Nottingham City Safeguarding Adults Board

Addendum to Safeguarding Adult Review 'Billy'

August 2023

This document provides an addendum to the Safeguarding Adult Review (SAR) 'Billy' which was published on Thursday 11th May 2023. The original SAR report remains available to view without alteration but from 2nd November 2023 should be read in conjunction with this addendum which sets out amendments to a small number of paragraphs within the original report.

Section 44 of the Care Act (2014) requires Safeguarding Adults Boards (SAB) to undertake a Safeguarding Adult Review (SAR) in specific circumstances and places a duty on all Board member agencies to contribute by undertaking the review, sharing information and applying the lessons learnt.

The Care Act (2014) requires local SABs to arrange a SAR when an adult with care and support needs, in its area, dies or experiences significant harm as a result of abuse or neglect (whether known or suspected), and there is concern that partner agencies could have worked more effectively to protect the person at risk.

The purpose of a SAR is not to hold any individual or organisation to account as there are other processes and regulatory bodies available for that; they are about learning lessons for the future. SARs identify learning, so that all organisations involved can improve as a result.

SARs are separate from other investigations that may be occurring, for example by the police, CQC, Coroner, or civil and criminal courts; however, the findings of those investigations (if available and in the public domain) can help to inform a SAR.

In order to provide independent challenge, SARs can be undertaken by an appointed Independent Author with relevant experience who will review existing information and identify areas where things could have been done differently, so that agencies and the wider system can consider those findings and recommendations for future cases. This is not to say that statutory duties were not met, or that agencies did not act in accordance with their policies and procedures; but that there are pathways, routes and options that were not explored that may have changed the outcome. The Board and its member organisations then have a responsibility to take forward these findings, and recommendations, to ensure that this learning is applied to future cases.

Whilst it is hoped that the independent author's opinion on findings and recommendations is aligned to that of the agencies involved, this is not always the case.

Since the publication of SAR Billy, NCSAB has considered further information, namely the content of a Work Capability Assessment completed by the Department for Work and Pensions (DWP) with 'Billy' in June 2014, which the author considers would have been reflected within the content and analysis of the SAR had it been available at that time.

At the initial scoping stage to determine whether the SAR criteria was met, SAR agencies were asked to briefly summarise information held; DWP provided the following information in relation to the assessment in 2014:

"On 1 June 2014, Billy attended a Work Capability Assessment, and on the 18 June 2014. The Decision Maker was satisfied that Billy's award of ESA should continue and that there should be a further review of his entitlement in three years' time."

The criteria for a SAR was met and Terms of Reference developed - this included the following:

"The scope period for the review is from June 2017 - the date Billy's benefit review process began - until 20.6.2018, the date Billy unfortunately died. However, if agencies have information of relevance to the ToR before that date (Billy moved into his address in 2011), it would be helpful if they briefly summarised that as well."

It should be noted that the aforementioned 2014 assessment was considered by the High Court during judicial review proceedings which took place in January 2021 with the judgment published on 3rd March 2021. However, the principles to be applied during a SAR as set out above, are entirely different to those applicable to other procedures and enquiries that may be linked to the death of an adult at risk. Paragraph 14.168 of the Care and Support Statutory Guidance informs participants that *"SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. Its purpose is not to hold any individual or organisation to account. Other processes exist for that…"* and a reminder of this key principle was included within the supporting documentation created for the SAR.

Therefore, in accordance with the further principle that SARs should be transparent in order to obtain maximum benefit from them, the author was invited to revisit the report and its recommendations. The author was asked to consider whether the additional information that the DWP had knowledge of Billy's mental health challenges, which was contained within the June 2014 assessment, at the time of the June 2018 review would have been reflected in the contents of the SAR.

The following amendments to the SAR are made in the light of a reconsideration of the report (additions in italics and retracted sections scored through):

Introduction Paragraph 1.5: *In June 2014, Billy attended a DWP Work Capability Assessment. Information provided by Billy, (supported by a benefits advisor) and through his medical assessment, referenced his anxiety and low mood, low motivation, isolation, active suicidal thoughts and that he experienced hallucinations. The decision was that the award of ESA should continue.*

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.

Introduction Paragraph 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 *from his 2014 ESA review assessment but*

did not have the additional information about his acute phase of illness in 2015 and the risks at that time. ~~specifically the risks when in an acute phase of illness~~.

Paragraph 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.

Note - having revisited the findings of the Inquest and that of the High Court review the author is not of the view that the information considered by these was 'extensively' reviewed as they did not have all the supporting information – the outcome / findings reports from these were taken into account as part of the SAR report and consequently the word extensively in relation to these is removed from the report.

Paragraph 5.3. *In June 2014, DWP asked Billy to complete a 'Limited Capability for Work' questionnaire and to attend for a face-to-face medical assessment for a DWP Work Capability Assessment. Billy had the support of a benefits advisor to complete the form. He referenced having depression, receiving medication for this, and that he would need to be accompanied to attend a face-to-face assessment. Billy reported difficulty with his mental, cognitive and intellectual functioning, including a lack of motivation, achieving tasks, taking a long time to get things done and that he could not plan. Billy described being unable to cope with unexpected changes, feeling under threat, anxious and panicky in new situations. Billy's benefits advisor noted that he required assistance to complete forms. Within his medical assessment, the Doctor referenced Billy's depression and psychological problems including isolation, severe problem with socialising -avoiding contact, active suicidal thoughts and self-reported hallucinations. Their report from the assessment referenced that Billy felt low all the time, lacks confidence and motivation. The Doctor felt that 'at this point he appears to meet support group criterion.' The Decision Maker was satisfied that Billy's ESA should continue*.

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.

Paragraph 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, *the DWP Work Capability Assessment from June 2014*, 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, *(their last assessment being 2014*) 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.

Paragraph 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~~ *Billy's depression from his 2014 DWP Work Capability Assessment* 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.

Paragraph 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. *However, DWP did have relevant information from their 2014 assessment that highlighted the difficulties Billy faced because of his depression and his vulnerability: his low mood, lack of motivation, difficulty completing tasks, high anxiety and actively avoiding social contact were likely to all have been barriers to him being able to complete a formal assessment. DWP did not have any further information to suggest these needs remained or had lessened*. 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.

Paragraph 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. *Their view was that* 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. *However, this does not take adequate account of the information that was known to DWP from their Work Capability Assessment of 2014, and how Billy's depression may be impacting on his ability to engage in the review process. This information should have raised sufficient flags about whether there may have been 'good cause' for why Billy had not responded to requests for a review and triggered making further enquiries with other agencies.*

Paragraph 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. *The DWP guidance did reference that a decision maker may also seek further information from other agencies to help make a decision and to ensure all sources of evidence are considered. While there was no requirement to seek additional information, there was discretion to do so – this discretionary option was not taken and in the author's view, should have been*.

Paragraph 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.~~

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

Learning Point 5:
Bringing together multi-agency information, strengthens assessments and decision making. There was historic information that Billy's depression may impact on his ability to engage in a DWP assessment. There were missed opportunities to use this knowledge and exercise discretionary criteria to gather further information from other agencies.

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.

Paragraph 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:

- 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. *This protocol should support an open and transparent culture for learning, and provide external assurance that the changes DWP have put in place, are making a difference.*

Nottingham City Safeguarding Adult Board has noted that no change to the author's original recommendations has resulted from this further review exercise.

The NCSAB's view is that the additional learning reinforces the importance of recommendation 4 as it aims to promote a collaborative, open and transparent learning process between SABs and the DWP as an external partner.

The contents of this addendum report have been shared with Billy's family.