Overview Report Executive Summary
For Mr AF (Father)
and Mr AS (Son)

1. Purpose and Reason for Briefing Paper

A request was received from the Devon and Cornwall Police to the Devon Safeguarding Board for a Serious Case Review. The reason being a perceived failing of the agencies involved to prevent the escalating neglect experienced by AF and his son. As a result of the request for a Serious Case Review, Single Agency Summary Reports were requested from all agencies involved, spanning a period of 7 years in total.

An overview report of the Single Agency Summary Reports was commissioned and completed, the outcome of which recommendations were made.

This briefing paper is in response to one of a number of recommendations contained in the case of AF and his son AS

The purpose of this paper is to facilitate an exploration of the outcomes of the overview report and the subsequent lessons to be learnt.

2. Background

The single agency reports cover a 7 year period following the family's move (mother, father and son) from the Midlands to Torbay in order for AS to receive what was felt to be a quality home tutoring service. Shortly after moving to Torbay the parents separated and AS lived with each parent on a 50:50 basis. In 2007 when AS was 13 years of age, he and his mother came to the attention of Police and Torbay Children Service following complaints from neighbours regarding the care provided by his mother. At this time it was also established that AS was 'a child missing from school'. No further action was taken from social services and it is unclear what action was taken by education. Approximately two months later, the death of AS' mother was reported to Torbay Children Service by the Education Service. They were concerned as to the whereabouts of AS as he had not been seen. It was subsequently established upon further investigation by Torbay Children Service that he had gone to live with his father who lived in Devon.

In September 2008, approximately a year after moving to live with his father, AS then aged 14, again came to the attention of Education Service. It was then that the neglect was first identified and documented by the Police and Devon Education Service. The home was described by the Police as appearing very dirty and messy with no clear surfaces or floor space. AS presented as "scruffy". The Devon Education Service expressed concern regarding the home environment and described the home as very cluttered and chaotic with an array of items having been collected and hoarded over a period of time. On the 10/02/2009 the Devon Education Department recorded that the home environment was the same as previously. During a hospital admission for surgery in June 2009, concern was expressed by hospital staff and documented regarding AS' poor hygiene. In September 2009, AS' case was closed to the Devon Education Welfare Officer as AS was then 15 years of age and was actively engaged in Education. There were no other services involved.

From September 2009 to September 2012 there was no further evidence of neglect documented. AS and AF did not come to the attention of services. However, on the 26/09/2012 during an appointment at the Retinal Clinic, a letter was sent by the Consultant to AF's GP expressing concern about his generally unkempt state with the suggestion the GP may like to complete a

review. It was not until AF'S admission on the 03/06/2013 that further neglect was identified. AF's health appeared to deteriorate with him being admitted to Torbay hospital on 3 separate occasions (03/06/2013, 04/12/2013, and 27/04/2014) where self neglect was highlighted on each occasion. The length of these admissions and discharge dates were not provided.

Following AF's admission on the 04/12/2013, the neglect and squalor within the family home as identified by the Police and Environmental Health consisted of:

- No running water
- Overflowing toilet with faecal matter
- Serious hoarding
- Little food
- Faeces on the floor
- Home full of rubbish
- Terrible smell
- No water supply
- Plumbing defective
- Mould and damp on walls due to lack of ventilation, accumulation of waste and items within the property
- Accumulation of waste and food throughout the property
- All rooms littered with food and general waste
- Unable to find heating source
- Unable to find boiler for hot water supply
- No taps working
- Soft furnishings appeared soiled.

During the period of time from September 2008 to AF's last admission on the 27/04/2014, numerous agencies were involved, with no single agency appearing to take the lead. AS had spent these 6/7 years, from the age of 13 to 19 living with his father in deteriorating neglect. The agencies involved included Torbay Children Service, Torbay Education, Devon and Cornwall Police, Devon Education Department, Devon Environmental Health Service, Devon Children Service, Adult Social Care/Care Direct, Torbay Hospital/South Devon Healthcare Trust, Torbay Adult Social care, General Practitioner.

From the evidence available it appears that the neglect identified in 2008 continued, leading to a life of squalor for the two people involved, including a potentially life threatening condition suffered by AF who now lives in residential care. The family home was "deemed as unwholesome and prejudicial to health" under the Public health Act 1936, and AS was initially re-housed in supporting living and now resides in rented accommodation on his own.

3. Areas of Concerns Highlighted in the Overview Report

AS

- Child left at home possibly at risk with no full assessment completed. (S17 and S47 Children Act 1989 Child in need assessment)
- Child not interviewed or spoken to. Working together 20O3, The Children Act 1989 (as amended by section 53 of the Children Act 2004). This requires local authorities to give regard to a child's wishes when determining what services to provide.
- Limited inter-agency communication between Torbay Children Service, Torbay Education Service and GP. Section 10 of the Children Act 2004, the local authority has a responsibility to promote inter-agency cooperation to improve the welfare of children.
- No handover to Devon Children Service or Devon Education Service by Torbay Children Service

- 9/10 months for a referral/transfer to take place between Torbay and Devon Education Service.

AF & AS

- Poor communication between agencies
- No ownership by one agency or lead agency
- No inter-agency risk assessment, planning or management of the case
- No core group working
- Individual agency decisions being made and actions taken in isolation of each other
- Possible gaps in each agency access criteria
- Individual agency access criteria not appropriately applied.
- Appropriate implementation of the Safeguarding Adult Process and the Mental Capacity Act not applied.

4. Conclusion

In hind-sight, there will be many reasons or rationale for these concerns arising, and it must not be forgotten that some good working practice with individual agencies was identified. However, the overview report concluded from it's analysis that attempts could have been made to prevent an escalation of the situation. The recommendations within the report have been made not to apportion blame, but with a view to creating changes that will further inform individual and inter-agency practice, thereby ensuring the safety and protection of those most vulnerable.

The analysis of the single agency reports highlights a series of lapses by individual agencies and at times collectively. The main findings are as follows:

- Agencies working and making decisions in isolation
- No ownership or leadership of the case by one agency
- Poor sharing of information and communication
- Incorrect application of access criteria with gaps in access criteria between agencies
- Lack of understanding and application of Safeguarding Adults process and Mental Capacity Act
- Information being accepted at "face value" with a lack of verification, analysis or challenge.
- Possible influence on the response of agencies by the eloquence and intellect of the two people concerned

In order to address the issues highlighted above, a number of recommendations have been made.

Recommendations from the Overview Report.

Most overview reports list a large number of recommendations that agencies can find difficult to implement effectively. The suggestion of recommendations in this case is further complicated by the length of time since the incident and also the development of policies and practice over the intervening period of time. However consideration should be given to the following recommendations:

1. The Devon Safeguarding Adults Board (SAB) should consider appointing a senior manager to convene a meeting of appropriate level managers of all the agencies involved in this case. The terms of reference for this meeting would include:
(i) Briefing the managers on the findings of this report
(ii) To establish and agree the scope of dissemination of the findings of this report within all the agencies.

(iii) To establish the understanding of referral criteria in; Safeguarding of Adults; Safeguarding Children and Environmental Health. A simple questionnaire is one way of accomplishing this.
(iv)To identify the training needs from any gaps in knowledge as highlighted within the report and decide how to address this need.
(v) To consider incorporating the notion of 'lead agency' and 'core group working' in cases such as this in each agencies polices.
(vi)To agree a time period for completion of this work and to report back to the Devon SAB within 6 months of the date of this report

2. In order for current staff working in these agencies to learn from what went wrong in this case, the Devon Safeguarding Adult Board should ensure that managers of the relevant agencies use this report as a basis from which to organise a briefing for all current staff involved in these processes today. This could be completed via a specific multi agency briefing session(s) or team meetings. To be completed and reported back to the Devon SAB within 6 months of the date of the report

3. In order that members of the public do not fall between gaps in referral criteria of the agencies and that these criteria are not written in isolation, an appropriate person should be commissioned to review the relevant agencies current referral criteria. The aim would be to identify any gaps or areas of concern between the agencies criteria. To be completed and reported back to the Devon SAB within 6 months from the date of the report

4. The Education Service to investigate how a child missing from school went undetected for so long and to feed back the outcome of this investigation with conclusion to the Devon SAB within 6 months of the date of the report.

5. The Devon SAB to consider inviting a senior manager from Environmental Health onto the board not only in response to this case but also in light of the 2014 Care Act's focus on self neglect.

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27/03/2015