help them identify vulnerable customers and take a more holistic approach to Decision Making. This also rolled out in 2019.

7.16. DWP has revised ESA guidance relating to home or core visits and the inquiries made. Where the DWP knows that a claimant has a condition which could affect their ability to understand or comply with their obligations, '*a Core Visit to their home must be considered prior to any sanction or disallowance decision being made*." Consideration must be given to contacting other agencies e.g. next of kin, appointee, community psychiatric nurse, social services, the police to make them aware of concerns around vulnerable claimants in order that they can assess and manage those concerns.

7.17. The revised policy directs decision-makers to hold a case conference to review the concern. If there is still a concern, benefit payments will not be stopped and the case will be referred to the local ACSSL who will then consider again, whether it is appropriate to contact other agencies. There had previously been provision to convene a case conference, but this was not well supported by policy and guidance.

7.18. The DWP's position is that these changes support vulnerable customers and allow cases to be considered individually with the right level of information shared with the relevant agencies. The DWP note the new processes are having a positive impact and will address gaps highlighted within this review (a positive example is described below), such as Housing agencies being informed of mental health needs where there is potential for their claim to end.

7.19. DWP has also strengthened the system wide learning process so that learning from incidents informs organisational change. In 2020, The National Audit Office provided a report as ordered by the House of Commons. This related to how the DWPs identified and learnt from serious incidents. The report by the National Audit Office identified systemic weaknesses in the Department's approach to investigating and implementing changes after serious cases, including those involving deaths by suicide.[26]

7.20. The Permanent Secretary for Work and Pensions acknowledged that though processes for learning lessons from individual cases had been in place, these were not systematic across the DWP or with senior enough engagement.[27] DWP formed their Internal Process Review Group in late 2020 to increase oversight of Internal Process Reviews at a more senior level and to track and monitor recommendations. Key themes and systemic issues identified by the group feed into wider Customer Experience improvement activity.

Recommendations Arising

7.21. DWP established a Serious Case Panel in 2019 to help learn lessons and address systemic issues and themes arising in serious cases, Internal Process Reviews and other sources. It was through this panel in March 2020, that the new process for case conferences and deferring ending a claim was introduced.

7.22. Billy's family questioned how DWP involve their customers in policy and strategy development and learn from customers and their families where serious incidents occur. DWP confirmed that they have a Customer Experience Directorate to access the views of their customers and communicate this to DWP senior team. ACSSL's also gather information about local emerging themes and trends and feed this up to the Serious Case Panel to inform future policy and reviews of systems.

7.23. At the Learning Review, DWP presented an anonymised case example that demonstrated the difference that these changes had made. This case example spanned from late 2019 to the present day. The man, 'Mr C's circumstances mirrored many of the difficulties faced by Billy. Mr

[26] National Audit Office 2020 Information held by the Department for Work & Pensions on deaths by suicide of benefit claimants https://www.nao.org.uk/report/information-held-by-the-department-for-work-pensions-on-deaths-by-suicide-of-benefit-claimants/ [Accessed October 2021]
[27] House of Commons Evidence Session Work and Pensions Committee July 2020 https://www.parliamentlive.tv/Event/Index/2d0d9a4b-4da3-449d-9f03-245c56f8e727

C also experienced anxiety and depression and was struggling to attend appointments with his GP and DWP. He wasn't providing the medical certificates required to maintain his health-related payments.

7.24. The case example demonstrated the multiple occasions that DWP visited Mr C at home to support his engagement to sustain his existing claim and to access additional benefits he may be entitled to. There were good examples of DWP personnel taking additional steps, helping him re-register with a GP closer to his home and supporting him to get to his GP. During the Covid Pandemic, despite restrictions in place, DWP continued to make home visits (whilst following guidelines) due to concerns about his mental health. DWP demonstrated flexibility and creative solutions in supporting him; one example was providing Mr C with a phone.

7.25. There was good evidence of using the ACSSL's to give advice to the Decision Makers and reach out to local services. There were enquiries with Housing and the ACSSL liaised with his GP and Adult Social Care. The ACSSL planned and coordinated a joint visit with those services. When Mr C declined this joint visit due to feeling over-whelmed, they worked through his GP. His GP was making attempts to engage Mr C in the GP Practice Social Prescribing activities.

7.26. Mr C continues to struggle with his mental health. The DWP Health Assessor and Decision Maker continue to take additional steps, adapting to his needs and working through the GP to support Mr C to have some financial security.

7.27. This was a positive example of how the changes are making a difference to people's lives. It is clearly important that these improvements are sustained and consistently applied. At the time of this report, The Parliamentary Work and Pensions Committee had launched a survey to hear about first-hand experiences of the assessment processes for Personal Independence Payment (PIP) and Employment and Support Allowance (ESA). The survey was part of the Committee's inquiry examining the effectiveness of the application and assessment processes for benefits paid to disabled people and people with long-term health conditions, amid continuing concerns about the problems being experienced by people making claims.[28]

7.28. It is a welcome development that DWP is increasingly contributing to Safeguarding Adult Boards around the Country and to SAR's as is evidenced in this review. However, DWP has stated that the Department does not have a statutory safeguarding duty or legal duty of care.

7.29. Given the numbers of vulnerable people that the DWP supports, it is important that there is strong interface between learning that occurs through the DWP's Internal Process Review Group, DWP Serious Case Panel and the multi-agency learning carried out by SABs. This will ensure that DWP, as non-statutory partners, refers cases to the relevant SAB where criteria for a SAR appear to be met; and that SABs alert DWP where a SAR has identified learning that DWP needs to feed into their internal learning processes. This will strengthen processes to meet Care Act statutory guidance:

14.167 The following principles should be applied by SABs and their partner organisations to all reviews:

[28] UK Parliament Committees November 2021 MPs want to hear your experiences of applying for PIP and ESA - Committees - UK Parliament [Accessed December 2021]

- *there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice*

A recommendation is made to develop a national protocol between Safeguarding Adult Boards and DWP to develop a protocol toward that end.

Recommendation Arising

8. Conclusions

8.1. The circumstances of Billy's death are shocking and disturbing. The Coroner in their Inquest Report referenced.
'The safety net that should surround vulnerable people like [Billy] in our society had holes within it.'

8.2. This review has considered those essential components of multi-agency working that should have formed Billy's safety net. The benefits of multi-agency working are a recurring theme in Safeguarding Adult Reviews[29] and this review is no exception.

8.3. There were a series of missed opportunities to share information between services. Had information been shared, this may have revealed the true nature of Billy's mental health torment and mobilised the care and treatment he needed.

8.4. There has been significant learning for the agencies involved. Many improvements have been made since Billy died. There is evidence that these changes are making a difference to people in similar circumstances to Billy. However, the review has also identified further measures that will build on these improvements, strengthening the multi-agency response to people like Billy and reducing the risks of such a tragedy occurring again.

9. Recommendations

The review recognises the substantial changes made since Billy's death. The recommendations are therefore limited to additional measures identified during the course of the review.

Agencies should report back to the NCSAB progress on the recommendations within 6 months.

Recommendations
Recommendation 1: Procedural Change

[29] Local Government Association 2020 Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019 [Accessed October 2021]

NCH to review their systems to strengthen the checks and balances when taking high impact actions such as cutting off gas supply without consent or seeking eviction. This should include a protocol that is compliant with the Data Protection Act, to liaise with relevant Health and Social Care agencies to check any unknown mitigating circumstances or vulnerabilities, and alert those services of any risks arising to the tenant from NCH's intended actions (where justifiable in line with the DPA)

Recommendation 2: Procedural Change

NCH to review their processes for recording information on tenants' contacts, specifically:

i) Requesting contact information for GP (and any other relevant agencies)

ii) Requesting contact information for families or representatives (to include two means of contact)

iv) Seeking consent to share relevant information with named agencies and families or representatives

Recommendation 3: Procedural Change

The NCSAB needs to review and revise:

iii) Nottingham and Nottinghamshire Multi-Agency Safeguarding Adults at Risk Self-Neglect Advice and Toolkit and

iv) Failure to engage service users framework: Supporting adults who experience difficulties engaging with services in Nottingham City

This guidance needs to set out agencies' responsibilities to take additional steps, as reasonable and proportionate to the risks of harm, to proactively engage adults who may be at risk. Non-engagement of a capacitous adult does not negate the fact that a person may be vulnerable.

Recommendation 4: Procedural Change

National Recommendation – Develop a protocol between DWP and Safeguarding Adult Boards

The NCSAB Chair should escalate the recommendations from this SAR, using the agreed national escalation protocol, to the National SAB Chairs network.[30] The aim of the escalation is to ensure that a protocol is developed to achieve the following outcomes:

iv) The DWP to consider whether any case under internal review, may meet criteria under the Care Act section 44 for a Safeguarding Adult Review and make referral to the relevant Safeguarding Adult Board

[30] National Network of Safeguarding Adults Board Chairs National Escalation Protocol for Issues from Safeguarding Adults Reviews (SARs) from Safeguarding Adult Boards (SABs) July 2021

v) Chairs of Safeguarding Adult Boards should identify where any SARs they have commissioned, indicate learning relevant to DWP. This should be referred through the relevant DWP channels so that the DWP Internal Process Review Group are sighted on that learning and themes can be considered by the DWP Serious Case Panel to inform organisational change

vi) The protocol should be evaluated within 12 months of implementation to understand effectiveness of application and outcomes achieved.

DWP representatives contributing to this SAR, should share findings with the DWP Serious Case Panel.

Recommendation 5: Staff Support

Training and development:
The NCSAB partner agencies should disseminate the learning raised within this report and use in the agencies' staff training and ongoing quality improvement work.

NCH should share the report with the wider Nottingham City Housing sector so that this learning can be applied across Housing partners.

Sylvia Manson

Date: June 2022

Glossary

ACSSL Advanced Customer Support Senior Leaders

AMHS Adult Mental Health Services

DWP Department of Work and Pensions

ESA, Employment Support Allowance

NCH Nottingham City Homes

NNCCG NHS Nottingham and Nottinghamshire Clinical Commissioning Group

NHCT Nottinghamshire Healthcare NHS Foundation Trust

NCSAB Nottingham City Safeguarding Adult Board

SAR Safeguarding Adult Review

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About the reviewer

The review was conducted by Sylvia Manson, of Sylman Consulting.

Sylvia is a mental health social worker by background and has many years' experience in Health and Social Care senior management and commissioning. Sylvia has held regional and national roles in implementing legislation and developing safeguarding policy, including as Department of Health, lead for NHS, developing the Safeguarding Adult Principles, now incorporated into the Care Act statutory guidance.

Sylvia now works for the Mental Health Tribunal along with independent consultancy focused on partnership development, service improvement and statutory learning reviews.

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