social care
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Safeguarding Adult Review "Daniel"

Commissioned by Richmond and Wandsworth Safeguarding Adult Board

Independent Reviewers:

Sheila Fish (SCIE) and Eliot Smith

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By Richmond and Wandsworth SAB

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1 Introduction

1.1 WHY THIS CASE WAS CHOSEN TO BE REVIEWED

The Care Act (Para. 44) states as follows:

> ***44 Safeguarding adults reviews***
>
> (1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—
>
> (a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
>
> (b) condition 1 or 2 is met.
>
> (2) Condition 1 is met if—
>
> (a) the adult has died, and
>
> (b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).
>
> (3) Condition 2 is met if—
>
> (a) the adult is still alive, and
>
> (b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.
>
> (4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

1.1.1 In the case of Daniel, it was felt that his case met the criteria for a mandatory Safeguarding Adults Review under section 44 Care Act 2014. The Safeguarding Adults Board reached this conclusion as self-neglect was felt to have played a part in Daniel's death. Daniel died as a result of a brain haemorrhage following an epileptic seizure. There were concerns about how agencies worked together to support Daniel in the context of dependent alcohol consumption, non-concordance with medication, and global self-neglect.

1.2 SUCCINCT SUMMARY OF THE CASE

1.2.1 Daniel, a white British man, died at the age of 36-years-old. He had historical diagnoses of asthma, attention deficit hyperactivity disorder (ADHD), mild learning disability, and epilepsy. Daniel was also believed to have suffered head injuries. Daniel was known to drink alcohol excessively, and consumed alcohol to a level of dependency. Daniel suffered from depression and low mood, and had experienced trauma, loss, and bereavement in his life. Prior to the start of the period under review Daniel had been victim to financial exploitation and cuckooing. Daniel's mother had died, and, in his 20's, he lost a partner who died after having a seizure in the bath.

1.2.2 At the start of the review period Daniel was in his early 30s and had been living in his own tenancy, drinking heavily, and had been admitted multiple times to hospital after taking overdoses of prescribed medication in the context of alcohol intoxication. Following one particular admission Daniel was discharged into residential care, and from there into supported living.

1.2.3 Over time Daniel began to disengage with services and with treatment. There were concerns about his ability to sustain his tenancy, use of alcohol, non-concordance with medication and the neglect of his room and himself. Daniel's room in the supported living project was described as dirty, infested with flies, empty beer cans, and vermin.

1.2.4 The agencies working with Daniel attempted to engage with him, professionals' meetings and network meetings were held, and referrals were made to safeguarding and the local Community Multi-Agency Risk Assessment Panel (CMARAP). Referrals were also made for mental health assessment. On 2 August 2018 Daniel had an epileptic seizure at home and died from a brain haemorrhage. Daniel's case has been the subject of a Coroner's inquest and an initial review under the Learning Disabilities Mortality Review (LeDeR) Programme. The initial review compiled chronological information but did not identify any evidence of abuse or neglect, systems issues, gaps in services, significant safeguarding concerns, or best practice. The initial review did not identify any learning, nor indicate that further multi-agency review should be considered.

1.3 METHODOLOGY, PERIOD UNDER REVIEW AND THE RESEARCH QUESTIONS

1.3.1 The purpose of a SAR is to provide findings of practical value to organisations and professional for improving the reliability of safeguarding practice within and across agencies (Care Act Guidance Para 14.178), in order to reduce the likelihood of future harm linked to abuse or neglect, including self-neglect.

- To promote effective learning and improvement to services and how they work together,
- To learn lessons about how the local safeguarding system works that will help to reduce the likelihood of future harm,
- To understand what happened and why.

1.3.2 The SAB decided to use SCIE's tried and tested Learning Together model for reviews to conduct this SAR (Fish, Munro & Bairstow 2010). Learning Together provides the analytic tools to support both rigour and transparency to the analysis of practice in the case and identification of systems learning.

1.3.3 The time period under review was from 13 October 2017 when Daniel was seen for an assessment until his death at home on 2 August 2018.

1.3.4 The use of research questions in a Learning Together Review is equivalent to Terms of Reference and describes the key lines of enquiry the Safeguarding Adults Board are interested in reviewing to learn more about the system and what can be done differently. research questions provide a systemic focus for the review, seeking generalisable learning from the single case. The research questions agreed for this review were: What can we learn from Daniel's case about what is helping and/or hindering practitioners to:

- assess mental capacity and have regard for the Mental Capacity Act 2005 when working with people who self-neglect and use substances; and
- work together effectively to support people who use substances who do not want to engage with support services?

1.4 A COLLABORATIVE, SYSTEMS-FOCUSED WORKSHOP

1.4.1 Daniel was well-known to services in Wandsworth, and a number of organisations made the commitment to engage in the Safeguarding Adults Review. A practitioner workshop was held and was well-attended. The meaningful engagement of practitioners, contributing to the review without fear of blame for actions taken in good faith enhanced the quality of the evidence provided to the reviewers, adding a richness of experience that was able to offer valuable insights into Daniel's experience of receiving care and support in Wandsworth.

1.4.2 The practitioner's workshop was structured around Key Practice Episodes (KPEs) that had been identified and prepared in advance from evidence and chronology data provided by organisations involved in Daniel's care. The practitioners and reviewers worked through the key practice episodes during the workshop, evaluating what went well and where responses could have been differently and exploring factors that influenced actions and decision making at the time. In addition to reflecting on the details of the case, participants were also supported looked to identify any generalisable issues that impacted on the case in the past and continue to impact on contemporary practice. In this way, the reviewers seek to identify findings that apply to the system more widely and enable to Safeguarding Adults Board to act "to prevent future deaths or serious harm occurring again" (DHSC, 2020).

1.5 BUILDING SENIOR LEVEL OWNERSHIP OF SAR SYSTEMS FINDINGS THROUGH THE PROCESS

1.5.1 Effective systems learning in Safeguarding Adults Reviews benefits from the engagement with senior representatives from the agencies who were involved in

the case. This “review team” plays an important role in bringing wider intelligence to the SAR process in order to ascertain which issues are case specific only, and which represent wider trends locally. Their ownership of the review findings is crucial.

1.6 INVOLVEMENT AND PERSPECTIVES OF THE FAMILY

1.6.1 The family were contacted, however did not wish to be involved in the review.

1.7 REVIEWING EXPERTISE AND INDEPENDENCE

1.7.1 The review was led by Dr Sheila Fish, Head of Learning Together at SCIE, and Eliot Smith, an Independent Health and Social Care Consultant. Both are independent of all services in Richmond and Wandsworth. Sheila is an experienced reviewer across children’s and adults. She also trains, accredits, and supervises reviewers. Eliot is an experienced reviewer and by background a Social Worker. Eliot has worked in Local Authority and NHS safeguarding.

1.8 STRUCTURE OF THE REPORT

1.8.1 The remainder of the report is structured around an appraisal of professional practice in the case, and the generalisable systems findings.

1.8.2 The appraisal of practice provides an overview of what happened in the case, exploring the context and practice environment in which professionals and organisations worked. The practice in the case is evaluated against the prevailing standard of the day – identifying where practice met or exceeded expectations, or fell short, and examining why.

1.8.3 The systems findings that have emerged from the SAR are then explored. Each finding also lays out the evidence identified by the Review Team that indicates that these are not one-off issues. Evidence is provided to show how each finding creates risks to other adults in future cases, because they undermine the reliability with which professionals can do their jobs.

2 Appraisal of professional practice in this case

2.1 BRIEF TIMELINE OF THE PERIOD UNDER REVIEW:

Oct-Nov 2017	• Admission to A&E and hospital following overdose, alcohol use. Discharged to residential care pending supported housing • Supported by alcohol services
Nov 2017 - Feb 2018	• Attending and engaging in alcohol breakfast club • Living in residential care pending supported living • Working towards residential detox
Feb 2018	• Move to Supported Housing project
March 2018	• Reluctant to surrender previous tenancy • Disengagement: not attending breakfast club and cancelling visits, including with father • Signs of deterioration: falls and injuries in flat (maybe in the context of alcohol?)
May-June 2018	• Continued avoidance and disengagement • Self-neglect • Accommodation deemed unsuitable • Stated "has capacity" • Request for mental health referral
June-July 2018	• Continued avoidance and disengagement • Self-neglect • Accommodation deemed unsuitable • Stated "has capacity"
July-Aug 2018	• Attempts to engage • Assault on another resident • Request / for MHA assessment • Died on 02/08/2018

2.2 IN WHAT WAY DOES THIS CASE PROVIDE A USEFUL WINDOWN ON OUR SYSTEM?

2.2.1 The review period begins after an admission to hospital and breakdown in previous independent accommodation. By this point Daniel was reporting up to five seizures per week and had been admitted to the Emergency Department on numerous occasions having taken overdoses of prescribed medication in the context of alcohol intoxication. After a number of admissions Daniel was admitted to a ward and a search for supported living placement was started. In the meantime, Daniel was discharged to a residential care setting where things seemed to improve. He later moved into a supported living project where his engagement with professionals deteriorated, and concerns of self-neglect were identified.

2.2.2 At the heart of this case was a focus on disengagement and self-neglect, which limited the effectiveness of agencies trying to support Daniel with his co-existing conditions.

2.2.3 The case of Daniel provides an opportunity to consider how professionals seek to engage with individuals whose decisions may be seen as unwise, and where complicating factors, such as dependent drinking, may have a negative impact on individual's concordance with medication treatment, advice, and support, with serious outcomes for health.

2.3 APPRAISAL SYOPSIS

2.3.1 Daniel's admissions to hospital and the breakdown in his accommodation prompted a change in approach for professionals. There were concerns about Daniel's self-neglect in his private tenancy and vulnerability to exploitation by others. In addition to this Daniel had other motivations to move, he had known a local person who had been stabbed, the door to his property was broken, and a deep clean was required. Daniel's first wish was to return to his property after a clean of the environment and repair to the broken front door. There were concerns among professionals about his safety and in this context, Daniel's social worker formulated a plan to look for a supported living placement.

2.3.2 In the interim Daniel was encouraged to accept a place in a residential care home. Daniel accepted this on the basis that it would be temporary, and to avoid a return to his previous housing.

2.3.3 On the face of it, Daniel's time at the residential care home was successful. During this period, he attended a local breakfast club[1] where he could meet others, have some food, and social interaction. While in residential care the number of hospital admissions reduced, with fewer episodes of harm, overdose, and accidental injury. Daniel engaged with professionals and there were fewer concerns about self-neglect and non-concordance with medication. But his

[1] The breakfast club was a contemplative service for individuals who used alcohol, and who considered 'change-resistant'.

placement was not without challenge, and benefits were achieved through significant interventions from staff. Daniel continued to drink, and staff of the care home would have to go out and find him. Daniel struggled with the loss of personal freedoms and autonomy and repeatedly expressed the desire to move to his own place. During this period Daniel's social worker received almost daily calls from Daniel chasing a move-out date.

2.3.4 The view of professionals at that time was that they did not want to close the door on high-level care. While Daniel was keen to move out and achieve a greater level of independence professionals were asking themselves and Daniel *"what was the highest level of support that [he] would accept?"*, no options were ruled out, and Daniel was offered, and supported to make a decision between a return to his own flat, a move to supported living, or a placement in a residential care home. This demonstrated a responsive and person-cantered approach. Daniel was genuinely influential in his support planning and the plan to move to supported living was made collaboratively and together. Nonetheless, this approach demonstrates the role of negotiation and persuasion. Daniel initially wanted complete independence, while his Social Worker sought better outcomes for Daniel and was also acting under a protection imperative, and balance of community need and public health. Ultimately Daniel accepted the idea of supported living, but there was limited exploration of what a good life would look like. The supported living placement secured was also a compromise as a project for individuals with learning disability. It was known that Daniel did not identify himself as having a learning disability, which may have limited the potential of the placement to offer a full and meaningful inclusion and integration into community. Security and success of tenure appears to have been the priority.

2.3.5 After the stabbing, Daniel was keen to move, and wanted autonomy and independence – he wanted his own front door. Visits were carried out to the supported living project, and Daniel was keen to move. During the transition period Daniel continued to engage with support workers, his social worker, and the breakfast club for a time.

2.3.6 Around this time Daniel received a back-payment of benefits. This gave Daniel greater financial freedom which he wanted to enjoy – he stated he was going to enjoy this freedom for 1 month and then re-engage with alcohol treatment and prevention services at that point.

2.3.7 However, professionals and the staff at the project began to notice a decline in engagement. Daniel remained in contact but began to cancel or avoid appointments. Professionals noticed an increase in use of alcohol, including drinking in his room (despite this being against the house rules). Daniel was also allowing visitors – while not letting know staff about who they were. The response by Daniel's project workers, alcohol support worker, and Social Worker was to continue to attempt to make contact and to offer flexible appointments and locations – to go for coffee, and to offer additional support through flexible Direct Payments (declined by Daniel).

2.3.8 In March 2018, a professionals meeting was called, and the following month a network meeting that included Daniel and his father. By May 2018 there was a shift in professional thinking. Daniel had begun to accumulate rent arrears, had

entered a prolonged period without contact with support workers or professionals involved in his care, and was non-concordant with medication. His room was also reported to be in a state of neglect. A decision was made to escalate the case to a Community Multi-Agency Risk Assessment Panel (CMARAP) although no meetings or panels took place. The decisions to escalate to at least a CMARAP (if not safeguarding) was an appropriate as an earlier multi-agency process may have allowed for more timely escalation to GP, or mental health. That no meetings took place seemed to have been a sign that the professionals involved were less confident in the use of the legal frameworks underpinning multi-agency processes, or in the processes themselves. While this seems to have disincentivised practitioners from persevering with the CMARAP or Safeguarding, there is evidence from the review team that those multi-agency processes are able to act as a conduit for information sharing – that the CMARAP can be a good source of intelligence about a case and offer the opportunity for a greater number of minds to work together to seek solutions to dilemmas in practice. The failure to bring Daniel's case to the CMARAP or safeguarding enquiry was a missed opportunity.

2.3.9 In June 2018 the view of the Multi-Disciplinary Team was that through Daniel's continued disengagement, his case had progressed, and risks had increased. At this time there was a tangible shift in professional perspective. His accommodation was no longer deemed suitable, and concerns had escalated about its unsuitability – that the other residents had diagnoses of learning disability, but that Daniel did not. A mental health assessment was sought, and Daniel's local GP attempted to see him at home. Finding the door closed but unlocked, the GP managed to make contact with Daniel but found him to be angry and refusing contact. The GP noted that he was neglecting himself and drinking heavily. The flat was reported to be *"in a state, knee deep in beer cans, full of flies and very odorous"*. Support staff also stated that there were vermin (rats) and that he had refused support to clean his environment. The response to these concerns was appropriately to raise a safeguarding referral, and a request was also made to local mental health services for a formal assessment of Daniel's mental health. This was received as routine by the mental health team – despite the safeguarding concerns.

2.3.10 Concerns throughout the review period centred upon self-neglect, disengagement, use of alcohol, and on outcomes for physical health. Apart from an attempt to work with Daniel's father, there were limited attempts to work with Daniel's wider family or social network, and a lack of weight given to historical issues of loss, trauma, and psychological needs. Decisions and interventions were too focused upon the presenting issues and current situation, but were not adequately history-informed, or focused upon underlying reasons for Daniel's previous low mood, overdosing behaviours, or use of alcohol.

2.3.11 Professionals were concerned about Daniel's low weight and non-concordance with medication. Professionals regularly considered Daniel's mental capacity and ability to make decisions and took the view that his addiction and use of alcohol resulted in fluctuating mental capacity that became finely balanced in the context of the value Daniel placed upon autonomy and independence. Mental capacity in relation to drinking and self-neglect was regularly discussed and reflected

upon in network meetings and professionals' meetings, with the dilemma recognised between rights and autonomy, and that more forceful interventions would have proved against Daniel's known views and wishes.

2.3.12 Judgements on Daniel's mental capacity (that he had mental capacity in relation to drinking, medication, engagement, and self-care) were also seen as a barrier to safeguarding – meetings could be held, and the offer of *"the most appropriate treatment possible"* could be made, but that there were limited interventions against the person's wishes. These perceived limitations explained the escalation to a request for assessment for admission to psychiatric hospital under the Mental Health Act 1983 – a piece of legislation that would allow professionals to admit Daniel for treatment, even against his wishes, and without his consent.

3 Systems Findings

The review has identified the following findings for the Safeguarding Adults Board to consider:

	Finding
1	**FINDING 1: Approaches to multiple vulnerability and alcohol use in homelessness** A sequential approach to multiple needs and problem drinking in the context of homelessness, is standard across agencies. This means that services focus on practical aspects of homelessness, and then alcohol use without tackling other vulnerabilities including childhood conditions, loss, bereavement and recent experiences of abuse and exploitation. Such an approach risks responding to symptoms and not causes, undermining the potential effectiveness of professionals' efforts.
2.	**FINDING 2: The importance of 'developing and maintaining family or other personal relationships'** In the formulation and assessment of need, there is insufficient weight given to developing and maintaining family and personal relationships as a step towards a good life for everyone. This increases the risk of a stand-off between the person and professionals about their safety, rather than jointly focusing on factors critical to their happiness.

3.1 FINDING 1: APPROACHES TO MULTIPLE VULNERABILTY AND ALCOHOL USE IN HOMELESSNESS

A sequential approach to multiple needs and problem drinking in the context of homelessness, is standard across agencies. This means that services focus on practical aspects of homelessness, and then alcohol use without tackling other vulnerabilities including childhood conditions, loss, bereavement and recent experiences of abuse and exploitation. Such an approach risks responding to symptoms and not causes, undermining the potential effectiveness of professionals' efforts.

3.2 CONTEXT

3.2.1 System responses to individuals with complex or multiple needs often follow a task-centred approach. There exists in safeguarding and in social care an approach which tends to prioritise a hierarchy of need, and favours solutions to problems that can be solved. When faced with social needs, alcohol misuse, and the threat of homelessness, many social care approaches follow a crisis intervention approach.

3.2.2 Assessments of need within acute and urgent care, or in moments of crisis can focus upon interventions that will mitigate and reduce risk in the short-term. Solutions tend to address immediate and pressing needs, to achieve a sense of equilibrium – addressing the crisis, where crisis is "an upset in a steady state, a moment when our usual coping resources are overwhelmed" (Thompson, 2002).

3.2.3 There are currently limited alternative options when crises occur in relation to a situational issue (risk of homelessness) in the context of self-perpetuated risk, alcoholism, or self-neglect. Therefore, an approach focused on immediate practical solutions often fails to address underlying causes of maladaptive coping resources, or the impact of previous crises, historical traumas, or hidden vulnerabilities and health conditions.

3.3 HOW DID THE FINDING MANIFEST IN THIS CASE?

3.3.1 Daniel had multiple vulnerabilities and underlying health conditions which were known of, but a striking feature of this case is the way in which they appeared to be hidden from view in the focus by professionals on the most pressing needs of threat of homelessness and problem drinking.

3.3.2 The documentary chronology of events and interventions focuses primarily on resolving concerns of recent abuse and trauma, including self-neglect, and dependent drinking. At the start of the review chronology Daniel had been admitted to hospital and offered intensive treatment for alcohol misuse, including vitamin injections and anti-epileptic medication. Daniel's independent tenancy was at risk, his front door was open, and the property was in need of a deep clean. There had also been concerns of cuckooing, exploitation, and abuse.

3.3.3 Practical solutions were found and presented to Daniel – medical treatment for alcohol dependency, alternative accommodation in the form of supported living, and a temporary placement into residential care in the interim. Daniel also had

the opportunity to attend the breakfast club – a place to meet and talk, and have some food, with a focus on alcohol harm-reduction rather than cessation or moderation. Throughout the chronology period agencies offered practical support and engagement, while noting the risks of increased alcohol consumption, re-introduction of 'unknown' friends, non-concordance with medication, and environmental deterioration.

3.3.4 It was not until the practitioner's event held as part of this SAR, that a more complete picture of Daniel's life and experiences could be seen. Professionals involved had known of Daniel's underlying health conditions that had been identified in his childhood – diagnoses of mild learning disability and attention deficit hyperactivity disorder (ADHD). But these did not result in any proactive treatments or adaptation of engagement approach. Similarly, Daniel's experiences of bereavement linked to the losses of firstly mother, and also, the unexpected death of a previous partner, had not been incorporated into the understanding of his needs. Further, once alternative accommodation had been found there were no attempts to repair or remedy the effects of trauma, abuse, and exploitation that Daniel had experienced most recently.

3.4 HOW DO WE KNOW IT'S UNDERLYING AND NOT A ONE-OFF?

3.4.1 As part of the review process, we discussed the extent to which this focus on practical needs over and above addressing other conditions and trauma even after crisis issues are addressed, was unique to Daniel's case. There is a general feeling among the agencies involved in the review that there is a tendency to take a practical focus when approaching cases such as Daniel's. It is the nature of human relationships that individuals may have a long and complex personal and social history. When working with people with care and support needs, practitioners will often take a practical approach – assessing presenting needs and offering the service that the person will accept. When people may be at significant risk of harm, as a result of their care and support needs, or presenting behaviours, a practical response to immediate and current needs is commonly the default.

3.4.2 Further input from the review team highlighted that drug and alcohol services Recovery Worker roles are intended to form a therapeutic relationship. Motivational interviewing is being embedded widely as an attitude. There are psychological clinics held where cases can be brought for discussion. This is part of supporting psychologically informed treatment.

3.4.3 Among wider partners however, factors that contributed to this focus on practical needs. These included a varying level of history taking across agencies as well as selective sharing of that history with some agencies but not others, for example housing. In addition, Regenerate and Adult Social Care highlighted the amount of time available to spend with people as a very limiting factor in being able to engage with someone's history and legacy thereof.

3.5 HOW WIDESPREAD AND PREVALENT IS THIS AS SYSTEMS FINDING?

3.5.1 We have done limited research on how widespread this finding is, and would assume it is common across London boroughs, and probably nationally. It will potentially affect all people who draw on services who are facing immanent risks related to problem drinking, including homelessness.

3.6 SO WHAT? WHY SHOULD THE SAB AND PARTNERS CARE?

3.6.1 A sequential-needs approach which focuses only on providing a practical response to immediate and pressing housing needs may fail to address underlying issues and vulnerabilities. The impact of adverse childhood experiences, and trauma more generally indicates that the psychological effects of historic and recent experiences and abuse can endure beyond the resolution or mitigation of risk. Effective information-sharing that results in a holistic understanding of an individual can result in assessments of need that incorporate the influence and impact of history. Psychologically informed services will be far more effective in tackling longitudinal problems of homelessness and alcohol addiction than those that follow a simple sequential approach to tackling presenting needs and resolving current crises.

FINDING 1: APPROACHES TO MULTIPLE VULNERABILITY AND ALCOHOL USE IN HOMELESSNESS

FINDING 1: A sequential approach to multiple needs and problem drinking in the context of homelessness, is standard across agencies. This means that services focus on practical aspects of homelessness, and then alcohol use without tackling other vulnerabilities including childhood conditions, loss, bereavement and recent experiences of abuse and exploitation. Such an approach risks responding to symptoms and not causes, undermining the potential effectiveness of professionals' efforts.

SUMMARY OF SYSTEMIC RISKS

The issues of homelessness and alcohol addiction should be viewed through a conception of need that goes beyond immediate and practical, with solutions that recognise the long-term impact of homelessness for those who are housed, and of alcohol addiction for those in recovery. Systems that fail to identify and address the underlying causes and experiences of individuals, however complex, are well designed to improve an individual's immediate circumstances, and safety, and may provide a foundation for further work, but increase the risk that an individual will be supported to tackle psychological outcomes, to learn from crises, and to develop future resilience.

QUESTIONS FOR THE SAB TO CONSIDER:

3.6.2 What would enable practitioners working with people facing homelessness and problem drinking, routinely to seek an understanding of a person's history including childhood conditions, loss, bereavement and recent experiences of abuse and exploitation?

3.6.3 Is any work across partnerships currently focused on enabling a psychologically informed approach to be at the forefront of practitioners' minds even when responding to crises?

3.6.4 Are pathways and service provisions for repair or remedy of the effects of trauma, abuse, and exploitation available, known and/or adequate?

3.6.5 How would the SAB know if there was improvement in this area?

3.7 FINDING 2: THE IMPORTANCE OF 'DEVELOPING AND MAINTAINING FAMILY OR OTHER PERSONAL RELATIONSHIPS'

In the formulation and assessment of need, there is insufficient weight given to developing and maintaining family and personal relationships as a step towards a good life for everyone. This increases the risk of a stand-off between the person and professionals about their safety, rather than jointly focusing on factors critical to their happiness.

3.8 CONTEXT

3.8.1 The Care Act 2014, in addition to consolidating and modernising existing care and support law, sought to introduce a more holistic and personalised approach to "helping people achieve the outcomes that matter to them in their life" (DHSC, 2020).

3.8.2 To achieve this the Act introduced a set of principles and duties in relation to the concept of well-being and gave local authorities a general duty to promote an individual's well-being.

3.8.3 Section 1 Care Act 2014 sets out a definition of well-being that is broad and encompasses personal dignity and autonomy, self-determination and participation, community engagement, relationships, and principles of prevention and protection.

3.8.4 The intention of the Care Act goes beyond simple assessment and service provision to meet practical or physical needs, but embraces concepts of lives worth living, societal participation, and the creation of a 'good' life captured by the #socialcarefutures movement as follows: "We all want to live in the place we

call home, with the people and things we love, in communities where we look out for one another, doing what matters to us (https://socialcarefuture.org.uk/)

3.8.5 An important part of legislative consolidation was to combine existing assessment duties and powers with the standardisation of eligibility criteria comprising of gateway needs and outcomes.

3.8.6 In practice, many findings about legal literacy have focused on identifying and articulating the legal mandate for interventions, under safeguarding, or mental health or mental capacity law, even those that have a greater impact on personal freedoms and autonomy. In situations of risk, decisions and interventions may be motivated by a protection imperative focused on meeting basic or physical needs and ensuring safety, while giving less weight to 'higher' psychological or self-actualisation needs (Maslow, 1970). Research in child social care has shown that *"taking a systematic approach to enquiries using a conceptual model is the best way to deliver a comprehensive assessment for all children"* (HM Government, 2018). The assessment framework referenced in Working Together guidance views the welfare and safeguarding of children through the domains of basic needs (parenting capacity), family and environmental factors, and psychological needs (developmental needs). The advantage of this model is the representation of these domains as equally important, in a way that has been accessible to practitioners, and with the placing of the child at the very centre of their life – past, present, and future.

3.8.7 The growing Social Care Futures movement, and the initiatives it has represented since the enactment of the Care Act 2014 demonstrate that there is still some progress to be made in recognising the importance of outcomes in relation to relationships, community engagement, inclusion, and full societal participation – including work, training, education, or volunteering.

3.9 HOW DID THE FINDING MANIFEST IN THIS CASE?

3.9.1 In the assessment of his needs and the provision of services to Daniel there remained a focus on practical outcomes and basic needs. Finding 1 focused on the lack of focus on Daniel's history including childhood conditions and non-recent as well as recent abuse, bereavement and exploitation. This finding highlights that lack of emphasis evident on identifying and supporting Daniel to develop and maintain personal relationships or identify community facilities to support engagement in building a new life to accompany his new start. There is no doubt that this would have been challenging in the context of Daniel's engagement (or disengagement) style, and fierce independence, however these issues themselves may have been a product of an approach that was not quite giving him what he really needed.

3.9.2 On initial evaluation, Daniel's period on residential care was positive – he engaged with professionals, was more reliable at attending the breakfast club and keeping appointments, was concordant with medication, and many of his practical outcomes were well-met. However, this came at a cost. In order to maintain this placement and meet a duty of care, staff would locate Daniel when he had been drinking and return him to the care home, Daniel was unhappy at being in a care home, and made daily calls to ask for a move. When he did move,

it was to a project for people with a learning disability – a cohort of peers that Daniel did not identify with as he was not viewed as a person with a learning disability.

3.9.3 These interventions and services would have met practical needs, basic needs, duty of care, and a protection imperative – Daniel was safe – but they failed to support him to engage or participate in a community he could connect with, nor (notwithstanding his close relationship with his father) develop or maintain a wider network of family and personal relationships.

3.10 HOW DO WE KNOW IT'S UNDERLYING AND NOT A ONE-OFF?

3.10.1 Discussions during the review process of family and activities related to this case, suggested an embedded approach. Family and personal relationships tended to be through the lens of risk – viewed as either protective (family) or risky (previous 'undesirable' friends, or people who had been exploitative), rather than as the fundamental building blocks of a fulfilling life.

3.10.2 Interventions and activities offered through the placement were viewed as "organised" by Daniel and rejected. There was apparently little exploration of Daniel's likes, or ambitions, or of where he may feel a better fit. Other social opportunities were linked to Daniel's alcohol use, such as the breakfast club, another place where Daniel felt he did not fit in.

3.10.3 Discussion about this finding more widely tended to anchor in issues of information sharing and consent about engaging with family members, rather than linking to questions of Daniel's inclusion and connectedness in the wider community.

3.11 HOW WIDESPREAD AND PREVALENT IS THIS A SYSTEMS FINDING?

3.11.1 The development and creation of such initiatives as Social Care Futures, Triangle of Care, and others highlights the national prevalence of this issue and the need for to reframe the narrative about social care to an emphasis on people of equal worth leading lives of value that they choose to lead as part of a reciprocal web of community-based support.

3.11.2 Input from the review team highlighted that in some areas of provision, there is more focus on enabling people who draw on services to have a good life. For example, in Shared Lives arrangements there is a requirement that the Support Plan includes access into community services and how that goal is going to be put into practice.

FINDING 2: THE IMPORTANCE OF 'DEVELOPING AND MAINTAINING FAMILY OR OTHER PERSONAL RELATIONSHIPS'

In the formulation and assessment of need, there is insufficient weight given to developing and maintaining family and personal relationships as a step towards a good life for everyone. This increases the risk of a stand-off between the person and professionals about their safety, rather than jointly focusing on factors critical to their happiness.

SUMMARY OF SYSTEMIC RISKS

The ambition of the Care Act is that social care makes a major contribution to everyone's wellbeing. This means going beyond simple assessment and service provision to meet practical or physical needs, and embracing the vision of lives worth living, societal participation, and the creation of a 'good' life. This finding highlights how the basic approaches of ASC assessment and formulation of need, does not yet match this vision or support this ambition. It creates a systemic risk that in circumstances where people are putting themselves at risk, professionals reach for any legal framework that will legitimise interventions, rather than enabling them to work in a more humble way with the person drawing on services to understand what sort of 'good life' and happiness they want to achieve.

3.12 QUESTIONS FOR THE SAB TO CONSIDER:

3.12.1 To what extent is the SAB championing the wider ambitions of the Care Act around well-being?

3.12.2 How can practitioners be supported to think more widely about Care Act outcomes?

3.12.3 How can 'community outcomes' be better integrated into Adult Social Care approaches and tools?

3.12.4 How can practitioners be supported to have conversations about the option of a Family Group Conferences without jeopardising relationships, where the person and/or relative(s) are initially reluctant?

3.12.5 Is there good practice in other London boroughs that could be drawn on?

3.12.6 How would the SAB and partners know if there was improvement in this area?