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Safeguarding Adult Review (SAR) Adult G FINAL REPORT

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OVERVIEW

1. Notes from the Author

1.1 There were very few people who knew Adult G personally and were still working within Doncaster and this, alongside changing IT systems made locating information especially challenging for this SAR. Agencies contributed to an initial chronology of events pulled together by the Safeguarding Business Unit and followed up by the independent author. Further discussions were undertaken with representatives of these agencies. A practitioner's event was held In December 2023, to discuss the emerging themes. Therefore, the information contained here is as comprehensive as possible within these limitations and the conclusions drawn from this information alone.

1.2 All findings were shared with both the Doncaster Safeguarding Business Unit throughout the SAR period (1st September 2023 to date) within monthly project meetings as set out by the project plan and within the practitioner's event where they were discussed, agreed to, alongside identifying other areas for follow up. This report is therefore a professional view based on the information shared.

1.3 The extended timeline (2009 – 2022) is unusual for a SAR which initially was set as a two-year period prior to death. However, there was very limited information available on Adult G's life as an adult. The most recent interaction with adult social care whilst at home was in 2021 with a section 42 adult safeguarding enquiry being made. 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'. It was agreed at this point that, the SAR needed to explore the early experience of Adult G with services as a possible explanation for the family's response to support prior to her death 8 months later.

1.4 The extended timeline has inevitably raised practice issues from a decade ago which may seem out of touch with current practice, particularly within children's services which has had a robust improvement plan delivered through the Children's Trust since 2013. This was acknowledged in the way in which the practitioner's event was managed, in that alongside reviewing the evidence to date, participants were asked to discuss, 'if a similar case presented itself in 2023, what would happen now?' This aimed to identify both the improvements already made alongside identifying improvements still to be made.

1.5 The voice of the family is limited within this report. The SAR process found difficulties engaging them face to face in the process. Following attempts to engage them, both through a home visit and correspondence, a message was received from Adult G's mother clearly stating they did not want to be engaged in the review. Therefore, their views are taken from secondary sources such as their input to Special Educational Needs Plans (SEN) and Education, Health, and Care Plans (EHCP) from secondary school and college. Adult G and

her parents both provided written contributions to these, and her mother was present at most annual reviews. In addition, there are currently no practitioners working in post who knew the family well. The author is grateful to the team at Pennine View who were able to locate her original paper file which covered her entire time at secondary school and the Learning Standards and Effectiveness team at Doncaster Council who were tireless in locating additional education documentation.

1.6 This is a multi-agency learning review, focussing on how agencies work together and as such not a detailed analysis of any one agencies practice. Inevitably, when reviewing such reports, there is a tendency to focus on your own sector, however, a key message in this report is that to achieve sustained change for families struggling with neglect, action needs to be multi agency and long-term. Readers of this report are encouraged to think about their contribution to this rather than focus on single agency issues alone.

1.7 Three key recommendations are made here which will need translating into an action plan with SMART (Specific, measurable, achievable, relevant, and time-bound) objectives. The author would be happy to work with officers to develop this as a next step, once the report has been consulted upon.

1.8 Resources are provided in Appendix C to support the understanding of the link between hoarding and health and the improvement of practice.

2. Adult G's life and experiences of services

2.1 The following section aims to provide the reader with a picture of Adult Gs' life based on what we know to date and her experience with services. It is not intended as an analysis at this stage but as an introduction to Adult G and her experience of services, all evidence is presented in the chronology and assessed in the analysis section of this report.

2.2 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 owned 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.

2.3 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 from 2011 to 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 in any of these incidents.

2.4 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 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's secondary school reports on her presentation ('model student) were in stark contrast to reports regarding her behaviour at home (aggressive and emotional).

2.5 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 the qualification. The Department of 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 which meant she needed to attend work focussed interviews. The GP confirmed Adult G was receiving GP MED3 forms (fit notes) covering the period October 2021 to July 2022 in support of her claims.

2.6 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 as they were refused entry and had no powers to enforce entry. They closed the case in 2016 due to non-engagement and referred onto social services although there was no record of this having been received by children's social care. There was no further children's social care after 2013.

2.7 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'.

2.8 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 CT scan. The integrated safeguarding team based in hospital conducted a Section 42 enquiry based on sexual abuse.

2.9 Adult G was discharged on 8th July 2022 with a discharge plan encompassing a supply of anti-biotics, an ENT 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. On 11th July 2022, she was found dead on the sofa by her mother in her home, she was age 23 years old.

2.10 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.

2.11 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 (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.

2.12 The Doncaster Safeguarding Adult Board Case Review Subgroup (DSAB CRG) decided on 26th April 2023 that the case met the criteria for a Safeguarding Adult Review. An independent author, a former Chief Executive Officer of a mental health provider, was appointed to undertake this review from 1st September 2023, with a completion date of March 31st, 2024. This was later extended to April 30th, 2024, to allow further time for consultation and explore further opportunities for family engagement.

3. Terms of Reference

3.1 The focus of the review was an analysis of the effectiveness of multi-agency working and whether robust systems were in place to identify and respond to concerns that Adult G was suffering neglect leading to her death.

3.2 Specifically, the DSAB CRG focussed on the following lines of inquiry.

- The effectiveness of current multi – agency working to protect adults at risk of neglect specifically where the care is sought from family and whether safe systems are in place.
- Whether information was shared across multi agencies when Adult G transitioned to adulthood. Was information shared during the transition to adulthood, and information shared with parents.
- Whether any support was identified for the parents (carer's assessment).
- Whether relevant policies and procedures were followed where there were repeated concerns of self-neglect.

3.3 The timeline for the review was from 2009 to 2022, please see paragraph 1.3 for rationale.

4. Methodology

4.1 The PRINCE project management approach was applied to the SAR given its complexity and extended timeline. This established a project team, consisting of the Safeguarding Business unit manager and deputy (who was the key point of contact throughout), the DSAB CRG chair alongside the independent author. A project plan was signed off and monthly project meetings took place to report on progress and problem solve. Early challenges included how to best engage the family and how to access additional information from different agencies.

4.2 The key steps taken by the author were as follows.

- Producing project plan, agreeing terms of reference and approach with project team.
- Informing agencies and the family of the SAR and introducing the independent author/contact details.
- Reviewing chronology and identifying and following up gaps.
- Producing an integrated timeline of events from 2009 to 2022.
- Organising the practitioner's event and signing off the agenda with project team.
- Producing discussion papers for group work against 4 key themes.
- Follow up from event and additional fact checking.
- First draft report for Project team.
- Second draft report for Children's Social Care.
- Produce third draft report for full consultation process.
- Produce fourth and final draft.
- Board and CRG presentation.
- Seek family engagement.

4.3 A 'just culture' approach has been applied throughout this SAR, which refers to 'a system of accountability in which organisations are accountable for the systems they have designed and for responding to the behaviours of their employees in a fair and just manner.' (www.brighamandwomensfaulkner.org) In other words, a 'just culture' encourages a culture where individual mistakes are not punished (unless gross professional negligence). Instead, perceived poor practice is analysed against the system to review any gaps or inconsistencies in policy and resources which account for this. 'Just culture' approaches are particularly effective at encouraging a learning environment by removing the 'blame game' (one party blames another for something bad rather than attempting to seek a solution www.languages.oup.com) that inevitably comes from scrutinising specific cases. This in turn leads to better identifying what system issues need to be addressed to support improved practice in the future.

4.4 For the purpose of this review, the definition and understanding of self-neglect by the Social Care Institute for Excellence was utilised (www.scie.org.uk) The institute describe self – neglect as an extreme lack of self-care, it is sometimes associated with hoarding and may be the result of other issues. This may include people with or without mental capacity, who demonstrate the following.

- Lack of self-care to an extent that it threatens personal health and safety.
- Neglecting to care for one's personal hygiene, health, and surroundings.
- Inability to avoid harm as a result of self-neglect.
- Failure to seek help or access services to meet health and social care needs.
- Inability or unwillingness to manage one's personal affairs.

4.5 This is in keeping with the definition referenced in Doncaster's Policy on Self-neglect taken from Care and Statutory Guidance published in March 2020 which states that self-neglect is a form of abuse and neglect and defines self-neglect as, '' a wide range of behaviour neglecting to care for one's personal hygiene, health or surrounding and includes behaviour such as hoarding.''(www.gov.uk).

5. List of Agencies

5.1 Adult G had been involved with the following agencies from 2009 to 2022 and all provided information (directly or indirectly**)** to inform the SAR.

- Doncaster and Bassetlaw NHS Foundation NHS Trust - Specialist School Nursing Team (DBTH)
- Rotherham, Doncaster, and South Humber NHS Foundation Trust (RDaSH)
- Doncaster Council Learning Standards and Effectiveness
- Doncaster Council Environmental Health
- South Yorkshire Police (SYP)
- South Yorkshire Fire and Rescue Service (SYFR)
- Stronger Communities Team
- Doncaster and Bassetlaw NHS Foundation NHS Trust – A and E and ward (DBTH)
- Doncaster Council children's social work team
- Doncaster Council adult social work team
- Yorkshire Ambulance Service (YAS)
- Northfield GP Surgery
- Pennine View
- Goole College (now Hull college)
- Department for Work and Pensions (DWP)

6. Documentation List

6.1 The list of documentation obtained and reviewed to inform this SAR was as follows.

- Initial Chronology produced by Safeguarding Business Unit (South Yorkshire Fire and Rescue, School Nursing, DBTH, Children's Social Care, Children's Adult care, Yorkshire Ambulance Service). Produced September 2023.
- Postmortem report for Adult G including toxicology report. 2022.
- Minutes of Initial Child Protection Conference, Core Group and 2 Reviews relating to 2013.
- Statement of SEN and annual reviews for Pennine View 2010 to 2014
- Education, Health, and Care Plan (EHCP) Goole College 2016 to 2018.
- Section 42 adult safeguarding inquiries from 2021.
- Adult Safeguarding Referral from hospital admission. June 2022.
- Case notes summary from hospital admission DBTH. June 2022.
- Photographs of the house on the day of Adult G's death from South Yorkshire Police. July 2022.
- Previous learning reviews to identify common themes.
- Doncaster Safeguarding Adult Board (DSAB) Self- Neglect Policy 2022
- Environmental Health Case notes for 2009/10 and 2012/13.
- Department for Work and Pension case notes on Universal Credit Claims by Adult G.
- GP case notes.

7. Practitioners Learning Event

7.1 A practitioner's learning event took place on 7th December 2023 involving members of the DSAB CRG, and practitioners who had had either a direct or indirect involvement with Adult G and the Safeguarding Business Unit with representatives from both children and adult services. There was full representation from agencies who are listed as having some involvement with Adult G. Please see Appendix A for the agenda for the event and Appendix B, Group work discussion papers.

7.2 This event was crucial in 'sense checking' (a review to establish whether or not an argument is logically coherent www.collinsdictionary.com) the issues emerging from the chronology and identifying improvements that had already been made by agencies since 2009 and the areas that still required addressing or strengthening.

7.3 Participants identified the following key issues.

- That Adult G's EHCP and SEN documentation were not comprehensive, the health and social care sections were blank and annual reviews were not multiagency, but a new online system was in development which would address these issues.
- That there were practice issues in the early care of Adult G by children's social services, but that children's services had been subject to a robust improvement programme with the establishment of the Children's Trust in 2014.
- That opportunities had been missed for Adult G to be assessed by learning disabilities services and had this occurred, Adult G would have been subject to 'transition planning' into adult services, ensuring access to a range of support as a young adult.
- The powers of environmental health in supporting agencies deal with extreme hoarding and poor home conditions had not been fully understood and they should be more clearly signposted in Doncaster's policy on self- neglect.
- That hoarding was not fully understood in terms of its link to mental illness and poor physical health and that it required long term, sustained support from services to change behaviours.
- That there was a service gap for this type of sustained long-term support and a need to identify short term and longer-term solutions to address this gap, potentially through the role of stronger communities' teams.
- That the Doncaster Policy on Self-Neglect was a good start to addressing the issues and a number of areas within it should be strengthened and clarified.

CHRONOLOGY

8. Points of Note

8.1 The following chronology has taken the case notes shared by the list of agencies (see list in 6.1) and the additional documentation (see list 5.1) to produce a cross agency timeline of events to the best of our knowledge.

8.2 It is important to re-emphasise that this information has been difficult to retrieve by agencies due to the different systems of recording information across agencies since 2009. For example, school information taken from the original paper file was found in the school's attic. Within social services, there were at least three different systems across this period, CareFirst, Liquid Logic, and Mosaic. Information shared from these systems was dependent on how well they had been transferred across. Where there is more detail, this means that the original minutes of meetings or diary entries have been located, they are noted in 6.1 documentation list.

8.3 Personnel changes and structural changes, for example, the Children's Trust formation, have further complicated this picture with those currently in post seeking to answer follow up questions from the author for the decision making of those who are no longer in post. Different policies and versions of policies have also changed over time, for

example, the Doncaster Policy on Self neglect was first introduced in 2018, but it is the 2022 version that is currently in operation.

8.4 Agencies have done their best to provide this information within these constraints but inevitably there remain some questions unanswered which are noted throughout.

8.5 The chronology provided here is divided into 5 distinct stages of Adult Gs' experience of services to support understanding. It aims to present the information received in a factual way to provide the reader with the evidence base (as we know it) for the analysis that will follow.

9. Part One: FIRST INTERACTION WITH CHILDRENS SOCIAL CARE

9.1 This covers the period November 2009 up to and including January 2011 when Adult G was aged 10 to 12 years old. It describes the first time she becomes engaged with Children's Social Care (CSC) and the subsequent child in need assessment.

9.2 November 2009, the first record of statutory services involvement with Adult G was noted by CSC. Several concerns were raised at this time. They included the home conditions, which were subject to significant hoarding, parenting issues in relation to the father's chastisement of Adult G and giving Adult G alcohol at 10 years old. A child in need core assessment was completed which noted additional issues that Adult G slept with mum, hygiene issues and local youths shouting abuse.

9.3 December 2009, a third unknown party raised concerns with the school nurse regarding Adult G's hygiene, describing Adult G as unkempt, having dirty fingernails and recurring headlice. The person was advised to contact social services. There is no further record of who the third party was or of this having been actioned.

9.4 January 2010 the school nurse had further contact with Adult G through the National Child Measurement Programme. Adult G was sent a letter by the national programme in June 2010 informing the family that she was in the obese category, and this was followed up by the school nurse with the parents.

9.5 February 2010, Adult G was excluded from Thorne Brook Primary School (which she had attended from 2002) for violence towards adults and in February 2010 started attending the Levett School, a pupil referral unit until July 2010.

9.6 February 2010, a referral was made by educational welfare to CSC for abuse and neglect.

9.7 May 2010, the school nurse received confirmation that the Child in Need initial assessment was being undertaken due to ongoing concerns about neglect and the school nurse saw Adult G in school in the same month.

9.8 September 2010, Adult G moved to another pupil referral unit, the Gateway Centre and an Education, Health and Care Plan was issued by them in December 2010.

9.9 October 2010, a Child in Need meeting took place with the school nurse in attendance who stated that Adult G had learning difficulties and that the school had tried to get a Statement of Educational Need without success. Improvements in the living conditions were noted.

9.10 November 2010, the case was closed to social services.

9.11 January 2011, Adult G moved to Pennine View School, a specialist provision for children with special educational needs and disabilities (SEND) in Doncaster where she remained until June 2015.

10. Part Two: SECOND INTERACTION WITH CHILDREN'S SOCIAL CARE

10.1 This covers the period May 2012 to November 2013 when Adult G is 13 and 14 years old. It describes the second interaction with CSC when child protection processes were initiated.

10.2 May 2012, police received concerns regarding Adult G and her behaviour to neighbours who complained that she was exposing herself, throwing sweets and being verbally abusive. The incident noted that there was no social worker for the family or any other agency support and that the parents were portraying signs of learning difficulties.

10.3 May 2012, complaints were also received by Environmental Health (EH) from neighbours who referred to a vulnerable child. The officer spoke to the Childrens Services Team who confirmed Adult G was not open to CSC and had no social worker assigned from the Learning Disabilities Children's team.

10.4 June 2012, a joint visit between EH and South Yorkshire Fire and Rescue (SYFR) took place, who on the same day made referrals to the CSC Duty and Assessment Team. The fire officer stated, ''to say that the house presents a fire risk is an understatement''. They had particular concerns for Adult G's health and safety after observing that in the room where she slept, there were 10 sockets, 2 TVs which were on 24 hours a day for the CCTV, a fan, CCTV recording equipment and several knives.

10.5 June 2012, the CSC Duty and Assessment team conducted next day assessment and noted that CCTV had been installed in the small bedroom, but that this was where the father slept, and the knives were his. Adult G was sleeping with mum again and whilst school was ok, Adult G could be outspoken. The children's case file system used at the time, noted referral to social care from 'other internal SSD team,' the stated category, abuse, and neglect.

10.6 July 2012, another joint visit between EH and SYFR took place and the outcome discussed with the duty team social worker. They noted that the fire risks identified were no further forward. The case was then passed to the Family Support East Team. The Area Manager wrote to the housing department, noted the vulnerability of Adult G, and referred to her as 'registered disabled' asking if housing could act on the home issues as the powers of EH were limited due to it not falling into the 'filthy and verminous' category.

10.7 August 2012, the neighbour was interviewed by the police following an allegation by Adult G's mother that neighbours assaulted her daughter. It was noted by the police that the social worker present had concerns that the parents were able to look after her. No further action for the neighbours. A strategy discussion took place the next day to discuss the incident and agreed section 47 inquiries should be initiated.

10.8 October 2012, the case was followed up by EH with CSC and they were informed that the case was being allocated to a district social worker.

10.9 November 2012, a three-month delay in progressing Section 47 inquiries was noted. A further strategy meeting took place and agreement was reached to proceed to an Initial Child Protection Conference (ICPC).

10.10 15th January 2013, the ICPC took place and meeting attendees were unanimous that Adult G should be the subject of a Child Protection Plan for the category of neglect. Adult G was described as a vulnerable 13-year-old with learning difficulties. The meeting was attended by all agencies. The minutes of the ICPC noted the following key points.

- There had been a long family history of involvement with neighbours and the police with Mr Fearon stating they had been targeted by local youths but police noting there had been reports of Mr Fearon selling alcohol to young people and allowing them to consume this in his shed in addition to driving a car with stolen goods. Police had been unable to establish culpability for either party.
- That a 19-year-old friend of Adult G's brother had moved in with the family and this needed investigation.
- There had been concerns since 2010 about the poor home conditions; there was no lounge door, there were clothes piled up around the fridge and freezer, there were overloaded electrical circuits and surrounded by paper clutter all creating a significant fire risk. The family had cleaned up at the time, but it had reverted back to the same condition.
- That there was a marked difference between Adult Gs' presentation at school and at home, described by school as a ''model pupil'' who had minimal intervention for pastoral care and ''emotional and unpredictable at home.'' This was concerning as this may be due to a lack of good parenting and consistency.
- That Adult G had been treated for headlice and personal hygiene at school and given advice about her weight by school nursing and that the school nurse last received contact from social care in July 2011 but none until the meeting that day.
- The chair's summary noted: concerns around emotional and physical neglect since 2009, that despite support and advice home improvements were never sustained, that there was a significant delay in bringing the matter to conference given the incident which had led to the strategy meeting took place in August 2012.

10.11 24th January 2013, the core group met to formulate the Child Protection Plan (CPP), minutes and CPP not located.

10.12 31st January 2013, a Legal Planning Monitoring Group (LPMG) took place to understand whether the threshold had been met for legal proceedings. The group concluded that further work was required such as securing an electrician for the electrical fire. Family not invited nor informed of outcome.

10.13 February 2013, the core group met. The minutes of the February core group noted the following.

- Minutes of last core group incorrectly filed.
- School transport Issues had been resolved.
- Adult G had been registered with a dentist.
- That height and weight were checked and appropriate for her age.
- That Mr Fearon did not want to cooperate with any assessment by the adult learning disabilities team as he felt that if too many people were involved, they will get conflicting and confusing advice.
- That Adult G found it difficult fitting in socially at school and at home in the community.
- The continued disparity between Adult G's behaviour at home and at school.

- That Parent Partnership would no longer be involved as their role was specific to events.
- That the statutory social work visits noted electrical overloading but no further actions.
- No attendance at the meeting from environmental health or the fire service.

10.14 March 2013, the Child Protection Plan was reviewed, and the chair concluded that little progress had been made since January and 'drift is identified'. The main safeguarding concern remained the risk of fire and that the parents remained vulnerable in their own right, as their own capacity to understand had not yet been assessed. The Child Protection Plan remained in place for neglect. The minutes of the Child Protection Review meeting noted the following.

- No reports had been received by school or environmental health and the report received by social care provided very little information.
- Core group meetings had been recorded in the case notes incorrectly.
- 4 statutory social work visits had been noted but there was no information contained in two of the records.
- The March core group meeting had been cancelled.
- A number of social care actions from January were still outstanding.
    - The chronology for the legal planning monitoring group.
    - The core assessment focusing on family dynamics and parent's capacity to understand key issues.
    - Contract of Expectations with input from core group on how to keep Adult G safe.
    - Referral to Integrated Family Support Service to support parents put in appropriate boundaries in place.
    - Contact with the Private Sector housing Officer.
- Father did not want any further involvement from adult social care.
- Informal support for the family not available from M25 as they only worked with council tenants.
- The parents had not been informed of the LMPG that had taken place or its outcome.
- It was confirmed by the social worker that he had only seen Adult G once and 'most, if not all' actions from the LMPG remained outstanding, in particular the application for financial support for house works.
- The school nurse confirmed that the outstanding health issue was her emotional health and the big difference between behaviour at home and at school and parental lack of understanding.

10.15 April 2013, the Mosaic IT system (originally CareFirst but information transferred across) noted that parents finally agreed with social services for them to refer to adult learning disabilities, the same entry notes, ''this should at least provide some assessment of their capabilities.' Adult learning disabilities have since confirmed there is no current record of an assessment for Adult G's parents, so it is unlikely that this occurred.

10.16 Core Group meetings are noted to have taken place in April, June, and July 2013, although the minutes have not been located. At the July meeting a disagreement was noted in school nurse records between the social worker and school nurse, the latter felt that there should be a referral to adult services to assess parental functioning. Adult social care has confirmed that there is no record of this referral or a subsequent assessment.

10.17 May 2013, there was a change in allocated social worker.

10.18 September 2013, a Child Protection Conference took place to review the Child Protection Plan, and whilst some actions remained, progress had been noted since May with the new allocated social worker. It was noted that plug points had been installed and the electrics no longer presented a fire risk. Adult G was in her own bed. The home was clean, and the school report was positive. The key issues going forward were identified as being able to sustain the improvements and clear monitoring being provided. It was agreed to end the Child Protection Plan and a Child in Need Plan be put in place with the opportunity to monitor and complete the parenting assessment. The minutes of the meeting noted the following additional points.

- Statutory visits had taken place regularly from May onwards.
- Electrical work had been undertaken by the family at the house.
- Parenting assessment was still ongoing.
- Core group had decided that no further referral to adult services was required to assess parent's level of functioning and that this was considered to be adequate.
- Social care referral to integrated family support to enable one to one support with Adult G and help parents put in boundaries not taken forward. The social worker felt he could undertake this work.
- Multi agency chronology still ongoing.
- Key risk factor identified as long-term sustainability of improvements.

10.19 October 2013, Child in Need meeting, attendees informed that children's social care were planning to withdraw following improvements made.

10.20 November 2013, the case was closed to Children's Social Care. The school nurse assigned to the case was away. The social worker and manager made the decision with a school nurse representative present.

11. Part Three: AGENCY ACTION AFTER CASE CLOSED TO CHILDREN'S SOCIAL CARE

11.1 This period covers the rest of Adult G's childhood, from the age of 14 up to the age of 18, December 2013 to 2017. There was some contact by agencies noted until 2016 but no record of any service involvement thereafter. Adult G transferred to Goole College in September 2015.

11.2 December 2013, the school nurse challenged the decision on her return from leave, to close the case so soon before sustained change had been evidenced and requested a professionals meeting. This was denied by social care as the case had already been closed. There was no evidence of further escalation by the school nurse through formal procedures. The school nurse informed SYFR and EH and requested further monitoring of the home conditions.

11.3 January 2014, a podiatry appointment took place for Adult G who was given advice on nailcare and adequate footwear.

11.4 March 2014, the school nurse checked with EH and noted that the family were no further forward in the home issues.

11.5 April 2014, a property inspection was undertaken by EH and noted actions from the original CPP had still not been addressed. They spoke to the school nurse who advised

them to inform social services. The social worker originally allocated to the case was away, but a colleague from the same team was informed.

11.6 September 2014, SYFR conducted a further home safety check and noted a wide range of problems. SYFR noted that the level of hoarding had increased again, and smoke alarms pulled out. At this time, SYFR were not allowed access to refit as the family said their daughter did not like the noise. This was shared in an email with the Vulnerable Person Advocate (East area) within SYFR. This was discussed with housing and EH and a further joint visit was agreed with the plan that, if there were concerns, they could decide whether to make a referral to CSC.

11.7 September 2015, Adult G moved to Goole College (now Hull College) and an EHCP was updated. There was no mention of the home conditions.

11.8 November 2015, a home safety check took place by SYFR who noted continued poor home conditions, hoarding, and that the family had removed the smoke alarms due to Adult G smoking.

11.9 November 2016, SYFR closed the case due to non-engagement by family and concerns were shared with EH and CSC. The smoke alarms were however back in place. EH confirmed that there was no record of a referral received from SYFR. There was no CSC involvement after the case was closed in 2013.

12. Part Four: ADULT G INTERACTION WITH SERVICES AS AN ADULT

12.1 Part four covers Adult G's experience with services up to her admission to hospital in June 2022. There is no record of service interaction after SYFR discharge Adult G in November 2016 until February 2018; this period therefore starts here, when Adult G is 19 to 23 years old.

12.2 February 2018, Adult G left Goole College before completing her qualification, reasons unknown and the EHCP was updated. College records noted that Adult G appeared to be disengaged after returning from Christmas 2017 and there seemed to be a sudden change in demeanour.

12.3 August 2018, the Department of Work and Pensions confirmed that Adult G was receiving Universal Credit (UC) until her death in July 2022. Her declared health conditions were moderate learning difficulties, social communication difficulties associated with global cognitive delay.

12.4 February 2019, the Job Centre work coach noted Adult G had not been engaging with the 'work health programme,' a universal credit programme to support barriers to work, since November 2018. Adult G stated she could not get there and felt people were making fun of her.

12.5 March 2019, the work coach booked her onto a 'youth obligation workshop' in March 2019, a programme of intensive support for 18- to 21-year-olds, which she also failed to attend.

12.6 April 2019, the work coach noted that Adult G was not engaging in the workshop because she ''does not want to work and is quite happy and does not see the problem of living off benefits.''

12.7 September 2019, referral for Work Capability Assessment made.

12.8 September 2019, Adult G attended A and E for finger sprain.

12.9 May 2020, the family were visited by EH in response to complaints relating to the condition of the external areas only, not housing standards. It was resolved by the neighbour through the construction of a surrounding fence. No referral had been made for an internal inspection.

12.10 July 2021, Adult G awarded Limited Capability for Work (LCW) which meant she had to engage in work focussed interviews and work-related activity as part of her claim.

12.11 September 2021, Adult G was subject to Section 42 of the Care Act 2014, due to neglect and the state of the property. It is not noted who made this referral but the section 42 form notes, ''I have cause for concern for the well being of this young lady after visiting the property. Also, after complaints from this area led me to the property.''

12.12 October 2021, January 2022, and April 2022, three separate GP attendances noted requests for MED3 (fit note). Three fit notes were administered by the GP covering the period 19th October 21 to 28th July 2022 in total, the reason stated as learning disabilities, to support her claim for universal credit.

12.13 October 2021, Adult Safeguarding Team involved. The social worker spoke to Adult G on the phone and asked if she was alright at home and if she could come to visit her. Adult G did not want her to come. Noted as having a learning disability and parents voiced concerns that their daughter did not want contact with the council. The father was noted to say, 'she was messed up by social workers and she does not want them'. The social worker attempted to engage the GP with a potential joint approach. However, Adult G noted not to engage with her GP with few attendances unless for fit notes.

12.14 January 2022, SYP and members of the stronger communities' team conducted a joint welfare visit, Adult G was deemed safe and well, but they had concerns about hoarding and a referral to SYFR was made for a 'safe and well' check. An attempt to conduct a home visit was made by SYFR but they were refused entry by the parents. As SYFR had no power of entry, the case was closed to them and referred back to stronger communities.

12.15 February 2022, the safeguarding inquiry was closed due to the visit to the property by police and stronger communities who had physically observed Adult G to be safe and well.

13. Part Five: ADULT G INPATIENT ADMISSION

13.1 Part five focusses on the last three weeks of Adult G's life, 16th June 2022 to 11th July 2022 which incorporates Adult G's presentation through A and E, hospital admission and discharge shortly before death.

13.2 16th June 2022, GP attendance by Adult G with mother, diarrhoea and vomiting for last two days. Physical examination noted some signs of dehydration, but abdomen examination was normal. Noted as looking well, slightly dry lips, oral mucus moist, pulse rate 85 per minute and regular. Was advised re hydration and remembering to drink.

13.3 23rd June 2022, Yorkshire ambulance contacted the police for assistance at a medical emergency at Adult G's home. They had been called out by the parents to attend to Adult G who was thought to have a viral infection and they were struggling to manage her behaviour. SYP noted the house to be cluttered, dirty, difficult to navigate and hot with no fresh air and made a Vulnerable Adult Referral (VAR) to adult social care on this basis. Adult G presented in hospital with vomiting and diarrhoea, she was incoherent, talking about Romanians and paedophiles at home, she was aggressive and not listening. Adult G was admitted to the assessment ward with suspected meningitis which was later confirmed to be

viral encephalitis. Her mother was noted to be unable to answer questions about her history. The integrated adult safeguarding team attached to the hospital were contacted for support.

13.4 25th June 2022, the father was contacted for support as Adult G was lashing out and shouting. He stayed with her, to support her behaviour, sleeping in the chair next to her bed.

13.5 27/8th June 2022, an adult safeguarding referral, category, sexual abuse, was completed by the integrated adult safeguarding team. The referral noted the following. Adult G stated that there were people touching her and had pointed at her groin/vaginal area. There was bruising all over her body which Adult G could not explain. Adult G was behaving aggressively towards herself, hitting herself. Adult G was assessed as not having capacity, but it was noted this may have been due to Adult G's infection. The case had been discussed with the Accident and Emergency (A and E) consultant and a third-party referral had been agreed between them. SYP had been informed. The Hospital Learning disability nurse had been informed and had agreed to make a next day visit to the ward.

13.6 SYP visited Adult G in hospital on the same day following safeguarding referral. Adult G was again noted to be incoherent and touched herself during the interview. Bruising was explained by the parents in that Adult G regularly threw herself on the floor. The postmortem report confirmed that bruising on the body was consistent with bumping into things. The parents were specifically asked about the allegation that their neighbour was a paedophile. Parents stated that Adult G often repeated things they were talking about, and they had spoken about the neighbour being a paedophile in front of her. It was noted that no disclosures were made to the police by Adult G, only to the A and E nurse on initial assessment. SYP noted that the family needed support but that there no evidence of sexual abuse. A second Vulnerable Adult Referral to adult social care was completed.

The hospital integrated adult safeguarding team requested a number of actions, safeguarding support for discharge planning, an investigation by police into the comments by Adult G's mother on paedophilia and an update from the agreed visit by Learning Disabilities Nurse employed by RDaSH to support adults with a diagnosed learning disability in hospital.

13.7 2nd/3rd July 2022, the integrated adult safeguarding team discussed their safeguarding concerns with Adult G and the family, who shared that there had been an increase in the frequency of falls at home. Adult G was not deemed medically fit for discharge at this point.

13.8 4th July 2022, SYP confirmed that the neighbour in question, was not on their system and ruled out the paedophile accusation by Adult G's mother. No interview took place with the neighbour, but SYP clarified that procedurally, as there was no evidence, the neighbours did not need to speak to them, and they could not force an interview.

13.9 5th July 2022, Pelvic Inflammatory disease, a potential marker for sexual activity did not present in CT scan.

It was also noted that the Head of Community Adult Learning Disabilities Team stated that no formal diagnosis was known for Adult G but that once screened they would look at appropriate referral pathways.

13.10 6th July 2022, Adult G found to be covid positive but asymptomatic.

13.11 8th July 2022, Adult G was discharged from hospital. The discharge plan referred to a supply of anti-biotics, an ENT 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.

13.12 11th July 2022, Adult G was found dead by her parents at home. Photographs taken by the police on the day depict extremely poor conditions at home.

13.13 The cause of death was later confirmed to be Bronchopneumonia and Urinary Tract Infection. The toxicology was clear with no evidence of unusual substances.

ANALYSIS

14. Points of note

14.1 By way of explanation the following analysis is based on the chronology of events set out in sections 9 to 13. The overall point is made and followed by evidence taken from sections 9 to 13. All points were discussed at the practitioner's event in December 2023 and formed the basis for the discussion papers presented on this day (Appendix A).

15. Hoarding, poor home conditions and the impact on health

15.1 The NHS website (www.nhs.uk) has a helpful explanation of hoarding. Additional resources on hoarding and its health and social care implications are provided in Appendix C. These sources explain that hoarding is a complex disorder with the reasons for hoarding not entirely understood. It can be a symptom of another condition such as learning disabilities whereby people may be unable to categorise and dispose of items or organise themselves. It is associated with mental health conditions such as severe depression, psychotic disorder, and obsessive-compulsive disorder.

15.2 It is also a condition in its own right and more likely if people have grown up in a cluttered home and have never learned to sort items. It is considered a significant issue if it is causing distress or negatively effects a person's life, for example, getting upset when someone tries to clear it. It is a difficult condition to treat as people often have little awareness of how it is negatively impacting their life, or they feel ashamed and guilty about it.

15.3 Hoarding can become a health risk as it leads to unhygienic conditions with areas being difficult to clean encouraging infestations. It is also a fire risk blocking exits in the event of a fire. It can also cause many trips and falls.

15.4 If we apply this research to what we know about Adult G and her family, Adult G grew up in a cluttered environment, with her father inheriting the house from his parents. Case notes suggest that professionals believed she had learning disabilities and came from a family history of learning disabilities, please refer to point 17 for the evidence for this. Therefore, it is likely the family did lack an understanding of how best to organise themselves. Adult G suffered from trips and falls. The home was reported as a fire risk by SYFR with smoke alarms pulled out and exits blocked. Adult G was recorded by school as taking a strong antihistamine and as such likely to be suffering from asthma. Adult G was in poor physical health prior to her death with kidney infections and was covid positive. The photographs taken on the day of Adult G's death in July 2022 are consistent with Doncaster's definition of squalor in the 2022 Self- Neglect Policy.

15.5 In all respects, Adult G exhibited the signs and symptoms of someone suffering from the impact of hoarding and associated poor home conditions and as such a multi-agency response was needed and to be sustained over a long period of time.

15.6 Reviewing the evidence from the chronology, we can see that, the home environment is the key issue which brings Adult G to the attention of social services for the first time in 2009 with the impact on adult G's safety the key issue.

15.7 Within the two periods of social care engagement 2009/10 and 2012/13, home improvements are observed to have been made with exits cleared and electrical overloading improved. However, once the case was closed to social care, conditions deteriorated again. This suggests that without continuous monitoring and support the family were unable to take care of the home environment on their own which is in keeping with the definition of hoarding.

15.8 The notes of the CPC in September 2013 note the key risk factor for the family as being unable to sustain the improvements and the decision to step down to a child in need plan on the basis on clear ongoing monitoring being in place. However, the case closure without this being put in place suggest that the risk of hoarding occurring again and its detrimental impact on the health of a vulnerable young person was not fully understood.

15.9 The case notes of the school nurse note there was professional disagreement between school nurse and social worker as to closing the case to social care in 2013 too soon because she felt that a longer time was needed to monitor sustained improvements. Indeed, whilst unable to change this decision, the school nurse referred onto SYFR to check up on the property and their visit in 2014, just a few months after the case was closed did indeed show all of the original concerns recurring.

15.10 There was a missed opportunity in 2020, for a referral to environmental health for an internal inspection of the property (a referral was made for an external inspection) which with their power of entry could have been enforced. There appeared to be a lack of understanding of this agency's enhanced role in relation to enforcement, amongst other agencies.

15.11 It is likely that education systems also need further guidance on the impact of hoarding on their pupil's wellbeing. Despite school being involved in the Child Protection Plan, there was no reference to the home conditions in the Statements of Education Need (SEN) covering Adult G's secondary education at Pennine View, or within their transition planning with Goole College. The school nurse had also been involved in the Child Protection Plan, however at this time (2013-16) was not engaged in the development of the SENs or EHCPs, nor was she invited to the annual review meetings. It is possible that had the significant impact of hoarding been more fully understood and considered by the school, a further opportunity to support Adult G could have been explored.

15.11 In summary, the full impact of hoarding as a key aspect of self-neglect on physical and emotional health does not appear to be fully understood by agencies and practitioners. Given the 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 over a sustained period of time, formulated throughout her life and in the months before she died. Individual actions from individual agencies had a limited and short-term impact.

16. Parental Assessment and Support

16.1 The parents were clearly struggling to keep a safe environment for their family. From 2009 onwards up until Adult G's death, reference is 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. We have no record of what was done with this information regarding the sibling.

16.2 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. We know from the minutes of the CPC in September 2013 that the parenting assessment was still outstanding, less than two months later the case was closed to social care, so it is likely that this was not completed.

16.3 Throughout the chronology, there are concerns expressed in relation to parenting and the view that parental support was needed. However, there is no evidence that this was either assessed for or put in place. For example, parenting was referred to in the initial social care interaction in 2009 but there was no evidence of how this was addressed.

16.4 There was an altercation with a neighbour with accusations that Adult G was exposing herself and being verbally abusive in 2012 and the police incident noted that the social worker expressed concerns that the parents could not look after her.

16.5 When Child Protection processes were initiated in 2013, a number of parent related actions were identified such as to refer them to the Integrated Family Support Service for help with setting boundaries with Adult G and for one-to-one support, to refer them to adult services for assessment of their capabilities and to complete the parenting assessment. The minutes of these meetings suggest that none of these were taken forward.

16.6 Reviewing Adult Gs' most recent interaction with services, during the hospital admission in 2022, immediately prior to Adult G's death, upon investigating the safeguarding referral, the police officer concluded that there was no evidence to substantiate the sexual abuse claims but that the family needed support, and a referral was made to social services. However, Adult G's death occurred before further action was possible.

16.7 The possibility of the family refusing all support if assessed for and offered can be considered. The family were resistive to being referred onto other services in their early statutory involvement with social care (2013), the father noting that he didn't want too many agencies involved because different advice can get confusing. However, they did consistently attend multi agency meetings where invited and work shift patterns allowed, this included school meetings and child protection meetings at this stage. Indeed, they expressed disappointment at not being invited nor informed of the outcome of the Legal Monitoring Planning Group in January 2013. In addition, they did initially refuse referral to adult learning disabilities services during 2013 but eventually agreed to this support although there is no evidence of a referral being made. It is the author's view that had support been offered at this time it is likely to have been accepted.

16.8 In summary, despite repeated incidents and views expressed by practitioners that family support was required, there is no evidence in the chronology that the parents were either assessed or accessed any parental support of value to them in their early interactions with statutory services during 2009 – 2013.

17. Learning Disabilities Diagnosis and Support

17.1 Adult G was described throughout her interactions with agencies as, a vulnerable child with learning difficulties. We know from the SEN documentation that Adult G was assessed by an educational psychologist when she was 8 years old as having cognitive impairments with particular mention of her vision and motor skills, however there is little

detail and no record of what happened next in terms of further support. We know that Adult G was expelled from primary school for violence towards a teacher and was moved to two pupil referral units and then Pennine view, the community special school where she settled. As the health and social care sections of the SEN documentation are blank and it was confirmed by the Community Adult Learning Disabilities service that Adult G was not a client and had never been transferred from the children's disabilities team, we can conclude that referral to these services for further assessment and support did not occur either as a child or an adult.

17. 2 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. There appeared to be limited professional curiosity across sectors as to the reason for these behaviours and referral on for further assessment.

17.3 The possibility that Adult G may not have made the threshold for specialist services was considered. Adult G was expelled from mainstream primary school for physical violence but thrived educationally in the special school where additional support was in place. However, police reports involving Adult G in 2012,013 2018 and 2022 refer to her displaying a range of challenging behaviours such as physical aggression (2013, throwing street signs at passing cars), verbal abuse (use of sexualised language) and inappropriate exposure of herself. Behaviour issues continued into adulthood, with Adult Gs' parents describing her as regularly throwing herself on the floor and hitting herself. Adult G was covered in bruises on admission to hospital, the postmortem results confirming they were consistent with trips and falls. These aspects of Adult G's needs were not identified in the initial assessment in 2007.

17.4 The current system as confirmed by the Community Adult Learning Disability team allows young people to transfer into adult services at varying points and stages and from varying referral sources. Schools, colleges, parents, and young people can all refer in and this is not limited to age.

17.5 If Adult G had been within the children's learning disabilities team, a referral to the transitions team in adults would usually be done between 16 to 17 prior to 18, to allow the team to become involved and start planning for adulthood.

17.6 Had either of these routes been taken up, Adult G could have accessed a range of support to include information, advice and guidance, support with benefit changes, planning for further education and importantly involvement in EHCP reviews. In addition, planning for activities they may need access to, referrals to health services as required and potentially a budget for support services, amongst others.

17.7 Reviewing the chronology, it would appear that there were a number of missed opportunities to refer on for further support throughout Adult G's life and whilst referred to as a child with learning disabilities, there was no clear explanation of how this was arrived at or what the implications were for Adult G.

17.8 For example, the SEN and EHCP documentation describe Adult G's primary need as Moderate Learning disabilities. This term refers to pupils who have much greater difficulty than their peers in acquiring basic literacy and numeracy skills and in understanding concepts. They may also have associated speech and language delay, low self-esteem, and low levels of concentration (www.wigan.gov.uk). As noted, the health and social care sections of these plans remained blank throughout secondary school and college. This implies that referral to

more specialist support provided by health and social care was either not considered or not deemed necessary.

17.9 Adult G was referred to as, ‘a vulnerable child with learning disabilities’ in the Child Protection Plan in 2013 yet no children’s learning disabilities services were involved. As a result, there is little detail available on what this meant for Adult G and how these needs were to be addressed. It may have been that attendance at a special school was deemed enough support, but the behaviours exhibited by Adult G (see point 17.2) would suggest that additional support was indicated.

17.10 Adult G’s mother was also referred to as an adult with learning difficulties. Notes transferred from the Mosaic system in 2013 showed that mother and father did not want to be referred. However, they were eventually persuaded by the social worker, to be referred to community adult learning disabilities to assess their capabilities. However, it has been confirmed by the Community Adult Learning Disability Services lead that neither Adult G’s parents were known to these services, therefore it is likely the referral was not made.

17.11 Good transition planning in terms of Adult Gs’ career took place between Pennine View and Goole College, however, as there was no information on Adult Gs’ health and social care needs (these areas were blank in documentation), the potential for further support was not flagged up at this important and potentially destabilising period for Adult G. Adult G left college very suddenly in 2018, reasons unknown, and had the college been more fully aware of Adult G’s needs may have done more to alert other services to support her.

17.12 In summary, there seemed to be an assumption that Adult G had learning disabilities throughout her life but without referral onto more specialist services who may have been able to provide 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.

18. Role of education in identifying and acting on neglect

18.1 There was no reference to Adult G's poor home conditions or some of the behaviour issues Adult G exhibited outside school in any education documentation at secondary school and college. School attended the ICPC and the school nurse was also involved in all child protection processes although not invited to the SEN annual reviews at that time. It is possible that because Adult G had 100% attendance at school that they did not see them as key issues. Adult G’s parents were active in attending the annual reviews held throughout her school history; they were supportive of it and provided feedback through this process. Education could have provided a vital role in coordinating action around neglect. This can be seen in relation to Adult G’s school history.

18.2 Adult G had difficulties fitting in with her mainstream primary school and was bullied, 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 was very good, and her reports reflected someone who was happy at school, having made friends and enjoying her subjects. She aspired for the future in childcare or hairdressing.

18.3 A formal annual review meeting of the SEN took place for each of Adult G's academic years 7 to 11. The annual review documents noted that Adult G's primary need was Moderate Learning Disability (MLD). The annual review guidelines noted that support, provision, and action for the next 12 months should be discussed: what, when, where, why, how and with whom – across education, health, care and at home. In each of these 5 annual reviews in secondary school, there was no reference to health or social care needs. This area remained blank throughout her schooling, despite there being input from the school nurse who was aware of neglect and involved in the social care intervention. Other agencies had no input into the annual review meetings which represented another missed opportunity to make links across.

18.4 The parents were unable to attend the Year 9 review meeting and sent a letter instead. It is a clear articulate letter which states, 'there have been quite a few family and community issues that have caused Adult G great anxiety. We believe that having someone outside of the family to talk to and help her work through issues, may help her better than we can. We are not sure whether this is something that Social Services could help us with.' However, there is no record of this having been followed up or referred on by school, to whom it is addressed.

18.5 In the Year 11 annual review, there was evidence of good transition planning in terms of aspirations, with the notes of a career interview attached. A work placement in a shop was arranged, and Adult G had a clear idea of what she would like to do next.

18.6 An EHCP was developed in Adult G's final year at school, there was again no reference to any health needs. Social, emotional, and mental health needs are noted as 'a fear of exams.' This document is then used by the college for annual reviews which took place in March 2017 and February 2018.

18.7 Adult G attended Goole College (now Hull) and studied health and social care. She was reported to make great progress in the first year, achieved her goals and with good attendance. However, the 2018 EHCP annual review notes,' since returning from Christmas (2018) break, Adult G has had a complete change of personality. Adult G has become withdrawn, isolated, and stubborn.' Attendance became an issue and Adult G saw concern from her friends as 'poking their noses in'. Adult G referred to a fall where she hurt her back. The report noted that her father wanted her to stay on, but mother said she could do what she wanted, there is no record of what happened next.

18.8 In summary, the quality of information sharing throughout Adult G's school and college life between health, social care, the police, and education could have been significantly better. Pennine View was clearly important to Adult G, and she thrived here with 100% attendance. The family were very supportive of the annual review process and spoke highly of the school. However, school either, did not seem to be aware of the full picture and/or understood the potential significant impact on their pupil's wellbeing. In turn, college were not fully informed of the issues on transition.

18.9 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 there appeared to be no engagement of other agencies in annual reviews. Whilst transition planning was good between school and college in terms of career choices, 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. This left her with no connection at all to external agency support

once Adult G left education. The EHCP should have remained with her and actively followed until her 25th birthday.

19. Social Care Engagement

19.1 There were two periods of social care engagement, as a child between 2009 and 2013 and a further period as an adult late 2021 to early 2022. The case notes from the most recent interaction with the family note how difficult they were to engage because of their early experience when Adult G was a child, the father noting that 'they messed her up'. Several social care practice issues were noted in this early interaction. This raises a key question about whether the early experience of the family with CSC during 2009 to 2013 significantly impacted their willingness to accept support at this crucial time, 6 months before her death.

19.2 The practice issues can be evidenced and include the following. The time taken for social care to instigate child protection processes from referral in June 2012 to a Child Protection Plan in place January 2013. There was reference to chasing up by education welfare and a delay in actioning Section 47 inquiries. It is relevant to note that in October 2012 Children's Services in Doncaster were inspected by Ofsted and judged to be inadequate.

19.3 The minutes of the CPC in March 2013 note further practice issues. 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 housing had not been made.

19.4 A change in the allocated social worker in May 2013 led to more progress being made with connections between agencies, the family and Adult G put in place. However, issues remained outstanding such as a joint chronology between agencies, the parenting assessment and referral to learning disabilities. Other avenues of support were ruled out such as referral to the Integrated Family Support Service for parenting support because the social worker felt he could provide this himself. This could well have supported the family once statutory service involvement ceased.

19.5 The decision to end the Child Protection Plan was predicated on the need for ongoing monitoring with the key risk identified as a recurrence of the home conditions and the family being unable to sustain improvements. However, in less than two months the case was closed completely with no ongoing monitoring in place. By March 2014, the fire service noted hoarding had returned and smoke alarms removed increasing the fire risk once again. The school nurse disagreed with the decision and tried to reopen the case, believing it too soon to be sure of sustained improvements, but without success and made a referral onto SYFR and EH for follow up on the living conditions after the case was closed.

19.6 In 2021, the adult safeguarding team were faced with resistance from the family to engaging with them. The social worker was able to speak on the phone to Adult G and the parents but were unable to arrange a face-to-face meeting. 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 decision to end the adult safeguarding action in 2022 is based on this non engagement and the joint visit from stronger

communities and the police. They referred onto SYFR for a ‘Safe and Well’ check who were unable to gain entry.

19.6 Concerns over the performance of CSC and the subsequent decision to form a Children’s Trust in 2013 is a matter of public record. At that time, a review found that there was a ‘’culture of failure and disillusion that pervades the services and that serves to obstruct every attempt to reform’ ’The review followed several high-profile child protection failures and concluded that ‘’only a decisive break from its past and the council’’ could improve children’s services in Doncaster.

19.7 In summary, it is highly likely that the early experience of the family with social services in 2009/10 and in particular 2012/2013 caused them to be cautious of statutory children’s social care support. They experienced poor practice and a lack of tangible support. The need for significant improvement in children’s social care was acknowledged by the council at the time with the decision to form the Children’s Trust. Officers should reassure themselves that the service improvements that have occurred since have addressed these practice issues.

20. The differing authority of agencies to access properties.

20.1 The authority of environmental health in conducting internal housing inspections was not widely understood, being described as a ‘revelation’ at the practitioner’s workshop. Conversely, there was a view by agencies, that SYFR were the ‘go to’ for environmental issues with agencies referring or discharging clients to them for ‘safe and well’ checks.

20.2 However, there are limits to the powers of SYFR in relation to power of entry. Unless there is good evidence of risk to life, they cannot force entry, whereas the authority of environmental health is more far reaching.

20.3 The powers of the enforcement team for housing within environmental health can be summarised as follows. Their general remit is to inspect privately rented properties and ensure action is taken where significant hazards are found. There is a Housing Health and Safety Rating System (HHSRS) withing the Housing Act 2004 which can be applied to all types of tenure. Following this assessment, they have enforcement powers to require works be undertaken to address the hazards. These powers mostly fall under the team’s discretion but if a category 1 hazard is identified, there is a duty to take enforcement action. There is work in Default powers where a notice is not complied with where they can undertake the work and recharge as appropriate.

20.4 In addition, there are enforcement powers under the Public Health Act 1936 and Prevention of Damage by Pest Act 1939 to address conditions that are filthy, verminous, or unwholesome. Again, if work is not undertaken in relation to this notice, the team can undertake the work and recharge.

20.5 In summary, only one referral was made to EH 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 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 to Adult G’s death. Instead, agencies referred to SYFR who could not force entry without evidence of extreme neglect. This failed visit led to referral back to stronger communities and eventual discharge from social care.

21. The feedback loop on vulnerable adult referrals

21.1 There was a missed opportunity for closer working between social care and the police in relation to vulnerable adult referrals.

21.2 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 from social services 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.

KEY FINDINGS – A Summary

22. Understanding hoarding and the impact on health.

22.1 Doncaster have had in place a policy on self-neglect since 2018. However, there is a need to strengthen this, as despite it being in place it did not provide enough protection or support for Adult G and her family. Practitioners noted that it did not recognise the mental health aspects of hoarding and that current systems do not recognise this either in terms of support. There was a need too, to raise its profile, to re-emphasise its purpose. There are challenges and additional points of clarity required such as who triggers it, who leads it and what each agency can bring to the issue. Agencies mentioned the need for it to provide a list of contacts within it.

22.2 There is no clarity on ongoing support for intransient issues such as hoarding. Whilst social care can hold the cases for a time, unless there is engagement, they will need to discharge. There is a need for clarity on who picks this up. The possibility of stronger communities' teams addressing this longer-term support should be considered, in addition to the development of a specialist self-neglect team, given Doncaster's economic and social demographics.

22.3 There is an overreliance on the SYFR to act as the safety net for such cases, as people are more likely to open the door for them as they are not presenting the threat of social care legal actions. However, their powers are limited and unless there is a risk to life, they have no legal powers of entry.

22.4 There is not sufficient understanding of the support that could be provided by environmental health in such circumstances. They have powers of entry which supersede those of SYFR but the agency does not feature in the current self-neglect policy.

23. Information sharing issues between agencies

23.1 Information sharing across health, social care, education, and the police could have been significantly improved from 2009 onwards. Opportunities were missed by all agencies to communicate with each other and ensure the full picture of Adult G's life and needs was understood.

23.2 School were involved in child protection processes, but they appeared not to understand the full impact of the home conditions or the incidents involving the police on their pupil's wellbeing. The school nurse and social care were not involved in annual EHCP or SEN reviews despite both being involved in child protection processes. The school nurse did not appear to utilise policy to escalate her professional disagreement when she believed Adult G had been discharged too soon from social services, although she did raise this directly with the social worker and asked that this be reconsidered.

23.3 In the case of social care sharing information with what happens to vulnerable adult referrals with the police, this was noted as an important improvement in practice. Without feedback, there was a tendency to repeat such referrals repeatedly to ensure the adult was covered for support.

24. Clear pathways for learning disabilities diagnosis and support

24.1 There was agreement at the practitioner's event that the General Developmental Pathway (GDA) would have provided a way forward for Adult G's formal diagnosis of her learning disability and subsequent support if it had occurred in 2024. There was a sense that time had moved on significantly since 2013, when, the only route was through the GP, which if the child was not in contact with, they would not have been referred.

24.2 Referral to learning disabilities services was important for Adult G and if this had occurred at an early stage would have triggered support to be put in place. There is now a clear focus of this in the EHCP process and Special educational and/or disabilities coordinator (SENCO) have a role in identifying and referring on as appropriate. Adult G would also have been picked up in transition to adulthood with the Community Adult Learning Disabilities team taking on the case and ensuring ongoing support in early adulthood and on. In addition, most recently, we know that there is a Learning Disability nurse, employed by RDaSH to support people in hospital with a diagnosed learning disability. This nurse works across multiple sites, including Doncaster Royal Infirmary, Mexborough and Tickhill Road. This nurse was made aware of Adult G and arrangements were made for follow up, however, Adult G sadly died before this was possible.

25. The role of education in managing neglect

25.1 The documentation and processes attached to the SEN and the EHCP from all education providers involved at various stages, did not adequately consider, or engage health and social care. They did not understand the impact of home conditions on Adult G's wellbeing or anticipate a role for themselves in facilitating solutions.

25.2 Secondary school represented a missed opportunity to coordinate action and parental support, as an agency trusted by the family.

25.3 College could have done more to follow up on non-attendance and ensure the EHCP was followed through until Adult G was in an established situation in adulthood. However, information passed on from school as we have noted was missing key information about Adult G's life and additional needs.

25.4 Officers informed the review of a new electronic system being rolled out which should tackle these issues. The system manages the whole EHCP assessment process that gives both parents and professionals access to all documentation online.

26. Gaps in children's social care practice during Adult G's childhood

26.1 In the early days, the family reported that they did not have a positive experience of social services, and this appeared to impact their willingness to access support when they needed it. There were several practice issues noted such as the time taken to act on child protection processes, poor records, cancelled meetings, lack of follow through and engagement of other agencies who knew more about the case. In addition, they were too soon to discharge given the relatively short time to monitor sustained change in the home environment. The apparent lack of carer's assessment was a significant omission in not tackling the ongoing issues of parental support.

26.2 The decision to form a Children's Trust recognised the need to improve children's social care but it needs to be acknowledged that there are still clients like Adult G for whom this was too late. Steps should be taken to reassure the Board that the issues raised here have now been addressed.

27. Gaps in adult social care practice and services in relation to neglect

27.1 Adult G came to the attention of adult safeguarding in 2021 and were faced with the animosity from the early experience of the family with children's social care. This impacted their ability to engage and meet face to face although calls were made and taken by the family.

27.2 Adult social services closed their section 42 safeguarding enquiries on the assumption that stronger communities had been involved and physically observed Adult G to be safe and well. In fact, they had been involved at an earlier stage but had referred onto SYFR for a 'safe and well' check who tried to enter the property but were unable to gain access, leading to re-referral back to stronger communities' team. The home conditions were therefore not addressed.

27.3 There is a gap in service for this type of neglect in Doncaster given its social and economic demography and a need for a solution in the short and long term. There is also work now ongoing to understand better the area of non-engagement in Adult Social Care.

RECOMMENDATIONS

28. Neglect – Strategy, Policy, and Toolkits for practitioners

28.1 There is a recognition amongst all agencies that Doncaster's policy on Self-Neglect, first established in 2018 is key in managing cases of neglect. This sits within a broader strategy on neglect which incorporates an assessment tool for practitioners, neglect champions and policy. However, there is a need to build on this work, to strengthen the links with the Graded Care Profile tool and the Self-Neglect Policy. There is a need to raise the profile of neglect further across the system as despite a policy being in place, it did not provide enough protection or support for Adult G and her family. Indeed, it appeared not to have been utilised due to the family not willing to engage. Doncaster has an Adult Self Neglect Sub-Group which would be ideally suited to take this recommendation forward, once approved by the Board. Consideration should be given to the expansion of the membership of this group to input from children's services in order to ensure an all-age response.

This recommendation centres on the development of a broader strategy on neglect (see 28.2), the strengthening of the existing policy on self -neglect with the specific areas listed (28.3) and the consideration of additional training toolkits to support practitioners (28.4)

28.2 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. Key aspects of these strategies include.

- Recognising neglect is multi-dimensional and that children may have medical, nutritional, emotional educational, physical, or supervisory needs neglected all of which have different impacts at different stages of a child's life and can have an enduring impact on the rest of their life.

- Each organisation, whether working with children or adults, will have a different role but all have a responsibility to bring this unique perspective to the partnership assessment and response.
- Understanding the root causes of neglect and identifying neglect early.
- Understanding the prevalence of neglect and understanding the impact of support and how it can be improved.
- Adopting evidence-based tools to assess neglect and inform the offer of support.
- A workforce strategy which supports practitioners to differentiate between unmet needs and neglect, where families are living in poverty.
- A positive culture and language so that families feel respectfully challenged and supported to understand their concerns.
- Understanding what it feels like to be a child or family member suffering from neglect through focus groups.

28.3 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 hoarding issues and its profile further raised. This policy should therefore be revisited, to simplify the process and clarify certain aspects to ensure all agencies understand their role within it. The specific issues that should be addressed are.

- To agree hoarding requires a multi-agency response on a long-term basis and to provide information on the impact of hoarding and its direct link to mental health conditions and physical health consequences.
- To clarify who leads action on hoarding, how it is triggered and what each agency should bring to the table.
- To clarify the important role of environmental health in supporting the system manage neglect, making clear their powers to conduct internal housing inspections and subsequent clearing out of property, where appropriate.
- To ensure the system understands the limitations to the powers of South Yorkshire Fire and Rescue to gain access to any property and that this can only be forced where there is evidence of threat to life.
- To provide a simple contact list with email and telephone details of agencies involved.

28.4 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. Professionals score aspects of family life on a scale of one to five and through this process helps them identify areas where the level of care children receive could be improved. Importantly it aims to develop a constructive working relationship with families and increases confidence in decision making. It is in operation in 90 local areas across the UK.

However, training in the understanding of self-neglect, additional time to understand the particular challenges practitioners face, especially when balancing a person' rights with safeguarding issues is critical. Other sources of guidance and toolkits for additional training should be considered to support the workforce manage neglect in this complex field include.

- Camden's Multi-Agency Self Neglect Toolkit. This recognises the challenges of supporting families suffering from neglect and provides a toolkit aimed to support practitioners understand these challenges, providing definitions, easily understandable relevant legislation, and risk assessment tools. See www.camden.gov.uk
- Toolkit produced by the Dartington Trust, ''working with people who self – neglect''. Similarly, this brings into one document key research messages about neglect, guidance on how to engage with people who self-neglect and the legislative framework. See www.researchinpractice.org.uk
- Workbook produced by the Local Government Association, 'Making Safeguarding Personal in self-neglect'. This provides the resources and structure for workshops of various lengths including videos and quizzes to aid understanding. See www.local.gov.uk

29. Multi – agency targeted support services for neglect

29.1 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.

29.1 Browne 2014, in his review of interventions with families in difficulty and the role of the MDT in the UK noted that traditional classification of the early prevention and detection of problem parenting and child maltreatment came in three levels. Universal services aimed at the whole population (primary intervention), targeted services for families identified as in need of further support (secondary intervention) and services offered once difficulties have occurred (tertiary intervention). However, research now emphasises the greater success of a public health approach, problem parenting and child maltreatment should be considered within the broader context of child welfare, families, and communities. Furthermore that, the primary focus of professionals should be the prevention of child disability, morbidity, and mortality and to promote the early detection of child maltreatment identifying through risk assessment the risk factors associated with child abuse and neglect. He finds that most authors reviewed conclude that a multi-sector, multi-disciplinary approach as the most effective way to work to ensure the child develops and grows in a safe family environment. (www.researchgate.net).

29.2 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. However, their engagement in cases of neglect is on a case-by-case basis. Consideration should be given to strengthening the role of Stronger Communities teams in the short term to be able to provide ongoing monitoring and support to families suffering from neglect and become core members of the adult self-neglect group. Their status as non-statutory service would go far to address the resistance to support exemplified in this case.

29.4 In the long term, as we know that neglect is a long-term condition and requires a 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 as a minimum and links to the self-neglect policy above This type of specialist team, can work together to provide a plan around the person and work at their pace to support them to reduce and manage the risks, and ultimately achieve their personal outcomes, discharging only when that person is ready.

30. Independent Review of Children's Practice

30.1 Practice issues across all agencies, were identified throughout adult G's childhood, and it is likely that, given their feedback in 2021, this experience impacted the family's further engagement as an adult. There is a need to ensure that these specific issues have now been addressed.

30.2 The identification of these issues in this case could provide a set of indices for a useful practice audit which compares practice pre–Children's Trust with current practice in 2024.

30.3 This type of independent desk top study could provide useful quality assurance to officers across Doncaster that should a case like Adult G's occur again, the changes that have been put in place over the last ten years through the extensive improvement programme by children's services would ensure the same would not occur again. This type of 'before and after' study has been conducted by other organisations (private and public sector) and can help senior officers understand how the strategic changes made have supported practitioners on the ground. What has worked, what hasn't and what still needs to be done can inform the next strategic plan.

30.4 The areas that could be included and were highlighted in this review were.

- Children's social care practice - Processing of child protection proceedings, timescale taken for each stage. Managing professional disagreements especially in relation to discharge. Quality of carer assessments and ongoing support for parenting issues. Information sharing with schools on child in need cases.
- Education – Consideration of health and social care issues in EHCPs. Proactive engagement of health and social care in annual reviews. Use of EHCPs by colleges. Use of EHCPs in early adulthood.
- Health – School nurse engagement with EHCP reviews and sharing of information. Escalation of professional disagreements through line managers. Clarity of pathway to assessment, diagnosis, and support for children with learning disabilities.

CONCLUSION

31. Multi – agency effectiveness

31.1 Terms of reference point 1. The effectiveness of current multi – agency working to protect adults at risk of neglect specifically where the care is sought from family and whether safe systems are in place.

31.2 The understanding that hoarding is a mental health condition and that poor home conditions have strong links to physical health issues such as respiratory issues was limited amongst agencies resulting in single agency action with mixed results.

31.3 There was a pattern of referral to social services both in childhood and adulthood which led to short term action and early discharge either due to non-engagement by the family or a small improvement in home conditions. In the absence of ongoing support and, monitoring home conditions deteriorated again, and the cycle continued.

31.4 There was an overreliance on the fire and rescue service to be the 'catch all' for home conditions in their 'safe and well' checks despite the lack of authority of this agency to access properties unless there was a risk to life. Conversely, the authority of the enforcement team within environmental health was underutilised and their powers to gain

access not understood. Clarifying these differences in authority should be included in policy and added into the self – neglect toolkit.

31.5 Hoarding represents a long-term issue and there is a need for a multi agency service for the ongoing support of families struggling with home conditions. Formalising the role of stronger communities' teams in this regard presents a potential solution in the short term. Funding a multi-agency service with input from all the agencies engaged here a potential solution in the long term.

32. Information sharing.

32.1 Terms of reference point 2. Whether information was shared across multi agencies when Adult G transitioned to adulthood. Was information shared during the transition to adulthood, and information shared with parents?

32.2 There were no health and social care services involvement with Adult G from 2013 (aged 14 years old). There had been no referrals to children's learning disabilities services by any agency despite clearly being referred to as a vulnerable child with moderate learning difficulties throughout childhood and therefore no transition planning to adult learning disabilities. Social services discharged Adult G in 2013 therefore there was no transition planning to adult social care either. In summary, at the age of 18 there was no handover from child to adult services from health or social care.

32.3 In terms of education, there was good transition planning between secondary school and college with a career meeting taking place and a joint meeting between college and school. This was limited though by the information that school had understood as significant and therefore had recorded. Adult G left college in 2018 and before the course had been completed. There was no follow up and no record of what Adult G did on leaving college. Proactive follow up by all education providers involved with Adult G was required which may have ensured the full picture of Adult G's life and needs was understood across agencies and a multi-agency plan of support put in place.

32.4 There is a need to review the role of colleges in relation to the EHCP and follow up post 18. Northern College, Barnsley, represents an interesting model aiming to tackle the difficulty some young people particularly with learning disabilities have getting into work, vocational training, and further education at university. (www.northerncollege.org)

32.5 Health and social care needs remained blank in SEN and EHCP documentation both during secondary school and in college. The school nurse was not involved in the annual review process at secondary school at this time.

32.6 Processes and policies have been developed since Adult Gs' initial experience of the system in 2009 to 2013 with the formation of the Children's Trust in Doncaster in 2013. However, for Adult G, this lack of information sharing and referral onwards at this early stage led to Adult G not being placed in services that would have supported her transition to adulthood and provided crucial oversight in the three years before her death such as community adult learning disabilities.

33. Parental Support

33.1 Terms of reference point 3. Whether any support was identified for the parents (carer's assessment).

33.2 No carers assessments were found, nor specific parental support put in place during childhood or adulthood were found in this review. The ICPC notes in September 2013

that the parental assessment was still outstanding and two months later the case is closed to CSC. This is despite repeated observations in notes by practitioners across agencies to the need for family support throughout Adult G's life and links in with the findings from previous SARs.

33.3 In the words of the family, they perceived their early experience with children's social care in 2013 as negative and this appeared to lead to a lack of engagement with all services from this point onwards. Practice issues were noted such as, Child protection proceedings taking time to get started and the case being quickly discharged as soon as some home improvements had been observed. There was professional disagreement on discharging so soon, citing more sustained improvements should be observed first. They had not received any tangible service support and were disappointed not to have been engaged in elements of the Child protection process such as the Legal Monitoring Planning Meeting.

33.4 Adult G's secondary school was trusted by the family, and this presented a missed opportunity to facilitate a multi-agency dialogue around parenting support. Parents were actively involved in annual SEN reviews and had requested additional support in writing. School documentation showed no evidence they were aware of the full extent of Adult G's behaviour outside of school or an understanding of the impact of Adult G's home condition on their pupil's wellbeing.

33.5 In adulthood, the social worker attempted to engage with the family but were met with a lack of willingness to engage in face-to-face contact and in particular a home visit.

33.6 An assurance exercise is recommended that the issues identified here have been robustly addressed now.

34. Policies on Self- neglect

34.1 Terms of Reference point 4. Whether relevant policies and procedures were followed where there were repeated concerns of self-neglect.

34.2 The review found that whilst a multi-agency policy for self-neglect had been in place since 2018, there was a lack of clarity on its implementation and a low profile. The policy did not go far enough to support practitioners provide a service to Adult G and her family, particularly in cases of non-engagement.

34.3 The policy needs to be reviewed, simplified and agreements reached on which agency should trigger the policy and the role of each agency in relation to hoarding and intransient home conditions and how they work together to provide a multi-agency approach and ongoing support and monitoring.

34.4 The policy needs relaunching through the Board and its profile significantly raised amongst agencies, putting into the context of a wider, multi-agency all age strategy for self-neglect and the additional of toolkits and training for the workforce to have time to discuss how to deal with such challenging cases.

35. Summary of Recommendations

35.1 Three key recommendations have been made which once agreed should be translated into a detailed action plan with SMART objectives, they are.

- Strengthening the Self Neglect policy and raising its profile across Doncaster through an all age, multi-agency strategy and additional workforce training.

- Identifying a short-term solution and long-term solution for the ongoing support and monitoring of Self – Neglect, considering formalising the use of stronger communities' teams in the short term and with additional funding, a multi-agency specialist team in the long term.
- Conducting a quality assurance exercise to ensure the practice issues identified in 2013 have been addressed in 2024 across all agencies.

35.2 A list of useful references are provided in Appendix C to aid understanding of neglect, hoarding and its link to health and to provide useful links to policies, toolkits, and strategies in relation to neglect.

36. Additional Areas of Research

36.1 The impact of obesity as a symptom of self-neglect has been raised as a potential concern in the course of this review. Adult G was part of the National Childhood Obesity Programme which weighed primary school age children and sent the results home to parents in the form of a letter with an offer for support by school nursing teams. However, there is no evidence that further support was taken up at this time, nor that obesity was an issue in adulthood or raised in either the GP attendances in May 2022 or hospital admission immediately prior to her death.

The aetiology of adult obesity is still subject to ongoing research but in a review of three electronic databases (MEDLINE, PsycINFO and PsychINFO weekly), 8 studies were identified which found that psychosocial factors related to adult obesity were lack of childhood care, abuse, and childhood anxiety disorders. In addition, childhood depression adolescence tended to be related to adult obesity among girls only. In addition, learning difficulties and school performance below average were also risk factors. (www.pubmed.ncbi.nlm.nih.gov).

Not enough is known about Adult G's mental health in adolescence and physical health as an adult to focus on this area for the purpose of this SAR, however it remains an important area of research and issue in understanding the impact of childhood neglect and self-neglect into adulthood.

36.2 For many young people post 19, particularly those subject to an EHCP, the movement from an education environment into full independence and a working life can be too soon for them both academically and in terms of life experience and maturity.

The City of Doncaster Council have their Adult, Family and Community Learning, recently rated as good by Ofsted (Office for Standards in Education, Children's Services and Skills). Their mission is 'to provide local, accessible learning that improves wellbeing, skills and knowledge of adults, their families, and communities' (www.doncaster.gov.uk).

Not enough is known about what Adult G did after suddenly leaving Goole College, but it is possible she found the transition from school to a college environment challenging. It is likely that Adult G would have benefitted from onward support post 19.

Northern college in Barnsley represent another model of provision for young people who recognise these challenges. They are the only residential college for adults in the North for aged 19 plus aiming to prepare young people to re-enter education if needed, gain employment, or make a career change through residential learning and specialist support. They provide increased independence to young people but within a supportive residential environment. For example, one such course focuses on skills for life and work to build

confidence, understanding teamwork, self-management and provide practical skills such as CV creation and interview skills. (www.northern.ac.uk).

APPENDIX A

Practitioners Event 7th December 10am to 12pm

Doncaster Council Offices

Safeguarding Adult Review – Adult G

Agenda

1. Introduction to today's learning event (Ian Boldy, Chair)

2. Overview of Georgina's life and reasons for the SAR (Claire Thomson, Independent Author)

3. Emerging Themes (Claire Thomson, Independent Author)

    a. The impact of hoarding on mental and physical health.
        i. Accessibility Issues
        ii. Information Sharing; police and social services
    b. Parental Support; the assessment of and ongoing provision.
    c. Social Care Engagement
    d. Learning Disability Diagnosis and Support; child to adult.
    e. Role of Education in identifying and acting on neglect

4. Group Work: Discussion of emerging themes (Facilitators Angelique Choppin, Shabnum Amin, Yvonne Byrne, Safeguarding Business Unit)
    - Group One: Theme a
    - Group Two: Themes b and c
    - Group Three: Themes d and e

5. Group Feedback and discussion (Claire Thomson and facilitators)
    - General thoughts on key issues – explanations and comments
    - What would happen today?
    - Further improvement for 2023.

6. Summary of key messages and Next Steps (Ian Boldy and Claire Thomson)

APPENDIX B

Group One

Home conditions and the impact on Mental and Physical health

Hoarding is a mental health condition and associated with other mental health conditions such as major depression. The link between mould and poor physical health is well evidenced and Adult G was known to take a strong antihistamine, from childhood onwards.

The home environment is the key issue which brings Adult G to the attention of social services for the first time in 2009. The photographs taken on the day of Adult G's death in July 2022 show that these conditions persisted throughout Adult G's life. The cause of death for Adult G was Bronchopneumonia and a Urinary Tract Infection. Adult G had also caught covid whilst in hospital, noted as covid positive 5 days before her death. Neighbours and practitioners spoke of curtains and windows being shut all day. Poor ventilation, unhygienic living conditions over a prolonged period are likely to have impacted on Adult G's immune system and general health and arguably a strong contributor to Adult G's death. Arguably, agency response to poor home conditions was critical in this case.

Within the two periods of social care engagement 2009/10 and 2012/13, home improvements are observed to have been made with exits cleared and electrical overloading improved. However, once the case was closed to social care, conditions deteriorated again This suggests that without continuous monitoring and support the family were unable to take care of the home environment on their own. Why might this not have been considered as an ongoing requirement for the family and what would happen now?

There was disagreement between school nurse and social worker as to closing the case to social care in 2013 and whilst unable to change this decision, the school nurse referred onto South Yorkshire Fire and Rescue to check up on the property in the absence of any other agency involvement. How might this professional disagreement be managed today?

SYFR were the only agency who attempted to engage with the family during 2013 to 2016 with some visits made. However, they discharged the case due to non-engagement of the family who were resistive to visits. The same thing happened again in 2022. The family refused to engage with adult safeguarding and following a joint visit by the police and stronger communities, the family was discharged from safeguarding with a referral to SYFR for follow up. However, again, SYFR have no power of entry and are refused access. Should the monitoring of home conditions have the ownership of other agencies? What would happen now?

There is reference to referrals being made to environmental health in 2016 but no record of this having been received. Confirmation was received from environmental health that no referrals or complaints had been received by them about housing standards or conditions inside the property and there was no record of a multi-agency request to deal with conditions within the property. Given their ability to secure a warrant for entry, should this have been more actively followed up? What would happen now?

There is no mention of the home conditions in the SEN or the EHCP for Pennine View and Goole College. Could this have been another route for the School Nursing team to raise concerns and had home conditions been communicated between school and college?

The key issues are, was the impact of hoarding on physical and emotional health 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, should this have been treated as a higher priority for this family and consequently a stronger multiagency response formulated in the months before she died.

The differing authority of agencies to access properties.

There was a view that South Yorkshire Fire and Rescue were the 'go to' for environmental issues with practitioners, where they themselves couldn't continue to be involved, referred to them for 'safe and well' assessments However, there were limits to the powers of South Yorkshire Fire and Rescue Service in relation to power of entry. Unless there was good evidence of neglect, they could not force entry. If there was serious evidence of neglect, they could engage the police to gain access. Of course, this represents a catch 22, without access, evidence would not be available.

Conversely, no referrals were made to environmental health who did have more powers of entry for internal inspections of housing. Environmental health can gain access through the obtaining of a warrant. However, no referrals were made to them to do so.

The key issue is whether all agencies are aware of the limits or extended powers of these agencies according to circumstance.

The feedback loop on vulnerable adult referrals

Finally, where the police were involved with vulnerable adults, they can make a vulnerable adult referral to social services for follow up. This was done for Adult G, however, there would appear to be no feedback on action taken from social services which inevitably led to repeat referrals, leading to more workload the police and an extended referral list to social services.

The key issue is what steps could be taken to share more information with the police on what is being done to address the concerns they have raised with social services.

Group Two

Parental Assessment and Support

The parents were clearly struggling to keep a hygienic and safe environment for their family. From 2009 onwards up until Adult G's death, reference is made to several recurring issues. This included hoarding, electrical overloading, poor hygiene, 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. It was noted that Trinity Academy, the secondary school, where the older sibling attended were concerned about the poor home conditions, so it is likely that these issues were present from the beginning of Adult G's life.

Parenting was referred to in the initial social care interaction in 2009 but there was no evidence of their needs being assessed. There was an altercation with a neighbour with accusations that Adult G was exposing herself and being verbally abusive in 2012 and the police incident

noted that the social worker expressed concerns that the parents could look after her. When Child Protection Proceedings took place in 2013, the category is changed to emotional harm on the basis that the parents were not able to provide guidance and reassurance for Adult G to feel safe. However, there was no evidence that the parents' needs were assessed for and a plan for this put into place.

During the period 2013 to 2016, the parents deny access to their home to SYFR despite consistent hoarding and fire risk, the parents were highly reticent for services to be involved.

In 2021, when adult safeguarding became involved, the social worker spoke to the father who is highly resistive to the involvement of social care on the basis that they had a bad experience with them when Adult G was a child, saying they' messed her up.'

During the hospital admission in 2022, immediately prior to Adult G's death, upon investigating the safeguarding referral, the police officer concluded that there is no evidence to substantiate the claims but that the family needed support, and a referral was made to social services.

There is plenty of evidence that practitioners were aware that the family were struggling and needed support and of referrals being made, but there is no record of social care support for the parents and no record of formal assessment of their needs either as part of the earlier child protection proceedings or separately.

The key issues are why were they not assessed for and what support might have been available for the parents if assessed at that time and now?

Social Care Engagement

There were two periods of social care engagement, as a child between 2009 and 2013 and as an adult late 2021 to early 2022. The case notes from the most recent interaction with the family note how resistive they were to support because of their early experience when Adult G was a child, the father noting that 'they messed her up'. Several social care practice issues were noted in this early interaction. This raises a key question about whether the early experience of the family with social services significantly impacted their willingness to accept support at this crucial time, 6 months before her death.

The practice issues can be evidenced and include the following. The time taken for social care to instigate child protection proceedings from referral in June 2012 to a Child Protection Plan in place January 2013. There is reference to chasing up by education welfare and a delay in actioning the decision for Section 47 inquiries.

There is professional disagreement on closing the case so soon. In March 2013 the meeting noted no progress made by the family in addressing the issues, by November 2013 the case is closed. The school nurse tried to reopen the case without success and made a referral on to SY Fire and rescue and environmental health for follow up on the living conditions after the case was closed.

There was no assessment of parental need and support put in place and no reference to the sibling. There is no evidence of a referral being made to Adult Learning disabilities despite references to it being agreed. There is no evidence of information sharing with school.

In the 2021 social care engagement, the adult safeguarding team are faced with resistance from the family. The father sees ongoing agency engagement as interfering and that the early experience of support was poor. The social worker was able to speak on the phone to Adult G and the parents but were unable to arrange a face-to-face meeting. The decision to end the adult safeguarding action in 2022 is based on this non engagement and the joint

visit from stronger communities and the police. They referred onto South Yorkshire Fire and Rescue for a Safe and Well check who were unable to gain entry.

Concerns over the performance of children's social services and the subsequent decision to form a Children's Trust in 2013 is a matter of public record. At that time, a review found that there was a ''culture of failure and disillusion that pervades the services and that serves to obstruct every attempt to reform' 'The review followed several high-profile child protection failures and concluded that ''only a decisive break from its past and the council'' could improve children's services in Doncaster.

The key issue, is whether the service changes that have occurred since would have prevented these practice issues now and ultimately changed the outcome for Adult G.

Group Three

Learning Disabilities Diagnosis and Support

Adult G was described throughout her interactions with agencies as, a child with learning difficulties, however there is no evidence of a referral being made for a formal diagnosis and follow up care within either health or social care learning disabilities services.

Adult G was excluded from primary school, attended two pupil referral units, attended a specialist secondary provision for SEND and was noted by this school to have learning difficulties. The SEN and EHCP documentation describe Adult G's primary need as Moderate Learning Disabilities.

Adult G is referred to as, 'a vulnerable child with learning disabilities' in the Child Protection Plan in 2013, but there is no record of a formal diagnosis.

In addition, Adult G's mother is also referred to as an adult with learning difficulties. Notes from the Mosaic system in 2013 show that the family were resistive to support, with the father referring to his own poor experiences, but that they were eventually persuaded to be referred to adult learning disabilities on the basis that they may get financial support for rewiring.

However, it has been confirmed by the Community Adult Learning Disability Services that neither Adult G's parents nor Adult G were known to these services.

There were several missed opportunities to refer Adult G and her parents to learning disabilities services for diagnosis and potential support.

The key issues are, why were these opportunities missed? What might have been Adult G's journey been if this had been picked up? Are systems currently in place to ensure those with suspected learning disabilities as children or adults screened routinely both as children and adults?

Role of education in identifying and acting on neglect

There is no evidence in any key documentation that the school which Adult G attended with attendance of near 100% for all of her secondary years and the college she subsequently went to, were aware of any family issues, in particular the Child In Need Plan, despite the school nurse being actively involved and concerned.

In terms of Adult G's school history, Adult G had difficulties fitting in with her mainstream primary school and was bullied, 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 is very good, and her reports reflect someone who is happy at school, having made friends and enjoying her subjects. She aspired for the future in childcare or hairdressing.

The original Statement of Educational Need was produced in 2010 which led to the placement at Pennine View. It noted Educational Psychology input from 2007 and cognitive abilities within the limited range. Health issues were noted as her vision and motor skills. At this point, Adult G had a Child in Need Plan and known to Children and School's Social Work Service as it was called. There was no reference to neglect or the reasons for this plan in the SEN documentation.

A formal annual review meeting took place for each of Adult G's academic years 7 to 11. The annual review documents noted that Adult Gs' primary need was Moderate Learning Disability (MLD). The annual review guidelines noted that support, provision, and action for the next 12 months should be discussed: what, when, where, why, how and with whom – across education, health, care and at home. In each of these 5 annual reviews there was no reference to health or social care needs. This area remained blank throughout her schooling, despite there being input from the school nurse who was aware of neglect and involved in the social care intervention.

The parents were unable to attend the Year 9 review meeting and sent a letter instead. It is a clear articulate letter which states, 'there have been quite a few family and community issues that have caused Georgina great anxiety. We believe that having someone outside of the family to talk to and help her work through issues, may help her better than we can. We are not sure whether this is something that Social Services could help us with.' There is no record of this having been followed up or referred on by school, to whom it is addressed.

In the Year 11 annual review, there was evidence of good transition planning with the notes of a career interview attached. A work placement in a shop was arranged, and Adult G had a clear idea of what she would like to do next.

An EHCP was developed in Adult G's final year at school, there is again no reference to any health needs. Social, emotional, and mental health needs are noted as 'a fear of exams. There are no separate social or healthcare plans. This document is then used by the college for annual reviews which take place in March 2017 and February 2018.

Adult G attended Goole College (now Hull) and studied health and social care. She was reported to make great progress in the first year, achieved her goals and with good attendance. However, the 2018 EHCP annual review notes,' since returning from Christmas (2018) break, Adult G has had a complete change of personality. Adult G has become withdrawn, isolated, and stubborn.' Attendance became an issue and Adult G saw concern from her friends as 'poking their noses in'. Adult G referred to a fall where she hurt her back. The report noted that her father wanted her to stay on, but mother said she could do what she wanted, there is no record of what happened next.

Running alongside Adult G's educational experience is the family's experience with other agencies. There had been little information sharing throughout between health, social care and education. There was a missed opportunity at the beginning of the statement process where there is reference to the Child in Need Plan in the initial SEN document which is never followed up in subsequent reviews. Another missed opportunity occurred when the parents openly asked for support from social services; there is no record of what was then done. All annual reviews are entirely blank for health and social care interactions despite the school

nurse being actively concerned and involved in the 2013 Child in Need Plan. The school nurse or social worker was not involved in the annual reviews. There is no record of what happened to Adult G when she decided to leave college.

The key issues are, what could account for these missed opportunities and lack of information sharing during the period 2010 to 2018? What would occur now in 2023 in terms of attendance at annual reviews, information sharing between school nursing and schools, information between child in need processes and schools and follow up for young people who are vulnerable when they drop out of the education system? Shouldn't the EHCP had stayed with Adult G until she was safely placed in an alternative education or work placement? Ultimately, would multi agency information sharing have had an impact on the outcome for Adult G?

APPENDIX C

Links and References for Practice Improvement (non Harvard)

www.brighamandwomensfaulkner.org Understanding Just Culture

www.languages.oup.com Understanding the blame game

www.scie.org Self Neglect at a glance

www.gov.uk Practice Guidance on neglect

www.collinsdictionary.com Definition of Sense checking

www.nhs.uk Definition of hoarding and the linked conditions

www.mass.gov Risks Caused by Hoarding

www.hoarders911.com Hoarding and Health risks

www.ncbi.nlm.nih.gov Understanding the link between disabilities and hoarding, research article.

www.salaamedia.com Cluttered mind, cluttered life, the impact of hoarding on mental and physical health

www.kirklesschildcare.proceduresonline.com Working with uncooperative and Hard to engage Families, guidelines for workers.

www.lancashiresafeguarding.org.uk Multi – Agency Self- Neglect Framework (to support policy improvement)

www.camden.gov.uk Multi – agency Self – Neglect tool

www.local.gov.uk Making Safeguarding Personal in self-neglect workbook

www.tameside.gov.uk Multi - agency Self Neglect Strategy.

www.researchgate.net What works in cases of child maltreatment and neglect.

www.pubmed.ncbi.nlm.nih.gov Childhood neglect, abuse and adult obesity.

www.northern.ac.uk Residential college for adults age 19 + to prepare young adults to re-enter education, gain employment or make a career change through immersive residential and specialist support.