Waltham Forest Safeguarding Adults Board

Safeguarding Adults Review for ‘Jodie’

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Safeguarding Partnerships Work

Strategic Partnership Boards

SAFETY SAFEGUARDING WELLBEING

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1. INTRODUCTION

Waltham Forest Safeguarding Adult Board (SAB) has commissioned this safeguarding adults' review (SAR) as part of its statutory requirement to carry out such reviews as determined by the Care Act 2014. This SAR aims to establish if there are lessons to be learned about improving practice in relation to communications between partners and providing support to practitioners, managers, and leaders in responding to unusual circumstances such as this.

1.1 Why this review is being carried out

1.1.1 Jodie was a 51-year-old white British woman who lived with her mother, Janet in a registered social landlord (RSL) managed property in Waltham Forest. Her decomposed body was found in a wheelchair being pushed by her mother in the vicinity of the local market. This followed calls from neighbours about smells coming from the property.

1.1.2 The SAB commissioned this independent review to explore and establish what improvements can be made to how partners work together, particularly how agencies communicated with each other and escalated concerns in the period before her remains were found and also in relation to how they worked together to respond.

1.2 Scope

1.2.1 This is a review of what is known about Jodie with a focus on the recent history and includes reference to historical information. The initial intention was to only look back up to three years before Jodie's remains were found. Given the limited information on record during that time there was a need to review historical information about the family's involvement with services in 2013-2014. Pseudonyms have been used for both mother and daughter to maintain anonymity.

1.2.2 This SAR aims to add value to learning already underway as a result of the information and analyses that arose from the initial discussions through the One Panel[1].

1.2.3 There is a focus on Adult Social Care (ASC) in this report reflecting the review's findings.

1.3 How this review was carried out

1.3.1 The reviewer commenced by carrying out a desktop review of the available records relating to partners' recent involvement with Jodie and Janet prior to Jodie's remains being found. This extended to just three agencies and the discussions that had taken place within the One Panel as follows:

London & Quadrant (L&Q) Housing[2]	• Briefing note to One Panel • Internal Serious Case Review report
Metropolitan Police	Referral to One Panel

[1] One Panel is the local mechanism for how decisions for statutory reviews are determined.
[2] Registered social landlord and housing provider.

Waltham Forest Council	• Briefing note to One Panel • Adult Social Care (ASC) chronologies and accompanying narratives for Jodie and Janet • ASC papers submitted to the Coroner
Other	Minutes of the One Panel (x 2 meetings)

1.3.2 A Review Group was established that comprised the partners above as well NHS North East London Integrated Care Board (NEL ICB) and North East London Foundation Trust (NELFT, who are adult mental health providers subsequently involved with Janet). The review group acted as a point of reference for sense checking this report as it progressed. The desktop review was followed by a series of meetings held with representatives from the following agencies:

- The Independent Chair of the SAB
- Head of Service, L&Q Housing
- Lead officers in Adult Social Care, Waltham Forest Council
- Meetings were also held with two psychiatrists who assisted with providing insight around Janet:
    - Consultant Liaison Psychiatrist - Psychiatric liaison team, King George Hospital, Acute and Rehabilitation Directorate (Mental Health Services)
    - Consultant Old Age Psychiatrist - Associate Dean for Undergraduate Medical Education, Honorary Clinical Senior Lecturer (Older Adults Mental Health Team)

1.3.3 On reviewing the documentation provided, the following constraints were immediately apparent. It is therefore not possible to:

- determine the cause of death because the remains were decomposed to such an extent that a postmortem could not be conclusive.
- establish a detailed account of how Jodie lived in the years before her death as there is so little known about her. Her voice is consequently not directly heard.
- come to any conclusions about how Jodie lived or how she died.

1.3.4 Partners involved in this review demonstrated appropriate understanding and compassion about Jodie's mother, Janet. The focus of this review needs to be on Jodie but there is scant evidence about her life and her views, much of which is told through the voice of her mother, Janet and added to by professional records.

1.4 Family input into this review: Janet's views

1.4.1 In considering the input by family to this review, namely Janet, the reviewer was concerned that no further harm to her should result from this. Janet's clinicians (two psychiatrists) and their teams who have been supporting her together were consulted to provide advice on her capacity to contribute to the review. They have established a positive rapport with her, and they are gaining her trust. Janet has indicated to them that she would like to contribute to the coroner's inquest and would do so by writing a statement with their help and support. Writing this statement and working with Janet to establish her version of events is a highly skilled area of work. It seems that she has not provided detailed information about events yet and finds it very difficult to do so. There is consensus that this effort should only be made once, avoiding unnecessary duplication and emotional upset for Janet.

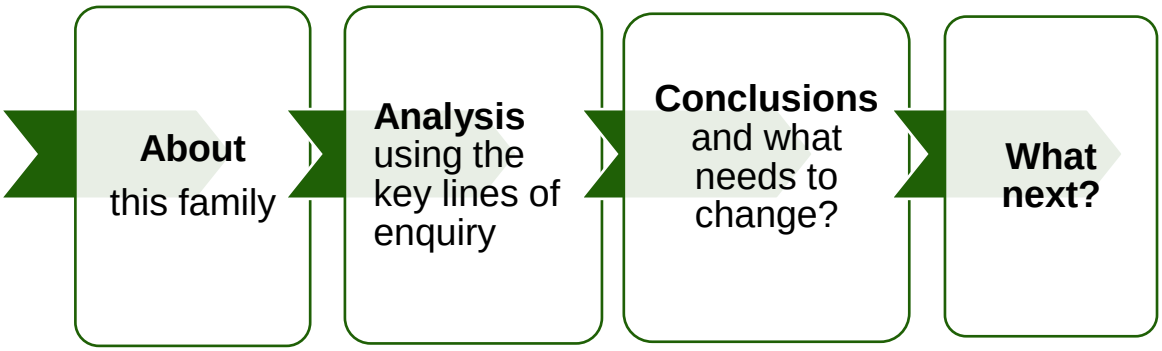
1.4.2 Both clinicians who continue to provide highly skilled care and support to Janet were of the view that the author meeting her directly would not be helpful to Janet, nor to this SAR process.

1.5 Principles of this review

1.5.1 This review aims to establish if any improvements need to be made about how partners work together, putting the needs of the person(s) at the centre.

- The process aims to ensure sufficient rigour and transparency to get to the point of learning.
- Learning should have demonstrable impact on practice.
- It aims to pursue learning without blame or judgement but with accountability.
- Only information relevant to learning and service improvement is assembled and analysed.

1.6 Structure of this report



This report has been structured around the key lines of enquiry agreed by partners as below.

Key lines of enquiry
One: What do we know about this family?
Two: How robust were the responses to the safeguarding concerns?
Three: Are there lessons to be learned about systems wide approaches to helping the community to know what to do if they are concerned about vulnerable people in their neighbourhood?
Four: Dealing with the out of the ordinary: Are there improvements to be made in how partners work together to respond to out of the ordinary and unexpected events? How do partners support each other when there is a concern that is difficult to define and express but is nevertheless extremely worrying?

2. KEY LINE OF ENQUIRY ONE: What do we know about this family?

2.1 About Jodie

2.1.1 Jodie was a white British woman, in her early fifties, who was living with her mother at the time of her death. It seems that they were very close and appear to have had a co-dependent relationship. She was a vulnerable adult who relied on her mother for physical and emotional care and support. In recent years she was known to have been a wheelchair user. It is not known whether she lived with her parents throughout her whole adult life, but we know that she was living with them at the time of her father's death, which records indicate was in 2010 when she was aged 39.

2.1.2 Jodie lived in isolation from the world around her and so it is difficult to fully establish the type of person she was, her likes and dislikes etc. The author has reviewed available records to establish what can be learned about her experiences. Most of the information has been acquired from the Adult Social Care (ASC) records which document the contact she had with them between April 2013 and June 2014. Also, in the lead up to the discovery of Jodie's remains, two referrals relating to the family were made to ASC, one in February 2023 and one in October 2023.

2.1.3 For the purposes of gaining insight into her life and experiences, a narrative summary, with Jodie positioned as the central figure, is provided below, relating to what is known about her when she was alive.

2.1.4 When her father was alive, he had been paying rent from his benefits to a private landlord. After his death, Jodie's mother, Janet fell into rent arrears due to a reduction in her benefits. Her landlord contacted ASC in April 2013 as he was concerned that Jodie and Janet were "burying their head in the sand" about the debts and he felt they were vulnerable and needed help as he was going to have to evict them. After several futile attempts to contact the family, the case was closed in July 2013 by ASC, however that decision was reversed just three days later when reviewed by management, with renewed efforts to make contact.

2.1.5 Jodie was evicted with her mother from their home on Friday 18 May 2013 and they became homeless. Janet contacted ASC and a local Councillor, who was the Cabinet Lead for Housing, also sought help for them. At first, the family were offered hostel accommodation, which Janet felt was unsuitable as it was on the first floor with no wheelchair access. Upon contact by Janet with ASC, appropriate hostel accommodation was urgently found. In May 2013 a reference is made to Janet which stated that she "*may not be in the right frame of mind to care for Jodie her daughter".* But there is minimal additional reference to this, nor any further exploration of the concern raised.

2.1.6 They soon became threatened with eviction again as they did not have formal identification papers, such as birth certificates etc. and the new landlord was concerned that they could not prove their eligibility. ASC supported them with this. Records from that time indicate that they had also had no contact with their GP for the past five years and had been removed from the GP patients' list. ASC supported them to re-register with a GP. The coronial investigation indicates that Jodie was not registered with a GP at the time of her death.

2.1.7 In 2013, Jodie was described as “unkempt” and there was concern about her and her mother needing support. She did not speak much, with her mother talking on her behalf. There is a reference on the records to Jodie indicating that “I will like my mother to be involved in any decision relating to my support plan.” An occupational therapist suspected that the relationship was “co-dependent”.

2.1.8 In January 2014, an “assessments and options officer” from the Council’s housing department said the following:

“As I have mentioned to you previously, there appears to be safeguarding concerns relating to this family, in particular Jodie, who appears to be under her mother's control. Although she herself is an adult, it is quite clear that Jodie is too vulnerable to be looked after by her mother, who I also feel has vulnerability issues herself. This is now leading to a situation where Jodie is not getting the correct attention she requires medically and possibly, psychologically too.

and

“I feel if Jodie could be separated from her mother, even temporarily so that she could be assessed fully, it would prove much beneficial for her, and she could then start to receive the adequate attention/ treatment.”

Jodie and her disability

2.1.9 Jodie’s medical condition was described in the ASC records as “severe arthritis” in one knee although she did not have a formal medical diagnosis then. An advocate had found a wheelchair for her, and it appears she used this for the rest of her life. Due to the weakening of her leg muscles, Jodie required assistance to have a shower or bath which her mother supported with. She also needed assistance to transfer between her wheelchair, bed, chair and toilet etc. She was able to use her upper body, however due to her physical condition, she had poor standing tolerance, so seemingly sat on her wheelchair all day.

2.1.10 Jodie was able to follow instructions given to her and she could keep herself occupied independently by watching TV, listening to music, and chatting with her mother. ASC records describe Jodie as needing regular support with leisure activities to maintain her psychological and emotional wellbeing. Her mother said at that time that she regularly pushed Jodie to the local park and around the hostel area for sightseeing. Her physical condition and the potential risk of burning herself meant that she required assistance with preparing her main meals. Jodie had shared that she did not have cooking skills as her mother prepared all her meals.

2.1.11 Following her death, initial information by the coronial investigation indicates that “*she was diagnosed with ulnar deviation of her hands in February 1999. An x-ray was performed at that time which reportedly showed severe osteoporosis. Subject to the limits of the autopsy, which was impaired by the fact that Jodie was found in a heavily decomposed state, profound physical co-morbidity in life was evident. Jodie was observed to be suffering from severe kyphoscoliosis affecting the spine and her hands were confirmed to show ulnar deviation with apparent nodules over the metacarpophalangeal joints. Each of these conditions would be painful and life-limiting and would likely be obvious to an observer”.*

2.1.12 This supports ASC’s observations in 2013 that she suffered from poor mobility and was unable to walk on her own. The social worker at the time felt that she required medical intervention as she appeared underweight and unwell. At that time, Jodie was not getting any welfare benefits. Her mother indicated that she had made several applications for disability living allowance and her applications had been declined. The social worker

advised that a report from the GP should accompany the application. It was noted that Jodie also had a deformation of her hand which was clearly visible around her thumb.

2.1.13 Jodie's overall physical presentation was summarised in the records as follows:

2.1.14 "*Everything physical about her was thin, slight, weak and white".* This suggests a certain vulnerability and dependency which was identified in 2013.

2.1.15 An e-mail exchange in the records in January 2014 between the housing officer and social worker describes how Janet and Jodie had agreed to go for blood tests with the GP. Janet had indicated that this was done but in fact later said that she had lied about this as Jodie was needle phobic and did not want to go through with it. *(The records provided to the author did not reflect the involvement of the GP/Primary care. The response and role of primary care was not explored further as this was not directly related to overall learning. This is referred to below in paragraph 7.4.1)*

2.1.16 In the same e-mail, a reference to Janet is made by the housing officer indicating that "*our requests are becoming too much and therefore she and Jodie may be moving away as Jodie cannot cope with our intrusions. I fear if this happens, this family will disappear where Jodie's well-being will be at risk."*

2.1.17 Jodie and Janet were re-housed to permanent accommodation in April 2014.

2.1.18 Legislation and safeguarding protocols have significantly changed since then, but according to the process used at the time Jodie's needs were considered to be "substantial" and a clear reference was made indicating that she was eligible for social care provision, was a vulnerable adult and plans were made to carry out a detailed assessment.

2.1.19 The offer of support from ASC continued. A detailed assessment was not completed as many attempts to contact Jodie by phone and letter had no response. A phone call made in February was recorded as involving both Janet and Jodie, but the record makes no reference to Jodie's voice, only that of Janet. A letter was sent encouraging Jodie to make contact if she needed support.

2.1.20 The case was closed to ASC in June 2014. There was no contact with the family until the more recent developments in 2023 and these are described below.

2.2 About Janet

2.2.1 At the time of the tragic events in November 2023, Janet was a 77-year-old white British woman. She had cared for her disabled daughter for many years, probably all her daughter's life.

2.2.2 As Janet and Jodie had so little contact with the outside world, there were no professionals who knew them well throughout the period of this review. The author met with the psychiatrist who assessed her when she was first admitted to hospital following the discovery of her daughter's remains as well as the psychiatrist who is currently supporting her. The author's intention was to establish if there are any clinical factors that could impact on her behaviours and her response to her daughter's death but also to learn about her as a person. These meetings established a range of factors that are likely to have impacted on Janet at the time.

Physical ill health

2.2.3 Following the incident, police escorted Janet to hospital. When first admitted, Janet was very unwell with a range of physical medical problems:

- Extremely low thyroid levels. Her psychiatrist advised that very low levels of the thyroid hormones can lead to psychosis.
- Bladder infection.
- Very ill at one point with respiratory symptoms and doctors thought she may have a clot in her lung. At that time this was considered very serious and possibly life-threatening.
- Very large tumour in her brain (which is considered benign). One psychiatrist indicated that it was probably occupying about 20% of her brain space. Whilst it is not unheard of for tumours this size not to produce symptoms, it is a factor that needs to be considered. The author is not qualified to advise on this. The psychiatrist has suggested the possibility that this affects her sense of smell.
- Consistently low cognition score, suggesting that she may have a learning disability.
- Heart problem - aortic calcification
- Spinal deformity

Emotional wellbeing

2.2.4 Upon arrival at the hospital, Janet was not happy to be admitted. She was considered to lack capacity to consent to treatment, so was admitted under section 136 of the Mental Health Act. Soon after, she accepted that she needed to be treated and the need for this section was rescinded.

2.2.5 In reference to her mental state, her psychiatrist described her as “blank and unresponsive”. She seemed completely detached from reality and did not want to talk about Jodie. Later, when she did feel she could talk about her, she referred to her as though she was still alive, in the present tense. Her psychiatrist believes that she has recently begun to accept that Jodie is now deceased, but she still finds it very difficult to talk about and has not yet spoken about the events surrounding the death. She becomes very tearful occasionally.

Physical hygiene

2.2.6 When she was brought to hospital, she was very dirty, with faeces and urine on her body and clothes. She brought with her bags with clothes in them that had a putrid smell. A diagnosis of “Complex Grief Reaction” was made initially at this point as it was the most likely diagnosis, given the complex circumstances.

Janet’s treatment in hospital

2.2.7 The psychiatrist had to consider several issues in the deferential diagnoses. It was important to provide her with the highest standards of care and kindness while, at the same time, being mindful of the possibility of dementia and depression versus a potential homicide. Given these circumstances and the possible threat to others, early on in her hospital stay, she had to have one to one care.

2.2.8 Her psychiatrist occasionally asked direct questions which were challenging for her. At one point, he asked her about why she had not given Jodie a dignified funeral if she loved her so much. She responded by saying that “she couldn’t do that to Jodie”. She said that she

just couldn't part with her. She did not know that it was a crime not to report the death. When asked "Did you do anything "(to respond to the death) she made the same reply. She could not part with her daughter.

2.2.9 As part of the forensic interview the psychiatrist asked about how she knew her daughter was dead and she said, "because she was not breathing". It seems that she had given the same reply when asked the equivalent question about her husband. Janet would not talk about her past life or history, so it has been difficult for clinicians to get to know her fully or understand her clinical history.

2.2.10 When investigating her bladder problems, a scan showed that she does not have a uterus so at some point, she must have had a hysterectomy. She told the doctors that it happened about 20 years previously.

2.2.11 The psychiatrist also considered whether she has a personality disorder or some sort of psychopathic disorder as she seemed to have a lack of remorse or guilt and was so detached about the tragedy, however that remains inconclusive.

2.2.12 The psychologist is getting to know her and trying to establish information about her past life and building a picture which is in turn supporting Janet with the statement she wants to provide to the Coroner.

2.2.13 Janet has mentioned that she had a difficult childhood and has referred briefly to a sister, but she has lost touch with her and does not know where she is. She has had no visitors. At one point she said she has no friends, but when asked about what she does at Christmas, she said she "has friends over". She does not have a mobile phone.

2.2.14 Several multi-disciplinary teams worked together to treat her various clinical conditions. On the ward and having been medically treated she was managing basic life skills very well and very much appreciated the care and support she was being provided with. She did not want to return to her past living circumstances.

2.2.15 The neurosurgeons have decided to manage the tumour conservatively due to the clinical risks of surgery.

2.2.16 Jodie's funeral took place whilst this review was being produced. It is understood that Janet did not attend because she did not wish to remember her daughter in those circumstances.

2.2.17 Janet is now living in a care home in a neighbouring borough and is settled there. She is happy and well, seems lucid and engages well in conversations.

2.3 Analysis of what we know about this family

2.3.1 Historically the interventions in 2013-2014 were responded to swiftly, appropriately attending to the urgent imperatives, in terms of housing, birth certificates, registering with a GP and help getting the right benefits.

2.3.2 One of the safeguarding partners suggested that there was a need for safeguarding and described concerns about the relationship between mother and daughter and concerns about the mother's ability to care for Jodie, even suggesting they be separated temporarily

to focus on each of their needs. This concern was dismissed in favour of continuing as planned.

2.3.3 For this period of time, responses were swift, but they were not robust enough. The view from a partner about safeguarding was not considered carefully and there was no curiosity about why Janet and Jodie ended up homeless with a need for urgent help to stay off the streets.

2.3.4 Jodie's need for a wheelchair and the family's acceptance of it did not follow an assessment by a medical professional. It is not clear if she really needed one at that time. It is possible that the wheelchair made her more dependent on her mother and possibly led to further loss of her mobility, but no conclusion can be drawn about this as an assessment was not completed.

2.3.5 It is clear that Jodie's voice was not sufficiently represented in the months leading up to the case closure in May 2014 and an opportunity was missed to provide long term support. The final telephone conversation before case closure in 2014 was recorded as being with Jodie and Janet, but there is no record of Jodie's voice in this call, only Janet's, so the case was closed without Jodie's input and without persistence in checking her situation with her directly. In 2013-2014, a person described as vulnerable and in need of assessment was not followed up with sufficient rigour and concern.

2.3.6 While the review of these documents validates that the initial involvement of ASC in 2013 was in relation to finding them a home, supporting them with birth certificates and registering with a GP, a housing options officer clearly indicated safeguarding concerns in an e-mail in January 2014 to the senior occupational therapist. She was able to express concerns about Jodie as "*under her mother's control"* and Jodie being too vulnerable to be looked after by her mother, who she felt had vulnerability issues herself. This officer very clearly expressed that she was concerned that this was leading to a situation where Jodie is not getting the correct attention she requires medically and possibly, psychologically too.

And

2.3.7 *"I feel if Jodie could be separated from her mother, even temporarily so that she could be assessed fully, it would prove much beneficial for her, and she could then start to receive the adequate attention / treatment."*

2.3.8 In response, the senior occupational therapist dismissed the safeguarding concerns and emphasised the need for an occupational therapist assessment and to help the family with benefits.

2.3.9 The safeguarding concern was not taken seriously. So, while it is true to say that no safeguarding referrals were made in this period, there was at least one professional who had a safeguarding concern about these two very vulnerable adults, and this was dismissed. This means that what happened in 2013-2014 was about more than just form filling and finding them a home. Housing was the most urgent need and imperative. This was probably the only opportunity to understand the needs and vulnerabilities of these two adults. This was a "reachable moment" when Janet came to ASC for help and was co-operative and receptive. The observations made about Jodie as "*Everything physical about her was thin, slight, weak and white"* and the concern about her health, having no GP, and

the housing options officer's views that these vulnerable adults needed safeguarding were not incorporated into the response provided.

2.3.10 In 2013 the Mental Capacity Act 2005 had been enshrined in legislation for eight years and was promoted across local authorities in the UK as the key instrument to help practitioners to navigate how to approach clients making decisions that might put them at risk or compromise their welfare. One of the basic assumptions in the act is that a person has mental capacity unless there are any indicators to suggest that they may not have.

2.3.11 The response did not prompt consideration of whether Jodie or Janet had mental capacity to make decisions about whether to accept or decline services. The opportunity was lost. It prompted an occupational therapy assessment which did not take place as the family withdrew soon afterwards.

2.3.12 There is no evidence presented to the author to demonstrate that consideration was given to why Janet and Jodie were in the predicament of finding themselves homeless in 2013 and in need of urgent help. Their previous landlord had referred them to ASC as he was concerned that they were in denial about the mounting debts and were vulnerable. It seems that the prospect of street homelessness was upon them both before they sought any help at all, suggesting a lack of foresight or consideration of the consequences of not making the right decision to find help. This suggests a deeper and more complex problem and the possibility of a compromised mental capacity which was not looked in to at all.

2.3.13 It would appear that decisions by this family were largely made by Janet. She was clearly unable to make a timely decision to find help to prevent her and her disabled daughter from becoming homeless in 2013-14 and this suggests that more enquiry about the root cause of their dilemma should have taken place then.

2.3.14 Processes and partnership arrangements have changed since then. The Multi-Agency Safeguarding Hub receives concerns and filters and prioritises them using an agreed rating system. The author has been informed that they have been further improved since this tragic event. The Care Act 2014 is a well-established legal framework, and the principles of Making Safeguarding Personal should be well embedded in practice.

3. KEY LINE OF ENQUIRY TWO: How robust were the responses to the safeguarding concerns?

3.1 While safeguarding concerns were evident in 2013-14, this line of enquiry relates to the period of time between August 2022, when concerns started reemerging and November 2023 when Jodie's remains were found. Below follows a summary of the events occurring during this time to help inform this aspect of the analysis.

3.2 The period August 2022 – November 2023

3.2.1 Concerns leading up to the tragic discovery began on ***17 August 2022*** when the housing provider gas team carried out a routine check at the property and shared concerns with the appropriate managers. This was about "*the condition of property from gas team, dirty home and resident looks like she is not looking after herself*".

3.2.2 He stated that the flat was filthy and there was a very bad odour. He also mentioned that the tenant is approximately 80 years old and seemed unable to look after herself and her clothes had brown stains on them. Janet was actually 76 years old at that time.

3.2.3 There followed numerous unsuccessful attempts by the housing provider to visit, including an attempt to make a "welfare check" visit. They closed down the concern in September 2022. There is reference in the records indicating that Janet had been seen and had said that all was well and there were no concerns. There are no details about where or when she had been seen or whether Jodie had been seen as well.

3.2.4 ***In February 2023*** a safeguarding referral was made by the housing provider to ASC. This related to Janet and concerns about self-neglect. In the narrative reference is also made to her role as carer for Jodie. ASC responded by telephoning Janet with an offer of a home visit. Janet declined, indicating that they are managing well and do not require services. The case was closed at that point. ASC records indicated that they had contacted the referrer to feed back the outcome.

3.2.5 The ASC records describe this referral as follows:

"Referral received in Feb 2023 by (housing provider). The main resident; the mother (Janet) was spotted by the Caretaker earlier on walking around the estate looking like they had soiled themselves. They also showed signs of distress as well as there being an alleged smell coming from their property. The resident has a middle-aged disabled daughter. The resident also is elderly. It's possible that the burden of social care / responsibility for their daughter could be having an effect on their mental well-being. Contact was made with Janet and her daughter, advised that the daughter is independent with personal care, and they manage between themselves, intervention declined and given info and advice. Referrer was updated. Case noted on daughter's records too".

3.2.6 ***On 20 October 2023,*** a safeguarding concern was again made by the housing provider as there were further concerns around the condition of property, smells coming from the property and self-neglect raised by caretaker. The neighbourhood housing lead had visited the day before with another officer and spoken with Janet. This appears to have been a doorstep conversation. Janet claimed not to know anything about the smells. The officers did not identify any concerning smell during this visit. Janet said it was just her and her daughter there and that they were fine. The officers asked her about Jodie's welfare and Janet reiterated that they were fine and needed no support, after which she went back inside and closed the door.

3.2.7 The referral described Jodie as a vulnerable resident in a wheelchair. It also stated that a friend had seen Janet defecating in the garden. This concern identified Janet as a heavy smoker and the smoke was in the communal hallway. It also described Janet as putting out black sacks late at night which had maggots in them and there was a complaint about dead flies in the communal area. The caretaker believed that the flies came out of their black sacks and said that Jodie had not been seen for some time. The housing provider continued to attempt to see Janet and planned to attempt to take photos of the inside of the property, but this did not transpire. The caretaker reported that he had found dirty marks outside the property.

3.2.8 There was no response to this referral. ASC records indicate that this was "BRAG"[3] rated as green and should be responded to within 72 hours. The referral described the following concerns:

"*I was asked to contact this resident due to complaints of severe smells of faeces and urine emanating from the property. There were reports of lots of flies in the building a few months ago, leading to one of the other residents to prop the rear entrance door open to help with the flies and smell. This however makes everyone in the building at risk of intruders. When I knocked, Janet answered the door. I explained why I was there, but Janet was shocked as she could not smell anything, had no complaints or support needs, and tried to shut me down. She mentioned living there with her daughter. I asked how she was and if there was any support we could offer but Janet said they were fine and went back inside. After speaking with the caretaker on site it has become apparent that there have been issues of smells and faecal matter dispersing into communal areas whereby our caretaker cleans this up. He states he has been inside the property and the conditions inside are reported to be bad, Janet often has faeces on her clothes / shoes. I was unable to gain access on my visit yesterday and will note her clothes appeared clean. Our caretaking manager who has an office near knows the majority of the residents in this building as it is fairly new. He commented that he has not seen Jodie for about 6 months now. Jodie is a disabled 52-year-old lady living with her mum. When they first moved in, Janet would take Jodie out multiple times a day, she is Janet's everything. I was unable to see or speak to Jodie on my visit. I will note the only smell I got was very strong stale cigarette as soon as the door opened. I spoke with the reporting party who claimed the smell is horrendous first thing in the morning. Our main concerns are for Jodie's welfare and the living conditions of this mum and daughter".*

3.2.9 ***On 3 November (2 weeks later),*** the referral was "chased" due to the lack of response.

"I attended a welfare check regarding reports of severe smells emanating from the property. Whilst there the tenant of the property spoke with me briefly stating there were no concerns, it was just her and her daughter, and they were fine. I asked if we could offer any support and about the welfare of her daughter, Janet declined and closed the door. After speaking with the onsite caretaker, he, (the caretaker) advised that Janet would often be seen pushing Jodie around the estate in her wheelchair however, he has not seen Jodie for about 6 months. Jodie is 52-year-old disabled wheelchair user. Attempts to raise a safeguarding to Waltham Forest Local Authority, on 20/10/2023. We at L&Q would like our concerns regarding the lack of response to our correspondence noted".

3.2.10 This escalation of concern was noted in the ASC records. It was not responded to.

3.3 7 November 2023

3.3.1 A wellbeing visit was arranged by the housing provider for 7th November and two officers went to visit the property. A letter was sent to Janet advising her of this visit. On arrival, they knocked on the door. Janet told them that Jodie was bathing so they couldn't see her. They waited outside as they felt something wasn't right and Janet came out to see why they were outside the property, but still wouldn't let them see Jodie. She then exited the property with the wheelchair, saying she was taking Jodie to a medical appointment. During this time the officers were making calls to several agencies, who at that stage refused to come out as it was a "mental health issue". The housing officers started following Jodie, and phoned the caretaker to ask him to check the property as they thought Janet had a doll, rather than Jodie in the wheelchair, and they knew Janet had left the flat door unlocked. The caretaker confirmed that Jodie wasn't in the property. Jodie was then reported as a missing person,

[3] BRAG is a colour coded risk rating system and stands for blue, red, amber and green

and the police and ambulance service agreed to attend. The officers followed Janet for approximately 45 mins to a nearby outdoor market. The emergency services, ambulance and police then arrived where they discovered a very decomposed body in the wheelchair, wearing a wig. The housing officers provided statements to police. The property was subsequently taped off and Janet was taken to hospital.

3.3.2 Police officers have reported that the body was just “bones” and in their opinion Jodie had been dead for a long time, and it was unlikely that they would be able to establish cause of death. They have also reported that when Janet’s husband died his body was concealed for two days.

3.4 Analysis of the response to safeguarding concerns

3.4.1 The missed opportunities in 2023 echo those in 2013-14. In relation to the concerns raised by the housing provider, it could be argued that a safeguarding referral should have been raised earlier, back in August 2022. The housing provider’s serious case review has identified this, and new training and protocols have been introduced to address this.

3.4.2 Referrals / concerns in 2013 and 2014 were largely about Jodie as the subject and those made in 2023 were about Janet as the subject. In each case, the focus from ASC was on the subject individual with not enough reference to the relationship each had with the other and the impact of that dynamic on each. The voice of one professional referenced a co-dependency, a need for safeguarding and a view that they should be separated for a while went unheard. Another referred to Jodie’s needs as not being met by her mother.

3.4.3 The author has learned that ASC have recently been concerned about the quality of referrals in general. This may be a valid concern and should be followed up with regular awareness raising and audit, but it does not explain why the information shared did not generate further enquiry.

3.4.4 The author was also concerned about the referrals made in 2023 which were about Janet. The first referral, in February 2023 did not appear to be responded to with sufficient rigour and enquiry. The case was closed following a phone call to Janet who said she did not need any support. There is no record of an enquiry being made about other family members and no enquiry made into the family history. The concern was shut down too quickly, following a telephone conversation.

3.4.5 As this key line of enquiry largely falls within the remit of ASC, the author has been keen to establish which aspects of practice have changed since Jodie’s remains were found, particularly how alternative views are heard, respected, and considered today. In addition to the scrutiny of the available records, the author met with senior officers in ASC to understand the reflections that have taken place since these tragic set of circumstances and what is now being done differently to prevent this happening again.

3.4.6 There have been reflections by ASC on the positive work carried out in 2013-2014, when a lot of effort was made to see Jodie and she said that she just wanted to stay with her mum so at this time Jodie’s views were considered in 2013 with the exception of the point of case closure. ASC senior leaders described common misconceptions of the role of ASC such as the common assumption that support is provided to all adults with disabilities. They also

described the limitations on them when consent is not provided in the context of the assumption of mental capacity.

3.4.7 Consent should not have been a barrier to the referral made in February 2023, when a telephone call made to Janet resulted in case closure. The referral contained essential information about Janet's carer role and Jodie's disability so more effort should have been made to explore these concerns and consider safeguarding and mental capacity issues.

3.4.8 Furthermore, if there are concerns about neglect and / or self-neglect, then individuals should be seen before cases are closed, as telephone contact cannot determine the extent of concerns.

3.4.9 There were safeguarding concerns and there were indicators to suggest that mental capacity may have been compromised and these issues were overlooked. ASC own records indicate that these issues were, in fact, known at the time of the referral in February 2023 and were not considered.

3.4.10 In response to the referral made on 20 October 2023 and "chased" on 3 November 2023, ASC wholly agree that their response was too slow. In fact, there is no evidence of any response to this referral on the records reviewed. There appears to be some confusion as to how escalation is defined and identified. The housing provider "chased up" a referral they made and completed a "professional concerns" form. They wanted to formally record with ASC that they are concerned about the lack of response. There is no record of a response to this concern on adult social care records. Whether it was specifically articulated as such or not, the contact made by the housing provider on 3 November 2023 was, in fact, escalation and an immediate response should have been made. The escalation process should not be constrained by the prescriptiveness of processes and protocols. Human dialogue should have taken the place of bureaucratic procedures.

3.4.11 Paragraph 4.3.9 of the London Safeguarding Adult procedures, dated April 2019, provides guidance on this. At the time of writing, these procedures are being revised. However, the current guidance is sufficient to support staff who are concerned about a case not being responded to appropriately.

3.4.12 The serious case review undertaken by the housing provider refers to advice they sought from the safeguarding adults' manager. They were concerned that the safeguarding manager gave the "wrong" advice. Their report indicates that "*The response from the specialist worker was very brief; 'yes please'. No offer of further advice or guidance".*

3.4.13 ASC records provided to the author contain only the completed professional concern form and there is no written documentation of this advice being given in those records.

3.4.14 ASC indicate that they have reflected on practice and acted on those reflections. They acknowledge that historical information could have been checked and that reference to Jodie as a disabled adult, cared for by Janet and referred to in the referral in October 2023 should have been considered as significant, particularly in relation to the inextricable links between mother and daughter.

3.5 Changes made in the last year within Adults Social Care

3.5.1 The author has been informed of a number of operational changes that have been implemented since Jodie's remains were found that are improving practice:

3.5.2 *Quality of referrals*

- It is now standard practice to contact referrers directly to gather further context to better inform the assessment and risk rating.
- The referral form is in the process of being updated, requiring greater detail to inform decision making.

3.5.3 Responses to safeguarding concerns are swift and robust

- A new 'best practice summary' template has been developed that enables the practitioner to capture all the relevant details needed to conduct a robust assessment of the concern. (*A series of headings prompt the practitioner to cover particular aspects of Care Act compliant practice, including mental capacity*.)
- Management will review and sign off the best practice summary, all sections of which must be completed and evidenced.
- ASC now have access to NELFTs electronic recording systems.
- The person's / family's history is reviewed on both ASC and NELFT's electronic recording systems (Mosaic and RIO) as part of the best practice summary.

3.5.4 Timely risk assessments take place in relation to decision making

- BRAG rating is undertaken by a manager.
- Where there is another vulnerable adult in the home the concern is now automatically BRAG rated as amber and will proceed to a section 42 initial enquiry which necessitates a 24-hour response.

3.5.6 Persistence and curiosity are used to reach a person directly and third-party refusals of services are not accepted

- A 'request for support or protection' (RSP) is raised for any other vulnerable adults or children in the home at the point of the referral coming in and both records are linked to each other on the electronic recording system.

3.5.7 Escalation is appropriately responded to

If any referral is 'chased up' by the referrer, the duty manager is informed and will review the case to check if any of the timeframes are in breach and re-BRAG if necessary.

3.5.8 Working better together with partners

- Joint visits are being more proactively offered.
- When feeding back 'no further action' to referrers, they are offered alternative means of support such as Adults' Early Help and the Team Around the Person Network[4] etc.

[4] This is a peer support forum that was established (following a previous SAR) to support practitioners with finding solutions for individuals who need support but do not meet the thresholds for ASC.

3.5.6 ASC indicate that they have already reflected and acted on these issues and understand the importance of the findings of this review. Whilst changes have been made that would appear to make safeguarding responses swifter and more robust, there remains a need to test this and gather assurances that the relevant procedures and processes, including escalation are clear and accessible to all staff working with adults who may need them.

3.5.7 Regular multi-agency audits, using standards agreed by partners, should be urgently carried out to determine the extent of improvements indicated and to verify that they are well embedded into practice. These should be scrutinised by the Safeguarding Adult Board.

3.5.8 Adult Social care should also assure the board that regular internal single agency audits are demonstrating improvements and are focussed on the learning from this review. For example, if cases do not meet the criteria for social care intervention or safeguarding, and the processes have changed to ensure alternative help is advised, audits need to demonstrate that this is indeed the case. Data should be provided to establish the proportion of such cases that lead to interventions alternative to safeguarding, such as early help.

4 KEY LINE OF ENQUIRY THREE: Are there lessons to be learned about systems wide approaches to helping the community to know what to do if they are concerned about vulnerable people in their neighbourhood?

4.1 Janet and Jodie's neighbours made complaints about the bad smells. The caretaker took appropriate steps to inform his line management about concerns and the housing provider was appropriately concerned and acted. Their experience must have been challenging and traumatic. There was concern about Jodie and Janet. There is not much more that they could do to try to draw attention to their concerns.

4.2 The case does beg the question about our community in general and whether public health bodies and safeguarding partnerships raise awareness in our local communities so that they know what to do if they are worried about a neighbour. This is tangential to this set of circumstances, but it could be considered by safeguarding partnerships working with public health.

5 KEY LINE OF ENQUIRY FOUR: Dealing with the out of the ordinary

Are there improvements to be made in how partners work together to respond to bizarre and unexpected events? How do partners support each other when there is a concern that is difficult to define and express but is nevertheless extremely worrying?

5.2 The housing provider officers are receiving appropriate support from their organisation to help them recover from their traumatic experience. They made several calls on the day of the discovery which did not result in any help. They were alone and isolated, dealing with a terrifying situation. When they made the visit, they sensed there was a serious problem and persisted by following Janet when she was pushing the wheelchair. They had the good sense to ask the caretaker to check the property to see if Jodie was there and the caretaker

confirmed that she was not. Once Jodie was considered a missing vulnerable person, Police instigated their missing procedure. The gruesome discovery validated the officers' strong suspicions that something was seriously wrong.

5.3 The officers concerned managed this situation very well. They had to think and act outside of normal parameters. They had no procedures, training or tools to equip them to respond. They acted on their human instinct. While this case is bizarre and extremely rare and hopefully will not happen again, it shows the need to provide support to individuals in these situations.

5.4 The Safeguarding Adult Board should consider how the multi-agency system responds to bizarre, shocking and urgent circumstances and what kind of leadership is required at moments such as these. It is important for all those involved to understand that professionals who are anxious and have a sense of urgency should always be taken seriously. Even if the information shared seems to be confusing, it is incumbent upon all of us to respect that professional's views and experience, showing compassion by asking the question "How we can help?"

6. SUMMARY OF FINDINGS

6.1 While there were two main episodes described in this report, the first in 2013-2014 and the second in 2022-2023, this report suggests that the response to the first episode had consequences for the second. It demonstrates that the first episode was a time when the family themselves called for help and there was a missed opportunity to provide more in-depth enquiry and analysis to establish their capabilities. It is clear that both members of this family were very private and reluctant to engage with the outside world so this rare opportunity to understand their needs was missed.

6.2 At that time, there was indication that Jodie's care was compromised and there was a professional concerned about safeguarding which was overlooked. The case was closed following consultation with Janet and not with Jodie, although it is likely that Jodie would have agreed with Janet. Jodie therefore missed out on the opportunity to have a detailed assessment so that she could be supported. This may have led to other professionals and other opportunities for her. Additional contact may have led to further exposure of the family dynamic, including the limitations on Janet's abilities and perhaps more about Jodie's cognition and general condition.

6.3 The case was closed without rigorous examination of the information available at the time and without professional curiosity to establish why the family were made homeless in the first place.

6.4 It is likely that this family would have, at some point, regardless of efforts, tried to withdraw as they did. But had the information available been used intelligently to inform analysis of their situation the outcome may have been different. Information about them not having a GP, not having birth certificates etc. may not necessarily trigger safeguarding concerns on their own. Similarly, being made homeless is not a specific indicator. This family were made homeless because of non-payment of rent and had sufficient notice to manage their affairs.

They lacked the foresight to understand the implications of rent arrears and so were unable to take any action until the eviction took place. The circumstances they found themselves in did not trigger any curiosity about why this came about. This episode was dealt with superficially and without any in depth assessment to understand the family's capabilities to prevent them falling into similar such circumstances in future.

6.5 Closing the case also closed down the opportunity and the family carried on with their existing problems for nine further years, the situation clearly worsening over time. It is difficult to comprehend the level of suffering of each of these women experienced. Janet continues to suffer in her bereavement.

6.6 Nine years later, in February 2023 the family were once again treated superficially and without rigour and enquiry. Janet's word was accepted without question. The whole system responded to the horror of this case with a combination of revulsion and natural enquiry and concern as to how this came about.

6.7 It would appear that Jodie was overlooked in the first episode as well as the second, Janet's voice led to case closure, ending both episodes. The final referral and follow up contact in October and November 2023 resulted in Jodie's needs being once again overlooked as the explicit concerns, which were very serious did not receive a response.

6.8 A great deal of compassion and kindness has been shown to Janet since the incident. However, Jodie had needs too and should remain the focus of this review and future actions on learning.

7 WHAT NEEDS TO CHANGE?

7.1 ASC have already put in place processes to improve multi-agency management of the communications processes at the point of referral. Evidence is needed to ensure that these improvements have been embedded and sustained.

7.2 The Safeguarding Adults Board should urgently commission a series of **multi-agency audits** and develop sustainable arrangements to have a direct line of sight on the front door.

7.3 This process should be led and co-ordinated by Adults Social Care operational leads, but the process should involve partners at the outset as this leads to a common understanding of audit standards around inter-agency communications at the point of and following a referral. When these standards are agreed by partners as opposed to a single agency understanding of expectations, it leads to a more multi-agency analysis and conclusions as well as consensus about positive practice and areas for development. It will also include agreed understanding of expectations of referrers as well as those receiving referrals and any services the case is diverted to (such as Early Help): Examples of such standards arising from learning from this review:

- The quality of communications at the point of referral.
- The referrer is contacted for discussion and to explore concerns further and then this is followed up with informing them about the outcome of the referral.
- The response to safeguarding referrals is carried out swiftly and robustly.

- Cases are appropriately prioritised for intervention in the MASH team.
- Assessments include consideration of the needs of other family members.
- Assessments include a search of the historical information.
- Case closure is carried out only following rigorous assessment of the facts, discussion with the referrer and discussion with the subject of the referral, ensuring that there is no suggestion of compromised mental capacity and signed off by an experienced supervisor.
- Regular, high-quality supervision is provided to those making and those receiving referrals.
- Lack of consent is not a trigger for case closure. It can be a trigger for mounting risk.
- Cases not considered to meet the criteria for social care intervention are appropriately referred to alternative provision such as early help.

7.4 The Safeguarding Adults Board should **update and promote:**

- **The escalation process for all agencies**
  The London Safeguarding Adult procedures are being revised. The SAB should not await this revision before promoting the local process which should include specifically, who to contact with phone numbers and e-mail addresses.
- **The referral process, including the importance of human dialogue and mutual respect**

7.5 Tangential learning

The focus of this review did not require immediate further enquiry into the role of the GP, but it has identified possible misunderstandings about this. The ICB should provide an updated account to the SAB on contemporary practice about patients who do not attend appointments and the criteria for removing patients from the GP list to clarify any misunderstandings about this.

The SAB should consider its role in communicating to the local community about what to do when concerned about a neighbour, perhaps working with Public Health.

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