SAFEGUARDING ADULT REVIEW

EXECUTIVE SUMMARY

Serious Case Review in respect of	Joan, Kate and Laura
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1. Introduction

Purpose

The subjects of this review are a family: the mother Joan and two daughters Kate and Laura who were 23 and 20 years of age respectively, at the commencement of this review. The mother and daughters lived together in local authority housing.

This review concerns the services delivered to the family over an extended period of time. The case was referred to the Safeguarding Adults Board in November 2018, after it was identified that members of the family were struggling to cope and this was resulting in neglect to such an extent that it was likely to have serious consequences for the family, particularly with their ability to maintain a tenancy and remain in their accommodation.

When examined it could be seen that there had been a repeating pattern of both children and adult services being involved with the family, but it appeared that there had been little sustained improvement for the family.

2. How was the review undertaken

The purpose of a Safeguarding Adult Review (SAR) is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again.

Reviews should be proportionate to the complexity and nature of the particular case. In this case the review panel decided that a proportionate and strength-based review, based on Pathways to Harm approach, using chronologies and practitioner events to draw out the learning regarding good practice would be used.

Practitioners from the agencies were then asked to attend a discussion event to explore the events and understand the challenges within the context at that particular time. There was also a focus to identify any good practice and learning opportunities to allow for continuous improvement.

Throughout the review consideration was given to the six safeguarding principles of empowerment, prevention, proportionality, protection, partnership and accountability.

This review has also focused on, where appropriate, the SAR Quality Markers which are focused on the commissioning, conduct and quality assurance of the review process.

The SAR subgroup identified the below agencies as being involved in the case and therefore requested them to supply chronologies.

Worcestershire Children First
Worcestershire Acute Hospitals NHS Trust (WAHT)
Worcestershire Health and Care NHS Trust (WHCT), including Community Learning Disability Team
West Mercia Police (WMP)
GP Practice
Wyre Forest Community Housing
WCC, including Area Social Work Team Wyre Forest and Connect
Day Care Centre

Within the terms of reference, the panel requested that agencies consider the following areas

- How the agency held Making Safeguarding Personal at the centre of the services provided to Joan, Kate and Laura.
- Was due consideration given to the Mental Capacity Act. Was it appropriately identified and documented?
- Were the arrangements for the transition of services from Children to Adult services appropriately undertaken?
- Was relevant information shared and were any concerns communicated?
- Was self-neglect a factor, and if so, was it identified and dealt with in accordance with guidance available at the relevant time?
- Were appropriate assessments undertaken, in particular with regard to the ability for Joan to provide care to Kate and Laura?
- Did domestic abuse have an impact on the family, were issues identified and available support services offered?
- What aspect of good practice can be drawn from this case?

The family have been referred to, and other significant persons have been referred to, by pseudonyms for the purposes of this review.

3. Family Involvement

3.1 The family were seen by the author and board representative and informed of the review, the purpose and how they could be involved. The family were happy to be involved and viewed the review as a positive step.

3.2 The family were seen together in February 2020 by the review author and Safeguarding Board Manager. This visit took some time to arrange to ensure that the timing was conducive to the family circumstances at the time. The family views were incorporated into the review.

4. Circumstances

4.1 This review focuses on Joan, and her daughters Kate and Laura. Kate was born in May 1995, Laura was born in April 1998 and therefore the daughters were 23 and 20 years of age respectively at the commencement of this review.

4.2 The family had a challenging early life with domestic abuse perpetrated on Joan by her now estranged husband who was also the girl's father.

4.3 Over an extended period of time Kate and Laura suffered severe neglect. This neglect was identified by their school and health professionals. This neglect presented in the form of physical, educational and medical (missed health appointments and care). There was evidence of significant environmental neglect in the form of very poor home conditions necessitating the family being moved.

4.4 There were a number of interventions by Children Services and other agencies in the form of a Child in Need Plan, Child Protection Plan and early stages of legal planning. Although there were temporary improvements at times, there was no evidence of sustained improvement and there was evidence that the neglect was impacting on Kate's and Laura's physical and mental health.

4.5 There was evidence that Joan suffered from depression and there were concerns over her mental health. Joan's parenting ability and mental capacity were not effectively assessed, to understand what the impact of this was on the children and young adults.

4.6 There were concerns that Kate had a learning disability and more latterly was diagnosed with autism and Laura was diagnosed with anxiety and epilepsy. Both as a child and young adult Laura performed a significant caring role within the family.

4.7 As the children moved towards adulthood there was a lack of coherent planning as to how support would be achieved for them as young adults. It was deemed that

they did not meet the criteria of care and support within the terms of the Care Act 2014.

4.8 On becoming young adults Kate and Laura started to present with self-neglect, as indeed did their mother Joan. This neglect was a continuance of the behaviour that had been presented over a period of years. This was exacerbated as the support in the form of school and some health provision was not in regular contact with Kate and Laura, to be able to raise and monitor concerns.

4.9 The referral that initiated the action leading to this review was as a result of the housing authority receiving complaints that the property was once again in an unsanitary condition.

5. Learning from this case

5.1 Dealing with neglect in children – The review identified that there was drift in the child protection plan and legal planning in the case and this led to the neglect not being effectively dealt with and escalated when there was insufficient improvement. This included the need for escalation and consideration of using legal measures to combat neglect and put clear boundaries in place. The review recognised that the ability of the parent or carer should be effectively assessed and mental capacity where appropriate. The review panel and Safeguarding Adults Board recognised that Kate and Laura transitioned to young adults 5 and 2 years ago respectively. The way that neglect in children is identified and responded to has changed. Evidence of developments, how they are embedded and monitored was provided to the review and Safeguarding Adults Board.

5.2 Carer assessments – Where a person is identified as undertaking a caring role this should be assessed to support the carer and in turn the person receiving the care.

5.3 Transitional safeguarding – The review recognised the complexities for professionals dealing with children transitioning to adulthood who have been subjected to adverse childhood experiences and these impacting on them as young adults, such as severe neglect. These young adults may not necessarily meet the threshold for care and support as set out in the Care Act 2014. The review recognised that there needed to be developed pathways between children and adult services to identify and provide support for these needs.

5.4 Self-neglect – The review identified that professionals need to be able to identify self-neglect, particularly in the context of understanding and assessing mental capacity and how it impacts on a person's ability and desire to afford

themselves appropriate care. When considering self-neglect in young adults their history and exposure to adverse childhood experiences should be considered.

5.5 The use of advocates – The review recognised the need to use advocates to support young people requiring care to assist them to achieve the support they require.

6. Recommendations

1. The Worcestershire Safeguarding Children Partnership should seek assurance that the legal planning in child protection cases is timely and effective.
2. The Worcestershire Safeguarding Children Partnership should seek assurance that in all appropriate cases that due consideration is given to police investigation into cases of neglect.
3. The Worcestershire Safeguarding Children Partnership and Worcestershire Safeguarding Adult Board to work together to develop a support pathway for young people who remain vulnerable, once reaching the age of 18, but who do not have 'care and support needs' as defined by the Care Act.
4. The Worcestershire Safeguarding Children Partnership and Worcestershire Safeguarding Adults Board should seek assurance that in cases of neglect there is a clear assessment of the parent's or carers ability and capacity to effectively care for the child or adult.
5. The Worcestershire Safeguarding Adults Board should seek assurance that professionals are able to recognise self-neglect and the need to understand whether mental capacity is a factor. In young adults their previous experiences as a child should be explored and considered.
6. Worcestershire Safeguarding Adult Board should raise professional and community awareness about Carers' and the rights of Carers.
7. The Worcestershire Safeguarding Adults Board should promote the role of advocates and should subsequently seek assurance that there is consistent and appropriate use of advocates.