A Joint Family Review (LSCPR and SAR)

Family A

Shropshire Safeguarding Community Partnership

Reviewers Clare Hyde and Mark Griffin

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Introduction

1. Jessica died in December 2022. She was aged 37. Paramedics, police officers and hospital staff who responded to the emergency were concerned by the level of neglect she had experienced and by her physical presentation. Concerns were also raised by the ambulance service and Shropshire Fire and Rescue regarding the condition of the home. This was reported to smell overwhelmingly of faeces, urine and rotting flesh. Soiled adult continence products and blood were observed on the floor. It was reported that there were no carpets on the floors, that there were holes in the walls and no lights in the room where Jessica was. Observations were made of live electrical wires hanging from the ceiling and light switches being damaged, with wires exposed. It was reported that there was no useful furniture in the room and rat droppings were noted.
2. The ambulance crew were advised by the family that Jessica had not been out of bed for 3-4 years and that Jessica had been being cared for at home by her two daughters, Olivia and Lucy during this time. Olivia would have been 9 or 10 years old at the start of this timeframe and Lucy 14 or 15. This time frame of 3-4 years was not verified by the author of this report however Jessica avoided contact with her family and community for a significant length of time.
3. The children's maternal grandfather who was present at the address reported that he had not been allowed into the home for the past 3 years.
4. The circumstances of Jessica's death were agreed to meet the statutory criteria for a Safeguarding Adult Review by the Shropshire Safeguarding Community Partnership Independent Chair.
5. The concerns about the children's experience were additionally considered by Shropshire Safeguarding Community Partnership to have met the criteria set out in statutory guidance Working Together 2018 for a Local Child Safeguarding Practice Review.

Independence

6. The lead reviewers Clare Hyde and Mark Griffin are independent of any service or agency in Shropshire.
7. Ms Hyde was CEO of Calderdale Women Centre for 14 years (between 1994 and 2009) and developed nationally acclaimed, high-quality services and support for at risk women and families. Ms Hyde contributed to Baroness Corston's review of women with vulnerabilities in the criminal justice system which was commissioned by the Government following the deaths of several women in custody. Ms Hyde also designed and facilitated a multi-agency review of child sexual exploitation in Rochdale in 2012 and in Bradford in 2021 has designed and led several Learning Reviews on behalf of local safeguarding children and adult's boards.
8. Mark Griffin has thirteen years' experience of safeguarding reviews, including Serious Case Reviews, Local Children Safeguarding Practice Reviews, Rapid Reviews, Safeguarding Adult Reviews (SAR's) and Domestic Homicide Reviews as Lead Reviewer and Author, Panel member, Chair of SAR sub-group and as a manager of Safeguarding Boards.

9. He also works as a safeguarding consultant providing strategic and operational leadership to a number of organisations and is the independent chair of the Diocesan Safeguarding Advisory Panel for the Anglican Church.
10. Prior to this he was the Head of Safeguarding in the Leeds District, West Yorkshire Police, responsible for one of the largest departments in the country as the Safeguarding lead. This involved both partnership and operational responsibilities. As a Safeguarding expert, he worked with and advised Her Majesty's Inspectorate of Constabulary (HMIC) undertaking inspections, at an operational and strategic level and within the partnership.

Methodology

Overall approach

Initial approach and development of a Joint Family Review

11. The Shropshire Safeguarding Community Partnership were clear from the beginning of the review process, that it was important that Jessica, Lucy and Olivia's experiences informed consideration of the way agencies support families in Shropshire. A joint family review therefore began. The family, for the purposes of this review are known as Family A.
12. It was agreed that the Joint Review's learning should be presented in a Joint Review Overview Report that while robust, should also be high-level, accessible and focused.
13. This approach was agreed by the Adult's and Children's Statutory Case Review Groups.
14. During a similar timescale, a Rapid Review took place concerning another Shropshire family who shared similar experiences and issues faced by Family A. The Rapid Review determined that a Safeguarding Adult Review should take place for the mother of the family who had sadly died, as on the balance of probabilities she was likely to have experienced self-neglect due to her inability at times to self-care and the poor conditions of the house.
15. It was also agreed that a Local Child Safeguarding Practice Review should take place as the issues for the family were perennial and the mother's inability at times to provide sufficient care for one child, if not both, was of concern.
16. The decision was therefore taken to undertake a joint family review in respect of this family using the same overall approach and that any shared themes and learning should be highlighted and disseminated. This family, for the purposes of the other review are known as Family B.

Practitioner Event

17. It was intended that a Practitioner Event for frontline practitioners involved in the family's life would be held. The full-day session would focus on Key Practice Episodes, which would have been used to illuminate some of the important learning.
18. Despite four attempts to engage practitioners there was not sufficient engagement to hold an event and an enquiry into the reasons for this lack of engagement has commenced.

The Overview Report

19. This Overview Report of the Joint Review is set out in a way that:
    - Provides a Summary of Key Events that enables the reader to understand what happened from the perspectives of Jessica, Lucy and Olivia and other family members.
    - Focuses on Key Practice Episodes
    - Considers system-wide learning.

The Review Panel

20. The Review Panel met on a number of occasions between October 2023 and December 2024
21. The overview report was ratified at the Adult and Children's Statutory Case Reviews Groups.
22. The Panel comprised of the following representatives:
    - Independent Reviewers
    - Shropshire & Telford & Wrekin Integrated Care Board Safeguarding Children's and Adult's representatives
    - Children's Social Care
    - Adult Social Care
    - West Mercia Police
    - Domestic Abuse Strategic Lead, Shropshire Council
    - Midlands Partnership Foundation Trust
    - Named GP
    - Education Access Service
    - Housing Plus

Understanding the family's experiences

23. All of those taking part in this Joint Review have been keen to ensure that the voices of Jessica, Lucy and Olivia are at the heart of the reflection and learning that has taken place. To achieve this several attempts were made to contact Lucy and Olivia, Jessica's sister and father to advise them that a review was taking place and to invite them to contribute in a way that was comfortable and meaningful for them.
24. Unfortunately, no response was received from any of the family members, and it was not therefore possible to seek their views or to learn more about their experiences.
25. This limits the opportunity to represent and learn from the children's experiences within this review and the author has attempted to 'listen' to their voices from information contained in agency chronologies and from relevant research.

Agency Participation in the Joint Review

26. The following agencies participated in all aspects of this Joint Review:
    - West Mercia Police

- West Midlands Ambulance Service
- Children's Social Care
- Adult Social Care
- Sixth Form College
- Early Help Services
- School
- GP Surgery
- Midlands Partnership Foundation Trust
- Shropshire Community NHS Health Trust
- Shrewsbury & Telford Hospitals Trust
- Shropshire Fire & Rescue Service
- Robert Jones & Agnes Hunt Orthopaedic Hospital

27. This Joint Review would like to acknowledge the significant effort and commitment made by all agencies in providing their reports and chronologies; the resource implications of reviews can be significant and the hard work in providing a chronology or report is not under-estimated.

Terms of Reference for the Review

28. The following Terms of Reference were agreed by the Review Panel. These formed the framework for the agency chronologies and for the Review Panel discussions.
29. The Family's lived experience
    - Understanding and exploring the lived experience of Jessica, Lucy and Olivia including from a family perspective.
    - How effectively did agencies engage and what were the barriers?
    - Did agencies recognise and respond to Lucy and Olivia as carers?
30. Assessment and consideration of Jessica's parenting capacity
    - Did Jessica's GP, orthopaedic, rheumatology consultants and other professionals understand the mental and emotional impact of Jessica's weight on her accessing treatment and/or support and on her depression? How did Jessica's children and wider family understand her illness and weight issues? What support or information did they need?
    - Did professionals consider the impact of Jessica's physical and mental health issues on her capacity to parent her children?
    - Describe and analyse how effective agencies were in identifying, understanding and responding to safeguarding risks and concerns (including timeliness).
    - Did professionals exercise professional curiosity in identifying and exploring all risks and concerns?
31. Single and multi-agency assessments and working
    - Describe and analyse the way in which organisations, interacted and worked with Jessica, Lucy and Olivia and with each other. How well was information shared, understood and responded to between agencies? Is there evidence of collaborative working between agencies to identify and mitigate risks associated with Jessica, Lucy and Olivia?

- Were opportunities missed by agencies involved in the care, treatment and support of Jessica, Lucy and Olivia to act sooner than they actually did in respect of the risks to them? (To include key events that would have provided opportunities for preventative action outside the time frame).

32. The Impact of the Covid Pandemic
    - How has the Covid Pandemic impacted upon Jessica, Lucy and Olivia and any support offered to them?

Summary of Family history

33. What is known about the family history is detailed below.
34. Jessica was aged 37 when she died. Jessica had serious health problems including an autoimmune disease and significant issues with her weight all of which are described in more detail below.
35. As a teenager and young adult Jessica experienced some difficult times and was both a victim and a perpetrator of different criminal offences between the ages of 16 and 22.
36. She gave birth to Lucy when she was 18 and she separated from Lucy's father when Lucy was eight. As far as agencies are aware neither she nor Lucy had any contact with Lucy's father during the time scale of this review.
37. Olivia was born in 2008 when Jessica was aged 23.
38. Olivia had regular contact with her father.
39. Olivia's father raised concerns to Olivia's school that Jessica was not leaving the house or allowing anyone in and felt this was due to her embarrassment about her size.
40. Jessica's sister and father provided support to Jessica and the children throughout the period covered by this review however both report that they had not been allowed access to the house or had seen Jessica for the three or four years prior to her death.

Overview of events and agency involvement

41. The period from January 2018 to 15th December 2022 will be the primary focus of the review.
42. Any relevant background information prior to this period is included in the review as it was considered relevant.
43. This section of the report does not chronicle every single agency contact with the family but describes key practice events and other information held by agencies.

2007

44. Anonymous referral to CSC alcohol use and neglect of Lucy no further action was recorded.

2009

45. Jessica was diagnosed with psoriasis.

2010

46. Jessica was diagnosed with psoriatic arthropathy (arthritis associated with psoriasis) in February 2010 and was treated under the care of a rheumatologist at Robert Jones and

Agnes Hunt Hospital. She had regular reviews for her arthritis with the rheumatologist and blood monitoring for her prescribed medication, sulfasalazine (a disease modifying anti-inflammatory medicine) and initially steroids. There is evidence of repeated prompting to remind Jessica to attend for the blood tests and several episodes where she did not attend booked appointments at the GP surgery in 2010 and 2011.

2011

47. In 2011 Jessica's medication was changed, with the addition of methotrexate to sulfasalazine. Methotrexate (medicine that treats inflammatory conditions) also requires regular blood monitoring but can lower the immune system. Her notes show there was a monitoring system in place for this medication and she was contacted regularly for these blood tests. She was seen at home in 2011 for severe joint pain and had regular GP contact for review of pain.

2012

48. Jessica continued to receive regular medication listed and regular invites to attend for blood monitoring through 2012.

2013

49. In April 2013, Jessica visited the GP practice and had a medication review with a GP. She described a 2-month history of anhedonia (no enjoyment), feeling tearful, poor sleep and low motivation. She denied suicidal thoughts. She was started on an antidepressant, citalopram. In June 2013, her records show she had not had methotrexate blood monitoring for a year. She explained she lived some way away and had no transport. The GP arranged for her to have bloods taken at closer to home instead, as this was felt to be more easily accessible and in July 2013, she had blood taken.

2014

50. In January 2014 Jessica requested a sick note due to her arthritis. She described struggling with joint pain and stiffness to her back, shoulders and knees. At this point she hadn't had blood monitoring for her arthritis medication for some time but had been sent reminders.
51. Jessica had sporadic blood monitoring of her arthritis medication in 2014 and sick notes through the year. She had several contacts with the practice regarding medication and sick notes.

2015 and 2016

52. At a GP review in January 2015, Jessica told the GP she had stopped her citalopram and asked for a pain clinic referral. She did not want to discuss the citalopram, but said she hardly got out due to her arthritis. At this time, it was felt her blood tests showing raised inflammatory markers reflected the pain she was experiencing. The pain clinic referral was put on hold to enable professionals to deal with the cause of pain by increasing the dosage of methotrexate to manage the root cause of the pain. Throughout 2015 and 2016, Jessica attended scheduled appointments with rheumatology, dermatology and orthopaedics, the GP practice and blood monitoring. She had regular sick notes and

medication issued. She had started Cimzia injections (an immunosuppressant causing increased risk of infection) in July 2016 for her arthritis.

53. At her rheumatology appointment in October 2016, it stated she had a great improvement in her psoriasis and joints were much better. She had come off the injections on two occasions due to urine infections. The consultant also discussed her weight which, at that point, was 160kg. He stressed the need for weight loss and asked for the GP to help with this.

2016 and 2017

54. Lucy attended her GP practice with her mother and maternal aunt over the course of 2016 and 2017 with heavy periods. It is documented she had had time off school because of this.
55. Lucy attended Thomas Adams School between April 2017 and June 2020
56. Lucy accessed pastoral support in school, however, this was often driven by staff members as Lucy seemed reluctant to engage voluntarily. The primary concern regarding Lucy was around attendance, which was 57%. The family was involved with the Education Welfare Officer and support was offered for Lucy to help her getting into school. Lucy had conversations with the School Counsellor and shared that she was "concerned for Mum's (Jessica) health and did a lot of caring at home". School spoke to other supporting adults, such as maternal Grandfather and Aunt who were heavily involved in offering to support Lucy (and Olivia) and their mother throughout this time.

2017

57. At follow up in July 2017, Jessica was seen with her sister and father. She had lost some weight, and her pain was much better, but she was using a rollator frame due to pain in her knees. At this point the arthritis was felt to be stable. The consultant asked the GP to refer for physiotherapy and dietician input. A letter was sent to Jessica in August 2017 to ask her to make a telephone consultation to discuss the letter. A letter was also sent to the consultant, advising him that GP's do not have access to slimming advice from dieticians, but Jessica could self-refer to Help-to-Slim. Jessica did not attend booked appointments for a Chest X-ray in Sept 2017 and Dermatology October 2017, but she was seen by Dermatology in December 2017 where her psoriasis was described as 'extensive'.
58. One GP consultation in 2017 stated that Lucy came with auntie as 'mum disabled'. The doctor did call mum to discuss Lucy's condition but did not explore their social circumstances.

2018

59. Jessica missed her rheumatology appointment in January 2018 but was seen in March 2018. She had stopped her sulfasalazine due to side effects and she wanted to change her injected medication to an alternative. The rheumatology team was reluctant to change this as the Cimzia was working well. She was seeing a physiotherapist at the GP practice. Her weight had increased to 163kg.
60. In July 2018, she cancelled her dermatology appointment, and the outpatient letter states that she did not want to re-arrange it. In August 2018, she did not attend her rheumatology appointment, and it was noted on this letter that she had not had any blood monitoring for her medication since July 2017. Her Cimzia medication was put on

hold. The rheumatology department tried to contact her by phone and asked the GP practice if they had the right contact details.

61. In June 2018, Lucy presented to her GP with low mood and had 'thought about killing herself'. She was seen in the practice with Jessica. There was no exploration of home situation or social circumstances. She was referred urgently to mental health services. The mental health letter from June 2018 states there was no relevant family history ('major trauma/life events/school/social life/parental mental health'). The practice did not receive any follow-up correspondence following this assessment.
62. A referral was received for Lucy by Shropshire Access (Mental Health service) in June 2018 as Lucy had reportedly had thoughts of self-harm. It was recorded that mother was a wheelchair user and the father left when Lucy was 8yrs old. Information was provided to mother following assessment for signposting to Beam and Kooth* for input. Mother was advised regarding young carer's support via Carer Trust 4all. Liaison with school took place and it was confirmed that Lucy would be offered counselling in school. Lucy was closed to the service In July 2018. Lucy was aged 15 at this point. **BEAM is an emotional wellbeing service for Children & Young People under 25 years old who are registered with a GP in Shropshire or Telford & Wrekin. The service is delivered by The Children's Society. *Kooth is a web based confidential support service, providing a safe and secure means of accessing mental health and wellbeing support designed specifically for young people*.
63. Lucy was seen for medication checks for the combined oral contraceptive pill, issued to help with periods in 2018. Her aunt accompanied her to appointments in 2018.
64. School record that maternal grandfather did much of the communication with school, however they had sporadic phone contact with Jessica who would authorise absences for the girls and phone school saying they were unwell. Lucy stated the attendance concern was often linked to her reluctance to get up in the morning in time to catch the bus. This was not, to schools' knowledge, linked to any caring responsibilities. Lucy did, in some conversations, reference feelings of depression and anxiety, and on one occasion referred to 'wanting the feelings to stop' and discussed considering taking pills (in conversation with School Counsellor in December 2018). Lucy was offered regular counselling in school but did not attend these appointments. To school's knowledge there were no instances of self-harm or attempts to take her own life during her time at Thomas Adams. Lucy appeared clean, well-cared for and nourished in school, she had a strong, stable friendship group and there were no safeguarding concerns raised in respect of Lucy by any staff members.
65. N.B. The fire service record that when they attended the property to assist the ambulance service in extracting Jessica from her home to take her to hospital her father was present. He stated that he hadn't seen his daughter for 4 years which would mean that the last time her saw her was sometime in 2018.

2019

66. Jessica had telephone appointments with a GP in August 2019 and December 2019 for minor illnesses. These were the last times Jessica consulted with a clinician. Following this, the GP practice proactively and repeatedly contacted her for cervical screening, but she did not respond. The practice also invited her in by text for flu vaccination, but she did not book this. Medication reviews (of the medical record) are listed in July 2020, August 2021 and November 2021, these were administrative reviews linked to the

dispensing of repeat prescriptions. Jessica was not seen or spoken to for these reviews. During this time, she continued to be prescribed Codydramol for pain relief.

67. A contact was received by Children's Social Care in April 2019 from an anonymous referrer. The details of which were-
68. "Concerns over Mum shouting at the children. Mum is disabled. She has 2 daughters, one is 15 (Lucy) and one is 10 (Olivia). Mum's not coping very well. She screams at the kids. She seems to spend all day in bed. She can't get around very well because of her disability. Nobody goes into the house, and if people knock on the door, she doesn't answer. The caller was concerned about the kids' welfare, and Mum's too. Dad left some time ago.
    The children are well fed and well dressed. The caller said that Mum could do with a visit from social services - she needs help. The caller doesn't know what's wrong with her. She definitely can't walk properly. She was seen getting in and out of a wheelchair. There are definitely problems with her health. These problems and the relationship between Mum and kids deteriorating has been going on for a couple of years - but it's got worse lately. Mum's been screaming more at the kids. The other night at about 11pm Mum was screaming that one of them should go and get a drink of water for her.
    The caller said that she wanted the children's social services team to be made aware of the concerns."
69. There were no telephone details for Jessica and a letter was sent to her address asking her to make contact with children's social care. She called back in mid-April and said that she had arthritis which is very painful for her. When she is struggling, she will use a wheelchair, however if she is having a good day, she will access her frame. She reported that there was some shouting at the property as her daughters Lucy and Olivia do not get along. She had been trying to manage their behaviour but admitted that she would sometimes shout too. Jessica described struggling with depression but stated that she had support for this. She was waiting on support from an Occupational Therapist to assist with moving house or adaptations and was living downstairs as it was difficult to climb the stairs. She had a single bed in the living room and a bathroom downstairs.
70. Jessica advised CSC that Olivia had contact with her father and was with him all this week for the Easter Holidays. Lucy was described as not seeing her father because he wanted "nothing to do with her". He did not contribute financially either and has gone on to have another family. Lucy was described as receiving support for anxiety and depression and was on the contraceptive pill as she struggled with bad periods. She was also feeling suicidal. The GP had now recently changed her medication, contraceptive pill and she was receiving counselling via the school. Jessica described that this had improved Lucy's mood greatly.
71. Jessica consented to further agency checks, however as school was closed for the Easter holidays, this information could not be obtained, and the GP was described as not responding to a request for information. The outcome of this contact was No Further Action on the 18th of April. Health Teams were not aligned with the Compass Teams[1] at this time.

2020

72. Olivia started at secondary school in September.

[1] Compass - Shropshire's Front door Is the single point of contact for receiving NEW enquiries regarding concerns for the welfare or protection of Children and Young People in Shropshire.

73. Olivia had significant pastoral input since starting at school, she could present with 'challenging, defiant behaviour and has low school attendance (currently at 62.4%)'. There have been a variety of internal supportive measures offered, such as regular counselling, anger management work, self-esteem and resilience courses as well as external agency support from the CHAT nurse. There was little meaningful engagement from Olivia with the support offered, and, as such school saw little change or improvement. School had several conversations with Jessica over the telephone and via email and offered face to face and 'teams' meetings, but these were declined or not attended. School signposted, and attempted to promote, Early Help Support for the family, including the parenting team. Links to the helpline and gave the free access codes to the online courses via 'inourplace'* were sent to both Jessica and Olivia's father. School also signposted the family to the Young Carers support team and Olivia was taken to meet a representative by a member of staff. However, there was no engagement with any of these supportive services. School also offered to complete a Whole Family Assessment with the aim of referring to Targeted Early Help, but this offer was not taken up by Jessica. **Inourplace provides online family and parenting courses.*
74. Primary liaison information given to school in June 2020 stated that Olivia's Mum was in a wheelchair and therefore struggled to attend any meetings in school, there were further references to her being a wheelchair user and suffering with multiple sclerosis in conversation with school staff.
75. Olivia was seen by a GP in December 2020 after Jessica contacted the surgery describing her panic attacks. It is not recorded who brought her to the appointment. Olivia said that had developed anxiety about going to school and the GP record states she was living with mum and sister, 'mum disabled, parents are split, aunt passed 2yrs ago and grandparents' dogs have been put down'. Olivia was referred to Shropshire Access Team in December 2020 by the GP. Referral was made in relation to Olivia presenting in low mood with anxiety. It is reported "lots of recent social stressors within the family". These were reported to be family bereavement and parental separation. Following screening of the referral it was agreed that Beam and Kooth were identified as the appropriate support at that time. It was also agreed that Olivia self-referred to Cruse – youth service due to multiple family bereavements.
76. Lucy was seen for pill checks unaccompanied during 2020. There is clear documentation of the medical issue and full assessment, but nothing detailing social circumstances/concerns.

2021

77. In March 2021 an updated Personal Independence Payment form was submitted to the Department for Work and Pensions by Jessica. Within this Jessica advised that she could no longer prepare food as she drops things and loses her balance. She reported that everything was now completed by her daughter or family and that her daughter and family help with day-to-day living. Jessica reported that she was now bedbound due to pain and anxiety. She reported that she was hoping to make adaptions to her home to make it more accessible or move to a suitable property. She stated that she needed help with her weight and physio and her depression and anxiety. The Department for Work and Pensions identified that the information supplied confirmed the Personal Independence Payment decision to continue to award the payment and a face-to-face medical review was not triggered. The information shared by Jessica was not escalated

to a Vulnerable Case Champion who could have explored Jessica and the children's situation further and linked in with wider agencies.

78. Olivia attended A&E with a greenstick fracture following a fall in June 21 and was subsequently seen by Orthopaedics.
79. Housing Plus advised that the gas to the family home was capped (cut off) in October 2021 until October 2022. This was due to there being no debt or credit on the account. Providers should pause prior to ceasing utilities when it is known that there is someone vulnerable, has a disability or where there are children residing within a property. This did not occur in this instance. Attempts were made by Housing Plus's Community Safety Team to contact Jessica and visit the address, but these were unsuccessful. It is not known if any policy includes unannounced visits to see families in these circumstances.
80. In November 2021 Olivia was seen by school nursing for routine vaccinations and was observed to have 'old self harm' marks. Olivia was signposted to school nursing support, however declined this. In June 2022, Olivia was referred to the school nursing CHAT* service by school. **Confidential Health and Advice for Teens (CHAT) drop-ins in secondary schools*

2022

81. Between February 2022 and April 2022, work was completed at the address by Housing Plus due to a rat infestation at the address after it was identified that there were rat droppings and a strong smell of rat urine at the property. Housing Plus took action to address the issue, place poison, block access and replace contaminated insulation from the loft. A follow up from Housing Plus in relation to the infestation did not occur.
82. In March 2022, Housing Plus attempted to contact Jessica to arrange an electrical safety inspection however there was no response to calls and visits to the address. A home visit was later successful however the inspection could not occur due to clutter in the home. Housing Plus liaised with a family member of Jessica's who works for the company, and she reported that the issue would be addressed. In April 2022, a successful visit occurred, and the electrical safety certificate was issued.
83. In June 2022, West Midlands Ambulance Service were contacted by Jessica who reported that Olivia had hit her head at school the previous day, was dizzy and had been vomiting. Jessica was advised to take Olivia to Royal Shrewsbury Hospital. The report from the 111 algorithm states 'blunt head injury with vomiting and dizziness' as the reason for her call. She was advised to go to hospital but there is nothing on the records to show she was seen in A&E.
84. The GP surgery was contacted by Maternal Aunt, in June 2022 who raised concerns for Olivia's emotional wellbeing. She described Olivia as 'depressed, angry, not sleeping, isolating herself, punching doors and walls and self-harming' It was reported that Olivia did not want to be around her parents.
85. During 2022 it appears that Olivia would frequently move between her mother and father's addresses. Further concerns were raised regarding Olivia self-harming in February 2022. It was recorded that Jessica was asking for support from school and noted that Jessica had a disability and used a wheelchair. Olivia also shared with school at this time that her mum is disabled and would not answer the door when people visited the address. In May 2022 further concerns were raised regarding Olivia self-harming and school signposted to Kooth and to speak with the GP surgery. In June 2022, Olivia's aunt shared concerns for Olivia's emotional wellbeing with school.

86. In June 2022 Olivia shared with school that she had argued with her mum because the electricity had gone off and they had used all the emergency on the meter. Olivia reported to school that her mum can't get up or move easily. She stated that she has to help her mum a lot due to her illness. Olivia shared that Lucy had previously done this, however had got a job so it was left to Olivia. Olivia shared that she felt frustrated at her mum but also sorry for her. School contacted Jessica via email and signposted her to Kooth, Beam, Cruse bereavement support, and the parenting team. They also referred Olivia to the school nursing CHAT service. Olivia was seen by the school nursing service on four occasions between July and November 2022, however it was recorded that she did not wish to engage with the service and she was subsequently discharged. It was reported by school that Olivia listened during these sessions but chose not to interact.
87. Early June 2022 Jessica mentioned in a teams message with school that she was unable to come in to school for a meeting due to having an operation the previous week.
88. Olivia was referred to School Nursing late in June 2022 by Thomas Adams School. Face to face appointments held by School Nurses with Olivia at Thomas Adams School in July. September, October and November. Discussed in case supervision in October with senior school nurse. Olivia chose not to engage with the service therefore discharged from the service in November. Information about CHAT health sessions offered in school was shared with Olivia, to enable her to access the service in the future.
89. In late June 2022 the EWO team advised the school that Jessica had been invited to a Student Attendance Panel (SAP) meeting to be held in July.
90. Olivia's father shared concerns that Jessica did not leave the house nor let anyone else in, he felt this was because she was embarrassed about her size. However, during this same time school report that they had conversations with Jessica regarding her and the girls having been on a family holiday together which confused this matter.
91. In late June 2022, Jessica was contacted by the Education Welfare Officer (EWO) who advised she could not attend the SAP relating to Olivia's attendance as she was bedbound. It is recorded by the EWO that it sounded as though Jessica was out of the house due to the background noise, however Jessica had reported this was a fan. Jessica discussed the services school had signposted her to but advised she had not looked into them.
92. In June 2022, the GP practice received an email from Jessica's sister who stated she was looking after Olivia and requested a referral to BeeU*. Olivia's aunt described Olivia as 'depressed, angry, not sleeping, and isolating herself, punching doors and walls and self-harming'. It goes on to say Olivia didn't want to be around her parents or her and that she and school were concerned she might hurt herself. The practice tried three times to contact Olivia via her aunt's number and sent a text to her listed phone number but had no response. **BeeU provides emotional wellbeing and mental health services for children and young people (ages 0 to 25) in Shropshire, Telford and Wrekin*
93. In July 2022 Olivia reported to school that she was self-harming. She also shared that she had fought with her mother about her attendance at school. Olivia reported that her mother was in a wheelchair and cannot look after her. Olivia shared that she and her mum rely on Lucy who supports her mother with toileting. Olivia shared that they did not have any support in the home from agencies. Olivia reported that she was self-harming twice a week. School spoke with Jessica who shared they had been away on a family holiday and would take Olivia to the GP. Jessica subsequently advised school that she (Jessica) had had an operation and couldn't attend school to discuss attendance and

support. School requested a visit from the Education Welfare Officer however there was no response at the home.

94. Further concerns were shared with school by Olivia's father in July 2022. He reported that Jessica did not allow anyone in the address and that he was worried about the environment in which the children were living. Olivia's father commented that he felt that Olivia was not always truthful. School subsequently spoke to Olivia about Young Carers support.
95. It was noted in July and August 2022 that Olivia presented as upset in school. On 13th of September 2022 school were advised that Olivia was residing with her father, however he later advised on 22nd September that Olivia was in her mother's care and shared his view of differences in his and Jessica's parenting, who he felt had less boundaries for Olivia.
96. On the 27th of September 2022, Olivia advised school that she looks after her mum, takes her to the toilet, makes sure she is clean, applies medication and makes meals. Olivia reported that she gets angry with her mum and wants time for herself. Olivia was signposted to Young Carers by school. School contacted Jessica who confirmed that she has arthritis however denied that Olivia was taking on a caring role at home.
97. A home visit was attempted by the Education Welfare Officer in late September 2022. Lucy answered the door and advised that Jessica had taken Olivia to the doctors. Previous attempts to complete home visits in February and March 2022 were also unsuccessful.
98. Early in October 2022, Jessica raised concerns with school that she was struggling to get Olivia to attend and that she felt that Olivia had purposefully damaged her school skirt. She also shared that there had been a rumour that Olivia had been sexually active when she was in year 7 (aged 10 or 11). There is no information to suggest that this was investigated or explored with Olivia. When Olivia attended school later that day, she reported that her skirt had been dirty, and she had tried to clean it which made it worse. School records note that they planned to offer Jessica Early Help support and a referral to young carers. Jessica advised school that she couldn't get to school as she was bedbound.
99. Early November 2022, Olivia reported that she and her mother had argued, and Jessica had told her not to return home. On the 10th of November 2022, Olivia received a 2-day fixed term exclusion. Jessica advised school that she was thinking about contacting Children's Social Care about Olivia. Jessica was agreeable to Early Help support however advised that she did not want to do video calls with school as she did not want to be seen.
100. School information identifies that Olivia's attendance at 62.4% and there have been several support measures implemented including counselling, work to develop her self-esteem, anger management and referrals to the school nurse. School feel that they had seen little improvement in Olivia's behaviours and identify these as being defiant and challenging. Olivia has also been described by school as being well presented and well-nourished and described to have a stable friendship group.
101. On 7th November Jessica telephoned Homes Plus to confirm that the gas was now back on.
102. On 15th November 2022 Jessica attended, via telephone, a school reintegration meeting to discuss Olivia following a suspension for poor behaviour and was described as being supportive of both school and Olivia. Jessica requested that this be via telephone as she could not attend the school and didn't want to be seen on a Teams

call. Jessica was signposted to support services and the school agreed they would offer Olivia anger management support.

103. On the 7th of December 2022, a gas engineer attended the address to complete a gas service check. It has been reported that the engineer did not observe anything of concern during their time at the property having walked the house to check all radiators.

104. Olivia is recorded as being absent from school on the 7th and 12th of December 2022 as she was unwell due to having a tooth removed.

105. On the 15th of December 2022 Jessica was taken to hospital by West Midlands Ambulance Service. On arrival in A&E, Jessica was in an extremely poor state and immediately taken into resus. Jessica died the same evening with her cause of death recorded as:

- 1a. Severe Sepsis
- 1b. Multiple Infected Pressure Ulcers
- 1c. Obesity
- 2. Psoriasis

106. Upon the Ambulance Crew's attendance, Jessica had reported that she had 'done this to herself' and 'hidden herself away' and had not had any involvement with services.

Analysis

107. The analysis is set out in response to the key lines of enquiry agreed by the Review Panel which formed the terms of reference for the review. The analysis is informed by:

- chronological information provided by agencies,
- Additional information provided by Children's Social Care in response to questions asked by the independent reviewer.
- Research
- Analysis of other serious case reviews

Psoriatic Arthritis

108. It is important, for the purposes of this review, to understand Jessica's condition of psoriatic arthritis with which she was diagnosed in 2010.

109. "Psoriatic arthritis (PsA) is a chronic, deforming arthritis associated with the skin condition psoriasis. A large number of patients with PsA are known to have another co-existing chronic disease, which adds to their overall disease burden and affects their quality of life. Depression is a common illness known to co-exist in about 20% of patients with PsA. Inflammation is a common factor between psoriatic arthritis and depressive disorders and is thought to play an important role in depression occurring in these patients. Recent research in the field has revealed that different dimensions of depression, such as the inability to feel pleasure, loss of intellectual functions and difficulty identifying and expressing emotions, may contribute to the overall disease. It is important to screen for these dimensions while assessing PsA patients with depression. A good understanding of depression in patients with PsA is useful in designing treatment strategies.

110. Over the years, there has been mounting evidence on the effects of PsA extending beyond skin and joint diseases, including cardiovascular disease, diabetes, obesity, metabolic syndrome, osteoporosis, malignancy, fatty liver disease, depression and anxiety. Patients with PsA tend to have a significantly higher burden of comorbidity than do patients with psoriasis alone and the non-PsA population, and these comorbidities pose an incremental burden on their long-term quality of life. In people with psoriasis, psychiatric disorders can both result from and contribute to disease progression, suggesting overlapping biological mechanisms". https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7211219/

111. In summary, Jessica had been suffering from a serious complex autoimmune condition and associated co-morbidities which may have included obesity and depression for over 12 years before her death. It is also of note that the medications Jessica was prescribed at various times in the treatment of this condition had a range of serious side effects and it is not fully known to what extent Jessica experienced them.

Term of Reference 1: The Family's lived experience:

Understanding and exploring the lived experience of Jessica, Lucy and Olivia including from a family perspective.

112. It is apparent from the chronologies provided by agencies that the family members individual and collective lived experiences were not explored or understood particularly during the last three years of Jessica's life during which she was bedbound and had no contact with anyone other than her children.

113. Whilst some agencies (school, GP, Shropshire Access service) were aware that Lucy and Olivia were carers and that both children were experiencing psychological distress there was little enquiry regarding their day to day lives. Neither child was asked about the practicalities of caring for a bedbound mother with serious health needs who was also very obese. For example, were the children providing personal and intimate care to Jessica? How were they managing financially? Were they responsible for food shopping and preparation, paying household bills, cleaning etc?

114. The impact of caring for their mother on the children's physical and emotional health and upon their education was not explored although their school attendance was a concern. For example, in 2018, Lucy who was often absent from school reported to school that she was woken at midnight by her mother to 'fetch her things' which may well have led to her being too tired to be ready for school. The impact of this, if it was a regular occurrence, on Lucy's health, her ability to function and thrive at school was not understood or assessed.

115. Jessica was not receiving any health care during this three-year period and her situation was deteriorating across all domains of health and wellbeing. She had excluded her close family and saw no one other than the children. When she did speak to professionals from the children's school, she was not always honest about her situation for example, in 2022 she told school that she and the children had been on a family holiday when they had not. This may have been in order to provide reassurance to the school. In summary, for a significant period of time, no one, including her immediate family, understood Jessica's lived experience and therefore the children's'.

116. The impact of Jessica's specific autoimmune disease on her weight and mental wellbeing would have been significant. Her mobility was restricted to the point that she was bed bound and unable to care for herself physically. The daily distress of living as she did may have been a compounding issue worsening her depression which in turn worsened her neglect of self.

117. By 2022 Olivia who at that time was 14 years old was communicating her extreme distress. She told school, her aunt and her GP that she was providing intimate and other care for her mother and that, at one point, they had no electricity in the home. It was also reported to school by Jessica that she did not wish to be seen and this was confirmed by Olivia's father who twice shared his concerns with school about the environment the children were living in.

118. The daily reality of this meant that the children were living in an unsafe unhygienic environment which must also have been unpleasant and distressing. They did not have family (or friends) visiting them at their home which meant that they were isolated and that their daily reality was not known or understood by anyone who could have helped them.

119. In essence Jessica's condition was exacerbated by self-neglect and was the root cause of the children's neglect and there is no way of knowing from agency records how supported or cared for the children felt by their mother or by each other. Their physical and emotional needs are very likely to have been unmet during the three years preceding Jessica's death.

120. Self-neglect is a challenging area of work for practitioners and agencies and an increasingly identified feature of some adults' lives. The Joint Review has highlighted the need for services in Shropshire, (in common with the majority in England) to consider self-neglect in the context of findings made by Michael Preston Shoot, Suzie Braye and David Orr in their 2015 publication of research on the subject. They highlighted five important themes from their research interviews with people who self-neglect:

- the importance of relationships
- 'finding' the person
- legal literacy
- creative interventions
- effective multi-agency working.

121. Each of these themes resonate in Jessica's case.

How effectively did agencies engage and what were the barriers?

Health Agencies

122. Jessica withdrew from all health care for psoriatic arthritis in March 2018.

123. Jessica did not attend booked appointments for a chest X-ray in Sept 2017 and dermatology in October 2017, but she was seen by dermatology on 14th Sept 2017 where her psoriasis was described as 'extensive'. She missed her rheumatology appointment in January 2018 but was seen in March 2018. She had stopped her sulfasalazine due to side effects and she wanted to change her injected medication to an alternative. The rheumatology team was reluctant to change this as the Cimzia was working well. She was seeing a physiotherapist at the GP practice. Her weight had increased.

124. In July 2018, she cancelled her dermatology appointment, and the outpatient letter states that she did not want to re-arrange it. In August 2018, she did not attend her

rheumatology appointment, and it was noted on this letter that she had not had any blood monitoring for her medication since July 2017. Her Cimzia medication was put on hold. The rheumatology department tried to contact her by phone and asked the GP practice if they had the right contact details. She did not attend her appointment in January 2019, and she was discharged. Jessica had telephone appointments with a GP in August 2019 and December 2019 for minor illnesses. These were the last times Jessica consulted with a clinician.

125. Following this, the GP practice repeatedly contacted her for cervical screening, but she did not respond. The practice also invited her in by text for flu vaccination, but she did not book this. Medication reviews are listed in July 2020, August 2021 and November 2021. During this time, she continued to be prescribed Codydramol (low strength codeine and paracetamol), ongoing since 2009.

126. The barriers to Jessica accessing or seeking health care may have been directly linked to her pain levels caused by psoriatic arthritis, immobility, and her weight. Research indicates that women who are obese avoid seeking health care including attending routine health screening.

127. In Jessica's case her mobility was limited by her weight but also compounded by her pain levels, immobility and other comorbidities of psoriatic arthritis. The research shows that obesity often carries negative mental and emotional impacts that can create barriers to accessing treatment and support:

- Shame and embarrassment - Obese individuals may feel ashamed of their weight and not want to be seen seeking obesity treatment. For example, Jessica told the paramedics who attended her the evening she died that "This is my own fault" which is indicative of guilt and shame. Her family also believed that she had hidden herself away because of embarrassment about her weight.
- Low self-esteem - Obesity is often internalised as a personal failure, negatively impacting self-worth. Individuals may feel unmotivated to seek help.
- Anxiety and depression – Obesity and psoriatic arthritis is linked to higher rates of mental health conditions like anxiety and depression that reduce motivation and energy to get treatment.
- Internalised weight stigma - Societal messages that stereotype obese people as lazy or lacking willpower can be internalised, making individuals feel undeserving of care. For example, Jessica's rheumatology consultant recorded "I have had a long discussion with her regarding reduction in weight, increase in exercise and motivating herself to get out of a chair and I have given her a target to do this in six months' time when we see her again". Jessica may have internalised that discussion as an opinion that she was lazy and lacking willpower.
- Judgment from providers - Perceived or experienced weight bias from doctors, nurses, dietitians etc. causes avoidance of the healthcare system.
- Physical limitations - Conditions like joint pain (and Jessica's pain levels were significant) or lack of stamina may literally prevent obese individuals from accessing in-person treatment and support programs.

128. The research indicates that, with empathy, education and improved access, the mental health impacts of obesity can be addressed effectively alongside physical health needs. A holistic approach helps obese individuals feel supported in their journey.

129. Crucially, in Jessica's case, the connection between Psoriatic Arthritis, obesity and depression will have presented additional challenges to her losing weight and there is no evidence in agency records that this was understood by health professionals or by Jessica herself.

130. Jessica's health records identify that there were several conversations with Jessica and the rheumatology team (Consultant and Specialist Nurses) to ensure that she understood the importance of continued engagement together with her treatment and the importance of blood monitoring. All of the letters were copied to both the GP surgery, as well as to Jessica herself.

131. As a direct result of this case, the Robert Jones and Agnes Hunt NHS Trust is currently in the process of reviewing discharge letters, specifically in respect to patients who Do Not Attend (DNA) or Was Not Brought (WNB) as part of preparations for implementation of a new electronic patient record system. The wording is being reviewed to ensure that any cases / individuals who have, or may have, more complexities and may require additional consideration, are highlighted to us by the GP to ensure that we can work together in attempts to offer a more flexible pathway.

Education

132. Lucy and Olivia's primary school made multiple attempts to engage Jessica in face-to-face or virtual meetings, however these requests were declined. Jessica is documented to have had regular contact via telephone and email with both the school as an agency, but also with key individual members of staff who were working in a supportive capacity. It is clear from the school's records that signposting to other agencies for help took place, and of this being reiterated on numerous occasions.

133. School was aware that Jessica was a wheelchair user and that this would limit her face-to-face contacts.

134. Jessica was given repeated opportunities to speak to professionals from Olivia's school and the Education Access Service team. The information she provided about her health was taken at face value, and there was no recognition of the fact that the severity of her condition might be impeding her ability to engage directly with services to help her children. Jessica's failure to attend meetings was perceived as her 'choosing not to engage' and therefore improve her daughter's attendance at school. It is not understood why she was not truthful with Education Welfare Officers (EWOs) about her own plight.

135. Olivia was spoken to in person by an EWO in school. Observations were made about her behaviour by school staff and about her conflicting feelings towards caring for her mother. This meant her role as a young carer was not formally recognised by school staff and the opportunity for her to access support and a chance to tell someone about her home life.

136. Within the Children's Social Care referral in 2019, Jessica shared concerns regarding her physical disability, care and support needs, mental health, the children's emotional wellbeing and difficulties with managing behaviours. Jessica consented to Children's Social Care making further enquiries of other agencies. This did not happen in respect of the children's school as it was the Easter half term, and the GP did not respond to enquiries. The case was closed without further attempts being made to contact school after the Easter break. The decision to close the case was not communicated to Jessica. Jessica had asked for help at the point at which she had effectively withdrawn from the view of agencies and family support and there was a deterioration in her health and the children's wellbeing. The process of assessing the

contact with Jessica and the outcome of this assessment was a barrier to Jessica, Lucy and Olivia receiving help and was an important missed opportunity. (Explored later in this report)

137. Jessica's withdrawal from health care and support was self-neglect and she made an active and determined choice to retreat from view. This did not raise a safeguarding alarm in respect of her or the children there was, therefore, no consideration of her mental capacity under the Mental Capacity Act (2005) to make 'unwise' decisions.

138. The Care Act 2014 Care and Support Statutory Guidance lists self-neglect as a category of abuse or neglect that may prompt a safeguarding enquiry. Under section 42, local authorities must make whatever enquiries they think necessary where an adult has care and support needs, is experiencing or at risk of abuse or neglect, [including self-neglect] and is unable to protect themselves because of their needs.

139. Self-neglect was not identified, by any agency, as a concern in Jessica's case.

Did agencies recognise and respond to Lucy and Olivia as carers?

140. Some agencies recognised Lucy and Olivia as carers but did not always respond accordingly, to, for example, request a carers assessment and/or make a referral to adult social care for support for Jessica which could have eased the responsibilities on the children.

141. It is also notable that no professional had a full and accurate understanding of Lucy and Olivia's daily life as carers for their mother. The extent of their caring duties and Jessica's physical distress, her weight, total lack of mobility and deteriorating condition had been endured by the children for years rather than weeks was not fully known to adults who would have been able to help.

142. Olivia's school signposted the family to the Young Carers support team and Olivia was taken to meet a representative by a member of school staff. However, there was no engagement with the service.

143. In recent years awareness of the roles and responsibilities of young carers has been raised within schools nationally and as a result there has been an overall decrease in the incidence of educational difficulties. A national survey of young carers shows missing school or experiencing educational difficulties fell from 42% of young carers of secondary-school age in 1995 to 27% in 2003 (Dearden and Becker 2004).

144. Many young carers believe that looking after a parent meant they lost opportunities for learning which subsequently limited their horizons (Edwards and Smith 1997). The majority of young carers don't want to relinquish their role but do want support to enable them to attend school regularly and participate in extra-curricular activities.

145. Conflict between the caring role and the child's own needs can lead to feelings of guilt and resentment (Edwards and Smith 1997; Barnett and Parker 1998).

146. Children may be so wrapped up in the needs and feelings of a parent that they find it hard to think or talk about themselves. This preoccupation with their parents can mean that they deny their own needs and feelings (ChildLine 1997).

147. The needs of young carers can be assessed under the Children Act 1989, the Carers (Recognition and Services) Act 1995 or under the Carers and Disabled Children Act 2000. There should, however, be no cause for complacency. A survey of young carers carried out by Dearden and Becker (2004) found only 18% of young carers had

received an assessment, with the majority of these having been carried out under the Children Act 1989. The Government's Carers' Strategy acknowledges the role of young carers and the difficulties they may have in identifying themselves 'because of family fears that they will be taken into care or because the young people themselves are concerned about the reaction of others and bullying by their peers' (HM Government 2010d, p.8, paragraph 103)

148. In Lucy's case reaching adolescence was a significant period of change for her and the family (and some caring duties passed to Olivia). Had she been formally assessed and recognised as a young carer she would have been entitled to a statutory Transition Assessment as a child likely to have care and support needs after she turned 18 years old. (Sections 58-66 Care Act 2014, Chapter 16 Care and Support Statutory Guidance)

149. In summary, whilst there was recognition by school, children's social care and health agencies that Lucy and Olivia were carers the response to this was to signpost or refer to other services and professionals did not acknowledge risks. These opportunities were not accessed in a sustained manner by Jessica on behalf of the children or by the children themselves. This meant that the response to both children was limited and had no impact on their lives or caring roles. This reluctance to engage on the children's behalf was not considered as possible neglect by Jessica within the context of the family's daily life.

Term of Reference 1: Key Learning

150. Schools play an important role in identifying children who are caring for adults and/ or other children within their family. In this case the children were known to be struggling with aspects of their caring roles and support was offered to both girls but not accepted. Olivia's distress manifested itself and was described by her school as 'challenging, defiant behaviour' but there was no understanding (and non was sought) of what her life was like at home. The information provided by Olivia, Jessica and Olivia's father in 2022 to her school coupled with her distress should, at the very least, prompted a consideration of a safeguarding referral to children's social care.

151. Understanding the reasons why some women who share similar issues to Jessica in respect of weight, mobility, pain levels, self-neglect and other health conditions 'do not engage' with or may withdraw from agencies is crucial. In Jessica's case she may well have felt judged by health and other professionals particularly about her weight.

152. The impact on the children of mothers who share these complex and compounding issues and who withdraw from agencies is poorly understood but it is highly likely to be detrimental and neglect should always be considered for the children of such parents.

153. The many serious and compounding issues faced by some people who suffer from psoriatic arthritis may not be generally known however, in this case they directly impacted Jessica and the children's daily lived experiences, and their quality of life was, at times, poor and their safety compromised. Awareness of the impact of this specific autoimmune disease should be increased where appropriate. Please note that it is not known how much Jessica (or her children and wider family) understood about her condition and the co-morbidities of obesity and depression. If she had known and

understood the complex co-morbidities and their impact on her weight and mental health this may have helped her and those caring for her.

154. Workers must exercise professional curiosity and follow through on signposting or referrals to ensure that children have been able to access support and if not, to try different options. No professional asked the children why they were not able or were unwilling to access support therefore the response was extremely limited.

155. There is little known about the impact on children of caring for a mother who was significantly overweight. She had stated to professionals that she 'done this to herself' and 'hidden herself away' and it appears she was, embarrassed. The fact that Jessica withdrew from public view compounded the difficulties experienced by the children and any shame, embarrassment or stigma they may have felt.

156. Ultimately, the children were not formally recognised or responded to as young carers.

Term of Reference 2: Assessment of Jessica's Parenting Capacity

Did Jessica's GP, orthopaedic, rheumatology consultants and other professionals understand the mental and emotional impact of Jessica's weight on her accessing treatment and/or support? How did Jessica's children and wider family understand her illness and weight issues? What support or information did they need?

157. The mental, physical and emotional impact of Jessica's weight on her accessing treatment and support is likely to have been significant. This would have been further compounded by her pain levels, immobility and other comorbidities of psoriatic arthritis.

158. There is no information to suggest that any professional understood this or displayed any professional curiosity to explore this with Jessica.

159. As previously described Jessica told the emergency services staff who attended her at home that 'this is my own fault'. She was, by then, in a shocking condition and had been so for some considerable time. It is impossible to understand the shame and embarrassment she felt and the mental and emotional impact of this on her (and the children) and there is important learning to share from this case with people who work with mothers who share similar issues to Jessica.

160. Olivia's father also shared with staff at school that he believed that Jessica had not allowed anyone to see her because she was embarrassed about her weight. This did not rouse any curiosity or conversations with the children specifically about this issue on even a basic level about how they coped physically with caring for their mother.

Did professionals consider the impact of Jessica's physical and mental health issues on her capacity to parent her children?

161. Jessica effectively disappeared from the view of professionals and immediate family members for the last three years of her life, but this was not seen in the context of Jessica's ability or capacity to parent. There was, therefore, no professional assessment or consideration of Jessica's parenting capacity and how this would have been affected

by her serious health issues. Jessica was unable to carry out routine household or personal care tasks and relied upon the children to do so. Her parenting of the children for that reason alone was compromised.

162. Her mental health would also have had an impact upon her parenting capacity. She and the children were living in poor and latterly extremely unhygienic and unsafe conditions and Jessica had made determined efforts to disconnect from the outside world.

163. Jessica's GP was aware of her care, support needs and vulnerabilities, however these were not further explored with her in relation to the impact upon her parenting. There were no referrals made to Adult or Children's Social Care.

164. During 2022 in particular, Olivia's distress was extreme, and she told staff at her school about the extent of her caring role and described having no electricity in the house (there was also no gas during this period). These were clear indications that Jessica's parenting was compromised but school did not explore to what, if any, extent Jessica was able to care for her children physically and emotionally and neglect of the children was not considered. At this point, a referral to children's social care should have been considered.

How effective were agencies were in identifying, understanding and responding to safeguarding risks and concerns (including timeliness)?

165. Professionals did not recognise safeguarding risks and concerns in respect of Jessica or the children.

166. There were clear indicators that risks were present and increasing. The cumulative and compounding impact on the family of these risks would have been significant but no one agency took responsibility for gaining a full family picture or making a timely safeguarding referral to adult or children's social care.

167. These indicators included:

- Jessica withdrawing from health care.
- Jessica's worsening health (she told Olivia's school that she was bedridden)
- Jessica withdrawing from 'public' view – she was open with Olivia's school about this stating that she did not want to be seen even in 'virtual' meetings.
- Concerns expressed about the children's environment by Olivia's father who also confirmed that Jessica would not let anyone see her or allow anyone into the house.
- Olivia's increasing and extreme distress.
- Lucy's distress
- Olivia and Lucy describing their caring roles which included intimate care and disturbed sleep.
- An anonymous detailed referral to children's social care which was corroborated by Jessica.
- Lack of gas and electricity in the family home
- Home too cluttered to carry out electrical inspection.

168. By 2019 when Jessica began to withdraw from the view of agencies and her family and community there were sufficient grounds for concern for the family to justify a whole family assessment. This could have taken place when the anonymous referral was made to children's social care, but this did not happen as information gathering was not completed and the case was closed.

169. Olivia's school was in possession of sufficient information and known concerns by the time Jessica withdrew from contact to justify a safeguarding referral to Children's Social Care.

Did professionals exercise professional curiosity in identifying and exploring all risks and concerns?

170. There was little professional curiosity in identifying risks and concerns although it was known that Lucy and Olivia were experiencing psychological distress and that Jessica had serious health problems which impacted upon her caring for the children. There were opportunities to explore this and exercise professional curiosity, but these were missed by the family GP, School and children's social care.

Term of Reference 2: Key Learning

171. It is clear from agency records that the emotional and mental impact of Jessica's weight was not understood or explored by professionals. There were certainly no discussions with Jessica recorded by health care professionals.

172. For women who are also mothers and who are significantly obese the learning is as important for their children and the implications for them as carers and should be routinely considered and explored by professionals when they are working with families.

173. The links between self-neglect and neglect of the children resulting from Jessica's compromised capacity to parent the children were not recognised or explored despite school and children's social care knowing that the family were in distress.

174. Difficulties experienced by parents because of underlying factors can link to the neglect of children, for example:

- Parents lack the capacity to provide care physically or emotionally.
- Parents' own problems are so overwhelming or intractable that they cannot prioritise their children's needs above their own.
- Parents lack the knowledge or skills to provide adequate care environments.
- Support networks are not in place.

175. In identifying risks and concerns about risk / neglect practitioners might also consider how parents interact with support services, whether they are open to advice and guidance and able to act upon it, or whether there is an apparent lack of engagement or lack of follow through with referrals. A multi-agency chronology could aid identification of patterns of emerging and historical concerns.

176. Accumulating and compounding risks may be identified by taking a 'whole family' or Think Family approach. Each member of the family was viewed in isolation and responded to accordingly. For example, Olivia's behaviour was seen as 'difficult' and not in the context of her family life. A further example being that the impact on the children of Jessica's withdrawal from all health care and contact with her family and agencies was not considered and therefore risks were not identified.

Term of Reference 3: Single and multi-agency assessments and working

Describe and analyse the way in which organisations, interacted and worked with Jessica, Lucy and Olivia and with each other. How well was information shared, understood and responded to between agencies? Is there evidence of collaborative working between agencies to identify and mitigate risks associated with Jessica, Lucy and Olivia?

177. There was very limited multi-agency working in this case and there was no multi-agency assessment.
178. Information was shared between school and the Education Access Service and between school and the Midlands Partnership Foundation Trust in 2018. There were no enquiries made between wider agencies, despite involvement from Housing, the GP surgery, Shropshire Community Health School Nursing service.
179. Housing identified that they had difficulty communicating with Jessica and have reflected (following the Rapid Review) upon how they need to review numerous indicators of risk and the cumulative impact of these on risk levels.
180. When the family gas supply was capped, (cut off) further enquiries did not take place to determine the vulnerabilities of those in the home and no referrals were made to safeguarding or support services. They were also unable to carry out an electrical inspection at the family home in March 2022 due to clutter. Housing Plus operatives undertake mandatory child and adult safeguarding and have a 'shout out campaign' and they can email/ call members or simply press an alert to notify management of the concerns. Housing officers will follow through with a triage / risk assessment/ investigation and of course refer to adult or children's services if appropriate. It is not clear why this did not happen in this case. The linked review Family B highlighted the importance of involving housing services in working with families in a multi-agency approach.
181. Opportunities for information sharing were missed as are described elsewhere in this report for example, school did not make a safeguarding referral or share information with other agencies when Olivia told them that the family had no gas at their home.
182. The anonymous referral to children's social care in 2019 was responded to within timescales but was incomplete. This was an opportunity to gather information from the children themselves and from their school and GP. This opportunity was missed (as described elsewhere in this report).

Were opportunities missed by agencies involved in the care, treatment and support of Jessica, Lucy and Olivia to act sooner than they did in respect of the risks to them?

183. During the conversation Jessica had with children's social care as a result of the referral in 2019, she shared concerns regarding her physical disability, care and support needs, mental health, the children's emotional wellbeing and difficulties with managing behaviours. Despite this, consent was not sought for a referral to targeted early help.
184. Targeted Early Help applies to "those children identified as requiring targeted support and who meet at least 2 of the 6 Strengthening Families criteria in the Whole

Family Assessment. It is likely that for these children their needs and care are compromised. These children will be those who are vulnerable to harm or experiencing adversity. In addition to the Whole Family Assessment, specific local tools and pathways should be used where there are concerns about possible harm to the child. These children are potentially at risk of developing acute/ complex needs if they do not receive targeted early help". Shropshire Children's Threshold document

185. The independent reviewer asked children's social care specific questions in relation to this referral and their response to it and these are detailed below.

186. The response to the referral and subsequent conversation with Jessica was to make enquiries with school and GP practice. These enquiries were not completed so how was a decision made to close the file?

187. **Response**: School was closed for Easter as noted in the contact form so not contactable. A check was requested from the GP however no response received. Decision made was based on the presenting information and the conversation with mother.

188. The scoping document states that "Appropriate action was taken by children's social care, as concerns raised would not have met the threshold for a social care response" however as agency checks were not completed and neither child was seen or spoken to how was that determined? School would have confirmed that both children were experiencing psychological difficulties and were carers for their mother and this could have triggered a carers assessment etc. Their school attendance was also an issue at this point.

189. **Response:** School was closed for Easter as noted on the contact therefore not contactable. A check was requested from the GP however no response received. Decision made was based on the presenting information and the conversation with mother. No referrals were received from School reporting concerns outlined.

190. The scoping document also describes that not receiving a response from GP's as "It was unusual for GP information to not be received; however it was felt that this would not influence the outcome of the contact". This was an unknown at the time the enquiries were made so was it acceptable/ safe practice to not chase a response?

191. **Response:** As per the Compass Operating Procedures a case seems as 'Amber' can be open no longer than 4 working days. The date this closed was the 4th working day, therefore the senior social worker will have made the decision based on in the information available to her.

192. Jessica was noted to have been open about the family dynamic and the shouting in the house and the impact of this on her mental health but there was no discussion about the impact of this for the children.

193. **Response:** A discussion was held around the shouting in the house, mother reported it was due to Lucy & Olivia not getting along and they constantly shout at each other. Mother tried to manage the behaviour but admitted she sometimes shouted too. Mother reported Lucy was receiving counselling from the school, and support for her anxiety and depression, and following a change in medication that her mood had improved.

194. Should a referral to family support have been made?

195. **Response:** Mother reported a number of supports were in place. A referral for family support could have been a further consideration.

196. How was the decision to close the case communicated to Jessica?

197. **Response:** There is no evidence on file of an outcome being provided to Jessica.

198. In this case the response to the family was process driven which meant the case was closed within 4 days because that is what the operating process demanded. There was no consideration of contacting the school after the Easter holidays and of re-contacting the GP. In essence this was an incomplete response and an important missed opportunity.

199. Jessica was signposted to support on numerous occasions by school however she did not contact any of the services suggested. Jessica was not formally offered support via an Early Help Assessment or referral to Targeted Early Help and there was no consideration of a safeguarding referral to children's social care by school. Given the information shared by Olivia regarding her caring responsibilities, issues relating to attendance and Olivia's emotional wellbeing, threshold for level 4 involvement would likely have been reached. Level 4 in Shropshire's children's services refers to children who are in need of intensive support and protection because they are suffering or are likely to suffer significant harm.

200. The Department for Work and Pensions information identified that upon the review of Jessica's Personal Independence Payment claim, the information provided by Jessica regarding an escalation of her care and support needs and the caring role being taken on by her children did not trigger involvement from a Vulnerable Case Champion or trigger any referrals to wider agencies including Adult or children's social care.

201. The GP Practice was aware of Jessica's long-term condition, care, support needs and vulnerabilities. However, neither the consequential wider care needs were not further explored with Jessica in relation to the impact upon her parenting nor the ceasing of her specialist review and medication and the potential serious consequences of being without treatment for psoriatic arthritis. There were no referrals made to Adult or Children's Social Care.

202. Assessment requires professional judgment. A professional judgment is an evidence-based analysis of all the information gathered from the child, their family and others, drawing on research-based evidence of child development and the known impact of abuse or neglect of children arising from research and findings of safeguarding practice reviews (see Working Together to Safeguard Children 2018, Chapter 1, para 51-75). Shropshire's Children's Thresholds document describes the principles of good assessment practice which include:

- Engagement: with the child and their family face to face in person; enabling them to speak for themselves; in their whole environment (not just at the doorstep) considering strengths and risks of others within it; with a view to understanding their day-to-day lived experience.
- Maintaining professional curiosity; ensuring respectful uncertainty rather than making assumptions or accepting things at face value. Listening and critically exploring uncertain or uncomfortable thoughts and feelings generating when working with a child or family. If you are concerned about asking a question or entering a property, what does this tell you about the risks to/from others to the child?
- Recording: observations, evidence-based judgements and rationale; highlighting any gaps in knowledge or further action required. Use the Assessment/Referral Questions and approved assessment tools to help you.

• Sharing: Consider your assessment as a piece of a jigsaw. What do you/others know that might help you/others to identify and manage any risks? Consider the legal basis upon which sharing is taking place.

203. In this case, no comprehensive single or multi-agency assessment took place.

Term of Reference 3: Key Learning

204. There were missed opportunities to identify and assess risk in this case. The approved multi-agency Early Help child and family assessment tool in Shropshire is the Whole Family Assessment. This tool should be considered as part of an assessment at the earliest point when there are indicators of concern related to risk of harm to a child(ren).

205. There was limited engagement with the individual family members and no engagement with the whole family which would have facilitated a 'big picture' whole family analysis of risk and need. Such an assessment would have included:

- Gathering information from other agencies and other family members
- Full parental history including parents' childhood experiences of abuse, loss or trauma.
- Consideration of who is part of a child's life and whether they are a protective person.
- Routine ongoing analysis of whether risk is decreasing/ increasing/ static particularly paying attention to patterns / capacity and willingness to change.
- Evidence and research including lessons from other case reviews.
- Routinely sharing the outcome of assessments or seeking information about the outcome of assessments particularly when there are multiple vulnerabilities and risks.

Term of Reference 4: The Impact of the Covid Pandemic

How did the Covid Pandemic impact upon Jessica, Lucy and Olivia and any support offered to them?

206. The Covid pandemic and the restrictions on members of the public and professionals will have made it easier for Jessica to withdraw from the view of agencies as many contacts, appointments etc were made electronically during 'lock down' periods.

207. The children will also have been rendered invisible to agencies as they were not attending school, and this increased risks to them. They were known to be caring for their mother and to have been experiencing distress but there is no record of any plans being put in place by school, or their GP, to monitor their safety and wellbeing.

208. There is no record that any support offered to them was negatively impacted by the pandemic, but this cannot be attributed to any cause/ effect as they did not engage with any services before or during the restrictions caused by the pandemic.

209. Additionally, Jessica was clinically vulnerable to Covid because of her health conditions and her weight. It is not clear that she was advised or supported by health

professionals during this time. It may well be that the anxiety relating to the covid pandemic added to her stress and isolation.

210. It is also not clear from agency records whether Jessica and the children had easy access to online resources and was able to use these during lockdown periods for example to attend online meetings, do grocery shopping, seek health information or advice.

Recommendations

211. It is recommended that Shropshire Safeguarding Community Partnership (SSCP) seek assurance that Shropshire's new practice guidance on self-neglect (which includes a section on mental capacity and executive functioning) is embedded in the system and that it is being used by staff across agencies.

212. Partners should ensure that the links between child neglect and adult self-neglect are highlighted and explored in cases where adult self-neglect is an issue.

213. It is recommended that schools are equipped with training and resources to understand the impact of caring for others on children and how that impact may manifest itself in that child's behaviours. Schools also need an understanding of the practical and emotional support that is available to children who are carers.

214. The SSCP should ensure that the assessment process for young carers is regularly re-promoted and that schools are supported to familiarise themselves with their role in the process.

215. Partners should recognise that reluctance or inability to engage to an extent that renders a family 'invisible' must always be considered as possible neglect or as an indication that the family is at crisis point. In this case the children's mother used strategies to actively withdraw from the sight of agencies and this should trigger professional curiosity and concerns.

216. It is recommended that partners review their service, and support offers to children and young people who 'do not engage' and explore what factors could improve engagement. The use of signposting and self-referral should be included in that review.

217. It is recommended that, if possible, the SSCP facilitate confidential and sensitive conversations with family members including the children of the main parental caregiver on how to better address the impact on children of parental illness and disability including obesity.

218. It is recommended that the SSCP ensure that the link between obesity, depression and psoriatic arthritis should be shared amongst relevant health and support professionals and people diagnosed with the condition and be considered in care and support planning including psychological support.

219. It is recommended that practitioners are reminded through supervision and case management processes to undertake a whole family review where there are several risks/ needs to ensure that these risks and needs are not escalating.

220. **Single agency:** It is recommended that children's services review their response to referrals which take place during school holidays and/ or where there is no response to enquiries made to other agencies.

Conclusions

221. This Review has been conducted with the Independent Authors' acknowledgement that supporting families in circumstances such as those experienced by Jessica and her children is challenging. Whilst comments are made about practice and approaches, the Review is focused on a reflective practice approach and recognises the benefit of hindsight. The intention is to support agencies in Shropshire to develop and improve how they work to minimise risk and harm when working with families who share similar challenges.
222. There is no indication that any services, (for example, secondary health care, the school/s or GP) considered Jessica's withdrawal from treatment and support in respect of risks posed to herself or her children.
223. There were significant implications for the children in her refusal of services as they were already caring for her and as her health and mobility deteriorated this increased the level of care she needed.
224. Agencies failed to consider Jessica's mental capacity or her parenting capacity during this time scale.
225. Jessica was not seen by her family or outside agencies for a significant period before her death and there were missed opportunities, as outlined in this report, for professionals to intervene and assess the situation particularly in respect of risks to the children.
226. The children were not sufficiently recognised as carers and their daily lived experience was not explored by professionals. When the children did share details of what their lives were like this did not trigger safeguarding concerns but led to repeated signposting or referrals to other services which did not address the key issues.

Linked Key Learning and Recommendations - Family A and Family B

Think Family Approach

227. There were numerous agencies involved with the families however there was no co-ordinated whole family approach in either case. A Think Family Approach would have enabled agencies to formulate a coordinated plan that addressed the known and unknown needs of the family and to identify and manage risks. The use of a multi-disciplinary team approach and where appropriate, multiagency chronologies would have assisted agencies in understanding the family dynamics and any relevant information, for example parental trauma and health diagnosis, which could have informed plans and decision making.
228. A whole family approach to need and risk would have addressed many of the following learning themes in these two cases.
229. Agencies should promote the use of Think Family Approaches and ensure that practitioners are supported through supervision and training to do so.

The Children's Lived Experiences

230. The daily lived experience of the children in both families was not understood or explored by professionals. They were living in homes which were, at times, unsafe, unhygienic and inappropriate. Their daily needs were not always met by their mothers, and, in the case of Andrew, he was not always kept physically safe.
231. For the girls in both families, caring for severely ill and morbidly obese mothers (and in Family A for a younger sibling with significant needs) meant that their daily lives were difficult, and their mental and physical health and their education were adversely impacted.
232. The voice of non-verbal children, as in family A, is a recurring learning point highlighted within Shropshire reviews. The child's extreme vulnerability meant it was vital that his daily lived experience within his home was thoroughly explored.
233. Agencies must establish the daily lived experiences of all children within families with complex child/ adult needs particularly when children have caring roles. Recommendation.

The Mothers Lived Experiences

234. Agencies did not explore any historical trauma that the mothers had experienced. In each case these experiences will have had a significant impact upon their mental health and wellbeing. There were missed opportunities to explore these, particularly in Ruth's case, therefore there was no understanding of how they affected her parenting and how she engaged with services, given that she was in fear that authorities may have taken her children into care.
235. Daily life for both women was extremely difficult and their serious health conditions and significant weight meant that they could not fully look after their children or manage their home environments.
236. The unhygienic conditions in both homes would have caused them distress and embarrassment so much so that they prevented professionals from visiting. Self-neglect was an issue for both women, and this would have added to their complex feelings about asking for and accepting help.
237. Agencies must take into account the daily lived experiences of parents who have multiple needs and the impact that this has on their parenting.

Engagement

238. There was an inconsistent approach by agencies in engaging and communicating with the families. Agencies did not explore why the families did not respond to communications and the term "non-engagement" was the generally used. Agencies did not differentiate between intentional non-engagement or consider that changes in physical or mental health, daily challenges or anxiety of agency involvement may have prevented them accessing services or attending at appointments. There was an emphasis that this position was due to the family rather than the accessibility of services. There was at times a need for a more creative, determined and proactive approach to engagement.
239. Professionals should work together to maintain engagement particularly at times of increased risk and vulnerability. There should be a recognition between an

intentional decision not to engage with services and where services are unable to engage with an individual.

240. There were occasions when the families were signposted or referred to supporting agencies with an expectation that the family -including the children -should take personal responsibility and a presumption that the family had progressed the referral. Most referrals resulted in minimal support to the families. Agencies should be alert to circumstances where there is a potential that individuals are unable to progress self-referrals and provide the necessary scrutiny and support. A lack of interagency communication around feedback and progression of referrals was also a factor resulting in minimal or no support.

241. Because there was little or no understanding of the reality of life for the children and their mothers the expectation that they would have the capacity and energy to follow through a self-referral was overly optimistic.

242. There should be appropriate feedback and monitoring of referrals by individuals and between agencies to ensure that they are triaged appropriately and acted upon, and where necessary escalate action to ensure appropriate support. Agency use of self-referrals for children should be particularly closely monitored and reviewed.

Visibility.

243. There were numerous occasions and time periods when the families became invisible to agencies. This included declined home visits, failure to respond to communications and non-attendance at appointments. Agencies did not show sufficient determination, curiosity or creativity in establishing contact which would enable an assessment of the family and home conditions.

244. Agencies should consider what arrangements may need to be put in place when there is a reluctance or where services are unable to engage and that this may be an indication that a child's needs are not being met or that risk is increasing. Agencies should be professionally curious when there is a lack of information and communication and offers of support are declined where necessary share this information and escalate concerns.

Young carers.

245. There was information across the system that evidenced that the three girls from both families were carers, but the identification and recognition of this role varied between agencies. There was a failure to respond to their needs as carers and particularly how this impacted upon their mental health and education. There was lack of professional curiosity by some agencies in exploring what their caring responsibilities meant daily and in Natasha's case a lack of challenge between agencies in responding to her as a carer.

Neglect

Parental Assessments.

246. There is no evidence that a single agency or collectively, agencies fully understood Ruth and Jessica's capacity to parent and the extent and complexity of challenges that impacted upon this. There was insufficient assessment pre-existing and ongoing trauma, vulnerabilities and other psychological impacts which affected how

each woman was able to care for herself and her two children, each of whom had their own specific needs.

247. In each case the mothers' health conditions and weight impacted upon their ability to adequately care for their children and this should have prompted consideration of a parental assessment leading to identify support needs and risks.

248. The impact of their serious health conditions and self-neglect meant that the parenting of both mothers was compromised, and the home conditions of both families were of concern. The links between self-neglect and neglect of children is well established and was not assessed or explored in either case.

249. Parenting assessments should have considered the whole family, including the fathers where they were involved.

Information sharing.

250. Agencies identified or were alerted to concerns in respect of both families yet there was a lack of recognition that this information should be shared. Sharing information could have prevented ongoing harm.

251. Sharing the learning from these cases will remind practitioners that sharing (or seeking) information is a vital part of their roles.

Glossary

CSC	Children's Social Care
EWO	Education Welfare Officer
SAP	Student Attendance Panel
PSA	Psoriatic arthritis