Safeguarding Adult Review

Overview Report: 'Jessica'

Author: Allison Sandiford

Publication Date : 04th April 2023

This report is written for publication in line with statutory guidance. To preserve anonymity, the author has changed the names of the subjects of the review.

BLACKPOOL SAFEGUARDING ADULTS BOARD

Contents

1. Introduction to the Review

1.1. Commissioning of this Safeguarding Adult Review

1.1.1. This Safeguarding Adult Review has been commissioned by the Chair of Blackpool Safeguarding Adult Boards in accordance with the Care Act 2014.

1.1.2. To ensure confidentiality, the subject of this review is referred to as Jessica.

1.1.3. Jessica lived with Down's Syndrome; a genetic disorder caused when abnormal cell division results in an extra chromosome.

1.1.4. On the 29th of August 2019, paramedics informed the Police that they had been called to Jessica's address and had discovered Jessica dead in her bed. Jessica was in an emaciated condition and was suffering a severe infestation of Norwegian Scabies[1].

1.1.5. Officers at the scene arrested Jessica's mother, sister and two other adults who were present in the house, under Section 5 Domestic Violence Crime and Victims Act 2004, for causing or allowing the death of a vulnerable adult.

1.1.6. Jessica's mother (hereafter referred to as Ann) eventually pleaded guilty to gross negligence manslaughter and was sentenced to 9 years and 7 months in prison.

1.1.7. The criteria for this review were met as Jessica, an adult with needs for care and support, has sadly died as a result of abuse and neglect.

1.2. Report Chair and Author

1.2.1. Vicky Shepherd was appointed to chair the review. Vicky sits on the Blackburn with Darwen Adult Safeguarding Board as a member for the voluntary and community sector and has been involved in the Board and other safeguarding developments for over 15 years.

1.2.2. Allison Sandiford has authored the report. Allison is an independent safeguarding consultant with no links to Blackpool Safeguarding Adults Board or any of its partner agencies. Allison gained experience in safeguarding whilst working for a police service. Since 2019 Allison has conducted serious case reviews in both children's and adults safeguarding, and domestic homicide reviews.

[1] Norwegian scabies is an infestation characterised by thick crusts of skin that contain large numbers of scabies mites and eggs. It is a severe form of scabies that occurs most often in people who have a weakened immune system or a neurological disease, the elderly, and the disabled.

1.3. Safeguarding Adult Review Process

1.3.1. The methodology used for this review is adapted from the Welsh Model, a nationally recognised model that ensures a streamlined, proportionate approach to reviewing and learning, and focusses on accountability, not culpability.

1.3.2. The panel[2] met[3] on the 30th of March 2022 to discuss terms of reference[4], chronology timelines, the learning event, and an expected date of completion.

1.3.3. The panel further met on the following dates to monitor the review process and discuss learning:

- The 23rd of May 2022
- The 7th of September 2022
- The 19th of October 2022

1.3.4. For effective learning, it was agreed that the scoping period for this review would be extended from the 12-month period recommended by the Welsh Model and would be from the 7th of December 2016 (when Jessica was first presented to a support service in Blackpool) until the 29th of August 2019 (when Jessica was found deceased).

1.3.5. Further historic incidents which have occurred prior to the review period, but prove significant to learning, are referred to in the report.

1.3.6. A practitioner learning event[5] was held virtually on the 14th of July 2022.

1.3.7. Additional conversations between the Independent Author and professionals[6], some of whom had been unable to attend the practitioner learning event, helped to clarify practice and shape the learning.

1.3.8. Feedback from the practitioner participants generated positive discussion around areas of practice that could be developed, improved, and highlighted much good practice.

1.3.9. This feedback has formed the basis of this report.

1.3.10. It was agreed by panel members that the review would follow a question-based learning format in place of traditional recommendations. The questions developed during this Safeguarding

[2] Please refer to Appendix A for members

[3] Covid considerations necessitated that panel meetings and the Learning Event be virtually attended. As such they convened using Microsoft Teams.

[4] The Terms of Reference appear at Appendix B and detail the particular areas for consideration.

[5] Please refer to Appendix C for attendees

[6] An Education provider in East Sussex, a home care provider attending the address re another family member, a Day Centre in Leeds, and the senior police investigating officer.

Adult Review process will drive Blackpool Safeguarding Adults Board and its partner agencies to develop an action plan that will respond directly to the identified learning.

1.3.11. Panel members had an opportunity to review the final draft of the report and discuss the learning prior to presentation to the Blackpool Safeguarding Adults Board.

1.4. Parallel Investigations / Reviews

1.4.1. On the instructions of Her Majesty's Coroner, a Consultant Home Office Pathologist performed a post-mortem examination on the body of Jessica and concluded that the cause of death was severe emaciation and neglect with extensive and severe scabies skin infection.

1.4.2. Following Lancashire Constabulary commencing a criminal investigation, Jessica's mother pleaded guilty to gross negligence manslaughter and as previously mentioned, was sentenced to 9 years and 7 months. The Crown appealed the sentence as unduly lenient, but this was dismissed at the Court of Appeal and the original sentence remains untouched.

1.4.3. Jessica has been subject to a Learning Disability Mortality Review. The Learning Disabilities Mortality Review Programme (LeDeR) established in 2016, is a non-statutory process set up to contribute to improvements in the quality of health and social care for people with learning disabilities in England. All deaths of people with learning disability or autism over the age of 4 years, are subject to a Learning Disability Mortality Review. The main purpose of a review is to identify:

- any potentially avoidable factors that may have contributed to the person's death,
- learning and plans of action that individually or in combination, guide necessary changes in health and social care services to reduce premature deaths of people with learning disabilities.

1.4.4. A summary of the LeDeR Learning Disability Mortality Review Report for Jessica can be found at Appendix E.

1.4.5. Ordinarily, a Coroner's Inquest into any homicide is opened and then adjourned, pending any criminal trial, which takes precedence. It is the Coroner's prerogative to resume an inquest following a criminal trial. On this occasion, no Coroner Inquest had been resumed by the time the Safeguarding Adult Review had completed.

2. Involvement of Family and Wider Community

2.1 The view of family members is an important aspect of the Safeguarding Adult Review process. Their personal experiences of support and services proves hugely beneficial. Jessica's father, mother, aunt, and cousin were notified of this review by Blackpool Safeguarding Adults Board and invited to participate. There is no obligation on any individual to contribute and Blackpool Safeguarding Adults Board and the Independent Chair and Author, respect the decision of those who chose not to.

2.2 Both of Jessica's parents agreed to contribute to the review and meet with the Independent Author. Both parties contributed by virtual meeting and were very helpful in providing insight into the life and circumstances of Jessica. Their valued contributions are woven into the body of this report.

2.3 Jessica's father is hereafter known as Bob and as previously stated, her mother as Ann.

3. Background Information

3.1 Who was Jessica?

3.1.1 Jessica was born in May 1995, with Down's Syndrome. As previously mentioned, Down's Syndrome is a genetic disorder caused when abnormal cell division results in an extra chromosome. Down's Syndrome varies in severity among individuals causing intellectual disability and developmental delays. It also commonly causes other medical problems including heart conditions and gastrointestinal disorders. Almost half of children with Down's Syndrome are born with a heart condition and in August 1995 Jessica underwent surgery to correct a patent ductus arteriosus[7].

3.1.2 Jessica's parents separated when Jessica was around 2 years old. From this time, Jessica lived with her mum in East Sussex. Ann met a new partner who moved into the family home.

3.1.3 As Jessica developed, her level of independence was established; Jessica was independently mobile and able to use stairs. She did not require any aids or adaptations to the property. Whilst Jessica was able to independently undertake many of her personal care needs, Jessica was fully dependent on others for her meals and the provision of a clean and tidy home environment.

3.1.4 Jessica presented to professionals as shy and despite being able to communicate verbally herself, would look for her mother or others to speak for her, particularly when she was attempting to communicate her wishes, feelings, or preferences to those she did not know.

3.1.5 When Jessica was 18 years old, Ann moved Jessica to Leeds in 2014. Professionals who knew Jessica when she lived in Leeds report that Jessica appeared to have a very loving relationship with Ann. They report that Ann was affectionate towards Jessica, regularly cuddling and kissing her. And that Jessica would respond with the same often 'clinging' to mum and appearing happy to see her.

3.1.6 In 2016 the family moved to Blackpool. Jessica was twenty-one.

[7] A condition where the opening between the two major blood vessels leading from the heart fail to close after birth.

3.1.7 Jessica lacked capacity for many of her decisions including how to manage her finances (Ann was made appointee) but she was able to make basic choices when offered choices from things she knew and had experience of.

3.1.8 Jessica required someone with her to access the community and it was stated by family that she never went out, or was left at home, alone. Therefore, without the support of others, Jessica was isolated and unable to access anything or anyone in the community. This review has been advised by professionals who worked with Jessica and her family that this isolation was further compounded as Jessica was unable to use the telephone and therefore could not contact anyone outside of the home independently. This has been agreed by Ann but contradicted by Bob who informed this review that about a year prior to her death, Jessica had contacted him by telephone asking if she could live with him.

3.1.9 Jessica's primary carer was her mother, Ann. Ann had four children who all had care and support needs as follows:

Child	Born	Care and support needs
Sibling 1	1992	Learning Disabilities
Jessica	1995	Down Syndrome
Sibling 2	1996	Complex mental health needs
Sibling 3	1999	Cerebral Palsy and Diabetes

3.1.10 Throughout the scoping period of this review, Jessica lived with Ann, Ann's partner[8], sibling 1, sibling 1's son (born in 2016), and sibling 3. Jessica had not made any friends in Blackpool and was not accessing any day care facilities, as she had historically when she had lived in other areas.

3.2 Chronological Agency Interaction Prior to the Scoping Period

3.2.1 A few months before her third birthday Jessica started to attend a school for children with severe and profound learning disabilities in East Sussex. Members of staff who worked with Jessica during her time at the school informed this review that Jessica presented as a cheerful, kind, and caring young person who had friends that were important to her. Staff described how Jessica as an older pupil, particularly enjoyed music, art, and dance. They recalled that Jessica had one or two members of staff that she was particularly close to and would chat with/seek comfort from, other members of staff she was much shyer with and would not communicate with. Jessica was able to communicate verbally but staff said that she perhaps would not have been understood by those who did not know her well. This was because of the clarity of her speech. Jessica used and understood Makaton signing and symbols to support her communication in school.

[8] This is not the same partner who lived with the family until 2011 in East Sussex.

3.2.2 Staff recall that Jessica regularly presented with poor appearance (at least weekly). Headlice was habitual, and Jessica would arrive with inappropriate clothing/footwear, and often 'grubby'. School's recollection is that this would be addressed in the short-term following instruction to Ann from school (except headlice) but was never maintained. Because school found it extremely difficult to get Ann to come to school for discussions with staff regarding learning/wellbeing, Jessica and her family remained on school's 'hard to reach' list throughout Jessica's time at school.

3.2.3 This description of Jessica and her family tallies with Jessica (and her siblings[9]) being subject to Child Protection Plans between 1997 and 2001, and again between 2009 and 2011, and an Interim Care Order (placement with their parents) from February 2000 until March 2001.

3.2.4 Case notes evidence how, as a child, Jessica experienced consistent neglect due to Ann's poor standard of parenting and her inability to meet the basic care needs of Jessica and her siblings.

3.2.5 In 1999, during the first period of Child Protection, Ann and her partner had a child together (Sibling 3).

3.2.6 The partner is recorded to have left the family home in 2011, and in March 2014, a few months before Jessica turned 19 years old and prior to an adult assessment of care and support needs had been completed, Ann moved Jessica to Leeds.

3.2.7 Ann informed Jessica's school of the move and the school notified Social Care who requested Ann's consent to share Jessica's information with Leeds. Ann did not give consent, but East Sussex Children's Social Care made a courtesy call to Leeds to advise of the family's move.

3.2.8 Between June 2014 and September 2016, whilst living in Leeds, Jessica attended a Day Centre four days a week. Staff at the Day Centre have described Jessica as generally presenting very happy and enjoying everything that was offered to her at the Day Centre. Jessica particularly enjoyed dancing, music, and sports.

3.2.9 Similar to what Jessica's school in East Sussex reported, the Day Centre in Leeds disclosed that Jessica constantly suffered headlice and wore poor fitting clothes. The Day Centre has told this review that Jessica regularly did not bring a packed lunch or any money to be able to partake in activities. Staff would chase this with Ann who would give an excuse as to why Jessica had forgotten her lunch. Staff compensated Ann's inadequate care by ensuring that Jessica was fed and had the opportunities to partake in the activities - even if Jessica did not have the money.

3.2.10 The description of Jessica provided by the Day Centre evidences that Ann was still unable to provide Jessica with sufficient care. As a vulnerable adult, dependent upon others for her care, Jessica continued to experience neglect.

[9] Full details have not been provided to this review, but it is known that paternal grandparents took over care for the older sibling.

3.2.11 The Day Centre said that when it became known that Jessica was moving to Blackpool, Jessica became very emotional and was clearly saying "Don't want to go." Jessica even asked if she could live with a staff member saying, "Live with you." On one occasion, Jessica locked herself in the toilet. Staff informed Ann how upset Jessica was and gave her information about supported living options but described how Ann was not interested in looking at anything else. Instead, Ann confirmed that the family would still be moving to Blackpool.

3.2.12 The staff at the centre arranged a small leaving party for Jessica and presented her with gifts, photos of her with her friends, and a card signed by everyone. They also gave Jessica the contact phone number for the Day Centre and staff email addresses and advised to "keep in touch."

3.2.13 Jessica left the Day Centre service on the 8th of September 2016.

3.3 Overview of Bob and Ann's Contribution to the Review

3.3.1 Parent's recollection of dates and early events in Jessica's life differed but that is understandable with the passage of time. However, both agreed unanimously that Jessica was a loving, and happy person.

3.3.2 Jessica's father informed the review that following him and Ann separating, the courts directed that Jessica live with Ann. Bob said that it was difficult for him to have contact with Jessica thereafter. However, whilst his contact was limited, he said that he had reported concerns to Children's Social Care in East Sussex when Jessica was younger, regarding headlice and poor fitting clothes and the care Ann was able to provide.

3.3.3 Ann explained to the review that she had always been Jessica's main support and carer. Ann spoke of activities she had enjoyed with Jessica when she was younger such as swimming and horse riding.

3.3.4 Ann described how she had moved Jessica and her siblings to Leeds in 2014 because she had been struggling with a significant bereavement and wanted to move away from East Sussex. Ann said that Jessica had subsequently met a man whilst attending the Day Centre in Leeds and he had become her boyfriend. Jessica would say that they were going to be married. Ann recalled how happy Jessica was, but explained that sadly, the address that the family rented in Leeds was cold and after sibling 1 had given birth, Ann became concerned for the baby. Ann said that she decided to move to Blackpool as she had friends there. Ann described how Jessica continued her relationship with the man she had met at the Day Centre, and how she helped them to stay in touch and visit one another.

3.3.5 Ann said that when she first moved to Blackpool, she asked friends whether they knew of places she could take Jessica and of a suitable Day Centre. Whilst she did not learn of a Day Centre,

Ann spoke of visiting a nearby recommended water park and said that she and Jessica would go shopping together.

3.3.6 Ann spoke about Jessica's skin condition. Ann said that it responded well to treatment received at the hospital around April 2018. Ann remembered that following the treatment, the hospital told her to contact Jessica's GP if Jessica needed support in the future. Ann said that when Jessica's condition deteriorated again, she did this on Jessica's behalf, but the GP would not prescribe the creams Ann requested (that Ann knew had worked before). Ann said that the GP diagnosed Jessica with eczema.

3.3.7 Ann struggled to recall an exact timeline, but she informed the review that she knew she needed more support regarding caring for her family about six months before Jessica died. Ann recalled asking the Social Worker (who was working with sibling 1's child) whether she could help her to get support with Jessica, but she did not remember receiving any subsequent telephone calls and/or letters (in March/April 2019) asking her to make contact with Social Workers for further assessment. Ann said that she did sometimes have problems with her phone and that with so many people in the address, it would have been easy for post to be mislaid.

4. Key Practice Episodes

To enable the review to meet the Terms of Reference, professionals at panel meetings and the practitioner learning event explored the following key practice episodes. Practice episodes are periods of intervention that are deemed to be central to understanding the work undertaken. The episodes do not form a complete history but are thought key from a practice perspective and summarise the significant professional involvements that informed the review.

Key Practice Episodes
Events Leading to Jessica Registering as a Patient at a New GP Practice
Events Surrounding the Domestic Incident on the 13th of October 2017
Diagnosis and Management of Norwegian Scabies
Assessment of Jessica's Care and Support Needs under the Care Act 2014
Events Leading to Jessica's Death (July and August 2019)

4.1 Events Leading to Jessica Registering as a Patient at a New GP Practice

4.1.1 Ann has told this review that the family moved from Leeds to Blackpool on the 17th of September 2016. Ann said that being healthy at the time, Jessica had no immediate medical need to be registered with a GP - consequently, Jessica was not registered with a GP Practice until the 1st of December 2016.

4.1.2 Jessica's first consultation with a GP at the practice was on the 7th of December 2016 and was for a fit note regarding her Employment and Support Allowance claim. At the same consultation, Jessica was weighed, and prescribed moisturising gel for her skin.

4.1.3 No further contact was had between Jessica and any professional until June 2017 when Jessica was taken by Ann to see the GP with infected eczema.

4.1.4 In July 2017 Ann contacted the 111 out of hours NHS service twice in the same evening because Jessica had spots and blisters. Jessica was not spoken to, but information was gathered from Ann, and she was advised to take Jessica to a Primary Care Service within 24 hours.

4.1.5 A week later Jessica was taken to the GP Practice where she was prescribed steroid cream, antibiotics, and antihistamines to help manage the eczema. A month later Jessica was taken back to the practice by Ann who reported that the eczema had responded to the treatment but had not ever completely cleared. The GP devised a care plan which was presented to Ann in written form, and a medication review appointment was made.

4.2 Events Surrounding the Domestic Incident on the 13th of October 2017

4.2.1 On the 13th of October 2017, a Police Community Support Officer contacted the Learning Disabilities Team to report that a lady (later identified to be Jessica) with Down's Syndrome had been seen getting hit by her brother (sibling 3). Jessica had been in the town centre with sibling 1, sibling 1's child and sibling 3. Sibling 3 had informed the Officer of everyone's names and address. The Officer had become concerned as all had presented as having learning disabilities.

4.2.2 The Learning Disabilities Team had no record of any of the individuals on the Adult Social Care system. The Police Community Support Officer advised that colleagues, who worked in the area where the family lived, had been asked to attend the family home and were scheduled to go the following day. The Social Worker advised the Officer to call back after the home visit had been undertaken but there is no record of the Officer contacting the team again.

4.3 Diagnosis and Management of Norwegian Scabies

4.3.1 Jessica continued to receive medication for her eczema with little improvement. In February 2018, the GP referred Jessica to Dermatology. Despite the GP Practice leaving several voicemails on Ann's phone, Ann did not respond to two letters requesting that she book a dermatology appointment.

4.3.2 On the 10th of April 2018, Jessica's GP wrote to the dermatology department documenting that the condition had worsened and describing Jessica's eczema as the *most horrific looking atopic eczema* seen in his career.

4.3.3 This review has been unable to establish how an appointment at the dermatology department was eventually made for Jessica, but on the 24th of April 2018, dermatology diagnosed Jessica with Norwegian scabies. Upon meeting with Jessica and Ann, a member of staff from the dermatology ward had an unsupported suspicion that things 'weren't right for Jessica' and contacted the Safeguarding Team at the hospital to report concerns of neglect. The staff member was advised to complete a safeguarding referral to Adult Social Care[10].

4.3.4 Jessica attended the dermatology ward daily for a further three days for treatment. On the 27th of April, Ann was provided with a treatment plan to follow, and asked to attend a follow up appointment with Jessica on the 4th of May, which, records suggest, Ann did not take Jessica to.

4.4 Assessment of Jessica's Care and Support Needs under the Care Act 2014

4.4.1 On the 21st of May 2018 Ann contacted the Learning Disability Team to request an assessment for Jessica regarding social activities. A Social Worker completed an Adult Request for Support for a Balance of Probabilities and Care Act Assessment[11] and on the 27th of June 2018, a Social Worker attended the home address and completed a Care Act Assessment for Jessica. This resulted in a Now Card Bus Pass for Jessica and a place at a Day Service.

4.4.2 Jessica was not taken to the taster days arranged with the Day Service. On two occasions Ann said that she had forgotten, on the third occasion Ann reported that Jessica was not well. On the fourth occasion, Ann said that Jessica no longer wished to attend.

4.4.3 On the 30th of January 2019, Ann told Children's Social Care (who were visiting Sibling 1's child) that Jessica was isolated and needed more social time. With Ann's agreement, Children's Social Care referred Jessica to the Learning Disability for assessment. A referral was completed for a new Care Act Assessment and Jessica was advised that there was a waiting list.

4.4.4 On the 4th and 11th of March, and again on the 1st of April 2019, a Social Worker tried to contact Ann by telephone regarding the assessment. Ann did not respond to voicemails and a letter was sent requesting that she contacted the team. As stipulated in the letter, the referral was closed when no contact had been made by the 22nd of April 2019.

4.5 Events Leading to Jessica's Death (July and August 2019)

4.5.1 On the 26th of July 2019, Children's Social Care made a formal written referral to Adult Social Care after having received a telephone call from a family member who reported serious concerns for the care that Jessica was receiving from Ann. On the same day, family members contacted Adult Social Care to report concerns directly, and Jessica's GP - who they requested to make a home visit.

[10] This process is considered further later in the report.

[11] The Balance of Probabilities is not now used within the Learning Disabilities Team. A full Care Act assessment is now completed alongside Social Workers completing an eligibility checklist to determine the likelihood of a learning disability and validating people for the GP register.

The GP Practice subsequently contacted Ann and advised that the doctor would be attending later that same day.

4.5.2 The GP attended the home address after evening surgery. Jessica was downstairs with family and allowed the GP to examine her. The GP recorded that there was no evidence of scabies but that the skin was very dry. The GP noted that home conditions were acceptable but not very clean. The GP did not go into any other rooms.

4.5.3 On the 29th of July 2019, two Social Workers from the Learning Disabilities Team attended the home address but sibling 1 informed the workers that Ann was out, and Jessica was in bed. Sibling 1 refused the workers entry. The Social Workers advised that they would be returning at 13:30 hours, but when they attended, Sibling 1 again refused them entry stating that Ann was still out. A male was present at the address – he said he was sibling 1's child's father and was visiting. A Social Worker attempted to call Ann but there was no answer and no facility to leave a message.

4.5.4 Successful contact was made with Ann by telephone at 15:34 hours and the concerns explained. Ann reported that Jessica had been struggling with her skin but was now getting up, eating well and spending time downstairs. A visit was arranged for the 1st of August 2019. On this visit Jessica was downstairs curled up on the sofa. She was described by the visiting worker as looking tired and having shiny skin on her face. Entry to the bedroom revealed that Jessica's bedding had not been changed but Ann stripped it whilst the worker was present stating she had been busy helping Jessica shower and apply creams. The worker arranged to visit again in four weeks.

4.5.5 The following week domiciliary carers who were attending the house to visit sibling 3 heard Jessica crying and discussed this with Ann who told them that the behaviour was part of Jessica's learning disability.

4.5.6 The GP attempted to re-visit the home address on the 16th of August 2019 but there was no answer. The GP had told the family during the visit on the 26th of July that he would come again, but there had not been any interim communication to remind them of the appointment. The GP attempted contact with Ann by telephone and left a voicemail requesting that Ann contact the Practice to arrange a follow up consultation. There is no record of Ann scheduling this appointment.

4.5.7 On the 22nd of August 2019, two trained and experienced Detective Police Constables attended the property to visit a family member. The officers did not go upstairs but neither detected any smell, nor saw anything that raised concerns.

4.5.8 On the 29th of August 2019, Ann contacted North West Ambulance Service to report that Jessica had died. As per protocol, the police were informed. Jessica was found in an emaciated state and covered in Norwegian Scabies. Jessica's bed was covered in faeces and maggots. The criminal investigation was launched.

5. Analysis by Theme

The following themes have been recognised as areas which contain practice and organisational learning for the Blackpool Safeguarding Adult Board.

They have been identified from:

- agency reports,
- professional consultation,
- and panel consideration of the terms of reference alongside the key episodes.

5.1 Transferance of Information Across Borders

5.1.1 In September 2016 Jessica and her family moved from Leeds to Blackpool. In Leeds Jessica:

- Had been registered with a GP Practice,
- Had attended a Day Centre until September 2016,
- Had a Social Worker in the Learning Disability Team

5.1.2 The Social Worker and staff at the Day Centre in Leeds were aware that Jessica was moving to Blackpool. This review has been informed that Jessica's Social Worker asked Ann if she would like her to make a referral into Blackpool on their behalf, but that Ann declined. The Social Worker has recorded that Ann was subsequently advised to make a referral of her own when she moved. Ann has informed the review that she does not recall any such conversation, and records show that Ann did not contact Social Care on behalf of Jessica until 2018 – almost 18 months after the family had moved.

5.1.3 It remains unclear as to why it is recorded that Ann's permission was being sought for a referral to be made. The referral was for Jessica who was an adult, thus it was her permission that was required.

5.1.4 When Jessica was a child, Ann as her mother had the right to make decisions about her care and upbringing. This is because Ann had parental responsibility which afforded her legal rights, duties, powers, responsibilities and authority for Jessica and her property. However, the power afforded through parental responsibility is never retained over a child when he or she becomes an adult. Even when, like Jessica they do not have the capacity to make some decisions for herself.

5.1.5 In law, young people over the age of 16 are presumed to have capacity to make their own decisions. This means being able to:

- understand information given to them in relation to a decision.
- remember the information long enough to make a decision.
- use or weigh up the information available.
- communicate their decision in any way which can be recognised.

5.1.6 If Jessica were not able to meet these criteria, she would be considered to be 'lacking capacity' and different people and agencies would become involved in making best interest decisions on her

behalf. Ann would be one of the people involved in the decision-making process but depending upon the complexity of the situation, it would also include relevant professionals such as healthcare or social work practitioners.

5.1.7 As such, professionals should have assessed whether Jessica had the mental capacity to decide whether a referral should have been made to Blackpool when she was moving. If the assessment had concluded that Jessica lacked the capacity to make such a decision, then a decision should have been made in her best interests. Given the level of support that Jessica required, the life-long standing inability of Ann to meet Jessica's basic care needs, and Jessica's love of attending the Day Centre and socialising – it is unlikely that it would not have been found to be in Jessica's best interest to refer.

5.1.8 The Independent Author asked Ann whether anyone had ever explained to her the law governing Jessica's decision-making as she became an adult. Ann said that she did not think so. This is discussed further in section 5.5 of the report.

5.1.9 In the absence of a referral to Blackpool being made by Leeds, no information regarding Jessica's care and support needs was transferred. And most importantly, no information was shared evidencing Ann's historic and continual inability to meet Jessica's needs.

Question 1 for Blackpool Safeguarding Adult Board:
How can partner agencies assure Blackpool Safeguarding Adult Board that professionals are empowering vulnerable adults by communicating with them directly and applying the Mental Capacity Act as and when required?
How can Blackpool Safeguarding Adult Board share this lesson with Leeds and other Safeguarding Adult Boards?

5.1.10 When Ann registered Jessica with the GP Practice in December 2016, a member of the administration staff at the practice applied for her previous medical notes to be transferred.

5.1.11 When a patient is de-registered from a previous GP Practice, their records are sent or recalled to a central processing department. Many GP surgeries now have an instant transfer of electronic records, but any paper records must be posted (to the central processing department).

5.1.12 On the 3rd of December 2016 Jessica's electronic records dating from between August and December 2016 were received at her new practice. Some older paper records were received on the 17th of January 2017 but despite the GP Practice contacting Primary Care Support England on many occasions, Jessica's full paper records from birth to August 2016 had still not been received by the practice when Jessica died.

5.1.13 GP Practices maintain a list of people registered at the practice who have a learning disability. This is known as a Learning Disability Register and being subject to the register triggers invites for annual health checks and physical and emotional support. None of the previous GP records

received by the new GP Practice indicated that Jessica had learning disabilities or had previously been on a learning disability register[12].

5.1.14 It is important to note that at that time, Jessica's Down's Syndrome did not automatically cause Jessica to be included on the register. It is only since March 2020 that the Quality and Outcomes Framework has directed that a patient with Down's Syndrome be automatically included in the register of people with a learning disability.

5.1.15 However, had Jessica's full medical records been received by the new practice in a timely manner, it is possible that when Jessica first consulted with her GP on the 7th of December 2016, the practice may have known that, as a child, Jessica had attended a school for children with learning disabilities. This could have resulted in Jessica being made subject to the practice's Learning Disability Register.

5.1.16 In the absence of any historic information suggesting that Jessica had a learning disability, and in the absence of Jessica, or a family member informing the practice, Jessica did not become subject to the new Practice's Learning Disability Register. And, because Jessica did not become subject to the register, she was not offered an annual health check which would have involved her weight being recorded on her notes. Had this happened, her subsequent weight loss may have been recognised and addressed. This omission demonstrates the importance of transferring information across border.

5.1.17 The GP Practice has assured this review that the practice has now employed a new procedure which ensures that all new patients with learning disabilities are identified on receipt of registration. The practice now has a dedicated administrator who reviews the entirety of medical records for references for learning disabilities and/or safeguarding issues. Any concerns are flagged to the practice safeguarding lead. Identified patients are prioritised for record summarising to ensure that they are added to the Learning Disabilities Register and recalled for a face-to-face review annually.

5.1.18 Furthermore, had Jessica's full medical records been received by the new practice in a timely manner, the GP Practice would have been in receipt of information which alluded to the fact that Jessica had been neglected as a child by Ann.

5.1.19 Jessica's new practice in Blackpool received case conference notes from the GP Practice in Leeds in January 2018. As this was a year after the GP Practice in Blackpool had received the initial medical notes, they were not sent to the GP – instead, they were put inside the Lloyd George Patient Notes - common storage media for doctors' practices and health centres.

[12] Despite contacts with previous authorities where Jessica had lived, this review has also been unable to establish whether Jessica had been subject to any learning disability register previously.

5.1.20 This review has been informed that expected practice would have seen the summariser at the GP Practice, upon receipt of the case conference notes, reviewing Jessica's file to confirm that it included a code which highlighted the historic neglect. In the absence of such a code – one would be added. It would appear that on this occasion, this was not done. Unfortunately, due to the passage of time the summariser is unable to confirm the specifics of these records and so the review is unable to understand why.

5.1.21 Had the GP seen a code or, had the GP's attention been brought to the case conference notes when they were received in January 2018, the GP would have known that there had been previous safeguarding concerns raised for Jessica when she was a child. This information would have highlighted Ann's inability to consistently provide adequate care and draw attention to Jessica's vulnerable situation.

5.1.22 Whilst it is recognised that the omission of a referral to Blackpool from Leeds increased Jessica's vulnerability and isolation when she moved to the area, there were occasions when Blackpool, having learned of where Jessica had previously resided, could have contacted services in Leeds.

5.1.23 The Learning Disability Team in Blackpool first learned of Jessica and her family living in the area when a Police Community Support Officer contacted them in October 2017. The Officer informed the team of an incident whereby sibling 3 had been seen hitting Jessica. During the phone conversation, the Officer disclosed that the family had moved from Leeds and that Jessica had a Social Worker when they had lived in Leeds. This incident is discussed further in section 5.2 of this report, but upon becoming aware of this, the Learning Disability Team could have contacted Leeds to try and learn more about the family's needs and circumstances.

5.1.24 The practice of contacting agencies/organisations where a service user has previously resided, is undertaken on occasions - When Ann contacted the Learning Disability Team in May 2018, a member of the team did contact Jessica's previous education provider in East Sussex for information for the referral. The school said that they would look to see if any information had been retained but that it was unlikely given that Jessica was now 22 years of age. The school did not ever re-contact the Learning Disability Team and professionals at the learning event acknowledged that this wasn't followed up. Had it been, it may have become known that Jessica had been neglected throughout her childhood.

5.1.25 As the assessment under the Care Act progressed, it became known that Jessica had attended a Day Centre in Leeds. Contact with the Day Centre in Leeds could have been hugely beneficial as it could have brought attention to the concerns of neglect that staff had recorded.

5.1.26 The benefits of improvised contact have been evidenced by East Sussex and Leeds. Upon learning of Ann's intention to move the family from East Sussex to Leeds in 2013, Children's Social

Care in East Sussex requested Ann's permission to share the family's information with Leeds. This consent was not ever forthcoming but East Sussex Children's Social Care still made a courtesy call to Leeds to advise them of the family. Potentially, because of this first contact having established a link between East Sussex and Leeds, Leeds contacted East Sussex in June 2014 for further information after Jessica had been found unaccompanied in town and learned that a similar incident had occurred previously.

5.1.27 Blackpool Safeguarding Adult Board has previously commissioned a review (Adult Q)[13], which has considered the effectiveness of cross border working. Whilst the Adult Q case differed from Jessica in that Adult Q was a care experienced young adult, there were similarities. In the case of Adult Q, no contact was had between Blackpool and the previous Local Authority until Adult Q had been living in Blackpool for around 10 months, and upon contact being established, no multi-agency meeting or discussion was considered.

5.1.28 The review's subsequent recommendation concerned assurance of the effectiveness of new arrangements brought into practice in Adult Q's previous Local Authority. The new practice comprised a multi-agency risk management meeting being arranged when a care experienced young person moves to another area.

5.1.29 Blackpool is also adopting this recommendation and this review would ask whether similar arrangements could be embedded into practice when any adult at risk of harm, moves from one authority to another.

Question 2 for Blackpool Safeguarding Adult Board:
How can Blackpool Safeguarding Adult Board obtain assurance of work being undertaken which ensures cross border multi-agency communication when an adult at risk of harm moves to, or from, the Blackpool area?

5.2 Referrals

5.2.1 The Police Community Support Officer who attended Jessica after she had been seen to be the victim of a domestic incident in the town centre (whereby she was hit by sibling 3), learned through discussions with the siblings that:

- Jessica presented as living with Down's Syndrome
- Sibling 1 and 3 presented as having learning disabilities.
- The family had recently moved to Blackpool from Leeds
- Jessica had a Social Worker in Leeds but no support in Blackpool.
- Ann worked away for two weeks at a time.
- Stepfather worked shifts.

[13] Published in May 2022

5.2.2 As a result, the Officer raised a Protecting Vulnerable People (PVP) safeguarding alert within the Multi Agency Safeguarding Hub. The alert was classified as a medium risk and stated that Jessica lacked capacity as she was unable to provide her name or address. This information was shared with Children's Social Care, Adult Social Care and Health professionals.

5.2.3 Whilst professionals at the learning event suspect that the response to this referral from Children's Social Care was to send it to Early Help, no one was able to confirm this with confidence. Adult Social Care recall that there was no telephone number for the family on the safeguarding alert but there was an address. Consequently, a letter was sent to Jessica at the address asking that she contact the duty Social Worker to discuss the referral and any assessment further.

5.2.4 Professionals have recognised that this response is not enough. It is very unlikely that Jessica would have understood the letter, and/or been able to follow its direction. Professionals informed this review that better practice would have been to address the concern directly with Jessica which, given her learning disabilities would have required a face-to-face meeting. The Learning Disability Team have since developed practice accordingly (refer to Appendix D).

Question 3 for Blackpool Safeguarding Adult Board:
How can Adult Social Care assure Blackpool Safeguarding Adult Board of a robust response to safeguarding concerns involving individuals who have presented as having learning disabilities?

5.2.5 The Officer also contacted the Learning Disability Team to report his concerns. The Officer told the Learning Disability Team that it had been arranged for a different Police Community Support Officer (from the area in which the family lived) to visit the family at the home address the following day. The Officer was advised to re-contact the team if any concerns arose from the visit. There is no further contact recorded between the Officer and the Learning Disability Team.

5.2.6 The Learning Disability Team have informed this review that best practice would see a member of staff who received a call like this one, setting themselves a reminder to follow up the following day and enquire how the visit went. However, even in the absence of following up the visit with the police, it was agreed that the Learning Disability Team had learned enough information from the Officer during the initial telephone conversation, to warrant more action. For example, contact could have been made with Children's Social Care regarding the young boy present and/or a member of the Learning Disability Team could have attended the home address to consider the situation first-hand.

5.2.7 The Learning Disability Team have identified to this review that it would be helpful to have a designated champion within the police force with whom concerns/information on people with a learning disability can be discussed. The designated champion could be contacted if any concerns arose about a person that fell below the threshold for safeguarding, but where a conversation

would be helpful to know how best to support the family unit across agencies. Meetings could be arranged which included other agencies as appropriate.

5.2.8 Whilst completing the 'Protecting Vulnerable People' referral, the Officer's focus was on Jessica's vulnerabilities and the domestic element of the incident was overlooked. The omission of a referral in relation to the domestic assault resulted in information not being shared with domestic abuse support agencies such as the Independent Domestic Violence Advisors.

5.2.9 A recent Blackpool Domestic Homicide Review[14] has already identified that Lancashire Constabulary needed to reinforce its domestic abuse policy regarding the correct recording of Domestic Abuse incidents when other significant factors are present. This Safeguarding Adult Review has been informed that the learning has now been disseminated to all staff within Lancashire Constabulary and to vulnerability coaches within Basic Command Units. The Force training department is also disseminating the message through training packages.

5.2.10 In addition, Lancashire Constabulary now have an Incident Monitoring Unit who review all referrals to check if all crimes have been recorded correctly. Had the unit been in place in 2017 when this incident occurred, the unit would have picked up that no crime report had been submitted for any possible assault and would have requested the Officer to 'tag' the report as a Domestic Incident.

5.2.11 Consequently, it is now anticipated that incidents such as the one witnessed in October 2017 between Jessica and her sibling, will be correctly identified as domestic abuse, and recorded appropriately. In addition, it is expected that staff will now record incidents of domestic abuse and investigate, parallel to sharing the details of the other issues with the relevant partner agencies through the Multi Agency Safeguarding Hub.

5.2.12 It is good practice that the Officer identified Jessica's vulnerabilities, submitted a 'Protecting Vulnerable People' referral, and contacted the Learning Disability Team, but better practice would have seen the officer escort Jessica home and effectively safeguard her from any further abuse. Instead, it was accepted that Jessica was safeguarded when she left to return home with her siblings.

5.2.13 The next safeguarding concern for Jessica had by a professional was on the 24th of April 2018 when, after Jessica had been presented to the dermatology department, staff contacted their hospital adult safeguarding team with concerns around neglect. The safeguarding team advised the caller to make a safeguarding referral to Blackpool Adult Social Care and to consider a referral to Blackpool Carers Centre. No further referrals were made. This was discussed with practitioners at the learning event who have concluded that the staff member, having informed the hospital

[14] DHR MM

safeguarding team of the concerns, was under the impression that a statutory safeguarding referral had been made.

5.2.14 If this situation were to arise now, the dermatology and the hospital safeguarding teams have assured this review that current practice would see dermatology staff completing the correct referrals. Since 2018 ward staff have completed much safeguarding training and the adult safeguarding team has expanded and has six practitioners around the hospital supporting the different departments.

5.2.15 Around the same time, there was an opportunity for the GP Practice to also make a safeguarding referral regarding Jessica - when in March 2018 Ann failed to respond to two letters requesting that contact be had with the dermatology department to book an appointment for Jessica. In addition to the letters, the GP Practice rang Ann and left voicemails asking Ann to contact them about the dermatology referral and offering support. The voicemails were not responded to. On the 20th of March 2018, having not heard from Ann, another appointment was sent.

5.2.16 Given that on the 10th of April 2018 the GP faxed a letter to the consultant which stated that the patient's condition had worsened, and that Jessica's eczema was *the most horrific looking atopic eczema I have seen in my career*, it is reasonable to conclude that Ann's failure to address the medical issue on Jessica's behalf necessitated consideration of a safeguarding concern.

5.2.17 The Blackpool Safeguarding Adults Board Decision Making Tool 2017 provides a *thinking framework for Adult Safeguarding and aims to support a consistent basis for action.* The tool lists types of abuse with examples of where safeguarding is not required, where safeguarding is possibly required and where a referral must be made. Whilst the tool does not offer guidance as to whether a safeguarding referral should be deemed necessary when a carer omits to make appointments on behalf of a person unable to make the appointment for themselves, consultation with the examples indicate that a referral could have been considered at this time given the amount of professional communication not responded to and the severity of Jessica's skin condition.

5.2.18 Whilst this review has been unable to establish why a safeguarding concern was not made on this occasion, it has been assured that the Integrated Care System receive safeguarding assurance from Primary Care GP Practices as part of the NHS contract by means of an annual Safeguarding Audit Framework assessment. Each GP Practice is required to assess their safeguarding processes against a set of evidence-based standards which are in line with Care Quality Commission standards. Each GP Practice RAG[15] rates themselves based on their present compliance position against each standard. Practices who have any standard rated partial or non-compliance are requested to put in place a time specific action plan to self-monitor with support available via the Lancashire and South Cumbria Integrated Care Board Safeguarding Team. Themes

[15] RAG is an acronym that stands for Red Amber Green and relates to performance.

from review of the Safeguarding Audit Frameworks are supported through the GP Safeguarding Leads Forum activity/education and training opportunities.

Question 4 for Blackpool Safeguarding Adult Board:
How can GP surgeries in the area assure Blackpool Safeguarding Adult Board that staff are understanding and consulting The Blackpool Safeguarding Adults Board Decision Making Tool to help them make appropriate safeguarding referrals?

5.2.19 On the 26th of July 2019 sibling 1's child's Social Worker was contacted by a relative of Jessica who raised concerns that she had visited Jessica at her home and Jessica had been 'in a shocking state'. The relative described that Jessica's skin was *'rotting, she was filthy, her hair matted, and she was wearing a nappy and was very upset and angry.'* The relative said there had been *'urine and faeces all over the floor.'* As a result, on the same day, the Social Worker made a Safeguarding Adult written referral to Blackpool Adult Social Care, referring to Ann having a history of neglecting Jessica and her siblings as children. The referral referenced that Ann's grandson had been removed from the home due to significant neglect and that the relative was concerned that Jessica was a very vulnerable adult, with Down's Syndrome, living in the care of Ann, and whose needs were not being met.

5.2.20 The Children's Social Worker recorded in the referral that Children's Social Care had also advised the relative to ring Adult Social Services to report their concerns and asked the relative to go back to Jessica's home address and if Jessica needed urgent medical support to call an ambulance or 111. Children's Social Care had advised the relative that if Jessica or Ann would not allow this, then a significant concern needed to be raised to Adult Social Services and perhaps 101.

5.2.21 The Children's Social Worker recorded a copy of the email confirmation received from Adult Social Care acknowledging that the referral had been received.

5.2.22 Adult Social Care has confirmed that a relative contacted them with concerns, but this review has been unable to establish what happened to the referral from Children's Social Care. Professionals at the learning event could see that it had been sent to the correct email address, but no one could trace any action.

5.2.23 This review has now established that at the time when this email was sent, all general enquiries went through an Initial Contact Team. At the time, all the email referrals received were printed off by administrative staff and passed directly to the duty workers in the Initial Contact Team to check and action.

5.2.24 Adult Social Care have now recognised how an email could be missed as there was no formal audit of the emails once printed. This process has now been amended and all new work is now electronic - emails go directly into a work tray and Team Managers or Deputy Team Managers

regularly check this, and action as required. Consequently, there is now an audit trail of when work is actioned, who by and where it goes.

5.2.25 In response to the relative's concerns, Adult Social Care decided to visit the address the following working day – which, because the call was made on a Friday, was Monday (the workers were refused admission into the property). It was established at the learning event that the referral from Children's Social Care offered more detail than the relative had. Had Adult Social Care seen the referral from Children's Social Care, the decision would likely have been made to attend the home address the same day and in the instance of staff being refused admission to the property, consideration would have been had to calling the police and requesting a welfare check. Instead, the conversation between the relative and Adult Social Care skewed Adult Social Care's perceptive to focus upon Jessica's health and Adult Social Care were reassured that Jessica would be receiving medical attention as the GP was requested to visit.

5.2.26 The family member contacted the GP Practice and reported that they had informed Adult Social Care that Jessica was being badly neglected, and that Adult Social Care had advised that a GP needed to go out and do a home visit. The practice was told that Jessica hadn't left her room for a month, was in an adult nappy and smelling of urine, faeces, and a very bad fishy smell. The GP Practice contacted Ann and arranged to visit that evening after practice had concluded.

5.2.27 When the GP attended the home address, Jessica was downstairs with Ann and some other family members. Jessica was presenting differently to how she had been described by the family member, in the sense that she was washed and dressed, but her skin was in poor condition. The focus of the doctor attending the house was Jessica' skin condition and no further concerns were noted. The remit of the GP home visit is considered further in section 5.6 of this report.

5.2.28 Following the GP visit on Friday evening, Adult Social Care attempted to visit the home address on Monday but were refused entry by sibling 1 on two occasions. During communication with Ann later in the day, a visit was arranged for the Thursday. This was six days after the initial concern had been raised by a relative and, potentially because Ann had time to prepare for the visit, entry to the address did not raise any concerns. There was nothing to suggest that only a week earlier, Jessica's bedroom had been described as smelling strongly of faeces or urine and there were no markings to indicate that faeces had been all over the floor.

5.2.29 The attending Social Worker hadn't ever met Jessica before and therefore couldn't say whether Jessica had lost any weight or whether Jessica or the house conditions were presenting different to how they usually would. Thus, in the absence of concerns, the Social Worker asked Ann to consider whether more support was needed.

5.2.30 Professionals at the learning event noted that practice could be improved by giving consideration as to whether there is ever another professional (inside the agency or out) who may

have some knowledge and experience of the family and be able to accompany a duty Social Worker on such a visit.

5.2.31 Although Children's Social Care did initially contact Adult Social Care to ask what action had been taken, this was prior to entry being had. No further conversations were had between Adult and Children's Social Care and no professional multi agency meetings were convened. Therefore, the full circumstances of the referral remained unknown to Adult Social Care.

5.2.32 A robust approach at this time, could have commenced with a multi-agency focussed meeting and would have demonstrated best practice.

Question 5 for Blackpool Safeguarding Adult Board:
How can Children's Social Care and Adult's Social Care assure Blackpool Safeguarding Adult Board of work being undertaken which ensures a dual agency approach which encompasses efficient information sharing and affords both services best visibility of their service users' circumstances?

5.3 Whole Family Approach

5.3.1 Jessica's family was complex and as such professionals from multiple agencies were entering the home to support other family members who lived there.

5.3.2 Children's Social Care became involved in June 2018 to support the child of sibling 1. The Social Worker and the Families in Need worker detailed neglect throughout their time working with the family members and records show that Jessica was sometimes present during their visits and at other times, was referred to as being in bed by either sibling 1 or Ann.

5.3.3 Children's Social Care thought that Adult Social Care were involved with the family and in January 2019 invited Adult Social Care to submit a report and to attend an Initial Child Protection Conference regarding the child of sibling 1.

5.3.4 Whilst it is clear from these actions that the Children's Social Worker had attempted familial practice and included professionals working with other members of the family in multi-agency discussion, records of the meeting evidence that a report was not provided and that no Adult Social Care Social Worker was in attendance. The minutes further evidence that during the conference the Chair asked family whether Jessica had a Social Worker, and the attendees were informed that she did not, but that she had one when the family had lived in Leeds.

5.3.5 Particularly as the protection conference concluded that sibling 1's child was at risk of significant harm and should be made subject to a Child Protection Plan under the category of Neglect, this review would ask whether in such circumstances, a conference chair could action Children's Social Care to contact Adult Social Care and share the concerns and conference outcome.

5.3.6 Adult Social Care has reflected that it sent apologies to the meeting as no practitioner had yet met and assessed sibling 3 (who they were going to be working with). Adult Social Care has recognised that consideration was only had regarding what a practitioner could contribute to the conference and did not consider what a practitioner could have learned from Children's Services who were working with the family.

5.3.7 Adult Social Care has assured this review that lessons have been learned from this which will be embedded into practice.

5.3.8 A month after the Child Protection Conference, Children's Social Care removed the child from the address and stopped visiting. Adult Social Care remained unaware of the neglect suffered by a child in the household and no consideration was given to any potential neglect of vulnerable adults in the property. Effective communication between Children's and Adult Services when concerns were known for the child of sibling 1, could have led to the early identification of potential neglect or abuse for Jessica within the family setting.

5.3.9 All professionals entering a home to see any service user must remember to take a holistic view of the whole family and always consider wider vulnerabilities of other family members, particularly when neglect within the family home is an issue. Consideration must be given to sharing information and concerns with appropriate safeguarding agencies, such as Adult Social Care. If consent is an issue, consideration should be given to overriding consent when there is a threat of serious harm or death through neglect or abuse.

5.3.10 In summary, risk of neglect must become a whole family approach held by all services and organisations working around any member of a family. To achieve this, staff across all services need support to build skills to identify the symptoms and triggers of neglect and to consider all vulnerabilities - whether adult or child. The challenge for the professionals is to be professionally curious through a wide lens that doesn't focus wholly upon the task concerned (professionals should be curious about anything that is a concern) and the challenge for the Blackpool Safeguarding Boards is to ensure that there are local mechanisms in place for professionals to share the information. Once shared, professionals can consider new information against their own organisation's intelligence. This will lead to better informed decision-making regarding intervention.

5.3.11 To example, this review has been informed that the day before Jessica died, Ann and sibling 1 attended a family centre to see sibling 1's son. Staff at the centre recorded that both parties presented unkempt with strong odour. It is good practice that this was recorded but better practice would see such information being shared with other professionals; in this case the professionals who were or could support the vulnerable adults also living in the home address. Had this information been considered against the concerns raised by a family member only a month earlier, it could have prompted contact with the family.

5.3.12 Professionals need support and guidance in adult neglect - whilst Blackpool has a Children's Neglect Strategy there is no framework to support professionals to identify neglect through an adult lens.

Question 6 for Blackpool Safeguarding Adult Board:
How can Blackpool Safeguarding Adult Board be reassured that professionals' deliberating any potential neglect of a child or adult, are adopting a Whole Family approach, and affording consideration of any other members of a household who may be at risk?

5.3.13 Importantly this whole family approach is not limited to statutory organisations.

5.3.14 In September 2018, a care agency had been commissioned to support sibling 3 and as a result carers were going into Jessica's home address three times a day. Three staff members from the care agency, upon hearing Jessica crying, raised concerns with Ann. This was good practice and demonstrates professional curiosity, but upon Ann informing them that it was part of Jessica's learning disability, no further curiosity was demonstrated. Staff were satisfied with Ann's explanation and the concerns were not further reported to their management.

5.3.15 Had staff discussed their concerns with management, conversations may have ensued in relation as to whether there were any other concerns and whether a safeguarding concern needed to be raised.

5.3.16 Since this time, the commissioned care agency involved have included further information in their training to give carers pathways to report family dynamics or unusual occurrences.

Question 7 for Blackpool Safeguarding Adult Board:
How can Blackpool Safeguarding Adult Board be assured that all commissioned care agencies in the area offer their staff adequate training to recognise concerns and understand when and how to report them?

5.4 Carer's Abuse

5.4.1 In the absence of the historic information that outlined a continuous pattern of neglect by Ann, professionals working around Jessica assumed that Ann had the aspiration and/or ability to provide Jessica with the care and support that she needed.

5.4.2 As Ann was Jessica's mother, this assumption is comprehensible, particularly as Jessica reportedly would look to her mum for support and had been seen by some professionals[16] to 'cling' to her. Such an affectionate relationship had the effect of drawing professionals away from thinking that Ann would intentionally harm Jessica, but for decades, researchers and practitioners have described personality commonalities among individuals with Down's Syndrome, with some

[16] Description used by staff at the Day Centre in Leeds

claiming a stereotype involving a pleasant, affectionate, and passive personality style[17]. This stereotype has been supported by studies of parent perception of children with Down's Syndrome[18]. Hence it is reasonable to assume that trust can be a common trait of a person with Down's Syndrome.

5.4.3 Tragically the assumption that Ann would always act in Jessica's best interests inadvertently left Jessica totally dependent upon a person whose ability to care for her was unassessed by Blackpool professionals. This was specifically risky because Jessica, with her learning disability was unable to recognise and/or alert others of any abuse or neglect and was therefore particularly in need of robust safeguarding.

5.4.4 On the surface Ann appeared to care for Jessica and cooperate with professionals. It was she who requested the Care Act Assessment in 2018, it was Ann who took Jessica to the GP and who contacted 111, and it was Ann who attended the dermatology ward with Jessica and reported to be helping Jessica with her personal care and cream application.

5.4.5 This disguised compliance behaviour displayed by Ann skewed professionals view of the circumstances and environment Jessica was enduring - but there were times when Ann's non-compliance with professional advice could have raised professional curiosity. For example, Ann did not contact Primary Care within 24 hours as advised by 111, Ann did not initially respond to the dermatology referral, and Ann did not take Jessica to the taster sessions at the Day Centre as arranged.

5.4.6 When a pattern of non-compliance with professional advice starts to emerge, or when a professional notices a carer struggling to engage effectively with professional advice, the professional must immediately give consideration as to whether safeguarding thresholds have been met and be curious. However, Ann's patterns of non-engaging behaviours were unrecognised in the absence of multi-agency information sharing. This examples why it is crucial that professionals come together and seek the full picture in Professionals Meetings.

5.4.7 Professionals could have considered convening a Professionals Meeting to help safeguard Jessica when:

- Jessica was seen without appropriate supervision and being hit by sibling 3,
- When Ann did not comply with professional direction regarding Jessica's healthcare, and
- When a relation raised concerns for her care.

5.4.8 A meeting would have been particularly helpful for workers around Jessica as because Jessica's family was one with multiple, multifaceted needs, there were many ancillary professionals

[17] Gibbs, M. V., & Thorpe, J. G. (1983). Personality stereotype of noninstitutionalized Down syndrome children. *American Journal of Mental Deficiency, 87*(6), 601–605.
[18] Carr, J. (1995). *Down's Syndrome: Children Growing Up.* Cambridge: Cambridge University Press.

who were working with other family members and who could have been invited to contribute and help build a picture of what life was like for everyone in Jessica's home.

5.4.9 Concerns regarding the house conditions were recorded by many professionals entering the home to see other family members but not shared collectively. As previously mentioned, this review has heard how Children's Social Care were concerned for the home looking unclean and being cluttered, and Families in Need workers reported similar concerns. In addition, the domiciliary care staff attending sibling 3, also described the home environment as poor, but static.

5.4.10 Although this review has not seen any documentation specifically regarding the house smelling bad, family members described an overwhelming stench in Jessica's room when they reported their concerns on the 26th of July 2019. This was the same day that both a GP visited and the domiciliary care provider. Neither of whom recorded a bad small in their notes, though none entered Jessica's bedroom.

5.4.11 A month later when Jessica was found deceased, her bed was described as heavily soiled with wet faeces and wet and dry faeces was noticed to have been smeared on the wall. Attending Police Officers described a strong fishy stench.

5.4.12 Whilst Jessica had died that day, Jessica, her bedroom environment, and the powerful stench, exampled protracted neglect and abuse that had been ongoing over a period of time - during which multiple professionals had been entering the home.

5.4.13 The domiciliary carers were attending sibling 3 in his bedroom (which is on the same floor of the house as Jessica's) and did not notice any deterioration to the home or permeating stench. And on the 22nd of August 2019, two trained and experienced Detective Police Constables attended the property to visit a family member. The officers did not go upstairs but neither detected any smell, nor saw anything that raised concerns.

5.4.14 Somehow Ann masked the stench and projected a false impression upon professionals by tidying the house to a good enough standard prior to visits. Ann even managed to clean Jessica's bedroom to a good enough standard so that the description of Jessica's room provided to professionals by the concerned family member, did not match with when the Social Worker visited. However, this visit, six days later, was pre-arranged and afforded Ann time to tidy the property and clean and address Jessica.

5.4.15 Given that it was summer is it possible that the windows were all open? Were air fresheners scattered around the property? Was there any other strong scent which could have been used to overpower bad odour? Unfortunately, it may never be understood exactly how Ann managed to hide her horrific neglect of Jessica, but professionals must remain alert to manipulations and report and share all their concerns with supervision.

5.4.16 In summary, there were some signs that Jessica was being abused and neglected[19] by Ann but Ann manipulated the circumstances and mostly gave an impression of cooperation with the professionals who were working directly with Jessica.

5.4.17 In addition, whilst short standing patterns were disguised and/or unidentified, (mostly due to Ann's manipulative behaviours but partly due to a lack of multi-agency meetings and information sharing), long-standing patterns of neglectful and abusive care were masked with house moves which took the family to different parts of the country.

5.4.18 Given that vulnerable adults who have a learning disability tend to be amongst the most common victims of abuse, any professionals entering the home of an adult at risk, even if they are there to visit another family member, must maintain a professional curiosity and always explore what is happening for the whole household. This requires professionals to use proactive questioning and challenge, and to not take anything at face value.

Question 8 for Blackpool Safeguarding Adult Board:
How can partner agencies assure Blackpool Safeguarding Adult Board that multi-agency meetings are being considered, and convened, as appropriate - to share as much information and professional curiosity as possible to identify safeguarding concerns at the earliest opportunity, and drive best decision making?

5.5 Jessica's Voice

5.5.1 As a person with a disability, Jessica faced daily barriers that restricted her from participating in society on an equal basis with others. Jessica, with her learning disability and communication problems was in danger of facing discrimination and being denied her equal rights in the community, for example, her right to live independently and make her own choices, her right to participate in activities, and her right to decide her own medical treatment.

5.5.2 To help overcome potential discrimination, it was necessary to empower Jessica to make her own decisions and to be in control of her choices. This empowerment could only be effective if professionals learned of Jessica's wishes and feelings, but Jessica found it difficult to communicate and therefore needed help to say what she wanted. This review has found that in the main, instead of finding a way to communicate directly with Jessica, professionals relied on Ann to speak on Jessica's behalf.

5.5.3 Whilst it is good practice for professionals to collaborate with the family of a person with care and support needs, when Ann spoke for Jessica or told professionals of Jessica's wishes and feelings, professionals should have still sought clarity directly from Jessica.

[19] Ann not following professional advice, conditions not matching concerns reported by concerned family members, a lack of supervision.

5.5.4 For example, the only explanation on record regarding Jessica not attending the taster sessions offered by the Day Centre is Anns. Ann said that she did not feel that the time was right for Jessica to attend[20], and that Jessica didn't want to go. Professionals should have worked directly with Jessica to seek clarity around this and to establish Jessica's wishes and feelings. This would have provided Jessica a chance to choose and control her own life.

5.5.5 Ann denies that she deliberately spoke for Jessica. Ann has told this review that she always allowed Jessica to make her own decisions and that she would only repeat what Jessica had told her. Ann also explained how Jessica would look to her for reassurance when professionals asked her any questions and Ann would therefore answer with what she knew Jessica would want her to. The Independent Author discussed with Ann how in order to overcome this and to ensure that Jessica's wishes were being heard, it may have been better for Jessica to have been seen by professionals alone. Ann agreed that this would have been possible but would have liked the reasons to have been properly explained to her and Jessica.

5.5.6 As referred to previously, any professional upon speaking with Jessica doubting her capacity to make the decision whether to attend the sessions or not, would have needed to complete a Mental Capacity Assessment. And if the assessment had found Jessica to not have capacity to make the specific decision, the Best Interest framework would have needed to be applied.

5.5.7 Discussion at the learning event acknowledged that professionals over relied upon Ann and concluded that Ann's explanation regarding the non-attendance of the taster sessions may have been accepted without any consultation with Jessica, because it was Ann who had requested the support in the first place; on the 27th of June 2018, as a result of Ann's request for support, a Social Worker had completed a Mental Capacity Assessment to decide whether Jessica had the capacity to understand the Assessment and Care Planning process. The robust assessment demonstrated that Jessica lacked capacity and consequently a best interest decision was taken. This was taken in discussion with Ann who agreed that it was in Jessica's best interest for the Care Act Assessment to be undertaken.

5.5.8 Professionals wondered whether because the initial request and/or best interest decision were from Ann, her voice was more readily accepted regarding the decision to not attend the taster sessions.

5.5.9 This review has been informed that this missed opportunity to hear Jessica has been addressed by the Learning Disability Team as part of the lessons learnt and assessment is now embedded in the Care Act Assessment/review process to ensure that the Learning Disability Team give their service users choice and control over their lives and support them to be as independent as they individually can be.

5.5.10 Good relational practice needs to go a step further - during consultations and assessments, professionals must also support parent carers to understand the Mental Capacity Act and the best

[20] Ann has told this review that she did not think the time was right to go because she worried that Jessica's skin condition was contagious.

interest principle. It is important that parent carers know that they can no longer make decisions on their adult children's behalf – even when their adult child does not have the capacity to make the decision themselves.

5.5.11 Professionals could signpost parent carers to the resource pack[21] for family carers of people with a learning disability, produced by Mencap, that addresses the Mental Capacity Act and practical decision-making.

Question 9 for Blackpool Adult Safeguarding Board:
How can Blackpool Safeguarding Adult Board ensure that parents of children over 16, who may not have capacity to make their own decisions, have access to information to help them to understand the Mental Capacity Act and Best Interest decision-making?

5.5.12 Whatever Ann's intention, asserting her interpretation of what Jessica wanted silenced Jessica's voice. Instead of accepting Ann's voice, professionals should have worked to communicate directly with Jessica. This review has heard from the education provider in East Sussex that Jessica was able to communicate using Makaton[22] signing. Could this have been explored?

5.5.13 This review has also heard how Jessica was able to communicate with the Day Centre in Leeds - Jessica had made it clear to staff at the centre that she did not want to move to Blackpool both verbally and through her behaviour. Yet their communication with Jessica also broke down when professionals turned to Ann instead of exploring alternative options with Jessica directly or explaining what was available to her.

5.5.14 It is recognised that such a conversation would have been difficult, but it should have included attempts to explain, consideration of Jessica's capacity to make such a decision, and consideration of an advocate.

5.5.15 Symbols and pictures can help people of all abilities to communicate. This review has seen no evidence of technology being considered – Widgit create software symbols to help people with learning disabilities to understand information and communicate easier. Could a computer or tablet have been considered for Jessica within the Care Act Assessment?

5.5.16 An independent advocate could have been contemplated to support Jessica to communicate with professionals. Despite the Care Act requiring consideration of advocacy when undertaking assessments, there is no evidence of any formal advocacy ever being considered to help Jessica communicate her wishes and feelings. This is an understandable omission as Jessica had her mother available to support her as 'an appropriate individual.' And because professionals weren't in possession of the history of Ann's neglect, they were unaware that Ann might not act in Jessica's

[21] mental capacity act resource pack_1.pdf (mencap.org.uk)

[22] Makaton is a language programme that uses signs together with speech and symbols, to enable people to communicate.

best interest. Had professional's known Ann's parenting history, a Care Act advocate may have been considered.

5.5.17 Representation of Jessica's voice in her healthcare was particularly crucial as Jessica, with her learning disabilities, would have experienced poor physical and mental health when compared with the general population. And her communication difficulties would have made it difficult for her to describe any symptoms.

5.5.18 Health professionals from the GP Practice discussed at the learning event whether Jessica was heard during GP consultations or whether Ann, who is described as presenting as quite domineering and of talking over Jessica, dominated the conversations. It was recognised that there is teaching on 'three-way' or triadic consultation where there is a parent with a child, but that teaching may not be being applied to vulnerable adults accompanied by a family member.

Question 10 for Blackpool Safeguarding Adult Board:
How can professionals from all agencies assure Blackpool Safeguarding Adult Board that triadic consultation[23] is being applied to meetings with a vulnerable adult and their carer or family member?

5.5.19 Professionals from the dermatology department where Jessica attended to have creams applied, reflected that Ann would have always been present with Jessica as good practice would have included teaching Ann about the creams and demonstrating their application. However, whilst this is excellent relational practice (which includes family in their patient's care), it reduced the interaction between the professional and Jessica.

5.5.20 One way of improving patient communication is by means of a Hospital Passport. The Hospital Passport has been developed by the Public Health Agency and the Regional General Hospital Forum for Learning Disability, for people with a learning disability to complete (with or without help) and present to staff every time they have contact with a general hospital. It gives staff important information on the person, and how they prefer to communicate, their medical history and any support they might need while in hospital. Staff can then make any reasonable adjustments in order to provide the best possible care for people with a learning disability.

5.5.21 Hospital Passports can be used in any health setting, not just hospitals, and LeDeR have informed this review that they are working on improving the use of passports and are aiming for their standardisation and digitalisation across Lancashire and South Cumbria. One of the problems LeDeR have encountered is that Blackpool use three different record keeping systems across the health service and subsequently trying to find a way that a digital Hospital Passport can be shared across all three is difficult.

[23] During consultations, vulnerable adults are often accompanied by an adult - requiring the clinician to conduct a three-way or 'triadic' consultation.

5.5.22 Blackpool Teaching Hospital assured the review that hospital communication passports are used but professionals are unsure whether they had been introduced in 2018 when Jessica was attending the dermatology department. Also, in Jessica's case, it would have been less likely that she would have had a Hospital Passport because she wasn't involved with the Learning Disability Health Team or utilising a Day Service, who could have helped her develop a Hospital Passport.

5.5.23 Since 2018, Blackpool Teaching Hospital has funded a role of Learning Disability Matron and there has been a drive to promote the use of communication passports. In addition, learning disability training has been delivered on a monthly basis across the hospital and the hospital has integrated Community Learning Disability Nurses into teams to help with appointments and assessments.

5.5.24 Jessica's voice was inaccurately represented when she was not presented for health appointments as her records showed that she 'Did Not Attend.' Yet Jessica lacked the physical ability and/or mental capacity to attend, or make the decision to attend, appointments. Therefore, when Jessica did not attend appointments, recording it as Did Not Attend was not appropriate. It was Jessica's family who were withholding the treatment/support, not Jessica.

5.5.25 A more accurate description of her not being present for appointments would be to record that she 'Was Not Brought.' Many professionals at the learning event had not heard of using 'Was Not Brought' when a patient who is unable to attend appointments independently is not presented.

5.5.26 Better safeguarding of Jessica would have seen more professional curiosity when she was not presented for an appointment to establish the reasons. Professionals at the learning event discussed how re-labelling 'Did Not Attend' with 'Was Not Brought' for vulnerable adults could provoke this professional curiosity and mooted the idea that upon seeing that a vulnerable adult, or an adult at risk, 'was not brought' to a hospital appointment, an action could be added to the GP discharge letter requesting the GP to review the attendance.

Question 11 for Blackpool Safeguarding Adult Board:
How can Blackpool Safeguarding Adult Board develop a 'Was Not Brought' procedure and culture across adult focused services regarding safeguarding adults who do not have the physical and/or mental capacity to bring themselves to appointments or meet their own needs?

5.5.27 In the absence of Jessica's voice being heard, the care and support Jessica was offered was not in line with a Making Safeguarding Personal approach.

5.5.28 A Making Safeguarding Personal approach would have ensured that Jessica's care and support was led by her, outcome-focussed, fully engaged her and improved her quality of life. In the absence of direct communication with Jessica, professionals have inadvertently neglected to

make Jessica's support personal. There is a sense of the professionals working around Jessica centring upon Ann's opinion rather than Jessica's.

5.6 GP Safeguarding

5.6.1 It is clear from conversations shared by professionals at the learning event that the remit of a GP undertaking a patient home visit is misunderstood between agencies. Professionals from other agencies envisaged that the GP would have a look around the whole property and discuss the safeguarding concerns raised. Whilst, when safeguarding concerns have been reported, agencies such as Social Care will do this, this review has been informed that a GP would not, as their focus is upon the healthcare required. In fact, this review has been informed that home visits are now discouraged by GPs because their aim to address medical needs, is better delivered in a purpose-built establishment.

5.6.2 The GP conducted a home visit on the 26th of July 2019 - the same day that family had raised concerns for Jessica. As is usual practice (to lessen the chance of a GP having to return if a patient isn't available) the GP Practice announced the visit beforehand. However, this, in effect, gave Ann almost two hours to get Jessica dressed and downstairs, and to potentially disguise any neglect.

5.6.3 The GP saw Jessica in the lounge with family and examined her. The GP did not go into any other rooms and did not share any details of his visit with other agencies.

5.6.4 This review has been informed that because the GP Practice was aware that a family member had already informed Adult Social Care of their concerns, the GP did not deem it necessary to liaise with Adult Social Care directly.

5.6.5 Professional discussion around the subject of GP safeguarding at the learning event has highlighted the limited understanding other agencies have of GP systems and practice, and how difficult the issue of GPs and safeguarding is. It is understood that GPs have thousands of patients and that patients will not always continually see the same doctor in their practice, but GPs are part of universal health services which, whilst having a duty to safeguard all patients, must provide additional measures for patients who are less able to protect themselves from harm or abuse.

5.6.6 Therefore, there is an expectation that GPs contribute and partake in safeguarding. High patient numbers, poor information sharing and systemic problems, such as a patient's records not being sent to a new practice in a timely manner, cannot be addressed overnight, but GPs can be careful not to accept anything at face value and should remember to show professional curiosity during their consultations both in and out of the practice.

5.6.7 Importantly to help other professionals to understand GP practice, GPs must be wholly transparent about all the safeguarding practice they use to support and protect vulnerable people.

Question 12 for Blackpool Safeguarding Adult Board:
How can Blackpool Safeguarding Adults Board improve multi agency understanding of the GP role and responsibilities to establish what agencies can reasonably expect of their safeguarding processes?

6. Good Practice

The agency reports submitted to this review, along with professional discussion, have highlighted examples of good practice[24]. Including:

- A detailed written Adult Safeguarding Referral was made by Children's Social Care on the same day as significant adult safeguarding concerns were raised by an extended family member.

- The GP completed a home visit on the day the practice was made aware that Jessica was not presenting well.

- The GP expediated the referral to dermatology.

- The Care Act Assessment completed in 2018 was well written.

- When Ann did not attend planned visits to the Day Centre, the Social Worker offered transport.

7. Developments Since the Scoping Period of the Review

Since the scoping period of this review, agencies have already made some important amendments to practice. Some have been included in the body of this report. Other developments include:

7.1 It is now current process and procedure that any adult with a learning disability who is admitted to Blackpool Victoria Hospital is automatically identified on a tracker system and this information is sent to the lead liaison nurse who reviews all new admissions and gains an update on health conditions, treatments, and discharge plans. This procedure was introduced after the death of Jessica. There is still a gap as the tracker does not cover Accident and Emergency and if people are not admitted. This gap is being explored and discussions are underway on how this system can change.

7.2 A Lead Liaison nurse is now based two and a half days per week in the hospital to be a presence, visit wards, departments and to develop a better working relationship between the hospital and the community.

[24] Good practice in this report includes both expected practice and what is done beyond what is expected.

7.3 Blackpool Learning Disability Team has identified much learning from Jessica and have produced an operational document detailing practice and process changes required from the Community Learning Team (refer to Appendix D).

7.4 Following the review of Jessica within the GP practice clinical meeting, new systems were put in place: any safeguarding concerns are now added to a template with the clinical system on the same day and flagged immediately to the safeguarding lead/deputy. The safeguarding lead/deputy actions any concern and this is disseminated to all practice staff via practice e-mail. These concerns are also discussed formally within monthly clinical and partner meetings.

8. Conclusions

8.1 As is evidenced by Jessica's continuing and persistent poor presentation and hygiene, Ann neglected Jessica from birth. Professionals working with Jessica were not always aware of this as Jessica was moved to different parts of the United Kingdom by family on three occasions in her life. The final move being from Leeds to Blackpool in 2016.

8.2 No information regarding Jessica's care needs or circumstances was communicated from Leeds to Blackpool. Occasions for agency intervention in Blackpool arose due to Jessica's skin condition, a domestic incident and Ann's request for support, and these occurrences created opportunities for cross-border discussion, which except for when the Learning Disability contacted East Sussex, were not ensued. Their omission contributed to the aforementioned neglect not becoming known to Blackpool to inform Jessica's future risk management and support.

8.3 This was particularly dangerous because, as Jessica lived with Down's Syndrome and associated learning disabilities and did not have capacity to make all of her decisions, professionals were allowing Ann to convey Jessica's wishes and feelings on her behalf.

8.4 Consequently, Jessica was not heard, and Ann made her decisions. Whilst this decision making on Jessica's behalf was legally acceptable when Jessica was a child, Jessica's decision making as an adult was governed by the power afforded her through the Mental Capacity Act. As such decisions which Jessica was deemed to not have the capacity to make, should have been decided using the best interest principle.

8.5 A further concern identified within this review is that professionals from all of the agencies involved with Jessica and other members of Jessica's household, did not apply a Whole Family practice approach. Opportunities were missed to inform professionals working with other family members of concerns arising within the household, and information was not shared effectively.

8.6 When in July 2019, a family member alerted Children's Social Care to the neglect of Jessica, Children's Social Care made a referral to Adult Social Care. Unfortunately, this proved ineffective as it got lost in the system. The information that was provided to Adult Social Care (from the family)

was in comparison, diluted, and diverted Adult Social Care focus to Jessica's health. Adult Social Care considered the urgency of this to be addressed by a GP visit. The GP, made aware of some of the concerns by a family member, presumed that Adult Social Care would be addressing the safeguarding and focussed wholly on Jessica's skin.

8.7 These miscommunications and presumptions left Jessica without professional safeguarding support for a further 6-day period before a Social Worker visited. By which time Ann had tidied the house to an acceptable state and consequently, following the Social Worker visiting and not having any concerns, Jessica was again left in the care of Ann - unsupported, invisible, and isolated.

8.8 There is no doubt that Jessica was failed and unless the learning of this review is used to develop practice, the same outcome could befall other adults at risk in Jessica's situation.

9. Learning

Good practice has been identified during this review and professionals have engaged well. The Independent Chair and Author would like to thank everyone for their honesty and openness. It is the professionals' reflection that has identified the following questions for the Blackpool Safeguarding Adult Board to consider.

It is the responsibility of Blackpool Safeguarding Adult Board to use the ensuing debate to model an action plan to support improvements to systems and practice.

Question 1:
How can partner agencies assure Blackpool Safeguarding Adult Board that professionals are empowering vulnerable adults by communicating with them directly and applying the Mental Capacity Act as and when required?
How can Blackpool Safeguarding Adult Board share this lesson with Leeds and other Safeguarding Adult Boards?

Question 2:
How can Blackpool Safeguarding Adult Board obtain assurance of work being undertake which ensures cross border multi-agency communication when an adult at risk of harm moves to, or from, the Blackpool area?

Question 3:
How can Adult Social Care assure Blackpool Safeguarding Adult Board of a robust response to safeguarding concerns involving individuals who have presented as having learning disabilities?

Question 4:

How can GP surgeries in the area assure Blackpool Safeguarding Adult Board that staff are understanding and consulting The Blackpool Safeguarding Adults Board Decision Making Tool to help them make appropriate safeguarding referrals?

Question 5:
How can Children's Social Care and Adult's Social Care assure Blackpool Safeguarding Adult Board of work being undertaken which ensures a dual agency approach which encompasses efficient information sharing and affords both services best visibility of their service users' circumstances?

Question 6:
How can Blackpool Safeguarding Adult Board be reassured that professionals' deliberating any potential neglect of a child or adult, are adopting a Whole Family approach, and affording consideration of any other members of a household who may be at risk?

Question 7:
How can Blackpool Safeguarding Adult Board be assured that all commissioned care agencies in the area offer their staff adequate training to recognise concerns and understand when and how to report them?

Question 8:
How can partner agencies assure Blackpool Safeguarding Adult Board that multi-agency meetings are being considered, and convened, as appropriate - to share as much information and professional curiosity as possible to identify safeguarding concerns at the earliest opportunity and drive best decision making?

Question 9:
How can Blackpool Safeguarding Adult Board ensure that parents of children over 16, who may not have capacity to make their own decisions, have access to information to help them to understand the Mental Capacity Act and Best Interest decision-making?

Question 10:
How can professionals from all agencies assure Blackpool Safeguarding Adult Board that triadic consultation is being applied to meetings with a vulnerable adult and their carer or family member?

Question 11:
How can Blackpool Safeguarding Adult Board develop a 'Was Not Brought' procedure and culture across adult focused services regarding safeguarding adults who do not have the physical and/or mental capacity to bring themselves to appointments or meet their own needs?

Question 12:
How can Blackpool Safeguarding Adults Board improve multi agency understanding of the GP role and responsibilities to establish what agencies can reasonably expect of their safeguarding processes?

10. Appendix A – Panel Membership

Role	Organisation
Independent Author	Independent
Chair	Independent (Age UK)
Designated Nurse Safeguarding Adults	Blackpool Integrated Care Board
Head of Quality Review Service & Principal Social Worker	Blackpool Council
Integrated Team Manager, Learning, Disability & Autism Team	Blackpool Council
Named Nurse for Safeguarding	Lancashire & South Cumbria Foundation Trust
Deputy Head Of Safeguarding	Blackpool Teaching Hospitals
Deputy Head, Adult Social Care	Blackpool Council
Safeguarding	North West Ambulance Service
Review Investigator	Lancashire Constabulary
Business Manager	Blackburn with Darwen, Blackpool & Lancashire Safeguarding Adults Board
Business Support	Blackburn with Darwen, Blackpool & Lancashire Safeguarding Adults Board
Head of Children's Safeguarding	East Sussex Children's Social Care

LeDeR Reviewer – Learning Disability & Autism Team	LeDeR

11. Appendix B – Terms of Reference

The purpose of the review is to

1. Determine whether decisions and actions in the case comply with the safeguarding policy and procedures of named services/ agencies and the LSAB

2. Examine inter-agency working and service provision for the adult and family, with a focus on the Adult with an acknowledgement of family information

3. Determine the extent to which care was person centred and compliance with Making Safeguarding Personal

4. Examine the effectiveness of information sharing and working relationships between agencies and within agencies

5. Compliance with valid consent and Mental Capacity Act

6. Establish any learning from the case about the way in which local professionals and agencies work together to safeguard adults including

7. Identify any actions required by the LSAB to promote learning to support and improve systems and practice

8. Ensure the LSAB policies and procedures are fit for purpose to respond to the safeguarding concerns identified during this review process

9. Consider enforced neglect and additional vulnerabilities of the adult such as self-neglect and domestic abuse

12. Appendix C – Practitioner Learning Events Attendees

- Blackpool Children's Social Care (Service Manager and Early Help Worker)
- Blackpool Teaching Hospital Trust (Safeguarding Lead and Staff from the Dermatology Department)
- The General Practitioner Safeguarding Leads
- Blackpool Adult Social Care (Deputy Team Manager and Social Worker)
- LeDeR

13. Appendix D - Blackpool Learning Disability Team Operational Document

Learning identified for your Agency	Action taken to promote learning	Date completed
Concerns raised by police for people not known to the team and not open to the team and known individuals to the team.	All concerns raised by the police for people not known to the team or known to the team where police are visiting must be followed up by the duty social worker / allocated worker and feedback from police visit gained to determine any future support needs or risks. Including safeguarding threshold.	20/4/2022
New referrals for people not known to the team.	Changes to the initial document gathering information on first contact, to ensure previous local authority assessments gathered and historical context. (Assessments / capacity / Pre-18 information etc.)	20/4/2022
Referrals	Reviewed updated process, practice considerations and decision making. Review previous case notes and identify any areas of concern noted to aid decision making on timescales to allocation. If new person to the team, follow guidance for new referrals not known to team.	20/4/2022
Allocation to a worker	Reviewed updated process, practice considerations and decision making when allocated a case to ensure all relevant available information is read and used to aid decision-making.	20/4/2022
Conducting visits	Reviewed updated process, practice considerations and decision making when setting up and conducting home visits. Clarity on what should be considered and taken into account. Detailed case recording.	20/4/2022
Where there are concerns raised around 'home conditions' – raised by another team / family member or other.	Reviewed updated process, practice considerations and decision making in relation to assessment of home conditions, what should be considered, detailed case recording. Including safeguarding threshold.	20/4/2022
On a visit where concerns have been raised –	Reviewed updated process, practice considerations and decision making when	20/4/2022

announced or planned visit.	conducting home visits where concerns have been raised. Clarity on what should be considered and decision-making. Consideration to Mental Capacity and Best Interest and detailed case recording. Using professional curiosity. Including safeguarding threshold.	
Care Act Assessment	Reviewed updated process, practice considerations and decision making when conducting and recording Care Act Assessments. To fully record a person's wishes, feelings and aspirations from the person perspective not just information from family. A pen picture who the person is what makes them happy, smile, what do they like to do, what is most important to them. To record a strengths-based assessment within domains of where the person requires support and the support in place to meet that need. To consider and record Mental Capacity to meet their care and support needs, and if lacking capacity the decisions are made in their Best Interest.	20/4/2022
Unscheduled reviews and annual reviews.	Reviewed updated process, practice considerations and decision making when conducting and completing annual and unscheduled reviews.	20/4/2022
Learning Disability Health Folders in Blackpool Teaching Hospitals	An audit to ensure Learning Disability folders are in place in all wards and in outpatient departments across BTH.	20/4/2022
Lead Liaison LD Nurse Role	Lead Liaison Nurse to share their pen picture, who they are what they do, their role and how they can support people with Learning Disabilities in relation to their health while either an outpatient or as an admission. Lead Liaison Nurse to share pen picture with all wards and outpatient departments and to request it to visual on staff boards. Lead Liaison to send reminder to all GP practices on who is their link Learning Disability Nurse and contact details.	20/4/2022
Eligibility/ likelihood of a learning disability	Joint review of the process for assessing the 'likelihood' of a person having a learning disability. To have a joint consistent approach across social care and health. Implementation work commenced in devising a joint approach Acting-Up Team Manager and	Commenced 20/4/2022. On-going

	Deputy Health Manager on this work, draft to be completed by 10/6/2022. To embed in the process the need to identify previous teams, local authority involvements (child or adult), other services and gain appropriate information to assess risk and aid decision making.	

14. Appendix E – Summary of LeDeR Report

LeDeR was notified of Jessica's death by the duty social worker from the LD team in Blackpool on 04.09.19. It was allocated to me as LeDeR reviewer shortly after my appointment to the role on 16.09.19. Some initial information gathering was carried out, but the review was put on hold due to an ongoing criminal investigation and safeguarding procedures, as well as an expected Coroner's inquest. Early in 2022, the criminal investigation came to a conclusion, with Jessica's mother being convicted of gross negligence and manslaughter and sentenced to 9 years and 7 months in prison.

It was agreed that the LeDeR review should take place alongside the SAR. The Coroner has postponed making a decision about holding an inquest until the SAR has been completed. The LeDeR review was reopened on 13.04.22. In line with the usual LeDeR process, an Initial review was completed, but because of the very concerning nature of the death a Focused Review has also been completed, subject to ratification by the Local Area Contacts covering the Blackpool Area.

LeDeR always encourages family members to take part in the review, but, despite considerable effort, Jessica's family declined to take part, so details of Jessica's life and death have been gleaned from her health and social care records and from a discussion with the manager of the Day Centre which she attended for about 2 years, prior to moving to Blackpool with her family in 2016.

The findings of the LeDeR review are summarised below: -

- Transference of information between services in the different areas where Jessica lived was poor and sometimes non-existent.
- Her recent electronic GP records were transferred, but the PCSE did not transfer her full paper GP records to the receiving GP Practice until after her death.
- Despite Jessica's clear lack of capacity to make more complex decisions, no MCA assessments were carried out relating to both her moves from East Sussex to Leeds and from Leeds to Blackpool and relating to whether a referral should be made to the services in either of the new areas.
- It is not known whether Jessica was on the Learning Disability Register when she was in Leeds, and she was not put on it when she was received by the GP Practice in Blackpool.

- Because of this, she was not invited to have an Annual Health Check and previous safeguarding concerns were not passed on.
- She did not have a Hospital Passport as she did not engage with any services in Blackpool who might have assisted the development of such (completion of a Hospital Passport had not taken place in Leeds either, despite being involved with a day service).
- Following the incident recorded by the police in 2017, the response by them and Blackpool Social Care was inadequate.
- An opportunity to raise a safeguarding alert was missed by the GP (when requests to Jessica's mother to make a dermatology appointment were not acted on, despite the extremely severe nature of her skin condition) in April 2018.
- An opportunity to raise a safeguarding alert was taken by the dermatology department, but the referral process was not completed, so this opportunity was also missed, in April 2018.
- Following a Care Act Assessment carried out by a social worker from the Integrated LD Team in Blackpool (who had been advised that there were a number of concerns about the living conditions in the house), Jessica was offered a Day Centre place. Over a period of 5 weeks during July and August 2018, 4 separate visits to the centre were arranged, with support being offered on the last of these, as well as reminders. Mum forgot about 2, then said Jessica was ill. When contact was made on the final occasion, Mum said it wasn't convenient, but when reminded this was the 4th attempt at a visit, she said Jessica no longer wants to attend and the case was closed 2 weeks later. The decision not to take up services was not subject to an MCA assessment.
- In Jan 19, another referral for support for Jessica was made to the Integrated Blackpool LD Team by Children's services. During the referral process inaccurate information was fed back to the referrer that Jessica and her mother had been shown round various Day Centres and services and had decided not to pursue a service. The referral was placed on a waiting list.
- Approximately 5 weeks later, several attempts at contact by phone were made and then a letter was sent advising the referral would be closed if there was no response by 22.04.19 and it was duly closed.
- On 26.07.19 Jessicas cousin contacted Blackpool Adult Social Care with serious safeguarding concerns. Jessica's cousin was advised to ring the GP straightaway, which she did. The cousin had also contacted children's services on the same day, who passed their concerns to Adult Social Care. This referral was apparently printed off but was not received by the safeguarding team.
- The GP arranged and made a visit the same evening, but perhaps Jessica had been cleaned up, and they only gave medical advice and did not liaise with Adult Social Care. Adult Social Care only visited on 29.07.19 (after the weekend) and in fact did not get to see Jessica until 01.08.19, 6 days after the original safeguarding referral.
- Having seen Jessica and her living environment and having been told that the GP was due to see Jessica again, no further visits were arranged.

- The overall safeguarding response was inadequate. Better liaison between the GP and Adult Social Care might have improved this. Subsequent attempts at contact by both the GP and Adult Social Care were unsuccessful and neither contacted each other to update.