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Safeguarding Adult Review (SAR) Adult G: Executive Summary

1. OVERVIEW

About the Safeguarding Adult Review

The Doncaster Safeguarding Adult Board Case Review Subgroup (DSAB CRG) decided on 26th April 2023 that the circumstances in relation to the death of Adult G met the criteria for a Safeguarding Adult Review (SAR). The review took place between September 2023 and April 2024 and focussed on the effectiveness of multiagency working and whether robust systems were in place to identify and respond to concerns that Adult G was suffering neglect leading to her death.

Definition of Neglect

The definition and understanding of self-neglect by the Social Care Institute for Excellence (SCIE) was utilised. SCIE describe self – neglect as an extreme lack of self-care, sometimes associated with hoarding and may be the result of other issues. This may include people with or without mental capacity.

Timeline

The extended timeline from 2009 to 2022 is unusual for a SAR. However, there was limited information available on Adult G's life as an adult. The most recent interaction with adult social care took place in 2021 and strongly suggested that Adult G's disengagement from services as an adult was linked to childhood experiences of services. The SAR needed to explore the early childhood experience of Adult G with services as a possible explanation for the family's response to support prior to her death 8 months later.

Methodology

An extensive chronology of events was undertaken to understand Adult G's life story. A practitioner's event considered these findings and their conclusions explored in relation to further evidence supplied. Several approaches were made to engage the family, but a formal response was eventually received by telephone whereby Adult G's mother clearly stated they did not wish to be involved. The project management (PRINCE 2) methodology was applied to help support the management of this complex review and a 'just culture' philosophy adopted with a focus on learning and development.

2. ADULT G's LIFE STORY

A young person with Learning Difficulties

Adult G was a young woman described throughout her life as having learning difficulties. Educational psychology noted cognitive impairment in 2007 (age 8). She lived with her mother, father, and older brother (by 6 years) in a house they had inherited from the father's family in Doncaster. Adult G's mother was also noted in case notes by professionals to have learning difficulties, but with no record of a formal diagnosis. There was no record of Adult G accessing health or social care learning disabilities services as a child or as an adult.

Neighbourhood Disputes

Altercations with neighbours were noted throughout the period 2009 to 2022. Environmental health reports note anti-social behaviour toward the family such as throwing snowballs and urinating on the window in 2009. Police reports note incidents in 2011, 2012, 2013, 2015, 2018 and 2022. Adult G's mother complained that her daughter was assaulted. Neighbours complained that Adult G was aggressive towards them, throwing things and using inappropriate language. In 2022, Adult G whilst in

hospital accused neighbours of ‘inappropriate touching’ prompting a police investigation. Whilst all incidents were followed up, culpability was impossible to determine and no further action was taken.

Primary and Secondary School Education

Adult G had difficulties fitting in with her mainstream primary school, was bullied and attendance was poor. This led to frustration and physical violence towards a teacher and permanent exclusion. She subsequently attended the Key Stage 2 Pupil Referral Unit (PRU) and then Gateway PRU. She then attended Pennine View, a community special school for pupils with moderate learning difficulties where she stayed until leaving for college. Attendance at Pennine View was very good, and her reports reflected someone who was happy at secondary school, having made friends and enjoying her subjects. She aspired for the future in childcare or hairdressing. Adult G presented very differently at school and at home with professionals describing her as the model student at school and aggressive and emotional at home.

Post 16 Experience

Adult G attended Goole College (now named Hull College) undertaking a qualification in health and social care, but left college suddenly in 2018, without completing it. The Department for Work and Pensions confirmed that Adult G was receiving Universal Credit from 2018 until her death in July 2022. Her declared health conditions were moderate learning difficulties, social communication difficulties associated with global cognitive delay. Adult G did not engage in any universal credit related work programmes and a sanction was issued. In July 2021, Adult G was assessed as having a Limited Capability to Work. Her GP confirmed Adult G was receiving GP MED3 forms (fit notes) covering the period October 2021 to July 2022 in support of her claims.

Engagement with Children’s Social Care

Adult G had been engaged with children’s social care in 2009 (age 10) and in 2013 (age 14), and she was placed on the Child Protection register in January 2013 for neglect, being described as a vulnerable child with learning disabilities. Poor home conditions were cited as a key issue with the significant risk of fire from hoarding and electrical overloading noted from 2009 and throughout her life. In November 2013, the case was closed to social care due to some home improvements having been made. However, these were not sustained, and similar conditions were noted again from March 2014. There was limited success from the fire service to conduct home visits thereafter as they were refused entry. They closed the case in 2016 due to non-engagement and referred onto children’s social care although there was no record of this having been received. There was no further children’s social care input after 2013.

Engagement with Adult Social Care

In 2021, when Adult G was aged 22, Section 42 adult safeguarding enquiries were made, prompted by complaints from neighbours and a joint home visit by the police and the stronger communities team. In the record of contact on 21st September 2021, Adult G’s mother was noted as raising her voice and being distressed by the call and advised that these issues had been dealt with many years ago and the father saying, ‘she was messed up by social workers and she doesn’t want them’. Adult G was also noted to say repeatedly, ‘No, No, don’t come’. The Section 42 enquiry was closed at this point on the basis that the stronger communities’ team had conducted a face-to-face visit in partnership with the police and that whilst they did not enter the house, Adult G was noted to be ‘safe and well’.

Acute Hospital Admission immediately prior to death

On 23rd June 2022, Adult G presented through Accident and Emergency with vomiting and diarrhoea and viral encephalitis (brain inflammation) and admitted to the assessment unit. She presented in a confused state and spoke of neighbours inappropriately touching her. The police investigated these allegations and found no evidence to support them. Pelvic Inflammatory disease, a potential marker for sexual activity did not present in a Computed Tomography (CT) scan. The integrated safeguarding

team based in hospital conducted a Section 42 enquiry based on sexual abuse. Adult G was discharged on 8th July 2022 with a hospital discharge plan encompassing a supply of anti-biotics, an Ear, Nose and Throat outpatient appointment in 6 to 8 weeks, a Urology appointment, an ultrasound scan in 4 weeks, and a referral to the community adult learning disability team.

Circumstances and Cause of Death

On 11th July 2022, Adult G was found dead on the sofa by her mother in her home, she was age 23 years old. The cause of death was Bronchopneumonia (a type of pneumonia that inflames the tiny air sacs in the lungs) and a Urinary Tract Infection (infections that happen when bacteria, often from the skin or rectum, enter the urethra and infect the urinary tract) and therefore a coroner's inquest was not progressed. A toxicology report found no unusual substances. Police photographs of the house on the day of Adult G's death show extreme hoarding, filthy and squalid conditions in every room with stained mattresses and a ripped and stained sofa. These photographs matched the highest level defined in the Doncaster Self-Neglect Policy (most recently updated 2022). The parents were interviewed as significant witnesses but there was no evidence for further action. Adult G was noted during hospital admission to be covid positive, which was 5 days before her death.

3. KEY FINDINGS

The impact of hoarding on health

The full impact of hoarding as a key aspect of self-neglect on physical and emotional health was not fully understood by agencies and practitioners. Given that poor home conditions had been an issue for the family since 2009 and repeatedly referenced throughout the following 12 years, this should have been treated as a higher priority for this family and consequently a stronger multiagency response put in place. This should have remained in place in the long term to ensure improvements in living conditions were sustained. Individual actions from individual agencies had a limited and short-term impact. The review found that the Doncaster Self- Neglect Policy had not been used, that it was not fully understood and that various aspects needed clarity, simplification and awareness raising.

Parental Support

The parents were clearly struggling to provide and maintain a safe environment for their family. From 2009 onwards up until Adult G's death, reference was made to several recurring issues. This included hoarding, electrical overloading, disrepair, smoke alarms that were pulled out each time they were refitted and Adult G sleeping in her mother's room because her room was being used to store knives and CCTV equipment to monitor the neighbours. It was noted that Trinity Academy, the secondary school where the older sibling attended were also concerned about the poor home conditions, so it is likely that these issues were present from the beginning of Adult G's life.

In accordance with the statutory guidance that was in place at the time, and is still current, the assessment of Adult G should have considered the parent's ability to meet her needs. This is one of the core domains in the Framework for the Assessment of Children in Need. The Initial Child Protection Conference notes in September 2013 that the parental assessment was still outstanding and two months later the case was closed to Children's Social Care.

No carers assessments, nor specific parental support put in place during childhood or adulthood were found in this review. This is despite repeated observations in notes by practitioners across agencies to the need for family support throughout Adult G's life.

Learning Disabilities Assessment and Support

Adult G was described throughout her interactions with agencies as, a vulnerable child with learning difficulties. There was an assumption that Adult G had learning disabilities throughout her life but without referral onto more specialist services who could have provided further support as a child and moving into adulthood. Despite being settled in secondary school, Adult G displayed additional behaviours at home which were serious enough to involve the police. It is likely that Adult G would have made the threshold for additional specialist support. There were several missed opportunities to refer Adult G and her parents to learning disabilities services for further diagnosis and support.

The implications of this were discussed in the practitioner's event and it was widely agreed that had referral taken place, it is likely that her needs would have been fully established at an early age and therefore would have been transitioned to adulthood within the learning disabilities system that exists providing crucial support in early adulthood.

The role of education in neglect

Pennine View School was clearly important to Adult G, and she thrived here with 100% attendance. Her family engaged well with school. Adult G was described as a 'model pupil' but this was in stark contrast to Adult G's behaviour at home.

School either, did not seem to be aware of the full picture and/or misunderstood the potential significant impact on their pupil's wellbeing. In turn, college were not fully informed of the issues on transition. This represented a missed opportunity for an agency (education), trusted by the family, to coordinate wider action on Adult G's behalf. Education documentation was incomplete for health and social care support and no attendance from other agencies in annual reviews. Transition planning was good between school and college in terms of career choices but there was no clear understanding on what pastoral support Adult G might need. There was no proactive follow up by college when Adult G suddenly stopped attending.

The impact of children's social services experience on family engagement

The early experience of the family with children's social services in 2009/10 and in particular 2012/2013 caused them to be cautious of statutory adult social care support when they most needed it. They experienced poor practice when Adult G was a child and a lack of tangible support, evidenced in the records of meetings at this time and the chair's comments. One such meeting noted; no record of 2 statutory social care visits, core group notes being incorrectly recorded in case notes and not in the care pathway documentation, a core group being cancelled, several social care actions still outstanding with the social worker present admitting that most, if not all had not been addressed. Contact with key agencies who had been involved in the case at the beginning within housing, the fire service and environmental health had not been made.

However, it is noted that the need for significant improvement in children's social care was recognised by the council at the time with the decision to form the Children's Trust.

Understanding the role of different agencies in relation to power of entry

Only one referral was made to Environmental Health for an internal housing inspection which led to a full clear out of the property by them in 2013. Lack of understanding of their role and powers of entry presented a missed opportunity to conduct a housing visit in 2022 which may have led to the earlier identification and support for the hoarding issues and squalid conditions, in the months before Adult G's death. Instead, agencies referred to South Yorkshire Fire and Rescue who could not force entry without evidence of extreme neglect. They were refused entry again and this led to referral back to stronger communities and eventual discharge from social care.

Working together in relation to vulnerable adult referrals adult social services and the police

More generally, the review identified a missed opportunity for closer working between social care and the police in relation to vulnerable adult referrals. Where the police are involved with vulnerable adults, they can make a vulnerable adult referral to social services for follow up. This was done for Adult G in the weeks before her death, however, there would appear to be no feedback on action taken which inevitably led to repeat referrals. Improved information sharing would represent fewer referrals, smarter working, leaving both agencies with more time to focus on supporting clients.

4. RECOMMENDATIONS

Revisit and relaunch Doncaster Strategy on Neglect to ensure all age and multi-agency.

Doncaster should revisit the current strategy on neglect, seeking to update it, considering current levels of prevalence and views on neglect by children, adults, and practitioners. The strategy needs to

ensure it encompasses all ages and agencies. See www.tameside.gov.uk and www.lancashire.gov.uk for excellent examples of different multi-agency self-neglect strategies.

Simplify and strengthen the Self- Neglect policy to clarify who does what and when.

DSAB have an excellent policy on self-neglect which sets out the incidence of neglect and has been updated as recently as 2022. It contains photographs of levels of clutter to support practitioners assess hoarding risk level. However, practitioners noted a number of difficulties in operationalising this and that it could go further to clarify the impact of hoarding issues and its profile further raised. This policy should therefore be revisited, to simplify the process of referral and clarify certain aspects to ensure all agencies understand their role within it.

Review current workforce training and skills when working with Self- Neglect.

Doncaster Safeguarding Child Partnership has already adopted a multi-agency assessment tool to help identify and measure risk of neglect, the NSPCC Graded Care Profile 2 (GCP2). This evidence-based assessment tool helps professionals measure the quality of care provided by a parent or carer in meeting their child's needs, with a focus on neglect.

However, further training in the understanding of self-neglect between practitioners is critical to allow time to understand the particular challenges they face, especially when balancing a person' rights with safeguarding issues. Sources of guidance and toolkits for additional training should be considered to include Camden's Multi-Agency Self Neglect Toolkit. (www.camden.gov.uk), the toolkit produced by the Dartington Trust, ''working with people who self – neglect'' (www.researchinpractice.org.uk) and the workbook produced by the Local Government Association, 'Making Safeguarding Personal in self-neglect' (www.local.gov.uk).

Identify a short- and long-term solution for the ongoing support for Self – Neglect.

There is a gap in the system for the ongoing monitoring and support for individuals and families suffering from neglect. For Adult G, adult social services undertook Section 42 inquiries, but in the absence of any engagement from them and feedback that Adult G was well, eventually needed to discharge the case.

Currently, stronger communities play a positive role in the community and are invited into cases of neglect to boost the network around the person if needed. They are valued by practitioners, and they have a good understanding and presence in the communities they serve. Their engagement in cases of neglect is on currently on a case-by-case basis. Consideration should be given to strengthening the role of Stronger Communities teams to be able to provide ongoing monitoring and support to families suffering from neglect and become core members of the policy group. Their status as a non-statutory service would go far to address the resistance to support exemplified in this case.

Self - Neglect as a long-term condition requires a sustained multi-disciplinary approach involving mental health input. Consideration should be given to the establishment of a specialist multi-agency team targeting neglect which brings together environmental health, fire and rescue, social care, the police, mental health support, community healthcare support and stronger communities. This team, can provide a joint plan around the person and work at their pace to support them to reduce and manage the risks, discharging only when that person is ready.

Conduct a quality assurance exercise to ensure the practice issues identified in children's services have been addressed in 2024 across all agencies.

The practice issues identified in this review, represent a useful set of indices that could be used to conduct an independent desk top audit to compare practice pre–Children's Trust with current practice in 2024. This type of 'before and after' study can help senior officers understand how the strategic changes made have supported practitioners on the ground to ensure a different experience should someone presenting with Adult G's needs occur again. What has worked, what hasn't and what still needs to be done could be used to inform the next strategic plan.

CJT, Independent Author, 18th July 2024.