Partnership response to the safeguarding adults review for 'Jodie'

Introduction

'Jodie' was a white woman in her early fifties whose decomposed body was found in a wheelchair being pushed by her mother within the local area, following calls of concern by neighbours about smells coming from the property of the registered social landlord managed property they both lived in. Jodie and her mother were very close and had little contact with the outside world, including professionals.

The Safeguarding Adults Board (SAB) commissioned the safeguarding adults review (SAR) to understand why things happened in the way that they did, and what Jodie's experiences tell us about how our systems work. This systems approach focuses on multi-agency professional practice and is not about blame. It is about learning and improving practice for the future.

Response by the Safeguarding Adults Board

The SAB accepts the reviewer's findings and agrees the changes needed to further improve practice.

We acknowledge that Jodie's circumstances span two different legislative processes, before and after implementation of the Care Act 2014. Whilst considering hindsight bias, we recognise that the response to the first set of circumstances had consequences in the second.

The period between 2013 2014 was a time of change. The Care Act received Royal Assent in May 2014 however did not fully come into force until as late as April 2016. In the context of adults' safeguarding there had previously been no statutory legal standing which may have further challenged processes around initial concerns. We will reflect on the now embedded Care Act processes from the most recent concerns in 2022 and onwards to ensure that as a Partnership and wider system we are assured that if a similar set of circumstances were to be flagged that processes are now in place to robustly undertake appropriate safeguarding enquiries.

Good practice is clearly present within the Partnership around safeguarding concerns however this review highlights an absence of professional curiosity within the system which regrettably did not lead to a fully proactive nor holistic safeguarding response.

Following significant work by the Partnership in recent years we have local guidance on mental capacity and a well-developed self-neglect pathway, which is underpinned by a 'don't walk away, walk alongside' approach. This SAR presents an ideal opportunity to further test how robustly embedded into systems this is, in addition to the other learning.

The learning and recommendations from this review are clear, which we commit to taking forward by:

- updating and promoting the local escalation and referral processes
- reviewing Primary Care policy and processes around patient registration as well as 'did not attend / was not brought'
- organising a programme of multi-agency audits, which will include an agreed set of standards
- identifying indicators that will evidence improved practice
- evaluating the current and future improvements being made by Adults Social Care
- scheduling an item for a future SAB meeting to reflect on what has changed since the tragic circumstances of Jodie's death

The detail of the action plan below will be expanded on and reviewed accordingly to gather what difference is being made as a result of this SAR.

Action plan for SAR Jodie			
What needs to change? What is the objective?	*How might this be achieved?*	*By when and by whom?*	*How might we know it's made a difference?*
i. A holistic approach is applied to safeguarding referrals	Resource(s) and / or training are developed that remind practitioners of the importance of the quality of referrals, Think Family and information sharing.	December 2024, Head of Strategic Partnerships, LBWF	Extent of reach to practitioners and those reporting improved understanding
	Further improvements are made within Adults Social Care, particularly around the Adults' front door	January 2025, Director of Adult Social Care Operations, LBWF	Data indicators to be agreed
i. Escalation is seen and used as a valuable practice tool	Review the escalation process	November 2024, Head of Strategic Partnerships, LBWF	Refreshed escalation process that is clear and accessible
	Resource and / or training is developed to promote the use of escalation	December 2024, Head of Strategic Partnerships, LBWF	Extent of reach to practitioners and those reporting improved understanding
ii. Robust processes exist within health for vulnerable adults who are seldom heard	Review health 'was not brought / did not attend' processes for patients who do not attend appointments and the criteria for removing patients and / or closing files	January 2025, Designated Professional for Safeguarding Adults, NHS North East London ICB	Understanding of areas of improvement

Action plan for SAR Jodie			
What needs to change? What is the objective?	*How might this be achieved?*	*By when and by whom?*	*How might we know it's made a difference?*
iii. The extent of improvements to practice around self-neglect are understood and evidenced	A common understanding of audit standards is agreed by partners around inter-agency communications at the point of, and following a referral	November 2025, Head of Strategic Partnerships, LBWF	Agreed set of standards that inform the audits taking place
	Multi-agency audits are scheduled using the agreed set of standards above	December 2024, Head of Strategic Partnerships, LBWF	Audit findings
	Internal single agency audits are planned and organised by Adult Social Care's that will demonstrate improvements and are focussed on the learning from this review, including responses to referrers.	December 2024, Assistant Director for Quality Assurance and Principal Reviewing Officer, Adult Care Directorate, LBWF	• Audit findings • Data which demonstrates appropriate signposting to interventions alternative to safeguarding, such as Early Help.
	Agenda item scheduled for SAB which aims to provide assurances around what's different since Jodie.	June 2025 Head of Strategic Partnerships, LBWF	Actions from SAB