SAR 'Billy' Case Summary

Nottingham City Safeguarding Adults Board

BACKGROUND: Billy was a single man in his fifties of Black African Caribbean heritage, who lived alone in his flat and died from starvation in 2018.

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. 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.

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.

We 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.

PRACTITIONER KEY LEARNING: 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.

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.**

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. Had the extent of Billy's struggles with his mental health been properly identified, it should have set agencies onto a different procedural route and initiated a multi-agency response providing Billy with the vital social, physical and mental health support he needed.

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.**

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AGENCY KEY LEARNING: 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.**

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.**

ACTION TO BE TAKEN: Please share this briefing and discuss the learning from it to inform future practice. If you have concerns about someone who is exhibiting signs of self-neglect and are unsure how to proceed, please speak to your agency safeguarding lead, even if the individual may not meet the criteria for a referral to social care.

HOW TO USE THIS BRIEFING: As with all Safeguarding Adults Reviews, there is learning for all practitioners and services, even if they were not involved in the original case. Here are some ideas on how you can take this learning forward:

- **Include reading this briefing in your personal development time and check whether you are familiar with the policies and procedures detailed within**
- **Discuss in your supervision/ 1:1 sessions – are the themes in this case familiar with what you see in your day to day work?**
- **Share with your comms team to put on your own agency intranet**
- **Add it to your agency internal newsletter**
- **Use it in your weekly team meeting to start a conversation – are there themes in this case that your team may struggle with? Would they know where to seek support if they were faced with the situation within the briefing? Is there a training need to ensure staff are well informed and confident in dealing with self-neglect and raising a safeguarding concern?**
- **Do you know where to find the Safeguarding Adults Board resources in your agency? If not, raise this with your manager**

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