Safeguarding Adults Review (SAR)

Following the death of

‘Daniyal’

Commissioned by

West of Berkshire Safeguarding Adult Board

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Glossary

AMHP	Approved Mental Health Professional
ASC	Adult Social Care
ASH	Wokingham Borough Council's Adult Safeguarding Hub
BHFT	Berkshire Healthcare NHS Foundation Trust
AMHP	Approved Mental Health Professional
CMHT	Community Mental Health Team
CPE	Common Point of Entry
EDT	Emergency out of hours social care
HTT	Home Treatment Team
JLT	Joint Legal Team
KLOE	Key Line of Enquiry
MASH	TVP's Multi-agency Safeguarding Hub
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983, as amended
MDT	Multi-Disciplinary Team
NHPT	Neighbourhood Police Team
OPCMHT	BHFT's Older Persons Community Mental Health Team
OPG	Office of the Public Guardian
SAR	Safeguarding Adult Review
SAT	Safeguarding Adults Team
SCAS	South Central Ambulance Service
TVP	Thames Valley Police
WBSAB	West of Berkshire safeguarding adults board
WICN	Wokingham Integrated Care Network
WBC	Wokingham Borough Council

1. Introduction

1.1. In February 2025 Wokingham Borough Council's Adult Social Care requested West of Berkshire Safeguarding Adults Board [WBSAB] complete a Safeguarding Adult Review [SAR] following the death of an adult believed to have experienced controlling behaviours. To respect his and his family's anonymity, this report will use the pseudonym 'Daniyal'. Daniyal died in January 2025, aged 59. The cause of his death is yet to be established through an Inquest. The WBSAB agreed the case met the criteria for a mandatory SAR to enable swift learning to support practitioners working with individuals and families who refuse access or are prevented from engaging with necessary support by family members.

1.2. Prior to his death, Daniyal and his mother (referred to in this report with a pseudonym 'Bhakti') had been known to several agencies, many of whom had raised concerns that both adults were likely to need social care support due to inabilities to manage daily care needs because of undiagnosed neurodiversity (Daniyal) and mental ill-health (Bhakti). Practitioners had also raised concerns Daniyal and his mother were extremely socially isolated and that his mother displayed controlling behaviours preventing him from accessing medical care or necessary support. Daniyal had not been registered with a GP since 1988.

1.3. Despite reasonable belief both required support to safely meet daily care needs, agencies were unable to complete assessment, care planning or treatment tasks over almost 9 years of the review period. Little is known about their background though it is believed Bhakti was raised in a Hindu family and converted to Islam prior to marriage. At the time of Daniyal's death she was 84. Daniyal was Muslim, of Pakistani origin. He is believed to be Bhakti's only child. She reported he was born and grew up in the UK where he attended school and university.

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2. Scope of Review

2.1. The purpose of undertaking a SAR is not to apportion blame, undertake human resources duties or to establish how someone died as other process exist to achieve those aims. It is to establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults, review the effectiveness of procedures (both multi agency and those of individual organisations) and inform and improve local interagency practice by acting on learning. This review will use a hybrid methodology to produce system learning which are systems focused, providing clear recommendations that can be translated by WBSAB organisations into 'SMART'[1] actions.

2.2. WBSAB asked the SAR to focus on events between May 2016, when Daniyal and Bhakti first came to the attention of statutory partner agencies until his death in January 2025. Information to inform the review was drawn from reports and chronologies provided by the SAR panel and individual management reviews provided by Wokingham Borough Council [WBC], the Joint Legal Team [JLT], Berkshire Healthcare Foundation Trust [BHFT], Thames Valley Police [TVP] and Bhakti's GP. The reviewer also facilitated learning events to discuss with practitioners and senior managers involved in the case to comprehend contextual information.

2.3. Daniyal is survived by his mother. It is believed his father died in 2008. Following his death WBC undertook enquiries to ascertain if he had any other family in the UK, but none were discovered. The reviewer met with Bhakti's current social worker who advised she should not be asked to contribute to the review given the fragility of her mental health and her grief.

2.4. The WBSAB have requested the final report explore the specific circumstances of this case to get an appreciation of the challenges faced by practitioners and safeguarding partners. The review provides learning for practitioners working with individuals and families who refuse access or are prevented from engagement by family members. Whilst a detailed chronology

[1] That is actions that are specific, measures, achievable, relevant and time-bound.

was made available to panel and participants attending the learning events, this report contains an overview of key events to respect Bhakti's privacy. The case analysis below also references key events to evaluate the key lines of enquiry [KLOE], namely:

I. Are diagnosis pathways too prescriptive, is there scope to enable effective, holistic, multiagency assessment?
II. How should organisations work to support adults at risk to secure suitable accommodation?
III. How were cultural beliefs and needs considered and formulated within the assessment process to ensure a culturally sensitive approach was taken whilst ensuring suitable momentum in the intervention?
IV. Are processes for securing legal advice to practitioners able to facilitate good safeguarding practice?
V. How should practitioners and legal processes balance safeguarding and wellbeing duties with obligations to respect privacy and family life?

3. Overview of the Case

3.1. In May 2016 Daniyal was conveyed to BHFT's Prospect Park hospital by TVP officers[2] as he was wandering on an A-road and seen acting '*erratically… responding to unknown stimuli*'. The assessing team[3] consulted his mother (as nearest relative) and concluded compulsory admission (under s2 MHA) would not be therapeutic. They did, however, raised safeguarding concerns to WBC's ASC and sent a contact sheet asking for follow up to WBC's Community Mental Health Team [CMHT]. It was noted he was not registered with a GP. Following review of the contact sheet, CMHT spoke with the AMHP and WBC's ASC duty worker and agreed to conduct enquiries. The safeguarding enquiry was subsequently closed when Daniyal, in the presence of his mother, confirmed everything was fine. He was sent information about services and encouraged to register with a GP.

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3.2. During 2017 DWP staff reported concerns to WBC about Bhakti's presentation and coercive control over Daniyal which was impacting on his wellbeing. The enquiry was closed when WBC received written notification purportedly from Daniyal that he did not want help and Bhakti threatened to take legal action against statutory services. WBC's adult social care case notes recorded '*Adult safeguarding to be closed as client has indicated he does not want it to proceed. Unable to establish whether he has capacity about this as he has not been seen in person*.'[4]

3.3. In 2020 electricity board workers contacted TVP, concerned about Bhakti and Daniyal's presentations and behaviours. Police officers visited the home, relaying similar concerns to BHFT. Over the following week officers carried out further welfare checks and raised concerns internally to TVP's safeguarding hub [MASH]. Initially MASH staff only referred concerns regarding Bhakti to WBC. Restrictions on their powers of entry meant they could not lawfully enter the family home or require Daniyal speak with them, so they had insufficient information to identify him as at risk. However, following another welfare visit, officers identified the home was without a gas supply, Bhakti was showing signs of self-neglect and queried if Daniyal had a learning disability. Their concerns that both might be 'adults at risk' was reviewed by WBC's Adult Safeguarding Hub [ASH] who advised care planning processes would be tried. An allocated safeguarding worker visited in January 2021 finding Bhakti at risk of self-neglect but closed the safeguarding enquiry as she had refused support. ASC's IMR noted this was the fourth time a safeguarding concern had raised self-neglect and potential coercive control, yet domestic abuse was '*not recognised as being a potential factor which would warrant*

[2] In line with powers under s136 Mental Health Act 1983 [MHA]
[3] In line with legal requirements the Mental Health Act [MHA] assessment was undertaken by two psychiatrists and an approved mental health professional [AMHP]
[4] Taken from WBC's IMR

undertaking a "safe enquiry" … There is a lack of professional curiosity to consider if [Daniyal] *is making "choices" around his own self-care, whether he has the capacity to make these choices or whether these decisions are being made for him*.'[5]

3.4. In May 2021 WBC requested a multi-disciplinary team [MDT] meeting to the Wokingham Integrated Care Network [WICN][6]. Bhakti's GP confirmed she had rarely sought medical assistance and had refused Covid vaccines. Demonstrating good safeguarding practice, her GP agreed not to de-register Bhakti despite her moving out of their catchment. Also, whenever possible, they sought to ensure she would been seen by the same GP (a partner in the practice) if she made contact. WICN concluded no further action was required. Consideration was given to whether they had capacity to refuse support. WBC's social worker reported '*both customers present as intelligent, academic individuals who were able to engage in conversation. They did not appear to have any difficulties understanding information presented to them and were very clear in their reasoning that they did not wish to engage with support*."[7]

3.5. Bhakti had initially presented to WBC's Housing Needs team as homeless in 2020 but had not subsequently engaged with the assessment process or provided the required information. However, in recognition of her age and likely vulnerability, WBC's housing needs team had made offers of social housing in June and September 2021. Bhakti declined both offers. The latter was for a 2-bedroom property in extra-care supported accommodation. She and Daniyal were later evicted from private rented accommodation in October 2022 and initially provided emergency temporary hotel accommodation by the Housing Needs team. Her presentations and behaviours remained of concern and resulted in frequent moves as private providers withdrew their offers. In February 2023 the Housing Needs team concluded Bhakti did not have capacity to manage a tenancy and was therefore ineligible for support under the Housing Act 1996. She had refused Daniyal permission to make an application under the 1996 Act.

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3.6. It was agreed WBC ASC would take over funding of the hotel accommodation in line with powers under s19(5) Care Act 2014. Between December 2022- May 2023 the matter was allocated to a social worker within WBC ASC's assessment team. They recognised the need to ascertain Bhakti and Daniyal's capacity to refuse social care support and that would need legal advice on how to put in place provision as Bhakti was opposed[8] to ASC's involvement and had prohibited Daniyal making any request for assistance either from the Housing Needs or ASC teams. The worker completed a 'self-directed assessment' in respect of Daniyal's needs. This was good practice; it documented their conclusions were incomplete as Daniyal had been prevented from speaking independently with the social worker. The needs assessment concluded he was at risk, that there were things that Bhakti and Daniyal could not be expected to do for themselves and it wouldn't be reasonably practicable to provide support without the provision of accommodation.[9] This assessment was shared with the Joint Legal Team [JLT] who confirmed they could initiate proceedings in the Court of Protection to seek legal powers to facilitate a full assessment of his and Bhakti's needs and mental capacity. JLT were thereafter provided with completed CoP3 assessments which included evidence from Bhakti's GP, WBC's CMHT service manager, the Council's Housing Need team and ASC together with draft witness statements. ASC also contacted the Office of the Public Guardian (in May 2023) and confirmed Bhakti did not have a registered power of attorney for Daniyal.

[5] Taken from WBC's IMR, p10

[6] WICN provides a pathway to enable Multi-Disciplinary Team [MDT] meetings for matters considered to be low to medium risk. Its focus is on moving from reactive to proactive interventions for patients aiming to avoid hospital admissions and reduce permanent placement in care. They have a complex case management tool using an integrated approach. Any health, social care or third sector party person can refer, and meetings are held on a monthly basis. This is not, however, expected to be used as an alternative to local adult safeguarding procedures.

[7] Taken from WBC's IMR, p12

[8] Which she reiterated in March 2023 directly to the Housing Needs Team

[9] *In SL v Westminster* [2013] the Supreme Court confirmed that where the adult has needs for care and support that is not available otherwise than through the provision of accommodation, the local authority must provide for this under their social care duties.

3.7. In June 2023 JLT drafted s49 Orders seeking permission to appoint a Court of Protection Visitor to complete assessments for each adult, but this application was never submitted. The safeguarding adult enquiry was closed as the allocated worker from that team understood the matter was to go before the Court of Protection. Thereafter, in line with service expectations for long-term social care involvement, the matter transferred from ASC's assessment team to the long-term ASC brokerage and support team. There is evidence of appropriate handover and, commendably, persistence by the senior social worker seeking to progress the Court application including into 2024. The allocated worker from the long-term ASC team met with JLT's allocated solicitor in May and understood it was agreed that the application would be submitted. Interventions by another senior ASC manager in June 2023 and emails from the social worker in July and August to JLT requesting an update on the Court application resulted in a letter to Bhakti and Daniyal informing them of the intention to issue proceedings. This prompted Bhakti to contact the allocated social worker and meet with her. Following this meeting, in autumn 2023 the worker confirmed to JLT they believed Bhakti had capacity to refuse social care. Over the next 18 months attempts were made to engage with and assess Bhakti and Daniyal but these proved unsuccessful.

3.8. In January 2025, after a few days where Daniyal had not been seen, a welfare check confirmed he had passed away. Bhakti was subsequently detained under s2MHA at risk of suicide. Following a period of in-patient assessment, she is now settled within a residential placement under a Deprivation of Liberty Safeguard authorisation.

4. Case Analysis

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KLOE 1: Are diagnosis pathways too prescriptive?

Within this section the SAR panel wished to understand the scope locally to enable effective, holistic, multiagency assessment.

4.1. Current pathways to access mental health diagnosis and secondary mental health support via BHFT's services are usually dependent on GP referral. BHFT's Older Person Community Mental Health Team confirmed they are commissioned to respond to referrals in respect of any adult presenting with mental ill-health aged 75 or over or anyone (including younger adults) exhibiting symptoms of degenerative cognitive decline associated with dementia. An alternative emergency/ crisis pathway is used if adults display signs of mental distress such that they pose a danger to themselves or others. The crisis intervention pathway was applied to Daniyal in May 2016 and Bhakti in January 2025. It is reliant on emergency responders (e.g. ambulance, hospital Emergency Department or psychiatric liaison teams, police and Approved Mental Health Professionals [AMHP] employed by the local authority). Crisis responses are, by design, reactive and time limited. However, as with Daniyal in 2016, they can refer on to relevant partner organisation's assessment and ongoing support.[10]

4.2. The responses to Daniyal's presentation and Bhakti's disclosures in May 2016 were consistent with expectations under the MHA. The assessors concluded he displayed '*autistic spectrum disorder and has an acute stress reaction and possibly a transient psychotic illness'*[11] following an argument earlier that day with his mother. In the following days Bhakti's accused the police of acting illegally, threatened to take an overdose (police completed a welfare check to ensure her safety), and notified BHFT's staff that he '*would be lost to her forever, and that his body would be used for experiments*'[12] if taken for further assessment. The AMHP raised a safeguarding concern to the local authority (which was shared with WBC's CMHT) concerned Bhakti was controlling all Daniyal's daily activities. The AMHP also reported concern Bhakti had asked if it was advisable to send him to Pakistan to avoid further social care intrusion.

[10] Where support is needed to manage mental health conditions or cognitive decline, this may be provided by BHFT's OPCMHT or WBC CMHT
[11] Taken from BHFT's IMR, p10
[12] Taken from BHFT's IMR, p11

4.3. The safeguarding enquiry was completed by WBC's CMHT without multi-agency input as the emergency responders from partner agencies previously involved had closed the matters on completion of their tasks. In it important to note that obligations to engage with partner agencies and complete safeguarding adult enquiries had only been introduced the previous year and so formal processes for inter-agency engagement were still in their infancy. However, it is also important to note that legal duties under the Equality Act 2010 were not given due regard within the enquiry or any care planning process. There was no consideration of what reasonable adjustments were needed to support Daniyal manage activities of daily life given what was known of his circumstances (namely, a high level of control by a family member and possible lack of insight to his ongoing mental health needs). This was the first opportunity partner agencies had, probably since 1988, to ascertain if Daniyal required assistance because of poor mental health, cognitive impairment or was at risk of domestic abuse. Sadly, this opportunity was missed.

4.4. The following year, notification by DWP of concerns to both WBC's adult social care and CMHT that Bhakti's control behaviours were impacting on Daniyal's mental health and that he still wasn't registered with a GP similarly failed to employ a multi-agency approach. This was closed without confirmation Daniyal had capacity to refuse social care, breaching s11(2)(b) Care Act.

4.5. There are clear statutory obligations, including within the Care and Support guidance,[13] for holistic assessments. Staff undertaking safeguarding, assessment or care planning activities are expected to have appropriate training and benefit from professional support from social workers, OT and other relevant experts (ch6.27). This includes in emergency situations in order they can fulfil duties to prevent needs escalating (ch6.60) and enable holistic, joint assessments, including with health and housing colleagues (ch6.75). The local safeguarding adult procedures and practice guidance enable practitioners to bring relevant partners together to ensure cooperation (s7 Care Act) and shared risk management (3.3.4 local policy and procedures). Yet, even when strategy or multi-agency meetings were undertaken, they did not result in a shared plan to address foreseeable risks given Daniyal had no monitoring of his overall health for most of his adult life. Throughout the review period a national LeDeR programme highlighted risks of premature mortality from preventable illness for adults with neurodiversity or learning disabilities. In 2024, research[14] also confirmed men diagnosed with autism without an intellectual disability were twice as likely to die prematurely (losing on average 6.14 years).

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4.6. There is evidence of professional curiosity and effective practice from police officers attending following welfare concerns in respect of Bhakti, but TVP's IMR recognised limited professional curiosity regarding risks to Daniyal despite awareness that he was also living in unsanitary conditions.

4.7. Following their eviction in October 2022 WBC's Housing Needs team recognised safeguarding risks when Bhakti disclosed her intention to kill herself and persuade Daniyal to do the same. There is evidence of an urgent response from WBC's Emergency Duty team that evening and evidence of multi-agency discussions when they went missing the following day. TVP' IMR accepted their response at this point should have been more pro-active. It should not have been closed as a repeat referral but rather graded as 'High Risk'. Both Daniyal and Bhakti should have been listed as missing person because the threats of suicide, the increased vulnerability while they were rough sleeping and their reluctance to being seen. This would have triggered a full review by a senior officer as well as additional resource and investigative

[13] Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

[14] Estimating life expectancy and years of life lost for autistic people in the UK: a matched cohort study. O'Nions, Elizabeth et al. The Lancet Regional Health – Europe, Volume 36, 100776

capability to locate them. Registering Daniyal's vulnerability separately from his mother could have prompted consideration of his wellbeing when they were located.

4.8. Unfortunately, as in 2016, once the immediate crisis was resolved the impetus to quickly secure a coordinated plan or strategy to address underlying significant concerns regarding the health and wellbeing of both Daniyal and Bhakti fell away. This was the fourth significant missed opportunity.

4.9. By contrast, the senior and allocated social workers undertaking the safeguarding enquiry between December 2022- June 2023 made pro-active enquiries across partner agencies, gathering information from the OPG, Bhakti's GP, CMHT, ASC and Housing Need teams to justify an application to the Court of Protection. The witness statements cited case materials to evidence reasonable cause to suspect both Daniyal and Bhakti lacked capacity regarding their care needs. These were identified as likely to include an inability to manage their nutrition, personal hygiene, toileting needs, make use of the home safely, maintain a habitable home or maintain family relationships or access necessary community facilities, including support via a GP. The statements recognised that in granting the request (to support a formal diagnosis and access appropriate accommodation, care and treatment), the Court would likely have to interfere with their article 8[15] rights (and possibly article 5 rights to liberty) but explained longer-term this would enable practitioners to support coordinated care for both Bhakti ad Daniyal and, thereby, maintain their family ties and promote their wellbeing in line with statutory duties.

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4.10. Attendees commended this approach but queried why this was so dependent on one agency to do so much legwork when a multi-agency strategy meeting at an earlier stage could have quickly identified matters the Court application should consider, including information outside the usual scope of the lead practitioner's remit, e.g. securing diagnostic information. Practitioners felt the Court application would have benefitted further from direct input about specialist diagnostic pathways. BHFT's OPCMHT explained that their current pathway requires GPs referring patients to include relevant information (including blood tests) so they can first rule out physical causes for symptoms which can often be misdiagnosed for mental health conditions or dementia. Had they been consulted, the Court's permission to carry out reasonable tests (including any invasive examinations) could also have been sought. In addition, ICB colleagues explained that, whilst there are processes to facilitate adults registering with a GP practice, this does not extend to registering someone against their wishes. The ICB's designated safeguarding lead was unaware of concerns (Bhakti's GP practice confirmed to this review that they had no record she lived with a son). The ICB designate confirmed they too could have support the application to the Court to request an interim order permitting Daniyal's registration. They explained that GP practice managers and designated safeguarding leads in any partner agency should be contacted for advice by partners even if not directly involved in a case. They can help identify solutions to overcome barriers, so there is a shared understanding of pathways to secure a diagnosis or how, without such a diagnosis, multi-agency risk processes (e.g. safeguarding adults enquiry) or panels (e.g. WICN[16]) could assist by coordinating plans to monitor and thereby prevent harm to adults. Crucially in this case, had the Court application had the support of a wider team around the family, this would have enabled stronger continuity of care during the transition between ASC teams. Recommendation 2 is intended to bolster current guidance on multi-agency strategic planning in response to persistent risks or safeguarding concerns.

4.11. Reflecting on the drift and inaction that occurred in securing a diagnosis and support for Daniyal and Bhakti, practitioners spoke of the benefit of seeing the chronology for this review. They explained, particularly in the early review period (2016-2021) statutory interventions were

[15] Article 8 of the European Convention on Human Rights protects a person's right to respect for your private and family life, home and correspondence.
[16] As noted above, WICN will usually only be involved in low-medium risk matters, though are encouraged to use the safeguarding adult process and refer for multi-agency input through the s42 safeguarding adults procedures where there are risks that the adult may experience abuse or neglect.

largely led by emergency responders. Understandably, therefore those practitioners would not have access to relevant case history. Referrals for wider system responses (WBC's responses to safeguarding concerns raised by AMHP (in 2016), DWP (2017) and TVP (2020) and WICN's evaluation) appear to have reviewed the immediate issue, without regard to the previous history of concerns. Drawing on good practice within child protection practice, senior managers and practitioners could see the benefit of maintaining brief chronologies of interventions so that it became easier to identify behaviour patterns or evidence issues regarding someone's executive capacity in line with NICE guidance.[17] WBC confirmed the benefits of chronologies within adult safeguarding was recognised. They have developed IT support to enable practitioners to pull together extract a history of safeguarding concerns and enquiries which will be operational in November 2025. Whilst this will not be a comprehensive chronology (this will still need to be manually created by reviewing all relevant case notes) it will give an overview of all past safeguarding concerns and enquiries and the findings from these. The ASH will then use this to inform interventions. This is helpful. Recommendation 1 is intended to complement this initiative so that the benefits of chronologies is felt across partner agencies and ASC teams.

4.12. Practitioners also recognised that there had been failings to explore all available legal frameworks and collate balance-sheet of suitable options to help Bhakti and Daniyal understand the interface between the legal duties owed to them, statutory partners' duty of care and the consequences of each decision or failing to make a decision. Discussions with practitioners and senior leaders involved in this review commented on the disparity between practitioners' assertions that person-centred, trauma-informed practice is widely used and the reality of having to work within systems increasingly challenged by balancing stretched resources with increasing demand and complexity.

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4.13. Balancing the duties owed to Bhakti and Daniyal was also made more difficult as Bhakti was known by two different names (making it harder to track her across Council and NHS services) and only wished to be contacted by letter. Drawing on the positive impact annual health reviews for adults with learning disabilities and/ or chronic mental health conditions, practitioners queried whether (perhaps as part of the move towards digitalisation) the NHS could track and flag patients over 80 who have had no face-to-face contact with primary care in a 12month period. The GP practice involved in this review currently completes a review of their client list, identifying 8 patients in 2024-25 enabling them to reach out directly to complete welfare and health checks. They also felt it would be important to have a clear reporting mechanism within integrated health systems to flag adults at risk (i.e. those who have come to the attention via the s42 safeguarding adults pathway) who are not registered with a GP so that any protection plan seeks to resolve this before closing an enquiry. Recommendations 3 and 4 are intended to address the gap and support wider benefits from LeDeR findings for those at higher risk, as Daniyal proved to be, from premature mortality.

4.14. Practitioners noted that the review period was demarcated by Daniyal's detention under s136 MHA in 2016 and Bhakti's detention under s2MHA in 2025. BHFT's IMR [p9] queried if, prior to discharging Daniyal from s136 detention[18], arrangements should have been agreed to ensure he access necessary care or treatment. Case notes confirm Daniyal and Bhakti were assessed by professionals from BHFT, ASC's ASH, EDT, assessment and long-term teams in the intervening years. Whilst there were limited examples of joint assessments (e.g. EDT in 2016 in line with duties under MHA, WICN's review in 2021 and a shared MCA assessment in March 2023) opportunities to formulate a plan across disciplines and organisations that could

[17] See https://www.nice.org.uk/guidance/ng108

[18] He was detained for 3 hours, but powers enable someone to be detained for up to 24 hours provided it is necessary. This would be determined on a case-by-case basis, but the legal power falls away after they have been examined by a doctor and interviewed by an AMHP in order that suitable arrangements can be made for the person's care or treatment.

prevent needs escalating and protect Daniyal and Bhakti from foreseeable harm were not seized.

KLOE 2: Securing suitable accommodation for 'adults at risk'

4.15. The evidence base (from research, SARs and case law) of the adverse impact of unsuitable housing and ill health has on social care needs and wellbeing is undeniable. Statutory guidance and case law therefore established clear expectations for public bodies which require practitioners to have regard to overriding duties to protect life and prevent against inhuman or degrading treatment. If there is reasonable cause to suspect an adult with care and support needs is at risk of, or experiencing, abuse or neglect and is unable to protect themselves, relevant partners are obliged to work together to safeguard the adult (s42 Care Act). This duty sits alongside, but does not replace, legal powers and duties to assess and meet health, housing and social care need under primary legal provisions.

4.16. The statutory duties to assess social care needs under the Care Act 2014 are triggered on the deliberately low threshold of an appearance of need for care and support (s9 Care Act). There are also corresponding low thresholds and duties to assess if carers require support (s10). Whilst there are powers to meet urgent needs pending assessments (s19 Care Act), there is a prohibition on local authorities meeting needs under s18-20 Care Act if it is to provide health services (s22 Care Act[19]) or housing (s23 Care Act). The Care Act restrictions are intended to give primacy within the statutory framework to obligations under the Housing Act 1996, MHA or NHS Act. However, these do not override specific duties of cooperation between Local Authorities (social care and housing), and NHS organisations so they work at strategic and operational level to promote wellbeing, prevent the escalation of needs, improve quality of care and safeguard adults with care and support needs[20] and prevent homelessness.[21]

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4.17. So, whilst often housing staff will take the lead to address issues of homelessness, all partners should be aware that the prohibition (under s23) falls away if someone does not have sufficient capacity to make an application for housing.[22] Instead there is an expectation that accommodation will be provided alongside any social care support whenever an adult requires an element of external assistance, i.e. they have a need for care and support. The need for care and support is interpreted as a need to be 'looked after'.[23] As a rule of thumb, the act of looking after should be of such a nature that the individual would still require this intervention even if they were wealthy. It is important to note that, there is no expectation that those provided with accommodation-based care must have needs requiring a CQC registered, residential care setting. In fact, the legal duty dictating how care needs can be met is worded widely to enable local authorities to provide '*accommodation in a care home or in premises of some other type*'.[24] Provision of accommodation under the Care Act is also not free; it is subject to charges as calculated by the Care and Support (Charging and Assessment of Resources) Regulations 2014.

4.18. At the start of the review period, in 2016, Bhakti and Daniyal resided in private rented accommodation. Between 2016-22, safeguarding concerns were closed despite recognition that Bhakti was refusing access to her son and showing signs of self-neglect, specifically in

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[19] Unless these are 'of a nature the local authority could be expected to provide and doing so would be merely incidental and ancillary' s22(1) Care Act, but see also National Framework for Continuing Healthcare

[20] S3, 6-7, 23-24, 76, 39-41 Care Act, accompanying regulations and Care and Support Guidance, DHSC [revised June 22], with regard to chapters 14, 17, 20-21.

[21] s.182 Housing Act 1996 and chapter 8 of the Homelessness Code of Guidance available at: https://assets.publishing.service.gov.uk/media/5ef9d8613a6f4023cf12fc67/current_Homelessness_Code_of_Guidance.pdf

[22] *R v LB Tower Hamlets, ex p Begum* (1993)

[23] "*Looking after means doing something for the person being cared for which he cannot or should not be expected to do for himself: it might be household tasks which an old person can no longer perform or can only perform with great difficulty; it might be protection from risks which a mentally disabled person cannot perceive; it might be personal care, such as feeding, washing or toileting. This is not an exhaustive list. The provision of medical care is expressly excluded… if there is a present need for some sort of care, then obviously the authorities must be empowered to intervene before it becomes a great deal worse.*" Lady Hale in *R (M) v Slough* [2008]

[24] s8 Care Act 2014

respect of maintaining her home. In 2022 Bhakti reported she lived alone and was facing harassment from her landlord. In response TVP's call handler arranged for PCSOs from their neighbourhood team to visit. TVP also responded sensitively to Bhakti following her eviction when contacted by a member of the public (concerned she was in obvious distress) and her landlord reporting criminal damage. Bhakti admitted to smashing windows and, given she had indicated suicidal ideation, officers liaised with BHFT's crisis team who (having spoken to her) confirmed they believed she did not have mental health issues. The officers reported it taking over 2 hours to persuade her to present to the Council's offices for support with their housing situation. Whilst the officers completed an adult protection notification, TVPs MASH concluded it was not necessary to forward the concerns as the crisis team had already been involved and Daniyal and Bhakti had been conveyed to the Council for assistance with their housing.

4.19. Initially they were offered temporary accommodation through WBC's Housing Needs team. During the immediate aftermath of their eviction, Bhakti's behaviours were recognised as raising significant safeguarding risks and possible care needs. The Housing Needs team referred her to WBC's adult social care [ASC] team for a social care assessment and alerted the Emergency Duty team given the need for an urgent responses outside of office hours. This was good practice and the decisions made by all practitioners responding to the acute concerns reasonable in the circumstances. When Bhakti and Daniyal could not be located, police were notified and her GP alerted to Bhakti's disclosures of suicidal ideation. During the first week of their homelessness, Bhakti frequently displayed erratic behaviours which indicated she could pose a risk to her own safety and Daniyal's. Permission for them to remain in several hotel placements was consequently withdrawn and alternatives found at short notice. Within the week WBC's ASH convened a strategy meeting[25] agreeing actions to assess Bhakti's lacked capacity to manage a tenancy and ascertain if decisions regarding her health and social care may need to be made in her best interests (in line with duties under s4 Mental Capacity Act [MCA]) and duties to refute incapacitated refusals of care (s11(2)(b) Care Act).

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4.20. There is also evidence that housing and social work teams tried to engage Bhakti to complete assessments and to offer her accommodation, but she was resistant to any offer of support from WBC's housing or social care teams. In total five separate properties were offered, including a 2-bedroom bungalow and for a two-bedroomed property within an extra-care facility. The Housing Needs Team also sought to engage directly with Daniyal, explaining that he could make an application to them in his name and that this would enable both him and Bhakti to be housed together. Bhakti refused to allow him to be spoken to or assisted to submit the application. Sadly, throughout the period, Bhakti responded with fixated ideas that indicated she would not comply with reasonable tenancy conditions. When her demands could not lawfully be met, she became aggressive to staff, threatened legal action and made a complaint to WBC's Chief Executive. In February 2023 Bhakti was assessed by the Housing Needs Team as lacking capacity, ending their legal duties.[26]

4.21. There was widespread agreement during the learning events that the interface between Housing and ASC duties to provide accommodation is made worse by ambiguous terminology and the complexity of assessing a person's capacity in a time and decision-specific manner. There is specific meaning attached to definitions used to differentiate 'supported housing' from 'supported accommodation'. Often this is linked to related legal considerations regarding how support attached to the specific accommodation is commissioned, regulated and funded. Careful thought is needed therefore to nature of the

[25] This was reported by WBC's Housing Needs Team. ASC did not have a record of the meeting and during the learning events BHFT confirmed they were not invited. The GP was also not invited but did get an email to confirm the meeting had taken place.
[26] This is in line with *R v Tower Hamlets LBC ex p Ferdous Begum* [1993] AC 509 (1993)

adult's vulnerability[27] and the type of support required (including if this is available on a consistent and predictable basis) to ascertain if any offer is suitable[28].

4.22. During learning events, housing practitioners and ASC staff questioned if supported housing (via the 1996 Act) was ever the correct pathway. By late 2022 the complexity of the familial relationship was well understood. Furthermore, partners had queried if Bhakti's presentations may be symptoms of undiagnosed mental ill health[29] and had raised concerns Daniyal may not be able to protect himself given his mother's control and his possible neurodiversity. There was evidence of significant self-neglect since 2016, including difficulties reported by utility companies within their private rented property, behavioural concerns identified by partner agencies and hotel accommodation providers that had resulted in evictions. Issues regarding possible domestic abuse in the form of controlling behaviours were first noted in 2016 but persisted throughout the review period. In 2022 it was accepted they would both be extremely vulnerable and likely to end up rough sleeping without statutory support. In such circumstances it seems unlikely that the level of support offered via support housing (usually time-limited and focused on tenancy sustainment skills, e.g. budgeting) would suffice. The case records suggest this was acknowledged; Bhakti was offered extra-care sheltered accommodation where she could continue to reside with her son. This would have been ideal, as it would have facilitated opportunities for social care practitioners to have oversight of Bhakti and Daniyal's ability to manage activities of daily living and, if necessary, seek legal powers to provide additional support, including personal care. Instead, Bhakti and Daniyal remained in hotel accommodation throughout the review period (from 2022-2025) with no oversight or support.

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4.23. With regards to the issue of capacity, there is no dispute that the Housing Needs team's decision in February 2023 that Bhakti lacked capacity to apply for support under Housing Act 1996 or manage a tenancy was reasonable. It was accepted this would mean she was ineligible for support from the Housing Needs team. Following this there was concerted effort by both allocated social workers to progress an application to the Court of Protection so ASC could lawfully explore providing suitable accommodation under the Care Act, notwithstanding Bhakti's objections. As noted below, there is no explanation for the delay by JLT in submitting this application. However, following notification of the application and Bhakti's meeting with her social worker they reasonable believed Bhakti had capacity to refuse social care. This conclusion created an impasse; taken at face value and without input from relevant partners (TVP, health and housing colleagues) this would have undermined any application to the Court of Protection[30] in respect of Bhakti. It is important to highlight that this should not have caused delay in submitting Daniyal's application. The social worker, applying person-centred practice, reasonably believed a least restrictive approach to compelling Bhakti to accept ASC support against her stated wishes, would be to build trust and help her regain capacity or, failing this, apply for legal powers (under s16 MCA) to sign a tenancy for supported accommodation on her behalf. For clarity, supported accommodation does not require WBC be appointed as a deputy, (in fact case law[31] may have prevented this) as powers (s8 and s19(5) Care Act) permits them to directly commission such provision. JLT legal advice should have made this clear. This may also have been identified had practitioners from across relevant partners come together via a strategy meeting to address the ongoing safeguarding risks and formulate agreed contingency plans to protect against further drift.

4.24. It is not unusual for practitioners to hold differing opinions regarding a person's capacity or for there to be more than one way to meet care needs. However, this case demonstrates the importance of clear mechanisms and strategic oversight of cases where there is professional

[27] In line with *Hotak v LB Southwark* [2015] UKSC 30
[28] Chapter 15.48 Care and Support Guidance defines suitable living accommodation as 'a place which is safe, healthy and suitable for the needs of a person, so as to contribute to promoting physical and emotional health and wellbeing and social connections.
[29] Following a period of assessment, she has received a diagnosis but continues to present with active symptoms despite 9 months of medication.
[30] *Wye Valley NHS Trust v Mr B* [2015] confirmed '*views of a capacitous person are by definition decisive in relation to any treatment that is being offered to him so that the question of best interests does not arise*.'
[31] *LB Havering v LD* [2010] EWHC 3876, available at: https://www.39essex.com/information-hub/case/london-borough-havering-v-ld

disagreement and/or conflict with one or more adults at risk. WBSAB has an escalation policy[32], whilst there is evidence in this case of senior managerial intervention, this did not resolve the risks to Daniyal or Bhakti and did not result in escalation to WBSAB. This was a critical system failing as there should have been tools in place to ensure continuity of a care plan notwithstanding changes of worker. Recommendations 1,2 and 5 are intended to address this gap.

KLOE 3: Cultural sensitivity within an effective approach

4.25. Knowing how to ask questions or communicate effectively with people and their families is essential to being able to better understand the context in which they view and experience their needs and the risks they face. The 2nd National SAR analysis found too few examples where the person's personal characteristics were actively considered. Ethnicity was not specified in over two thirds of cases. Nationally was not routinely recorded, 95% of SAR did not comment on the person's religion and 90% did not specify sexual orientation. The report commended one case[33] (out of 652, featuring 861 people) which had actively sought guidance from a community adviser with knowledge of effective cultural working and of the person's home country. There are many models[34] to support culturally safe practice, but most acknowledge this is an ongoing process, it requires an awareness of diversity and intersectionality, an open and non-judgemental attitude, recognition of the importance of co-production in designing the best approach to meeting needs and that cultural competence enhances our ability to care. There isn't an expectation for practitioners have a comprehensive cultural knowledge, but awareness of how our own biases or cultural context can influence judgements together with the skill to facilitate conversations to identify relevant cultural information and knowledge can improve engagement with people from culturally diverse backgrounds.

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4.26. It is also important to draw on academic research to provide important context, both in terms of this review process but also in direct practice. Relevant to the context of this review it is notable that studies[35] show a greater stigma (fear of public opinion) attached to mental illnesses in British Pakistani communities compared to that in white British communities, including within the diaspora in the UK[36]. Studies show associated shame, combined with culturally inappropriate services[37], reduce help-seeking and treatment avoidance, social exclusion, and reduced quality of life, thereby worsening mental health outcomes. The lower willingness to seek help may be derived from mental illness being perceived as a lack of religiosity[38] (religiosity being a protection from poor mental health). This is complicated by negotiating between two cultures which can induce acculturative stress (such as anxiety and depression), particularly for older adults with little social support. As psychiatric illness is a western construct, many Asian cultures use supernatural/ religious explanations for severe mental health issues, believe it is shameful and is something that is inherited through families. Thus stigma may affect not only those suffering poor mental health but the whole family. This leads to a greater desire for social distancing in Asian cultures compared to similar with a white British background.

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[32] Available at: https://sabberkshirewest.co.uk/professionals/safeguarding-adults-policy-and-procedures/escalation-policy-resolving-professional-disagreements-in-cases-that-meet-the-statutory-criteria-for-safeguarding-adults
[33] Lilian SAR available at: https://nationalnetwork.org.uk/2024/Newham_SAR_Report_Lilian__Pub_April_2024_.pdf
[34] See NHSE and Royal College of Midwives' e-learning tool available at: https://www.e-lfh.org.uk/programmes/cultural-competence/ and Hillingdon SAB's practice guide at: https://hillingdonsab.org.uk/wp-content/uploads/2024/10/Cultural-Literacy-1.pdf
[35] Ahmed S, Birtel MD, Pyle M, Morrison AP. Stigma towards psychosis: Cross-cultural differences in prejudice, stereotypes, and discrimination in White British and South Asians. *J Community Appl Soc Psychol*. 2020; 30: 199–213. https://doi.org/10.1002/casp.2437
[36] Knifton, L. (2012). Understanding and addressing the stigma of mental illness with ethnic minority communities. *Health Sociology Review*, *21*(3), 287–298. https://doi.org/10.5172/hesr.2012.21.3.287
[37] Ahmed S, Birtel MD, Pyle M, Morrison AP. Stigma towards psychosis: Cross-cultural differences in prejudice, stereotypes, and discrimination in White British and South Asians. *J Community Appl Soc Psychol*. 2020; 30: 199–213. https://doi.org/10.1002/casp.2437
[38] See for example, Ayub, R., & Macaulay, P. J. R. (2023). Perceptions from the British Pakistani Muslim community towards mental health. *Mental Health, Religion & Culture*, *26*(2), 166–181. https://doi.org/10.1080/13674676.2023.2215168

4.27. There are examples of good practice of culturally sensitive approaches within the case. For example in 2023 when WBC ASC allocated an experienced social worker from a similar ethnic background to Bhakti and Daniyal in the hope this might improve the opportunities to build rapport. The social worker also encouraged them to connect with suitably culturally sensitive community activities, but these were always declined. Her social worker reported to this review Bhakti said she '*was not a good Muslim'* but refused to elaborate. Neither Bhakti or Daniyal attended services at a Mosque. He did their shopping, reporting he complied with expectations to eat Halal meats. It is touching that, following his death, the local Muslim community came together to honour him and ensure he was buried in line with Muslim practices.

4.28. Partners queried, given the controlling nature of the mother-son relationship, if cultural stereotypes may have inadvertently prevented escalation to aid timely interventions. We found no evidence of this, for instance, it did not prevent the proposal to apply to the Court of Protection. There is also no evidence that bias factored within the long-term ASC team's reasoning for pausing that application. Given Bhakti's resistance to engage with agencies and her wider community, selecting a social worker from a similar cultural background and linguistic ability provided added benefits as it ensured evidence of instructions to Daniyal in their first language not to respond to reasonable enquiries were understood and recorded.

4.29. Practitioners speculated that, if they had experienced stigma in response to their neurodiversity or mental ill health from their community, this could explain their preference for social isolation. There isn't express confirmation within case records that this was explored with Bhakti. Neither was her understanding of societal and cultural expectations in the UK. So it remains unclear if her cultural perceptions influenced her behaviours. Throughout the review period, ascertaining her cultural knowledge would have been exceptionally difficult given the nature of her avoidant behaviours. It was also not possible to do during this review process. At the learning events practitioners could see the benefits of adopting such a culturally sensitive approach to identify and articulate the key information Bhakti and Daniyal required before they could make capacitated decisions to refuse social care. This would have enabled consideration of whether there were culture aspects to those decisions or if these were more closely linked to her delusional disorder. For example, direct discussions with them both to explain risks of premature mortality for neurodiverse adults was why practitioners repeatedly requested he register with a GP and receive regular health monitoring, or that in the UK parental responsibility to make decisions on behalf of their children is limited and falls away completely when they reach adulthood. Direct discussion with them about these issues would have helped staff form a view on if Bhakti's resistance to support had a cultural foundation.

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4.30. WBC reported equality and diversity was a priority within their Corporate plan. Presently supervision reports include prompts so cultural issues and equality duties are actively considered during case discussions. The Principal Social Worker is also looking to develop practice guidance to support practitioners gain further confidence. The ICB felt learning in response to this review could also draw on positive practice improvements achieved through the inclusion health projects and public health initiatives. They explained WBSAB partners may also benefit if training offers were multi-agency. Recommendation 2 is intended to support continued good practice in this area.

KLOE 4: Access to legal advice

4.31. Within the 2nd National SAR analysis recommendations were made to improve organisational support to ensure supervision and management oversight of frontline decision making as well as access to specialist legal advice to ensure that local processes and policies are used effectively to enable statutory obligations to be met.

4.32. As noted above, there were numerous notifications throughout the review period that should have prompted partners to explore if Daniyal and Bhakti could safely meet their own needs

and evidence that they needed support to do so. Despite this, there wasn't a common view on Bhakti's or Daniyal's capacity to make decisions regarding their care needs, housing or their executive functioning. It wasn't until March 2023 (7 years into the review period) that legal advice on possible options for next steps was first sought.

4.33. Staff attending learning events drew parallels with very clearly defined expectations within child protection to secure early input from relevant partners by way of legal planning meetings. Presently, as noted above, local and national policy encourage multi-agency strategic planning, but do not prescribe arrangements to secure this. Within WBSAB agencies, such a prescribed procedure will be complicated by the differing arrangements each agency has for access to legal support. JLT explained, they are not commissioned to provide legal advice and support to every relevant partner within WBSAB. In fact they are only instructed by two out of three of the local authorities involved in WBSAB. Nor do they advise on obligations under the Housing Act 1996 as WBC has a separate, in-house team for this. They also highlight their own professional standards obligations (imposed by the Solicitors Regulation Authority), would likely prevent them providing legal advice to multi-agency meetings as this could lead to a conflict of interest and undermine important safeguards such as legal professional privilege[39]. Notwithstanding, these considerations WBSAB partners could adapt existing child protection good practice to agree guidelines for staff to access specialist legal advice to inform strategic decision at the earliest opportunity. Recommendations 1 and 5 have been worded to enable partners to come together to propose workable solutions so that adults at risk can benefit from the good practice employed in child protection arrangements.

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4.34. Practitioners were equally keen to ensure any new procedure understood the importance of parity of esteem across partner agencies' staff and due respect given to their expertise in their field. Assumptions that another team might be better place to resolve risks or meet needs are dangerous, particularly if made in isolation without verifying this directly with that service (as happened in May 2016 and July 2023).

4.35. Equally, as noted in response to KLOE 1 and 2 above, local adult safeguarding procedures would likely also benefit from stronger guidance on parallel or contingency planning. Again, this is common practice in child protection procedures but still rare within adult safeguarding. Early legal support is crucial to support practitioners navigate possible parallel legal options to resolve cases where there are repeated welfare concerns, intra-familial domestic abuse and complexities regarding accessing adults with care and support needs or coordinating holistic assessments. Daniyal and Bhakti's circumstances were unusual, but it is common for adults with care and support needs to resist additional help or lack insight into the type of care they require. Too often poor outcomes are attributed to a lack of professional curiosity or over optimism on behalf of frontline practitioners. ASC reported they have improved their training offer so level 2 and 3 safeguarding programmes alongside specific lunch and learns cover expectations. This is a positive start, but it will be equally important to measure the take up of that training across teams and wider partners and the impact this has on practice. One way to do so would be to measure how frequently staff seek early advice/ guidance on legal options for parallel planning. The recommendations are intended to support relevant partners provide ongoing assurance to WBSAB that practice is improving.

4.36. It is important to note that there is no suggestion of a lack of professional curiosity or overoptimism in this case. JLT's IMR provides evidence of WBC social care proactively chasing updates. In May 2023 they notified the legal team that the matter was due to transfer to the long-term support team and asked if they have everything they needed to submit the application. They chased for confirmation two weeks later, at which time this was passed from the paralegal to the solicitor within the team. In early June the solicitor wrote requesting minor amendments to the witness statements and confirmation of instruction. Those tasks were

[39] More information is available at: https://www.lawsociety.org.uk/topics/civil-litigation/legal-professional-privilege-guide

completed by the senior social worker that day who replied expressing the urgency of the application. The matter was then transferred internally between JLT solicitors. This caused further delay, but the senior social worker again chased at the end of June requesting confirmation that the application had been submitted. Legal file records indicate the newly appointed social worker (brokerage and support team) also chased in July and August for timescales for the application. JLT's solicitor and social worker met in late August 2023. ASC believed the application was due to be filed. However, JLT did not record within their case files the meeting. Nor did they confirm their advice and actions they would take to their client department. This should have occurred so that, if there were any misunderstanding this could be quickly rectified. On balance, it is likely that the instructions to issue were understood by both the ASC and the solicitor as notification of the intended application was sent to Bhakti and Daniyal. Despite this, neither application had been submitted in late September when the social worker wrote to advise she believed Bhakti had capacity. At this time the social worker confirmed to the solicitors that their assessment of Bhakti's capacity was disputed by the Housing Needs team. Notes provided in JLT's IMR [p18] confirmed social care remained sceptical that Bhakti had insight into her self-neglect and Daniyal was unable to freely engage with support. JLT advised an application could be made based on controlling behaviours and, inexplicably, asked ASC to obtain a further capacity assessment for Daniyal.

4.37. The similarities between the circumstances in this case and the facts reported within *LB Havering v LD* [2010][40] should have been more carefully considered and, if it was the solicitor's view that the prepared application could not now proceed, clear advice given on what legal powers (if any) they had to continue to provide the accommodation under s19(5) Care Act. It should have been clarified that ASC's view on Bhakti's capacity to refuse social care would, if applied, mean their duty to accommodate fell away. However, this would not have overridden the reasonable, lawful decision by the Housing Needs team that (due to her incapacity) she was not owed a duty to them. As such, ASC should have been advised, because of the previous agreement that Bhakti would be highly vulnerable if made homeless, that they would need to provide careful rationale of their change in position given the enduring duty under s11(2) Care Act and, crucially, that the new assessment did not impact on the legal position in respect of Daniyal so the draft application should have acquired a greater degree of urgency. ASC should have been advised to follow guidance within caselaw (to assess her capacity in respect of residence), only after they had identified two or more options for living, the facilities that would be available, the legal nature of the tenancy or license and cost of the placement.[41]

4.38. Capacity to determine where someone should live (their residence) is often interwoven with their capacity to agree to care and understand risks if necessary care cannot be provided within certain accommodation types. These are separate issues, but the Court of Protection is clear these should not be artificially pigeonholed[42], particularly if there is already significant evidence (as for Bhakti and Daniyal) the person could not grasp why they needed support and what would happen if support was not provided. During the meeting with JLT, the newly allocated social worker reasserted concerns regarding Bhakti's insight into risks arising from self-neglect and the dispute between departments regarding Bhakti's capacity. In those circumstances, there was objective grounds for pursuing the prepared application. The solicitor's request that the social worker complete a further capacity assessment for Daniyal (though previous legal advice had already confirmed this was as good as it could be) is not explained. Following the meeting the application was paused, believing the plan was to seek a deputyship order so that the local authority could sign a tenancy. Though again, that application may also have failed given the findings in *LB Havering v LD* [2010].

4.39. Improving legal literacy within partner agencies workforce is a common finding within SARs. There is already a wealth of information in easily digested formats for practitioners and lawyers.

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[40] A summary of which is available at: https://www.39essex.com/information-hub/case/london-borough-havering-v-ld
[41] *LBX v K, L and M* [2013] EWHC 3230 (Fam)
[42] Liverpool City Council v CMW [2021] EWCOP 50

For example, 39 Essex Street Chambers provide comprehensive guidance notes[43] and regular newsletters[44]. This should be appreciated as a core responsibility for personal professional development, but partner agencies are also required to have in place mechanisms for ensuring staff are competent. This includes where critical support services (such as legal advice) are commissioned from arm's length organisations. WBC confirmed ASC practitioners can request managerial support and access to legal advice via a legal pathway meeting. But this will only be used if staff are already sufficiently legally literate to understand they will require legal advice and support. The quality of that advice should also be assured and mechanisms for monitoring JLT staff meet service expectations (including by confirming their advice in writing following meetings) so non-compliance can quickly be escalated by practitioners and team managers. Discussions at the learning events explored whether there were opportunities for legal briefings and planning meetings to have wider input (e.g. from lawyers with community safety, housing or health specialisms) to provide outcomes focused approaches for multi-agency risk stratification and overcome any tendency to transfer or end responsibility without full consideration how legal powers could facilitate a more proactive approach. Recommendation 2 reflects those discussions and is intended to address issues identified above (at 4.8) to ensure practical considerations regarding diagnosis and accommodation pathways were addressed. However, this alone will not address learning from this review regarding the importance of timely and competent legal advice. We have therefore made recommendation 5 to support improved practice.

4.40. There was no further activity by JLT until April 2024 when the previous senor social worker (and the team manager from WBC's learning disability team) wrote requesting a meeting. It does not appear that this meeting took place and whilst the Learning Disability team manager submitted a further legal referral in December 2024 the meeting wasn't scheduled until after notification of Daniyal's death. In their IMR JLT recognised frequent changes of solicitors and legal assistants responding to queries[45] as well as issues identified with how the legal case files had been set up made it difficult to identify drift or maintain a consistent case strategy. Since this time, they reported they had improved senior management oversight of matters both internally within JLT and how this is reported to ASC service directors. There is now a monthly report provided to ASC's service directors. In addition, the legal guidance protocol has been revised and shared across ASC. Following discussion during SAR "Ursula" it is understood WBC's principal social worker is working with JLT to establish regular legal clinics to enable practitioners from across services to learn from each other and use experts already in the system. They also welcomed proposals for training and information sessions from JLT to form part of ASC's induction programme for all new staff.

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4.41. This review also raised concern that procedural safeguarding within civil proceedings may not be understood or applied for vulnerable litigants. In October 2022 Bhakti's private landlord enforced an eviction order, suggesting the landlord was not aware (or had not made the court aware) that Bhakti and Daniyal may require a litigation friend within those proceedings. This is a matter for the Court, but it might strengthen practice locally for Council's legal teams to reach out (perhaps as through a local Court user forum or national adult safeguarding forums) to explore opportunities for the Court to engage, including through s42 processes, to enable joined up working and contingency planning where vulnerable adults are likely to be made homeless though private proceedings.

KLOE 5: Balancing safeguarding and wellbeing in a rights-based approach.

4.42. The Domestic Abuse Act 2021 clarified abusive behaviour that occurs between two people (16 or over) who are 'personally connected' to each other should now be responded to as domestic

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[43] Available at: https://www.39essex.com/sites/default/files/2024-06/Mental%20Capacity%20Guidance%20Note%20-%20Relevant%20Information%20for%20Different%20Categories%20of%20Decision%20May%202024.pdf and https://www.39essex.com/sites/default/files/2024-04/Guidance%20Note%20Capacity%20and%20Housing%20Issues%20May%202022.pdf

[44] Available at: https://www.39essex.com/information-hub/newsletter

[45] There were 3 handovers between JLT staff members from March 2023- Jan 2025.

abuse. Section 76 Serious Crime Act 2015 introduced offences linked to controlling and coercive behaviours requires '*repeated or continued behaviour that is controlling or coercive*'. CPS accompanying guidance warns prosecutors to explore if the actions cause substantially adverse impact on the victim including, but not limited to, physical or mental health deterioration and social isolation. They are also advised to be aware that '*the cumulative impact of coercive and controlling behaviours and the pattern of behaviour within the context of the relationship is crucial*.'[46]

4.43. All staff, including emergency responders, are commended for adopting a compassionate approach to both Bhakti and Daniyal. It is clear they were aware that interventions might also cause trauma, so looked to the s42 process or care management pathways to prevent harm. Whilst this was a reasonable decision, it should not have excluded consideration of multi-agency input to address controlling behaviours classified as domestic abuse. Responses to domestic abuse will always require a balance between duties to protect again abuse and respect of family and private life. So, correctly identifying circumstances as domestic abuse situations enables clarity on partner agencies roles and responsibilities to intervene.

4.44. BHFT and WBC's IMR identify missed opportunities to escalate concerns that Bhakti frequently blocked attempts by practitioners to speak with Daniyal and made threats to harm herself and him if agencies persisted to offer support. For example, in 2016 and 2017 following confirmation from Bhakti (or Daniyal in the presence of his mother) that he didn't have any needs WBC's CMHT closed their involvement despite previous agreement this met criteria for s42 adult safeguarding enquiry and concerns from DWP colleagues. Both should have required direct contact with Daniyal following the safe enquiry model. Contact between ASC and Bhakti throughout 2021-24 displayed similar patterns of obstructive controlling behaviour and, likewise, limited concerted effort to hear from Daniyal directly and independently from his mother. When approached independently, e.g. in 2023-4 Daniyal confirmed he 'couldn't speak' with practitioners. Though there is evidence within case files that this caused practitioners concern, it did not trigger escalation to verify if he could freely refuse social care or did not wish to pursue a housing application in his own name. Despite the familial relationship, this was not recognised as domestic abuse. Practitioners believed this failure arose, in part, due to gender and age bias.

4.45. Although no-one involved in this review believed a criminal justice response (e.g. Bhakti's arrest or civil injunctions) was proportionate[47], equally practitioners reported they felt a moral duty to seek resolution. They reported feeling frustrated by a lack of legal powers as this hadn't been characterised as domestic abuse. One participant spoke of how common this was and urged partners not to worry about a label- just name the behaviours they're concerned about.

4.46. The hope that risks could be mitigated via care management ultimately failed due to misperceptions that Bhakti understood the adverse impact of her behaviours had for Daniyal. As noted already, practitioners had not explained to Bhakti that she did not have legal authority to make decisions on Daniyal's behalf as there was no LPA or deputyship and her parental responsibility rights had ended. Whilst culturally this may have been difficult for her to accept, a balance-sheet approach would have ensured staff explain (in a manner they could both understand) that there are legal protections enshrined in MCA, MHA and Care Act to consult and consider family/ carer's views. There are also requirements that statutory interventions

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[46] Taken from CPS guidance (available at: https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship, accessed 03.10.23)
[47] As evidenced by reasoning set out within the draft witness statements prepared in May 2023.

promote wellbeing and, if someone lacks capacity, act in their best interest. Legislative powers also require a least restrictive approach.

4.47. Thereafter, as detailed above, partners should have agreed appropriate care and accommodation options that would safely meet their needs and, if possible, maintain their rights to family life. This had been considered (in 2021 by WBC's Housing Need team and within ASC's witness statement in 2023) but time had not been taken to draw up a balance-sheet of the benefits and risks or disadvantages to each of the options and the consequences of failing to make a decision. Nor had agencies attempted to communicate those to Bhakti and Daniyal. Consequently ASC's capacity assessment from July 2023 were legally flawed.

4.48. When Bhakti rejected WBC's Housing Need team offer of suitable accommodation in 2021. this should have triggered an immediate meeting involving ASC, health colleagues and legal input. The strategy meeting should have explicitly confirmed if, given what was known about their circumstances and on the balance of probabilities, statutory partners could legally defend a presumption that Bhakti and Daniyal could freely choose to refuse necessary care and treatment. In short, practitioners must always be live to the likelihood to when matters need assistance from the Court of Protection. This should never be an option of last resort.

4.49. The senior social worker who prepared the Court application was experienced in such applications and understood how the Court weighed up evidence to also apply the least restrictive approach. It was for this reason they had sought only an order to facilitate more comprehensive assessment. They rightly understood, even if the first application was successful, the Court would likely be required to adjudicate best interest options for both Daniyal and Bhakti in the future which is why it was necessary to transfer the matter to a long-term ASC team. Other practitioners involved in this review explained there isn't much exposure to Court applications in the context of adult safeguarding. Civil powers or criminal sanctions to seek redress for victims of domestic abuse were understood but, if considered, had been dismissed. Similarly, powers to compel an in-patient admission for either Daniyal or Bhakti under MHA were not triggered, but consideration could have been given to Guardianship (s7 MHA) to require that they reside at a specified place, attend for the purposes of medical treatment or require access where they are residing to a medical practitioners, AMHP or other specified person (s8 MHA). Similarly, as identified above, ASC could have arranged specified accommodation using s8 and s18 Care Act powers in combination with MCA principles.

4.50. Since this review period WBC report they have reviewed their risk register and high-risk panel process to improve senior management oversight. They have also planned in-house training to ASC staff on the application of MCA duties within the family context to improve responses to intrafamilial family abuse. Bitesize recorded learning sessions will be made available on their learning hub. They have also reviewed case allocation, reflecting that it is often necessary to allocated separate social workers to individuals within the same family and that this should always occur where there are behaviours which give rise to domestic abuse concerns.

5. Conclusions

5.1. In response to KLOE 1 the review found there were too few attempts at holistic assessments as MDTs and strategy meetings were not multi-agency. The GP (who had decided not to re-deregister Bhakti despite her moving far out of the catchment) was not included in care planning and was unaware Daniyal resided with his mother and was without access to a GP. Diagnosis pathways are prescriptive. They are also confusing as different local authorities within WBSAB have rightly commissioned different services in line with differing budgetary obligations and to meet the needs of their local population. Whilst these different pathways and service criteria may be understood at strategic level, some of the disconnect seen in this case implies insufficient consideration is given to reasonable adjustments, proactive support or preventative action by health partners for adults at risk of abuse (Daniyal) or neglect (Bhakti).

5.2. There was good practice by emergency responders and WBC's assessment team in seeking an order from the CoP. But between 2016-2023 and once the matter moved to ASC's Support and Brokerage (Long Term) team, consideration wasn't given to legal powers which could have enabled the holistic assessment or achieve a least restrictive intervention to avoid foreseeable harm. As noted within this review, there is scope for partners to work more effectively together to enable holistic, multiagency assessment and care/treatment planning.

5.3. Likewise, the pathways and decision-making between teams responsible for securing suitable accommodation for adults at risk was confused (KLOE 2). Sadly, the most suitable option (a 2-bed sheltered accommodation flat) had been identified in September 2021, but the Housing Needs team could not resolve this complex case in isolation. It required input from health and social care as the relevant legal frameworks (either s7-8 MHA or MCA) provided the least restrictive suitable options to impose care in Daniyal and Bhakti's best interest. The Housing Needs team's conclusion that Bhakti lacked capacity was reasonable and should have been understood by ASC colleagues to have triggered their duties. ASC could have used s42 safeguarding adults procedures to agree a multi-agency strategy with police and health input, given concerns regarding controlling (intra-familial domestic abuse) behaviours.

5.4. There are examples of good, culturally sensitive practice throughout the review period. However, as responses between 2016-22 were universally conducted under emergency/ crisis or safeguarding pathways this lacked the longitudinal overview which hindered classification of controlling behaviours as domestic abuse. Daniyal's position as a victim of controlling behaviours was not recognised and Bhakti's understanding of cultural expectations within the UK was not tested. This frustrated assessments of their cultural knowledge and the impact this had on her decision-making.

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5.5. ASC's and JLTs initial work to secure an order from the CoP was good. However, the delay by JLT in issuing proceedings was not explained either at the time or to this review. JLT record keeping did not meet expectations. Legal advice was not proactive in supporting ASC to find solutions and poor managerial oversight of matters allowed the case to drift. JLT and ASC identified improvements undertaken since to ensure senior managers have greater oversight to prevent a reoccurrence, but improvements are needed to the process for legal strategy meetings to enable these to consider safeguarding duties in the round and build in opportunities to include expertise from relevant partners and other local authority departments.

5.6. Whilst partners reported Bhakti's behaviours as coercive, failure to categorize these as domestic abuse made it harder for practitioners to balance safeguarding duties with their obligations to respect family and private life. Too much weight was placed on the qualified article 8 right to respect for family and private life without due regard given to if it was necessary (in a democratic society and for the protection of rights and freedoms of others) to intervene in accordance with the law. There were too few examples of good legal literate decision-making[48]. WBC and health partner organisations should urgently explore how they can improve legal literacy so that practitioners understand they must provide cogent reasons for ending involvement whenever there is reasonable cause for concern that an adult with care and support needs is experiencing, or at risk, of abuse and neglect and there are concerns that may be unable to protect themselves.

6. Recommendations

6.1. WBSAB should review their adult safeguarding policy and procedures to clarify criteria for when partners would be expected, firstly to collate a case chronology and make this available either as part of the concerns referral or for strategy discussions. Secondly revised

[48] Namely Housing Needs team's conclusion she lacked capacity, and, in 2023, the senior social worker's application to the Court of Protection

policy should specify when and how to convene a multi-agency strategy meeting. Partner agencies should provide assurance to WBSAB that their internal operating procedures and safeguarding adult policies and training programmes have been updated to reflect the revised WBSAB policy and confirm, through quality assurance audits, practice is improved so chronologies and strategy meetings are now routine.

6.2. A) WBSAB, working with partner agencies, prepare briefings to improve legal literacy across the workforce regarding:

- intra-familial domestic abuse,
- the interface between statutory duties (Housing and ASC) to provide suitable accommodation,
- health services and partners work together through multi-agency forums to ensure adults with care and support needs can access diagnostic pathways.

B) Drawing on learning from this review, briefings should detail practical arrangements for parallel planning and highlight cultural norms (and the rationale behind these) within the UK to ensure adults at risk have access to housing, health and social care.
C) Briefings should detail how multiagency forums, WBC's high-risk panel and s42 adult safeguarding processes interface to address concerns regarding family members blocking access and how these panels can access legal advice.

6.3. The ICB should explore if there is scope for a system-wide adoption of the good practice by the GP to review their patient list to identify patients over 80 where there was no contact within 12 months so that outreach support can be offered.

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6.4. Similarly, ICB working with WBSAB partners, should seek agreement on a local protocol to resolve issues of GP registration where there have been persistent safeguarding concerns and risk that the adult cannot access diagnostic pathways without a GP remains.

6.5. WBC and JLT should review their operational procedures and provide assurance to WBSAB that these permit flexibility for management regarding reallocation or transition between teams or allocated workers during the initiation of Court Proceedings.