DONCASTER SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULT REVIEW

OVERVIEW REPORT

ADULT V

Died 2020 – 22 years of age

Report Author: Chris Brabbs
Date: January 2022

CONTENTS

1. CIRCUMSTANCES LEADING TO THE REVIEW

1.1 Adult V, a white 22 year old young woman, died in hospital in April 2020 a few days after paramedics responded to a 999 call and found Adult V on the sofa which she had not been able to move from for the previous two weeks. The paramedics found pressure ulcers and severe psoriasis over her whole body area. She was dehydrated, had not had a wash for weeks, and had been lying in urine and faeces. Bariatric support was required from fire officers in order to move her safely before transfer to hospital.

1.2 A safeguarding concern was raised by the hospital because of possible neglect / self neglect. During the first week of the hospital stay, Adult V frequently declined interventions which contributed to a serious deterioration in her condition resulting in her transfer to critical care where she died 4 days later.

1.3 The Coroner approved the Medical Certificate of Cause of Death provided by Doncaster Royal Infirmary that Adult V's death was from natural causes as follows:-

1a. Multi Organ Failure
1b. Sepsis
1c. Infected Plaque Psoriasis
2. Severe Obesity,

1.4 During the past year prior to her death, there had involvement from Children's Services and health visiting services following the birth of her son Child W in May 2019 who was made subject to a supervision order and a child in need plan. There had also been involvement from the GP, community nursing services and the district hospital in provide treatment for Adult V's various health issues.

1.5 Throughout the period up to Adult V's death, Child W's 21 year old father (born 1998) had continued to live with Adult V, and was the primary carer for the baby, although they had ceased to be a couple in December 2019.

2. THE REVIEW PROCESS

2.1 The decision to establish a Safeguarding Adults Review was made by the Independent Chair of the Doncaster Safeguarding Adults Board on 13th August 2020. [1]

2.2 Given that a considerable amount of agency involvement with Adult V had been related to the care of her children, or her status as a care leaver, the Doncaster Safeguarding Children's Partnership (DCSP) agreed that while the review would be progressed as a SAR, it should include consideration of the services provided in respect of Child W.

[1] *Under Section 44 of the Care Act 2014, the Local Safeguarding Adult Board (SAB) must carry out a Safeguarding Adult Review (SAR) where an adult with care and support needs has died, and abuse or neglect is known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult.*

2.3 Rotherham children's services (RCS) were also involved in the review because it took over case responsibility from the Doncaster Children's Services Trust (DCST) in May 2019 at the start of the care proceedings as the family had moved into their area in March 2019. Although the family moved back to Doncaster permanently in August 2019, RCS retained case responsibility until the conclusion of the care proceedings in November 2019 when the case was transferred back to DCST.

Purpose of the Review

2.4 The purpose of the review is not to hold any individual or organisation to account but to:-

- determine what agencies and individuals involved might have done differently to prevent the harm or death;

- review the effectiveness of multi-agency safeguarding arrangements and procedures;

- identify the learning, including examples of good practice, and apply these to improve practice and partnership working to prevent similar harm occurring again in future cases.

Time period covered by the review

2.5 The SAR covered the period from the start of May 2019 in order to cover the child protection planning that took place in anticipation of Child W's birth.

Key Issues to be explored by the review

2.6 The key lines of enquiry (KLEs) included in the terms of reference were focused on the following key issues:-

- whether assessments reflected a holistic approach in line with whole family working principles, and included exploration of Adult V's health issues, and the possible impact of her own childhood experiences on her motivation / ability to self care, and her parenting capacity;

- whether consideration was given to making a referral to adult services for a Care Act assessment in respect of Adult V's physical and / or mental health needs;

- whether the change in the status of the relationship between Adult V and Child W's father had any impact on Adult V's capacity to self-care or seek help for her health issues, and if so, was this factored into assessments of the situation;

- what support was offered to Child W's father as the primary carer for both Child W and Adult V;

- the extent to which practitioners drew on existing local guidance in identifying possible indicators of child neglect and adult self neglect;

- the effectiveness of joint working, including the process when case responsibility was transferred between Doncaster and Rotherham;

- The robustness of the child in need plan and arrangements to review progress;

- The impact of the COVID-19 lock-down on the family's situation and agency involvement.

Agencies Involved

2.7 The Independent Chair and Overview Report Author was Chris Brabbs, a former Director of Social Services and experienced chair of SARs and DHRs. The SAR Panel, which held 2 online meetings, comprised representatives of the following agencies:-

Doncaster Council Adult Social Care
Doncaster Children's Services Trust (DCST)
Doncaster Clinical Commissioning Group (CCG)
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH)
Rotherham Doncaster & South Humber NHS Foundation Trust (RDaSH)
Rotherham Council – Children's Services
Yorkshire Ambulance Service
South Yorkshire Police
South Yorkshire Fire & Rescue Service

Submission of agency reports

2.8 As is standard practice, all agencies submitted a single report as requested covering the work of their agency, apart from DCST who submitted separate reports covering the involvement of the social work team and the leaving care team. [2]

2.9 Consequently, DCST was asked to submit an additional overarching report to draw together the findings and recommendations from the two reports, and provide its overall conclusions about the Trust's involvement. However, despite several approaches, this was not forthcoming, nor was any explanation offered as to why this had not been provided.

2.10 Additional information was also requested from the CCG given the limited factual information and analysis in its report covering the involvement of primary care. However the subsequent response still did not address all of the issues raised.

2.11 The gaps in the submissions from DCST and the CCG did affect the review panel's ability to reach conclusions on some issues in the SAR terms of reference. In the light of this, and the delays this caused in completing the review, the overview report includes a recommendation that DSAB should remind partner agencies of its expectations on the timeliness and quality of agency reports.

[2] *Discussions with DCST representatives did not establish the reason for this. Checks showed that all correspondence sent by the DSAB Safeguarding Unit to agencies, including DCST, referred to the submission of a single report being required. It is possible that as DCST had a representative from both services on the SAR panel, who each received the email request, an assumption was made that each needed to submit a report.*

Involvement of Family Members

2.12 Letters were sent to Adult V's mother and Child W's father to provide information about the SAR process with an invitation to speak with the Review Chair to share their perspectives about how Adult V experienced her situation, and the services that were provided. Although no response was received from Adult V's mother, Child W's father indicated his willingness to have a discussion. However, further efforts to arrange this did not elicit a response.

3. BACKGROUND INFORMATION

Adult V

3.1 Adult V experienced a difficult childhood. Following her parents separation, Adult V was exposed to domestic violence and was physically abused by her mother's partner when she was about 12 years old. The situation reached the point where Adult V told her mother she needed to choose between her or her partner. This led to the involvement of Child and Adolescent Mental Health Services (CAMHS) when Adult V started to self harm.

3.2 Adult V subsequently moved to live with her father around a year later when the relationship with her mother broke down. Adult V reported that she rarely attended school and her father did not take her to medical appointments, including those with physiotherapists to treat her back pain.

3.3 In 2013, when Adult V was 15 years old, she disclosed that she had been the victim of repeated rape over a 6 month period. She then experienced the additional trauma of giving evidence at the criminal trial which was not completed until 2 years after the offence was committed. The lasting impact of the rape was evident from the distress when talking about this during assessments, and the information provided in the RDaSH IMR of how Adult V experienced a flashback during a medical examination in 2016 which led to her being referred to the Doncaster Rape and Sexual Abuse Counselling Services (DRASAC).

3.4 Soon after reporting the rapes, Adult V became looked after by Doncaster Children's Services, and gave birth to her first child when she was 16 years old. Adult V returned to live with her mother in 2015 when she was 17. In respect of the circumstances of the removal of her 3 previous children, Adult V's view was that her inability to provide appropriate care was due to the impact of her adverse life experiences, and being a victim of domestic abuse from the 2 fathers of the children.

Child W'S Father

3.5 Child W's father also experienced a difficult childhood punctuated by several moves. During the parenting assessment, he described how his relationship with his mother was always difficult and he experienced physical and verbal abuse from her which his father used to protect him as much as he could. After his parents separated, Child W's father lived with his father who had serious problems with alcohol and substance misuse, and they subsequently moved to Lincolnshire to be nearer the paternal family.

3.6 At the start of the SAR review period, Child W's father was continuing to experience low mood and anxiety which in part appeared to be related to the ongoing difficult relationships with his family, and also unresolved grief over the death of his father in 2016.

The couple's relationship

3.7 Adult V and Child W's father met through a dating site in May 2018, and Adult V moved in 2 months later. The explanation given by Child W's father to professionals was that Adult V's home was nearer to his work than his mother's address.

4. NARRATIVE OF KEY EVENTS AND AGENCY INVOLVEMENT

May - June 2019

4.1 In early May, following a pre-birth assessment, an initial child protection case conference (ICPC) was held which included attendance from RCS [3] when the unborn child was made subject to a child protection (CP) plan under the category of neglect.

4.2 Immediately after Child W's birth, Doncaster Children's Services Trust (DCST) initiated care proceedings with a view to seeking an Interim Care Order (ICO) and the court's approval to place the baby with the parents. Agreement had been reached with RCS that the latter would take over as the responsible authority.

4.3 RCS and the Children's Guardian [4] took the view that it would be premature, and potentially unsafe, to place Child W immediately with the parents, and a revised care plan was approved by the court for Child W to be placed with foster parents with daily visits to be made by the parents to enable further assessment of their capability of providing appropriate care.

4.4 Positive feedback from the foster parent led to the court agreeing two weeks later to RCS's plan for Child W to be placed with the parents with continued support from the foster carer within the family home. RCS subsequently carried out a full parenting assessment to inform the care plan presented to the final court hearing in November 2019.

June / July 2019

4.5 In early June, the DCST Inspiring Futures Team (Leaving Care Team) [5] ended active involvement with Adult V because she did not want the support from her Personal Advisor to continue. The standard letter sent was sent reminding Adult V she could request further support if required up to the age of 25. [6]

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3 *The decision to convene the ICPC had been made at a strategy meeting held in mid April 2019*.

4 *In care proceedings, a Children's Guardian is appointed by the court to make independent enquiries and check the local authority's care plan to ensure that it protects children, promotes their welfare and is in their best interests.*

5 *The Inspiring Futures Team is the service which supports children as they approach the end of their time in care, and after they leave care and enter young adulthood. Since the inception of the Children and Families Act 2017 this provision can be in place, with the agreement of the young adult, to the age of 25. The team was previously referred to as the 16+ team and now the 18+team.*

The team had been involved with Adult V from her 16th birthday and there was a Pathway Plan in place which had recently been updated in March 2019.

6 *Although involvement ended in early June, the case was not entered as closed on the Leaving Care Team's system until December 2019.*

4.6 During this period, following a self referral, a practitioner from the Rotherham Improving Access to Psychological Therapy Service (IAPT) began to work with Adult V to address her anxiety around leaving the home and her needle phobia. [7] This was provided through telephone calls as Adult V said she did not feel safe walking within Rotherham to attend appointments. After the initial sessions, the support had to be put on hold because of the practitioner's extended sick leave. Rotherham IAPT kept the case open as Adult V did not want to be transferred to the Doncaster IAPT team because she valued the working relationship with the Rotherham practitioner.

4.7 In early July, Adult V and Child W's father informed the social worker that they were on a temporary break from their relationship because of their recurring arguments. The social worker noted there were some issues around conditions within the home which the parents acknowledged needed attention.

4.8 Following this visit, the social worker asked the Out of Hours (OOH) Social Work team to check the home conditions because Adult V was caring for Child W on her own while Child W's father was visiting his family in Cleethorpes. The OOH team found Adult V asleep, the house smelt of vomit, and there were unwashed pots. It was noted that Child W's father was due home later that day.

August / September 2019

4.9 Following the family's move back to Doncaster in early August, the RCS social worker noted that the home conditions were appropriate but that Adult V was still not leaving the home.

4.10 In September, Adult V spent 5 days in hospital after attending ED with pain in both ankles and hips, which was making it difficult for her to walk. X-rays of both ankles resulted in a diagnosis of osteo-arthritis. It was also found that the stitches from the caesarean section were leaking and the wound was infected.

4.11 During this stay, hospital staff encountered challenges in treating Adult V because she declined to have any baseline observations recorded or have a cannula fitted because of her needle phobia. Adult V progressed to mobilising independently with a zimmer frame, but it was noted that her obesity was contributing to her difficulties in mobilising.

October / November 2019

4.12 In early October, the RCS social worker shared her concern with the Rotherham health visitor for Looked After Children (HV LAC) that Child W might be overweight as he was wearing 9-12 months clothes at 5 months old. This was confirmed at the subsequent initial assessment visit by the HV LAC who found that Child W was on the 98th centile after being on the 75th centile at 7 weeks of age. Good attachment between Child W and both parents was noted but that Adult V was unable to provide full care to Child W following her recent hospital admission. The home conditions were found to be adequate but cramped due to Adult V's bed being downstairs.

[7] *Adult V had previously been referred to IAPT in January 2019 but had been discharged in March because of not attending the appointments.*

4.13 During October, the Community Nursing (CN) Service made 5 visits to provide care for the non-healing caesarean section wound, and raised concerns with Adult V and the GP that Adult V was not following the treatment plan. A review visit by the GP identified that Adult V showed signs of classic intertrigo [8] with rashes under both breasts, her groins, and guttate psoriasis [9] over her arms and forehead. During that GP visit, Adult V explained how she was feeling fed up because everyone was telling her to do different things to treat the skin condition.

4.14 The CN service subsequently informed the GP that it was discharging Adult V because she was still not adhering to the wound care plan despite being advised of the possible consequences should it not heal.

4.15 The HV LAC also raised concerns with the parents about the need for their home hygiene to improve because the kitchen was observed to be unkempt, with unwashed dishes and piles of household rubbish.

4.16 At the LAC review meeting in early November, many positives were noted about the care being provided to Child W but concerns remained about the pressure on Child W's father in being the carer for both Child W and Adult V. In addition to agreeing the case would be transferred back to DCST after the final court hearing 2 weeks later, the recommendations made by the IRO included:-

- monthly social worker visits and "Team around the Child" meetings – with these arrangements to be reviewed after 9 and then 12 months;

- Adult Social Care should be requested to complete a Care Act Assessment of Adult V's needs as her poor health was impacting on her parenting capacity.

4.17 In mid November, the court approved the care plan and made a 12-month Supervision Order to DCST who had agreed to take on responsibility for the order. During her first visit, the DCST social worker (DCST SW) raised the issue of the over feeding of Child W.

December 2019

4.18 Police officers responded to an incident when Child W's father was assaulted by a guest who had been staying with the family. This had culminated in the family locking themselves in the bedroom after the suspect made further threats. The suspect was subsequently cautioned.

4.19 At the 6 month review visit carried out by the HV LAC positive parenting by Adult V and Child W's father was observed although Adult V was unable to provide physical care due to the exacerbation of her skin condition. Adult V and Child W's father informed the HV that they were no longer partners but were committed to joint parenting. Following this visit, the case was transferred to the Doncaster Universal HV team because of the change in Child W's legal status, and an introductory home visit was arranged with the family for later in January.

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[8] *Intertrigo is a rash that usually affects the folds of the skin, where the skin rubs together or where it is often moist. This rubbing can cause a breakdown in the top layers of the skin, causing inflammation and a rash. The breakdown of skin makes it easier for bacteria or fungus to develop in this area*

[9] *Guttate psoriasis is a type of psoriasis that shows up on the skin as red, scaly, small, teardrop-shaped spots.*

4.20 The GP made an urgent referral to the dermatology service after visiting Adult V who had reported a significant flare up of her psoriasis.

January 2020

4.21 In early January, the CN service resumed involvement at the GP's request to apply dressings to treat the psoriasis but ended its involvement on being informed by Adult V that her mother was helping change the dressings. In addition, the CN judged that Adult V was fully mobile and able to access her GP for treatment. However, the CN involvement resumed after concerns were raised by the social worker with the GP about the withdrawal of the support. At the first visit after the service was reinstated, it was noted that Adult V's reduced mobility was resulting in her spending extended time on the sofa and only walking short distances.

4.22 Later the same day, a visit was made by an Emergency Care Practitioner (ECP) who had found Adult V covered head to toe in scaly skin and infections under her arms and around her ears. However, Adult V refused to go to hospital as advised. Adult V subsequently explained to the social worker that this was because she was already taking antibiotics and she had an outpatient appointment with the dermatology clinic the following week.

4.23 However, Adult V subsequently did not attend that appointment, and she also cancelled the introductory visit from the Doncaster HV - partly because another service was visiting that day and also because the family were under pressure to find alternative accommodation. The appointment was re-arranged for 3 weeks time.

4.24 Around the same time, the CN service informed the GP that it was discharging Adult V because of the ongoing difficulties in engaging Adult V with the treatment plan.

4.25 The following day, at the GP's request, paramedics took Adult V to hospital for an urgent dermatology opinion in respect of the psoriasis after Adult V reported that her broken skin areas were oozing green pus. After assessment by the Dermatology Team, she was admitted to the medical unit where treatment resulted in an improvement in her symptoms. During this stay, it was noted that Adult V was independent with her daily living needs, and used a frame to mobilise.

4.26 While Adult V was in hospital, the first Child in Need (CiN) meeting was held since the court hearing. It was noted that the Adult V and Child W's father were no longer a couple, and Adult V's health was affecting her ability to care for Child W. It was also recorded that re-allocation of a health visitor was pending to provide advice to the parents to address the concern that Child W was overweight.

February 2020

4.27 Following 10 days in hospital, Adult V was discharged and attended a follow up dermatology out-patients appointment. A further appointment was arranged for a month's time.

4.28 Soon after Adult V's return home, a GP made a home visit after Adult V reported that her skin was cracking again and bleeding. The GP noted that the skin had deteriorated and the scaling had restarted on Adult V's back, buttocks and legs. There was widespread erythema [10] where the plaques were reforming. Adult V was only able to get up and potter around, and also could not tolerate wearing clothes as these were causing irritation. She was also reluctant to continue using the flammable creams started in hospital as they might contaminate Child W. The GP later spoke to the Head Dermatologist who offered a choice of appointments resulting in Adult V opting to attend the following day.

4.29 At the social worker's next visit soon after, Adult V said she had a follow up dermatology appointment in early March, and that she had developed pressure ulcers from her hospital stay. The SW agreed to liaise with housing as the parents were anxious about the possibility of their being evicted.

4.30 When the HV attempted to make the re-arranged introductory visit a few days later, there was no reply, and therefore a letter was sent giving the date for a new appointment in a month's time. However, Adult V subsequently cancelled this citing the ongoing problems regarding their housing situation although her subsequent explanation to the SW was that it was because it clashed with her next dermatology appointment. However, Adult V did not attend that appointment, after which she was sent a letter asking her to make another appointment.

4.31 In mid March, the second CiN meeting was held in the family home when the HV gave advice about Child W's diet, and a plan was agreed for the HV to review Child W's weight and complete "HENRY" work with the parents. [11] It was also noted that the housing situation had been resolved and the tenancy extended.

4.32 During the meeting, Adult V was described as becoming defensive when prevention advice was offered to address her obesity, and concerns were raised about her ability to meet her own health needs. The importance of maintaining a clean and safe home environment was also raised given the dirt, grime and peeling skin that was observed on the sofa and the floor. Adult V explained that she was under the care of hospital for the psoriasis. It was noted that Adult V's mother had been visiting to apply cream to the skin, and help with cleaning the house, but she was no longer visiting to do this due to COVID-19 restrictions.

4.33 Ten days after this visit, the case was rated Amber Risk by DCST in response to the national COVID-19 restrictions – a rating that required visits to be made every 21 days.

4.34 At the end of March, a different social worker made a home visit because the allocated worker was self isolating, and saw Child W and his father on the doorstep in order to maintain social distancing. Although no concerns were identified about Child W's care, his father shared the concern about the impact of the COVID-19 lockdown given that Adult V's skin condition was so severe. The parents were also concerned because Child W had a cough.

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[10] *Erythema is a type of skin rash caused by injured or inflamed blood capillaries. It usually occurs in response to a drug, disease or infection. Rash severity ranges from mild to life threatening.*

[11] *The HENRY approach combines 3 elements - behaviour change strategies, parenting skills, improved knowledge about food and activity for under 5s and the whole family. Over the past 12 years, HENRY has established a partnership with local public health departments*

April 2020

4.35 At the start of April, Adult V contacted the GP Practice to report she was in bed with lower back pain, and although she could potter around when pain free, the cocodamol and naproxen were not really helping. A plan was made to prescribe nefopam [12] for the pain relief, and Adult V was advised to try and keep moving.

4.36 Later that week, a CiN meeting was held with both parents. This was a "virtual" meeting because of the lockdown. The minutes noted the continuing concerns in relation to Adult V's management of her skin / health issues and it was recorded that she had recently attended hospital to keep on top of this. It was again noted that Adult V's mother was no longer able to visit to apply the creams because of the lockdown. The concern was recorded that if Adult V was not able to manage the condition, Child W's father would have to support both Adult V and Child W which might potentially put strain on the family.

4.37 The positives noted were that Child W was clearly loved by both parents, and that they felt they were meeting his needs better now that they were co-parenting and were no longer arguing since their separation. However there was a continuing concern that Child W was overweight and it was uncertain whether this was being addressed by the parents.

4.38 The updated plan was for the HV to commence the HENRY health programme once face to face services were resumed and in the meantime "virtual" support would be offered. The SW would continue to provide support around the housing situation, and Adult V was to ensure that she was meeting her own health needs at all times. Monthly SW visits were to continue and the plan to be reviewed in mid June.

Events leading up to Adult V's admission to hospital

4.39 In mid April, Adult V informed the GP Practice that she had had knee pain for a week and was unable to bend it and was using a Zimmer frame. The GP carried out a remote consultation and sought the advice of rheumatology and orthopaedic specialists via consultant connect. The Orthopaedic opinion was that it was probably not septic arthritis, and Rheumatology felt it was likely to be inflammatory arthritis. It was agreed that a steroid injection would not be possible because of the COVID-19 constraints, and oral steroids would be prescribed.

4.40 Three days later, Adult V contacted the GP Practice to report that the knee was getting worse, and the pain was making her cry. She requested morphine or Tramadol as she did not feel the steroids were helping. Following two discussions with Rheumatology who offered to see Adult V as an outpatient over the next few weeks, the GP arranged for an ambulance to take Adult V to A&E. When the YAS paramedics attended, they were informed by Child W's father that Adult V had been immobile on the settee for over 2 weeks. The paramedics found that Adult V's skin condition, which had been left untreated, was infected. She was also covered in vomit and faeces.

12 *Nefopam is prescribed for the relief of acute and chronic pain.*

4.41 Although in considerable pain, Adult V refused to have a canula inserted to administer pain relief because of her needle phobia. The paramedics then requested bariatric support from the Fire Service as they assessed that they would be unable to move Adult V without causing significant distress. They were also concerned about the possible fast deterioration of Adult V's health if she was to be moved without additional resources.

4.42 On arrival, the fire officers were required to wear full protective clothing, goggles and respirators to enter the premises because of the area around Adult V being severely affected by biohazards. It was also noted that the kitchen was not suitable for food preparation because in addition to the many unwashed pots, there were bags of faeces, soiled bedding and clothing.

4.43 The fire officers were unable to gain much information from Child W's father as to why he had not sought help earlier. He stated that he had tried to telephone the GP but there had been no answer. It was also recorded that Child W's father did not appear to show much concern about Adult V's condition or how the situation had escalated. Both YAS and the Fire Service raised safeguarding concerns with DCST about the circumstances they found, and the concern that help had not been sought earlier.

Care provided by Doncaster Royal Infirmary

4.45 After assessment by ED, Adult V was transferred to the Acute Medical Unit where providing care proved challenging because Adult V was reluctant to accept help in moving due to the severe pain she was experiencing. This contributed to her screaming and shouting out – her behaviour being described as being child-like. Adult V declined cannulation, [13] and on occasions declined to have observations taken. She also often refused personal care even when she had been incontinent. Adult V was given gas and air in order for her skin creams to be applied. During this initial period, Adult V was fully orientated and deemed to have capacity to make decisions about her treatment. Three days after admission, DBTHFT submitted a safeguarding adults concern because of the apparent self-neglect.

4.46 Two days later, Adult V's condition began to deteriorate, she was drowsy for much of the day and unable to give or decline consent to care, which was therefore provided in her best interest. She was subsequently transferred to a critical care bed, and Child W's father informed of the poor prognosis. The family were allowed to visit to say their goodbyes four days later and Adult V died later that evening.

[13] *Adult V was therefore given antibiotic tablets, instead of the preferred intra venous antibiotics.*

REVIEW FINDINGS AND LEARNING

5. PRE BIRTH CHILD PROTECTION PLANNING

5.1 The decision to complete the pre-birth assessment, and convene an ICPC was appropriate given the history of Adult V having had previous children removed from her care. In addition, the assessment identified a number of other concerns:-

- the pregnancy had been assessed as high risk because of possible complications arising from Adult V having had 2 previous caesarean sections;

- Adult V's lack of engagement with appointments to monitor her pregnancy or to address her needle phobia, and Child W's father had not been able to support her to access these;

- there had been little evidence of change since the previous care proceedings in 2017 in terms of Adult V's willingness to act on advice;

- the parents' relationship was very new, and concerns as to whether this could be affected by the pressure that Child W's father, as a young and new father, might experience in being the main carer for Child W while also having to support Adult V with her health issues. The risk was that the relationship broke down the baby would be vulnerable if left in the sole care of Adult V;

- both parents were experiencing low mood and anxiety;

- the limited availability of support from the extended family.

5.2 However, the assessment and child protection planning were not completed until very late on in the pregnancy which was not in accordance with the timescales set out in Doncaster's multi-agency safeguarding procedures.

5.3 The ICPC was not held until early May just 18 days before Child W's birth following an initial strategy discussion 2 weeks earlier. It remains unclear as to the reason for this given that agencies had been aware that Adult V was pregnant at the end of 2018 and the case allocated at the start of January 2019. It appears that the need to hold a strategy meeting was only made after the completion of the assessment.

5.4 The consequence of the late timing of the ICPC was that it left little time to prepare the documents for the initial court hearing, and crucially allow sufficient time for discussions with partner agencies, particularly with RCS to agree the multi-agency protection plan. It also meant that the pre birth Discharge Planning Meeting (DPM) with midwifery and health visiting professionals was not held within the timescales that would usually be expected,

Conclusions and Learning

5.5 The above findings highlight the need for full adherence to the existing multi-agency procedures and practice guidance covering the safeguarding of unborn babies. [14] These set out the importance of a referral being be made at the earliest opportunity and wherever possible at around the 16 week stage of the pregnancy. This ensures there is sufficient time to carry out a full assessment, make adequate plans for the baby's protection and ensure all the necessary support services are in place prior to the birth.

5.6 The guidance also explains that early assessment and protection planning is important to avoid additional stress for the parents of decisions being shared with them in the last stages of pregnancy which can already be an emotionally charged time. It also provides more time for parents to contribute to the identification of solutions to concerns that have been identified.

5.7 Consequently, the guidance sets out the following target timescales:-

- the issue of whether a Section 47 Enquiry needs to be initiated should be taken through a strategy discussion held as soon as possible following receipt of the referral;

- the pre-birth ICPC should take place at least ten weeks before the expected date of delivery;

- the pre-birth planning meeting form should be completed by 32 weeks gestation to ensure plans are in place in case of a premature birth; [15]

- the core group should meet if at all possible prior to the birth, and definitely prior to the baby's return home after a hospital birth;

- the first child protection review conference should take place within one month of the child's birth or within three months of the date of the pre-birth conference whichever is sooner.

6. CROSS BOUNDARY TRANSFER OF CASE RESPONSIBILITY

6.1 Although the conclusion reached in the DCST IMR was that the conduct of the handover to RCS was handled appropriately, this was not a view shared by RCS. The latter's view was that it was right to decline DCST's request for RCS to initiate the care proceedings because there had been an earlier agreement that DCST would initiate these, and the request did not comply with the agreed protocols on when and how cases should be transferred.

6.2 It is evident from the court documents that DCST had not sought the views of RCS or the Children's Guardian (CG) about the care plan it was proposing to put before the court, and they were only informed on the day of the court hearing. This resulted in the hearing having to be adjourned until the following day to enable the CG to make further enquiries by visiting the parents in hospital to assess the current situation.

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14 *https://doncasterscb.proceduresonline.com/p_sg_unborn_babies.html*

15 *copies should beheld in both DCST and midwifery files*

6.3 It is understandable why the DCST' proposal to immediately place Child W was rejected by both the CG and RCS given the history of Adult V's difficulties in parenting her previous children, and there being little assessment of Child W's father within the pre-birth assessment.

6.4 In addition, the CG's further enquiries established that Adult V had been through a traumatic birth and was not at all fully mobile. This increased the worry as to whether Child W's father would be able to carry out all of the care of Child W and also support Adult V while she recovered. Although the CG's preference was for a parent and baby assessment within either a foster placement or residential unit, but RCS's view was that this was not a viable option because that had been tried in the past and was not successful.

Handover arrangements

6.5 The RCS IMR was critical of the fact that there was no joint handover visit made to the family by their respective social workers. This meant only Child W's father was introduced to the RCS social worker at court because Adult V had felt unable to attend the hearing. This was also an issue when the case was transferred back to DCST in November 2019 when there was just a case discussion between the social workers at the court.

Conclusions and Learning

6.6 The disagreements about the transfer of the case and the proposed interim care plan, underline the importance of adherence to the existing protocols governing the transfer of cases when children and families move across local authority boundaries.

6.7 Established practice which is included in the multi-agency procedures of both the Rotherham [16] and Doncaster Safeguarding Children Partnerships [17] is that where a Section 47 Enquiry is being considered or is in progress, it is the responsibility of the originating authority to complete the assessment and hold an ICPC if considered necessary, before transfer of case responsibility takes place.

6.8 However it should also convene a strategy discussion with the receiving authority - usually within 72 hours of notification of the child's move – so agreement is reached about the timescales for the completion of the safeguarding processes and transfer of case responsibility. Where there is disagreement about any of the planned actions, these should be referred to the relevant senior managers in the two authorities to resolve, and the subsequent outcome confirmed in writing and circulated to all the professionals involved.

6.9 Once the originating local authority is ready to transfer the case over, it must notify the receiving local authority sufficiently early to allow all relevant documentation to be shared, and for the receiving authority to carry out its own assessment and formulate a protection plan. These are then presented to an ICPC that should be convened within 15 working days of the notification of a child moving into its area.

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16 *See Section 17 - Transfer of Cases to Rotherham where the Child/Young Person is the Subject of a Child Protection Plan from Another Local Authority.* *https://rotherhamscb.proceduresonline.com/chapters/p_initial_cpc.html#transfer_plan*

17 *https://doncasterscb.proceduresonline.com/p_ch_fam_moving_across_la.html*

6.10 As outlined in the earlier analysis, best practice is for joint introductory visits to be made to the family to introduce the new social worker and ensure there is a shared baseline understanding of the past and current issues that will be the focus of future intervention.

7. QUALITY OF ASSESSMENTS

Rotherham Children's Services

7.1 RCS applied best practice in arranging for the foster carer to continue support to the parents within the family home for a short period, and also carrying out an out of hours safe and well visit the evening after Child W's return home. The comprehensive parenting assessment also reflected good practice by covering all the relevant ground through a combination of individual and joint sessions with the parents that included:-

- Mapping the problem and timeline;
- Exploration of childhood experiences, key events, and previous relationships;
- Ability to meet Child W's needs;
- Child W's father's understanding of the potential risk posed by Adult V;

7.2 Although Adult V experienced difficulty in talking about her childhood experiences, the social worker was able to draw out sufficient information to gain insights into the impact of these on Adult V's self esteem, emotional well-being and her previous parenting capacity.

7.3 The assessment also drew on information gained from other agencies and a psychological assessment carried out during the previous 2017 care proceedings. That had concluded that Adult V's past experiences, including the sexual abuse, had not prepared her for being a parent nor enabled her to function emotionally as an adult. These experiences had also contributed to a lack of trust. The psychologist's concern was that Adult V attributed all her difficulties to these early experiences, and despite support, there was a lack of acceptance of her failure to learn despite considerable involvement since the birth of her first child. Therefore the prognosis for of change was poor as there was little indication of sustained progress and the energy needed to make changes was absent.

7.5 As part of the assessment, the social worker visited Adult V's mother to find out more about her involvement and to explore the potential for her to become the carer for Child W if it were to be decided that he could not safely remain with the parents. Adult V's mother was quite abrupt during that visit, and was not prepared to give the social worker much time – the social worker recording that her attitude suggested a mistrust of professionals. It also made it difficult to build up a full picture of Adult V's mother's role as part of the assessment looking at the overall support network for the family.

Rationale for the supervision order

7.6 There was a clearly evidenced rationale underpinning the recommendation that a supervision order be made. It had been established that Child W was clearly loved by both parents, and both were interacting with him appropriately. The care provided by Child W's father, who was the main carer, was assessed to be positive – albeit often acting on the instructions given by Adult V as to what was required. He was therefore viewed as a protective factor for Child W.

7.7 However there was an understandable need for a cautious approach given that the level of responsibility falling to Child W's father in being the primary carer for Child W, needing to respond to Adult V's health needs, as well as managing the home. In addition, a major concern was if there was a change in the couple's situation which resulted in Adult V being left to care for Child W alone.

DCST Assessments after case responsibility was transferred back

7.8 The DCST IMR identified a number of gaps in the assessments completed in January and March 2020. First, there was little evidence that these drew on the findings contained in the court documents that were transferred over by RCS. Nor does it appear that health professionals were consulted in relation to these assessments which would have been particularly important given Adult V's ongoing weight and other health issues.

7.9 When the parents ceased to be a couple, there was insufficient exploration about the potential implications for Adult V's health care, and whether Child W's father would intervene to seek help for her. Instead the assessments remained focused on the potential risk to Child W if his father was to leave and Child W was left in Adult V's sole care.

7.10 Despite the expectation that Child W's father would continue to support Adult V, he was never viewed as a carer who was eligible to have an assessment of his own support needs,. This should have been considered after the change in the status of the relationship with Adult V when he became her carer rather than her partner. Instead of looking at ways of easing the pressure, these appear to have been increased by the expectation placed on him to take Child W to groups in the community.

7.11 No consideration was given to a referral being made to Adult Social Care for a Care Act assessment of Adult V's care and support needs as had been recommended at the final LAC review prior to the case being transferred back to DCST. As well as identifying whether Adult V was eligible for any practical support to assist with her daily living needs given her poor mobility and the impact of the Psoriasis on her ability to self-care, an assessment might also have identified the possibility of low level preventive support from the voluntary sector such as social prescribing, befriending or similar services to address her mental health issues. These could have acted as an alternative to the IAPT support that had lapsed because Adult V did not wish to switch to a new practitioner.

Conclusions and Learning

7.12 Irrespective of whether the primary reason for a professional's involvement is related to either the child or the parents, the above findings reinforce the importance of:-

- assessments being holistic and applying a "one family" approach so that the needs of all members of the family unit, and the linked implications of these, are identified;

- avoiding assessments being restricted to the specific issues that were the original reason for particular professionals becoming involved;

- being alert to the need to offer a carer's assessment, or referral to adult services for a Care Act assessment, where the need for support is identified.

8. RECOGNITION AND ASSESSMENT OF CHILD NEGLECT

8.1 There were 2 areas of concern that arose in relation to the care of Child W – one being the evidence that he was overweight because of overfeeding. The other was the concern at times about the cleanliness of the home which potentially posed a risk to Child W's health.

Home conditions

8.2 It appears that the home conditions fluctuated but were not a major concern for professionals. Although there were references to concerns were raised, mainly in relation to the state of the kitchen or piles of washing, there were also many positive comments at different points during the review period.

8.3 Prior to Child W's birth, it was noted that the home was clean and preparations hade been made for the baby. After the family's move back to Doncaster, the RCS social worker recorded that the home was observed to be well presented and furnished to a good standard, and no significant concerns were identified other than on occasions, piles of washing accumulating when Adult V was unwell and Child W's father was finding it difficult to keep on top of the home management as well as caring for Child W and Adult V.

8.4 The DCST IMR also stated that the home conditions were not seen as a significant concern, and the GP also told the DCST SW after Adult V's death that she had no concerns about the home conditions – describing the lounge as 'lovely' when she visited in February 2020.

8.5 What is clear is that the home conditions were not kept under review in a structured way. There was no reference to the home conditions in the January or March CiN meetings despite the HV including in her case recording her observation that there was evidence of dirt, grime and peeling skin on the sofa and floor area. Although the record of the April CiN meeting included the HV's concern about the cleanliness of the home, it did not result in this being added to the list of issues that the care team were worried about, or the actions agreed at the meeting.

8.7 The fact that the home conditions were never included as an issue which needed to be monitored, perhaps explains why other professionals did not routinely feed back their observations to the social worker.

8.8 The March meeting was the last time professionals were inside the home because of the introduction of the COVID-19 lockdown. The health visitor's observations about the state of the home at that point may have been the start of the deterioration that was found by the paramedics and fire officers in April.

8.9 In relation to concerns that were raised at points about the state of the kitchen, Child W's father provided a significant insight after Adult V's death as to the possible contributory factors which do not appear to have been picked up by professionals before. He explained that he had few skills in how to manage a home. In addition, his lack of ability to cook, meal plan, and budget for food meant that he had always relied heavily on takeaways – which would account for the comment about the number of used take-away boxes.

Child W's weight

8.10 The parents never accepted that Child W was overweight and that their approach to feeding was the reason. Assessments established that the parents continually resorting to feeding Child W when he cried rather than using other distraction strategies to comfort him if he had already recently been fed. In addition, the parents explained that that they had wanted to wean Child W early as he was always hungry, although they had been advised by the health visiting service that this was not recommended.

8.11 The recognition that the parents would need practical advice resulted in appropriate plans for the 10 week programme to be provided by the Early Years service, and the "Henry" work from the HV. When the start date for both these stalled, more urgency might have been expected to overcome the obstacles that had prevented these going ahead. However, the cancellations of the HV's visits by Adult V were accepted without challenge, and the start date for the Henry kept being pushed back at the CiN meetings by a further month.

Use of assessment tools

8.12 Neglect can be difficult to define, identify and communicate because most definitions are based on personal perceptions of neglect, including what constitutes "good enough" care and what a child's needs are. Lack of clarity about this has had serious implications for professional's decision-making about children experiencing or at risk of neglect. Therefore the completion of good quality assessments are crucial to identify the neglect that is taking place and ensure the right interventions are made.

8.13 At the time of this case, the Safeguarding Children Partnerships in both Doncaster and Rotherham already had in place multi-agency guidance around neglect which included use of the Graded Care Profile. [18] The benefit of using the GCP, which has a proven evidence base, is that it provides a structured approach for practitioners in gathering objective evidence and a measure of how well care is being provided across four areas of need. [19] However, none of the agency IMRs found any evidence that practitioners had drawn on this to inform their work.

Developments since this case

8.14 Since this case in action has been taken by both DCSP and RCSP to strengthen the response to child neglect by refreshing their neglect strategies, and through training focused on embedding the use of the Graded Care Profile (GCP) as standard practice where neglect is a possible issue.

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[18] The Doncaster guidance provided a multi-agency "neglect toolkit". *https://dscp.org.uk/professionals/neglect*

The Rotherham guidance can be found at *https://rotherhamscb.proceduresonline.com/chapters/p_neglect.html*

[19] *It achieves this by using a series of statements across 4 areas of need that are graded from 1 to 5 reflecting the continuum of how well each need is met. The focus on identifying successes / strengths as well as problems / areas of difficulty enables the potential of families to be better understood and guides interventions. Research into the use of the tool suggests that it achieved a high level of consistency in scoring, when different assessors used the GCP to assess the same case.*

8.15 Although a recent DCSP multi-agency audit of cases identified some good practice, it also highlighted that further progress needed to be made. As a consequence, the work of the neglect sub-group has been strengthened by the establishment of a strategic group chaired by the Director of Social Care to oversee the impact. A network of "neglect champions" has also been set up across the partnership.

Conclusion and recommendation

8.16 While the drive to increase the use of the neglect tools is a positive step, it will be essential that both safeguarding children partnerships first establish the baseline position on the extent to which the tool is being used to establish other action that is required to ensure its use becomes embedded.

8.17 Where it is found that the tool is not being used, it will be important to discover whether this is solely related to lack of awareness, or related to other contributory factors. This might be related to lack of time, or to another research finding [20] that the GCP can be viewed as over-complicated to use in practice. [21] Seeking the feedback of practitioners and front line managers will be an essential part of the exploration work.

9. CHILDREN IN NEED PLANNING AND REVIEW PROCESS;

Introduction

9.1 The SAR had identified the following issues in respect of the CiN planning process:-

- how the CiN Plan was developed;
- the content and implementation of the CiN Plan;
- the timeliness of CiN review meetings;
- attendance at meetings;
- the accuracy of information shared at CiN meetings;
- the quality of the record of the meetings.

Children in Need (CiN) Plan

9.2 Eight visits were made over the five months between DCST taking back responsibility for the case and Adult V's death which exceeded the requirement of monthly visits that was in the care plan approved by the court. The case was also discussed in supervision on 3 occasions – in December 2019, February and April 2020.

9.3 However, the conclusion of the DCST IMR was that the Child in Need (CiN) plan was not sufficiently robust. One reason was that the lack of direct work with Adult V to help her understand, and address, the patterns of behaviour which resulted in the removal of her previous children, and to support her in making the necessary changes to successfully parent the new child. Nor was there any consideration of the impact of previous grief and loss Adult V experienced. In addition, the support to help the parents on how to achieve "good parenting" was solely the plan for the 'Henry Health' programme to be carried out by the health visitor.

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20 *Wilkins David, 'Which assessment tool? A comparison of neglect tools used nationally to identify and assess levels of child neglect' (accessed 1.6.19)* https://www.ccinform.co.uk/guides/which-assessment-tool-a-comparison-of-neglect-tools-used-nationally-to-identify-and-assess-levels-of-child-neglect/

21 *Within the GCP, each area of need is made up of different sub-areas and some sub-areas are broken down further into different items of care.*

9.4 Another gap was that the plan did not address sufficiently the parents' physical and mental health issues which might potentially impact on the care of Child W. Although there was reference to Adult V being required to access appointments, and her reliance on her mother's support to attend these, there was no contingency plan in the event that Adult V did not access the health care she needed.

9.5 Inclusion of contingency plans would have been essential because although Child W's father had acknowledged the need for Adult V to keep appointments, he was not pro-active in seeking support for her, or in alerting other agencies of missed appointments. The social worker only became aware of these during home visits if the question was raised.

Timeliness of CiN Meetings

9.6 Although the DCST IMR made the observation that these were held regularly, the timing of the first two meetings was not in accordance with the monthly frequency set out in the care plan and DCSP's procedures.

9.7 These stipulate that the first meeting to draw up the CiN Plan should be held within 15 days after the final care plan has been approved by a court. However, the first meeting was not held until the end of January 2020 – more than two months after the order was made and DCST taking over responsibility for the case. The HV had previously asked the DCST SW in mid December when the first meeting would be taking place and was informed that it would be held soon but no date had yet been set. Although a date was fixed at the January meeting for the second meeting to take place within the stipulated monthly frequency, this was not held until 6 weeks after the first meeting.

9.8 The DCST IMR provided no explanation as to the reasons for meetings being outside the target time limits. Nor was it able to establish when and how the plan was first drawn up and whether this reflected active participation of other agencies or co-production with the parents.

Gaps in attendance

9.9 The effectiveness of the CiN review process was hampered by health professionals not being involved in some of the meetings. This meant that DCST did not gain an accurate and up to date picture about the input of health partners or the problems that they were encountering in trying to secure Adult V's engagement.

9.10 The information recorded from the January meeting in respect of the health visitor input was out of date as it referred to the case awaiting allocation to a new HV and a review visit to be carried out in mid December. By the time of the CiN meeting, these had already taken place, and the new health visitor had already arranged an introductory visit for later in January.

9.11 It does not appear that any consideration was given to inviting the GP or CN service to the meetings, or at least seeking updates from them prior to the meeting. Their input at the January meeting would have been important given the CN service involvement at that time. This would have ensured DCST had a full understanding of the situation in respect of Adult V's psoriasis, the difficulties encountered in providing treatment, and what further treatment was planned or needed so that this could be included in the updated CiN Plan.

9.12 The added value of the CN input would have been the possible additional insights gained about the home situation and the care being provided to Child W. It would also have enabled the CN service to become more aware of the overall family situation so that they could factor this into planning their approach in securing Adult V's engagement with the treatment plans.

9.13 If information had been sought from the GP in advance of the March meeting, this would have avoided the misleading picture that was presented by Adult V about the arrangements for the oversight of her Psoriasis. While the information provided was accurate that she was under the care of the hospital, DCST was unaware that Adult V had failed to attend a dermatology out-patient appointment 3 days earlier.

9.14 Had DCST been aware of this, it might have led to greater focus on this health issue and prompted liaison with the GP to explore what further steps could be considered to ensure the condition was monitored and Adult V accessed the required treatment – particularly given the physical evidence of the peeled skin in the home which might suggest the condition could be getting worse. On this point, it is surprising that there was no reference to this or the home conditions in the notes of the meeting.

Quality of the CiN Plan and Record of the CiN Review Meetings

9.15 This last observation leads into some further observations about the overall quality of the record of the CiN meetings. The record of the second meeting and third meeting held in April contained a considerable amount of information that remained unchanged from the first meeting. This related to the list of issues that professionals were worried about, the danger statements, and the safety goals. This meant that the record did not include any evaluation of what had changed, and the extent of any progress made by the parents and professionals in addressing the original concerns.

Conclusions and recommendations

9.16 The above findings provide an important reminder that in order to ensure effective planning for children subject to a CiN Plan, the following elements of the Doncaster's existing multi-agency guidance is applied fully:-

- an early multi-agency meeting is held to draw up the CiN plan and agree the arrangements for effective co-ordination of multi-agency involvement;

- the CiN Plan identifies the care team which should include all the professionals / agencies currently involved with either the parents and / or the child, and this is kept under review to include any additional professionals who become involved later;

- members of the care team contribute to assessments and attend all CiN review meetings;

- the CiN plan is clear about how concerns will be monitored and what information should be shared and when. This must include the lead professional being informed promptly of any missed appointments or visits cancelled by the parents.

- minutes of CiN / CP meetings should be sent to all agencies involved regardless of attendance.

GP involvement

9.17 Previous case reviews nationally have identified that a significant gap in CiN and child protection planning is the absence of input from GPs. Therefore it s essential that:-

- the GP is contacted for information to inform the assessment, provided with consent to share information forms signed by the parent(s), and receives a copy of the completed assessment and CiN Plan;

- GPs will be invited to attend CiN meetings, and provide information in advance if the practice is unable to be represented, and at all stages are proactive in sharing information that may impact on the safety and wellbeing of the child.

Development of Outcome Focused Objectives

9.18 One of the fundamental requirements that is included in the DCSP procedures to ensure effective intervention is the need for the CiN Plan to include outcome focused objectives which are SMART - i.e. that are Specific, Measurable, Achievable, Realistic and Time-scaled. These should be delegated to named individuals so that all the issues identified through the assessment are addressed, and are updated to cover new issues / changes identified through the review. SMART plans will minimise the risk of drift that many national serious case reviews have highlighted as occurring through professionals and families not being clear of what is expected of them.

9.19 Although the DCSP procedures refer to the need for objectives in plans to be SMART, they do not include any practical guidance on how to draft these. Therefore a recommendation from this SAR is that the Doncaster Safeguarding Children Partnership considers drawing up additional practice guidance similar to that adopted by many other safeguarding children partnerships in England.

9.20 Different examples of such practice guidance include that adopted by Cumbria, [22] City of York, [23] Leeds, [24] and Halton. [25] The latter is more extensive, including references to research findings on the value of SMART objectives and includes a commentary on examples of written objectives as to whether they are SMART, and how these could be re-drafted to ensure they are. In terms of training, the material developed by Gloucestershire is helpful because as well as including exercises for participants to work through in developing skills in outcome focussed planning, it includes essential messages about the importance of co-production of plans with the parents. [26]

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22 *https://cumbria.gov.uk/elibrary/Content/Internet/537/6683/6714/7032/42474141258.PDF*

23 *https://yorkchildcare.proceduresonline.com/pdfs/outcome_smart_guide.pdf*

24 *https://leedschildcare.proceduresonline.com/pdfs/cin_guidance_table.pdf*

25 *https://children.haltonsafeguarding.co.uk/wp-content/uploads/2017/09/SMART_Plans.pdf*

26 *https://www.gloucestershire.gov.uk/media/15633/outcome-focussed-planning-gloucesteshire-may-2017.pptx*

Response to missed appointments or visits cancelled by the parents

9.21 Previous children's safeguarding reviews has identified the need for professionals to pay careful attention to the possibility that cancelled visits to a child who is subject to a CP or CiN plan might be an indication that parents are seeking to avoid contact to cover up issues around the care of the child.

9.22 The earlier analysis commented on the month gap between the dates of health visitor visits that were cancelled by Adult V and those identified for the re-arranged visit to take place. The SAR received conflicting information from RDaSH and DCST as to whether the social worker was informed promptly, and on each occasion when planned visits did not take place.

9.23 In these situations, it is essential that the social worker is informed immediately, with confirmation sent in writing to avoid the situation in this case where DCST stated that it was unaware of the missed visits. Where there continues to be difficulties in securing contact, and the child being seen, a review meeting should be convened without delay to consider what further steps should be taken, which might include unannounced joint visits with the lead professional.

10. OTHER JOINT WORKING ISSUES

10.1 In addition to the issues around multi-agency working described in the last section, the review identified issues about the lack of joined up delivery of care within both RDaSH and DCST.

RDaSH internal joint working

10.2 The RDaSH IMR found no evidence of any liaison between the HV and CN teams which led to the finding that an ethos of joint working. On one occasion, this resulted in practitioners from both teams making a visit at the same time.

10.3 The lack of liaison meant that the HVs were not aware of the extent of the difficulties being experienced by Adult V from the infected wound, and later the psoriasis on her ability to contribute to the care of Child W. Equally, the CN service did not have a full awareness of the context of the situation they were going into and the particular safeguarding issues they needed to be alert to. [27] The only information they would have seen was the "high priority reminder" posted in May 2019 within the SystmOne records to alert clinicians logging onto Adult V's records that the unborn baby was subject to a child protection plan. However, this warning flag had not been updated to show Child W was now subject to a supervision order and a CiN plan.

10.4 A practical problem that contributed to the lack of awareness of each service's involvement was that at present the electronic record system is in separate modules so different services are unable to see each others unless a 'share' is arranged. This is now being addressed by RdaSH so that the patient record can be seen by anyone within the organisation who needs to access a patient.

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DCST internal joint working

10.5 When the Pathway Plan was updated by the Leaving Care Team in March 2019, Adult V expressed her wish for the support to end. However the view of her Personal Advisor (PA) was that the support should continue because of the ongoing issues in respect of her emotional well being, the stress of the pre-birth assessment, and the limited network of support other than Child W's father.

10.6 Given this, it might have been expected that this would have resulted in joint collaboration with the social work team to draw up a shared plan of intervention / support and the pathway plan being updated appropriately. However, the liaison between the two teams was limited with just 2 contacts in March 2019 when it was agreed that the Leaving Care Team would provide an overview of its involvement for inclusion in the pre-birth assessment. However, it does not appear this was provided, or that the Leaving Care Team was invited to the ICPC resulting in the minutes making no reference to its previous or ongoing involvement.

10.7 Ultimately, the Leaving Care Team ended its involvement following several discussions with Adult V between March and June. DCST was unable to provide any detail about these because of the limited case recording, and what was the eventual deciding factor in involvement being ended. [28]

10.8 It remains unclear whether the Leaving Care Team informed the social work team either prior to, or after, the decision was taken. It was noted that although the 2 teams can view each other's records, had the social work team looked at the Leaving Care Team records, it would have still shown the case as being open because the case was only closed down administratively 6 months later.

Developments since this case

<u>Joint working protocol</u>

10.9 Although DCST did not provide the SAR with any evaluation of the joint working between its two services, the recognition that there were issues which need to be addressed is evident from the implementation since this case of a protocol to ensure effective co-ordination of the different elements of DCST's involvement where there are concerns about the welfare and safety of a care leaver's child.

10.10 The protocol emphasises the importance of the two services' roles being agreed at the outset with an acknowledgement that a key part of the personal advisor's support for the care leaver will be to advocate on their behalf. The protocol also describes the situations where information must be shared, the need for ongoing liaison, and that the personal advisor will be involved in all statutory meetings in respect of the child.

[28] *The DCST IMR explained that decisions about ending involvement will reflect the underlying ethos of the teams' approach to promoting independence when care leavers have reached adulthood. Generally, the onus is placed on them to resolve issues and seek support needed on the basis they will usually have the capacity to make decisions about their lives given the relevant information.*

Pathway planning and support for care leavers

10.11 A number of steps have been taken by DCST to improve the support for care leavers since a focussed Ofsted visit in February 2021 which found that the support to care leavers was weaker than that provided to children in other parts of DCST. Issues that were identified, which mirrored the findings from this SAR, were that pathway plans did not address all future needs, and there was insufficient evidence of management oversight to ensure that work progressed in a timely way.

10.12 A monthly Support and Planning Panel has been established, chaired by the service manager, which considers the quality of the plans, whether these are on track, and the appropriateness of ending involvement for 21-25 year olds due to lack of engagement but where there are continuing concerns about the young person. In addition, from November 2021, the oversight of plans will be strengthened by the appointment of a "post 18" Independent Reviewing Officer, and the re-establishment of the Care Leavers at Risk Panel (CLAR).

Conclusion and recommendation

10.13 The above developments should address the issues from this review, but it will be essential that that DCST assures itself through dip sampling of cases, that these are delivering the required improvements, particularly in achieving effective collaboration between the social work teams and the leaving care service. This observation reflects the fact that these teams continue to sit in different service areas, with separate lines of line management reporting.

11. RESPONSE TO ADULT V'S HEALTH ISSUES;

DCST

11.1 The conclusion reached in the DCST IMR was that there was insufficient attention given to Adult V's health issues first because it was necessary to maintain a child focus in discharging the statutory duties of monitoring Child W's welfare. In addition, while there was a recognition that Adult V's history and health issues would impact on her ability to carry out her parenting role, the implications were not viewed as significant in terms of safeguarding Child W's welfare because his father had always been identified as the primary carer.

11.2 Concerns were raised with Adult V about the importance of addressing both her physical and mental health issues, with encouragement given to her to access appointments and engage with treatment plans. However despite the history of her failing to address these issues in the past, it appears it was then left to Adult V to follow this through on her own. It does not appear that there was any consideration of whether the cumulative nature of the concerns Adult V was experiencing impacted on her ability to do this.

11.3 There was therefore no indication of any pro-active steps being taken to support her when it was identified that appointments were being missed. This would have been additionally important given the indications that Child W's father was not able to influence her decisions about her self care. In addition, apart from the contact with the GP Practice in January 2020 to raise the lack of CN involvement for the psoriasis condition, there was no further contact with the GP despite visits and CiN meetings noting that this was an ongoing issue.

Primary Care

11.4 The limited factual information and analysis in the CCG IMR created some difficulties in gaining a clear understanding of the action taken by the GPs in response to Adult V's various health issues. Therefore the overview author requested sight of the GP electronic records to fill the gaps.

11.5 It was evident from the records that there were many consultations with Adult V and proactive ongoing oversight of her V's various health conditions. These included a number of home visits because of Adult V being unable at times to attend surgery - the last visit being in February 2020.

11.6 Prompt referrals were made to the CN service in respect of the caesarean wound care and psoriasis, and also to secondary care specialist services. The GP also went to great lengths to obtain the opinion and input of Rheumatology and Orthopaedic consultants when Adult V reported the increasing knee pain. The GP also acted promptly in arranging for her to be taken to A&E for assessment when it was established that there would be a delay before Adult V could be offered an outpatients appointment.

11.7 In respect of the treatment of the psoriasis, the SAR panel was informed by the GP representative on the SAR panel that the usual approach is to prescribe different creams where the condition does not improve immediately, and a referral being made to a dermatology specialist if the condition continues. Although confirmation was subsequently received that the GP's treatment of Adult V's psoriasis was appropriate, no detail was provided about the specific prescribing decisions in Adult V's case to explain the reason for that finding.

11.8 The IMR also did not provide any factual information about the revised operating arrangements applied by the GP practice when the COVID-19 lockdown was implemented and how these affected the response to Adult V. This meant the SAR panel did not gain an opinion as to whether other actions might have been considered prior to the final admission in response to the calls received from Adult V that the knee pain was becoming unbearable.

Community Nursing Service

11.9 The community nurses responded quickly, and were diligent in the way they provided care for both the caesarean section wound and the psoriasis. However the effectiveness of their treatment was hampered because Adult V was not adhering to the care plan, and also during the second episode of involvement, Adult V was refusing to let the team into the property. In terms of Adult V's actions, the IMR made the observation that there was no reason for the nurses to doubt whether Adult V lacked mental capacity to make decisions regarding her treatment even if these appeared unwise.

11.10 In respect of the decisions to end support, and refer care back to the GP because of what was termed Adult V's non-compliance, the IMR made the observation that the use of this term can place an element of blame or responsibility on the service-user for failing to engage with the treatment plan. In Adult V's case, the IMR concluded that at times, some of the treatment plans appeared to be somewhat prescriptive, and the possible reasons for her not adhering to the treatment plans were not taken into account.

11.11 This also seemed to be reflected in the view reached by the service that Adult V was able to attend her GP surgery and was not housebound as she asserted. This did not factor in sufficiently Adult V's poor mobility and long standing anxiety about leaving the house. In respect of the latter, this was despite the service's own assessment which had resulted in a score that indicated Adult V was experiencing mild depression and moderate anxiety. [29] The stance taken by the service on this issue had the potential to become a barrier to Adult V being able to access appropriate care and treatment.

11.12 In respect of the instances where professionals did not get a reply when they visited, the RDaSH IMR raised the question as to whether they considered if Adult V's poor mobility or not wearing clothes because of the psoriasis, meant she was unable to reach the front door quickly enough.

Conclusions and recommendation

11.13 There are two main areas of learning which flow from the analysis of the response to Adult V's health issues. One is that practitioners need to acknowledge when their original intervention or treatment plan has not worked, and consider alternative strategies to secure the service user's engagement. This becomes particularly important when working with a patient such as Adult V who continued to experience the impact of significant adversity and trauma in the past.

11.16 The second is that it is essential that professionals adopt a "think family" approach so they are alert to issues affecting all members of the family not just those of the adult or child who is the focus of their involvement.

11.17 It is positive therefore that both RDaSH and DCST are taking steps to embed this approach. From November 2021, DCST has published guidance which reminds staff that they should consider whether there is an adult who has care and support needs and / or should be referred for a carer's assessment. In addition it includes the referral pathways, contact details, and signposting to additional information on the DSAB website, including the latter's guidance covering self neglect.

12. RECOGNITION OF POSSIBLE INDICATORS OF SELF NEGLECT

12.1 The finding of the DCST IMR was that the issues around Adult V's possible self neglect were not recognised, and that practitioners were unaware of the Doncaster SAB's guidance covering this issue. [30] The RDaSH IMR similarly found no evidence that its practitioners viewed Adult V's apparent inability to address her health needs as possibly come within the scope of possible self neglect despite the agency records containing indicators of this being an issue dating back to 2011.

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29 *This assessment was carried out using the standard PHQ9 tool.*

30 *https://dscp.org.uk/sites/default/files/2019-05/Doncaster%20Multi-agency%20Procedure%20Self-Neglect%20and%20Hoarding.pdf*

Conclusions and learning

12.2 This finding underlines the importance of professionals being reminded of the need to draw on the DSAB guidance given that the situation that professionals encountered in Adult V's case were in some ways characteristic of 2 of the 3 main distinct areas of possible self neglect listed in the DASB guidance:-

- Lack of self-care – including neglect of personal hygiene, nutrition and hydration, or health, to an extent that may endanger safety or well-being;

- Refusal of assistance that might alleviate these issues. This might include refusal of care services, health assessments or interventions, even if previously agreed, which could potentially improve self-care or care of the home environment.

12.3 In addition, the guidance describes the different factors which need to be taken into account in gaining insights into why self neglect is occurring. These include the impact of mental health issues, previous trauma and other significant life events – all relevant issues to have been considered in Adult V's case.

12.4 It is also important to consider whether a person's apparent self neglect is in fact due to neglect, particularly through acts of omission by a person's partner or informal carer which might include:-

- ignoring medical, emotional or physical care needs;
- failure to provide access to appropriate health, care and support;
- withholding of medication, adequate nutrition and heating;

12.5 Where an agency identifies indicators of possible self neglect, or acts of neglect by omission, it is essential that safeguarding concerns are raised, or advice sought from Adult Social Care, on how the issues can best be addressed. As explained in the Care Act Statutory Guidance, [31] this may not result in a section 42 enquiry because in many situations carrying out a Care Act assessment may be the appropriate response.

13. SAFEGUARDING REFERRALS

13.1 South Yorkshire Police (SYP) and Yorkshire Ambulance Service (YAS) both identified issues about missed opportunities to raise safeguarding concerns.

13.2 The finding of the YAS IMR was that the paramedics should have submitted a safeguarding adult referral as well as the child safeguarding referral when Adult V was taken to hospital for the final time. This oversight has since been addressed by the YAS safeguarding team implementing a national model of mandatory training on safeguarding adults and children in line with the intercollegiate documents for health care staff. Compliance for this mandatory training is reviewed monthly and discussed at the trust's monthly training governance meeting.

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31 *Section 14.17 – Care Act Statutory Guidance.* *https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1*

13.3 The police IMR concluded that a vulnerable child report should have been submitted after the December 2019 incident when the family had to lock themselves upstairs after Child W's father had been assaulted by a lodger. The fact that a very young child was present during a violent assault should have made officers consider not only the actual risk at the time, but also the possibility of future risk. In exploring why this did not happen, the SYP IMR established that this was not recorded as a domestic incident, and therefore no DASH risk assessment form [32] was completed which would have generated an automatic referral to Children's Social Care.

13.4 The SYP IMR described various initiatives to support officers taking appropriate action in the future. The first is that the 'Gen 117332' form has been replaced with the Vulnerable Child application which requires a risk assessment and provides the trigger for additional safeguarding and protection via a multi-agency response where appropriate. The advantage of the VC App is that it automatically emails a copy of the form to the relevant Children's Services. Second, the ongoing SYP training on 'Domestic Abuse Matters' [34] and 'Every Child Matters" reinforces the importance of taking into account the voice of the child, and ensure officers and staff are provided with the most up to date knowledge in recognising risks around children and knowing what action to take.

13.6 In addition, training provided to the District Local Referral Units (LRU's) included the importance of creating and retaining accurate records to provide an audit trail of action that has been agreed and to focus any future action. This stemmed from the discovery that SYP did not appear to have received the notes of the April 2019 strategy meeting, or the minutes of the subsequent ICPC.

14. THE IMPACT OF THE COVID-19 LOCKDOWN ON SERVICE PROVISION.

14.1 The COVID-19 lock down did have a significant impact on both the formal and informal support provided to the family who became more isolated. Adult V's mother was no longer able to continue the support with the care of Adult V's skin condition or household management. It also meant that Child W's father was unable to access any facilities with Child W within the community.

14.2 The consequences for the social work input were the switch to doorstep visits, with the final one at the end of March having to be carried out by a social worker who was less familiar with the case because the allocated worker was self isolating. This may have been a contributory factor as to why the social worker did not pick up on the concerns raised by Child W's father that Adult V's skin condition getting worse, and not asking to Adult V to come to the door to explore this further, or at least contacting the surgery to check the GP was aware of the situation.

14.3 Crucially it affected the input of health professionals because both the GP Practice and the HV service had temporarily ended home visits. This affected the response to the 3 calls made by Adult V to the GP Practice in April – first in relation to the lower back pain, and then twice regarding the knee pain. It is evident that the GP was proactive in seeking specialist opinions, however without being able to examine the knee, their opinions could only be speculative.

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[32] *The Dash Risk Assessment Checklist should be completed whenever a practitioner receives an initial disclosure of domestic abuse. The DASH includes a series of questions to be completed with vistims to identify the level of risk, and high risk cases which should be referred for discussion at a multi-agency risk assessment conference (MARAC).*

[34] *Over 1,800 people were trained by March 2021 which includes staff from partner agencies as well as police staff.*

Learning

14.4 While it is understandable why health organisations nationally provided guidance about the need to restrict face to face contact during the COVD-19 lockdown, it is evident from this case that the consequence of the GP not feeing able to make a home visit to assess the pain in the knee that Adult V had reported hampered the diagnosis of the condition.

14.5 Given the possibility that the country could face the possibility of further lockdowns in the future, it will be essential that where virtual assessments of symptoms are inconclusive, there are agreed arrangements in place as to how a physical examination can be carried out whether in the community or at hospital.

15. MULTI-AGENCY RECOMMENDATIONS

1. DCSP should seek assurance that agencies are adhering to the following multi-agency procedures and practice guidance:-

   - safeguarding unborn babies;
   - children and families moving across boundaries;
   - multi-agency guidance on working with Children in Need;
   - notifying GPs where a Child is the Subject of an Early Help Assessment (EHA), Team around the Family (TAF), or Child in Need (CIN);
   - action to be taken when professionals are unable to gain access to a child who is subject to a Child Protection Plan.

2. DCSP and DSAB should seek assurance that when carrying out assessments professionals are:-

   - adopting a holistic “one family” approach so that the individual, and linked needs of all members of the family are identified;
   - offering a carer’s assessment and / or making a referral to Adult Social Care for a Care Act assessment, where potential support needs are identified.

3. DSCP should request its statutory partners to develop additional practice guidance on SMART planning to support professionals in writing outcome focused care plans that are specific, measurable, achievable, realistic and time-scaled.

4. DSCP should establish a baseline position on the extent to which professionals across the partnership are drawing on the child neglect toolkit in their work to identify any further action that is required to ensure its use becomes embedded.

5. DSAB should establish a baseline position on the extent to which professionals are aware of the multi-agency procedures covering self neglect and hoarding, and to identify any further action that is required to ensure its use becomes embedded.

6. DSAB and DSCP should jointly seek assurance from Doncaster CCG that during any period where national restrictions are in place due to a pandemic, there are clear arrangements in place to enable face to face consultations to be carried out by primary care and / or secondary health professionals when accurate diagnoses cannot be achieved through telephone or video contact with the patient.

7. DSAB should remind all partner agencies of its expectations in respect of the quality and timeliness of Individual Management Reviews, and the requirement that agencies should submit a single report covering the work of all its services that were involved.