Redbridge Safeguarding Adults

Redbridge
Safeguarding Adults Board

Safeguarding Adults Review (SAR)

‘Family A’

Overview Report

Published August 2024

Independent Reviewer:

Pete Morgan BA, MA, MA & CQSW

Contents

1. Introduction

1.1 For the purposes of this Overview Report, and in order to protect the identities of those involved, key subjects will be known as 'Jasmine' and 'Rowena', mother and daughter, respectively. Jasmine's son, brother to Rowena, will be referred to as 'Samir'.

1.2 It is easy for Safeguarding Adults Reviews (SARs) and Overview Reports to focus on events and the involvement and actions of a number of agencies. However, it is important that this SAR and Report recognise that, at their centre, are human beings, who should be treated with respect, and likewise their family members.

1.3 Jasmine was born on 7 September 1939 in France and was 83 years old when she died. Her daughter, Rowena, was born on 3 September 1966 and was 56 years old when she died. At the time of their deaths, they were living together in a privately rented flat.

1.4 The police forced entry to the flat, having been contacted by a neighbour who hadn't seen either woman for some time, and had noticed flies at the windows and a smell coming from the flat. The police found the bodies of both women in the flat in a state of decomposition. Jasmine was in her bedroom and Rowena in the hall, with no signs of violence or any previous forced entry. The flat evidenced conditions of neglect/self-neglect and hoarding.

1.5 Post-mortems were carried out on both women, identifying that Jasmine died from pneumonia and an abscess of her left chest wall and that Rowena died from a high-grade coronary artery atheroma. No inquest was held.

1.6 Jasmine had been known to have a number of physical health issues and Rowena had been known to mental health services in the past, though neither had had regular contact for several years and weren't open to any services at the time of their deaths. The Police had raised a safeguarding concern with the local authority in January 2023 after being called to a neighbour dispute due to concerns for Rowena's mental health and her inability to care appropriately for Jasmine.

1.7 The case was referred to the Redbridge 'One Panel' by the Police for consideration of a Safeguarding Adults Review (SAR) on 7 June 2023. The rationale for referral was that there were concerns regarding the response by the statutory agencies over concerns raised about Rowena's mental health and her potential neglect of Jasmine. The 'One Panel' is the local forum for determining whether a statutory review should be commissioned on behalf of the Redbridge Safeguarding Adults Board (the Board). The referral was considered at the One Panel's meeting on 17 July 2023 and it was agreed that the criteria for a SAR were met.

1.8 This Report was authored on behalf of the Board by Mr Pete Morgan, an Independent Reviewer, and Registered Social Worker, who had no previous involvement with the family, and no role within any of the organisations that had delivered services to her. The administration and management of the SAR have been carried out by the Board's Business Manager.

1.9 This Review was commissioned under s44 of the Care Act 2014 and conducted in line with the Redbridge Safeguarding Adults Board Safeguarding Adults Review Protocol (the Protocol), published in May 2023. It's findings and their implementation will be reported in the SAB Annual Report 2023 – 2024 as required under the Act. The Report was ratified by the Board at its meeting in July 2024.

2. Safeguarding Adults Review Panel

2.1 The Panel comprised individuals across a range of statutory and independent and agencies (see below) and met in December 2023 and January2024.

Agency/Service	Representative
Barts Health NHS Trust	Named Professional Safeguarding Adults
Barking, Havering and Redbridge University Hospitals Trust	Interim Named Professional Safeguarding Adults
Fullwell Cross Medical Centre	GP
London Ambulance Service	Safeguarding Team
LB Redbridge Health and Adult Social Care	Head of Service/Principle Social Worker
LB Redbridge Safeguarding	Head of Safeguarding
LB Redbridge Legal Services	Solicitor
North East London Foundation Trust (NELFT)	Assistant Integrated Care Director for Mental Health & Learning Disability
North East London Foundation Trust (NELFT)	Named Professional Safeguarding Adults
NHS North East London (NEL) Integrated Care Board (ICB)	Designated Professional Safeguarding Adults (Redbridge)
Metropolitan Police Service – East Area (EA) Basic Command Unit (BCU)	Superintendent Safer Neighbourhoods
Redbridge Safeguarding Adult Board	Board Manager
Independent Reviewer	Pete Morgan

3. Terms of Reference (ToR)

3.1 The meeting of the Panel, held on 6 December 2023, agreed the Terms of Reference (ToR) for the Review but agreed they would be regularly reviewed as the Review progressed to ensure they remained fit for purpose.

3.2 The finalised Terms of Reference are to be found in Appendix A.

4. Scope

4.1 The scope of the SAR was initially set, and remained, as the period from 1 October 2022 until 6 June 2023.

5. Information Sharing

5.1 The Board's Agency Information Sharing Return Templates were completed for the review period to ensure the Review was in possession of all relevant information about single and multiagency support offered and received by Jasmine and Rowena. Agencies were asked to include a summary of any earlier information about their involvement with either Jasmine or Rowena if they considered it to be of particular relevance to the Review.

5.2 The following agencies were asked to compete the templates with regard to their involvement with Jasmine and/or Rowena:

- East Area Basic Command Unit (BCU), MPS
- Fullwell Cross Medical Centre
- Barts NHS Health Trust
- Barking, Havering and Redbridge University Hospitals NHS Trust
- Adult Mental Health Services - NELFT NHS Trust
- Adult Health & Social Care – LB Redbridge
- London Ambulance Service

5.3 Agencies were required to make recommendations within their Information Sharing Returns as to how their own performance could be improved.

5.4 A full and comprehensive review of the agencies' involvement and the lessons to be learnt was achieved.

6. Family liaison and involvement

6.1 Contact was made with Samir, Jasmine's son and Rowena's brother, to offer him the opportunity to meet or speak to the Independent Reviewer and to do so accompanied by an advocate or supporter. He accepted the offer, but, as he lives in Scotland, the meeting with the Independent Reviewer was held virtually via an MS Teams meeting.

6.2 The Independent Reviewer advised Samir that he would take notes of the content of their discussion which he would be given the opportunity to see and comment upon to ensure their accuracy. The following is a summary of those notes. He would also have the opportunity to see the draft report, with the opportunity to comment upon but not make amendments to it.

6.3 Samir confirmed that he and Rowena were the only children of Jasmine and her ex-husband, but that there are half-siblings from his father's second marriage living in London. Jasmine also had more than 20 relatives - a sister, nephews and nieces and

cousins - living in France. Jasmine was French, their father Indian. Samir's parents divorced in 1968 and his father died 1994. Samir described remembering his father being bullying and abusive to him and Jasmine but not Rowena.

6.4 Samir described the relationship between Jasmine and Rowena as being one of mutual dependency, with each being the carer of the other in different ways. He described Rowena as being bullying and coercive in her relationship with Jasmine, and that Jasmine had treated Rowena from birth as being special. As a result, Rowena would expect to be the focus of Jasmine's attention.

6.5 Jasmine had once owned the flat they were living in when they died, having moved there in 1997. She had had to sell it to Samir in 2008 due to financing Rowena's life-style and accruing debts of over £70k. Samir had bought the flat but arranged with a friend to act as their landlord and had registered the property in the friend's name.

6.6 At one stage, Rowena had moved into a flat in central Ilford, purchased by Samir, but later moved back to live with Jasmine while retaining the proceeds of selling the flat.

6.7 Samir's contact with Jasmine and Rowena had been limited due to the deterioration in his relationship with Rowena. He continued to have telephone contact with Jasmine until Christmas 2022 but only when Rowena was out of the flat and Jasmine would terminate the call when she returned. During their final phone call, Jasmine was showing some sign of memory loss, but had held a lengthy conversation until Rowena returned to the flat and she had to end the call.

6.8 When Samir had married in 2004, Rowena threatened to take her own life if Jasmine attended the ceremony, which he felt was typical of Rowena threatening and controlling Jasmine and needing to be the centre of attention. Samir said that Rowena had had several jobs, including more than one as a nanny, but these often ended through her alleging unwanted attention from the father of the children or a male employee. She had also started but failed to complete a university degree course in London for a similar reason. When Samir checked on this, it was invariably the case that Rowena had been pestering or even stalking the male in question.

6.9 Samir confirmed that he had pleaded guilty to a charge of assault on Rowena in 2009 but stated that Jasmine paid the compensation to Rowena as he had only pleaded guilty at her request to prevent a deterioration in Rowena's mental health – he hadn't assaulted her at all. After this occasion, Samir was involved in legal proceedings to have access to his own children and wasn't prepared to put that at risk by admitting to any further assault on Rowena to assuage Jasmine. At a court appearance in August 2017, when charged with another assault on Rowena, Samir was acquitted on the basis of CCTV evidence that showed Rowena to have been the aggressor.

6.10 After Jasmine was in hospital in October 2020, Samir had visited at Jasmine and Rowena's request but stayed in his camper-van rather than the flat to avoid any confrontation with or allegation of assault by Rowena.

6.11 Samir said that Jasmine had stated that she didn't want any help at home and would have refused to go into a care home had it been suggested, partially because of feeling obliged to look after Rowena but also because she didn't trust services. She wanted to die in her flat.

6.12 Samir said neither Jasmine nor Rowena had a circle of friends. This was the case for Rowena as a child and young woman. Jasmine had had links to the Catholic Church growing up in Paris, but this wasn't based on any religious faith or belief, more on her employment as a cleaner. After her divorce, Jasmine had not had any other personal relationship and neither had Rowena had any lasting personal relationships.

6.13 In summary, Samir described Rowena as being coercive and bullying in her relationship with Jasmine; that she insisted on being the centre of attention and would threaten to self-harm if not getting her own way. Jasmine in turn would prioritise Rowena above herself or Samir and had always done so, effectively causing and reinforcing Rowena's behaviour. They were co-dependant and would have refused any offers of help that might have been made to them. Samir described Jasmine as a hoarder and suspected that the flat would have been very cluttered and possibly only cleaned in selective areas and more generally dirty, which might have been another factor in Jasmine not wanting help and Rowena not allowing anybody access to the flat. Samir accepted that the above are his views and perceptions and that Jasmine's and Rowena's might have been different.

7. Key Lines of Enquiry

7.1 The following Key Lines of Enquiry (KLOE) were developed by the Independent Reviewer and the SAR Panel:

- Which internal procedures were implemented and followed? Examples could include annual landlord checks, annual health checks, fire safety checks etc.
- Which multi-agency procedures were implemented and followed? Examples could include vulnerable adult risk management, multi-agency risk management, safeguarding, Mental Health Assessments, Mental Capacity Assessments, self-neglect etc.
- Were "Did not attend"/"Did Not Engage" procedures in place and implemented appropriately?
- Were escalation procedures in place and implemented appropriately?
- Were management/supervision procedures followed to ensure appropriate decision-making including triaging referrals/concerns and staff support?
- Did the Covid-19 pandemic impact on the services offered to Family 'A' and their management?

8. Agency involvement prior to the Review Period

8.1 As has been mentioned previously, agencies providing an Information Sharing Return, including a Chronology outlining their agency's involvement with Jasmine and Rowena. They were also asked to include brief details of any particularly relevant involvement prior to the Review period.

8.2 This Review is not aware of any contact between the family and the statutory services during the 18 months immediately prior to the Review Period.

8.3 On 28 September 2011, the Fullwell Cross Medical Centre (the Medical Centre) record referring Rowena to the Brief Therapy and Intervention Team within NELFT. This was passed to the Redbridge Access, Assessment and Brief intervention Team (RAABIT). As RAABIT had no contact phone number, Rowena was sent an "Opt in letter"; this is standard procedure asking a service user to get in touch and advising that if they don't their case will be closed. She attended a face-to-face appointment, accompanied by Jasmine, and advised that she suffered with "lots of black moods and poor sleep" and requested a psychiatric assessment. An appointment was made with a Community Mental Health Nurse (CPN1) from RAABIT. Rowena requested Cognitive Behavioural Therapy (CBT) (See Glossary) and didn't want any medication. As she wasn't showing any signs of paranoid or delusional beliefs, it was planned to refer her to Psychology Services and discharge her from RAABIT. The Psychology Service record receiving this referral but have no record of what action resulted; this may be due to the fact that practice at that time was to use paper records that aren't now retrievable.

Finding 1:

It is of concern that the referral wasn't chased up, either within NELFT or by Rowena's GP.

8.4. In 2014, NELFT record that Rowena was seen by the Podiatry Service but was discharged having been provided with advice regarding self-care.

8.5. In May 2015, the Police record that Rowena was suspected of racially aggravated harassment of another resident on the estate but no action was taken.

8.6. In May 2016, NELFT record that Jasmine was referred to the Continence Service but was discharged within a week as Rowena made contact stating that Jasmine no longer required a service.

Finding 2:

It is of concern that Jasmine was discharged by the Continence Service on the word of her daughter who had no legal right or power over her care.

8.7. In December 2015 the Medical Practice record initially referring Rowena to the Diabetes Service, when she was offered an appointment which she declined, and again in March 2017. In October 2019, NELFT record a phone call from Rowena in which she was advised the Service was awaiting an update from her GP, and she was advised to ask her GP to refer her again so that a new appointment could be made. There is no record of Rowena contacting her GP or of a new referral being made. The Medical Practice have no record of Rowena not engaging with the Service but were aware that she attended the diabetic eye screening service every 18 months until February 2022.

Finding 3:

It is of concern that, having had an appointment with the Diabetes Service and her need for support, presumably, established, that the referral wasn't followed up, either within NELFT or by Rowena's GP.

8.8 In August 2017, the Police record a domestic incident between Rowena and her brother Samir. Samir was arrested and charged with assault but was found not guilty in court in November 2017.

8.9. In February 2018, BHRUT record that an Oncology Outpatient appointment for Jasmine after breast surgery was cancelled and rearranged. She attended a follow up appointment after six months and annual follow up appointments until 2020 when the appointment was cancelled as it was inconvenient for Jasmine and rearranged for the 13th March 2020, which she attended. She also attended follow up appointments in September 2018 and 2019. It is not known if she was the discharged from the Outpatient Clinic.

8.10 In March 2020, the Police record that Rowena reported that a couple of women had tried to take her bank card while she was using an ATM machine. There were no grounds for concern about her, and so no Merlin Report (See Glossary) was raised with the Local Authority.

Finding 4:

It was good practice to consider whether a Merlin Report should be raised and appropriate to decide it needn't.

8.11 On 10 October 2020, the Police record attending the Family's address after Rowena called them about her neighbours. She said she had heard her neighbour who lived immediately above her talking about her and that she had unplugged her landline as the same neighbour "had wired everyone's landline phone", had fitted a motion sensor, had a loft "full of drugs" and was "protected by politicians". Rowena was described as not "making much sense" and would "constantly divert the conversations to something different". It was thought that Rowena might have mental health issues or be stressed due to Jasmine's poor health. A Merlin Report was submitted to the First Contact Team (FCT) (see Glossary)**,** containing an initial BRAG Risk Assessment (see Glossary) categorised as "Green". The receipt of the Merlin Report was recorded by the Senior Social Worker (SSW1) at RAABBIT but there is no record of it being triaged or any ensuing action (see 8.17).

Finding 5:

It is of concern that there is no record of this Merlin Report being acted upon.

Finding 6:

It is of concern that the Police didn't follow up the Merlin Report when they didn't receive an acknowledgement of its receipt, although it is accepted that this is current practice not to either acknowledge receipt of Merlin Reports or to chase their outcome.

8.12 On 10 October 2020, Barts Health NHS Trust (BHNT) record that Jasmine was admitted with chest pains after Rowena called an ambulance. She was treated for a myocardial infarction or heart attack. BHNT record that Jasmine reported she was managing at home with the support of Rowena, and while a referral was made to the Community OT Service for an assessment for transfer and bathing equipment, "No indication for a package of care" was noted. It was noted that the central heating in the flat wasn't working but Rowena was to arrange for its repair. Jasmine was discharged home on the 14th October 2020, with a discharge letter to Jasmine's GP requesting a GP review at home and a referral was made to the local cardiac rehabilitation service. The Medical Practice have no record of the discharge letter.

Finding 7:

It is of concern that there is no evidence of any of the above assessments or reviews being completed.

Finding 8:

It is of concern that there is no evidence of Jasmine or Rowena being advised of or offered an assessment under s9 or s10 of the Care Act 2014 (see Glossary).

8.13 On 18 October 2020. BHRUT record that Jasmine was taken to the Emergency Department (ED) at the King George Hospital (KGH) with shortness of breath, bilateral leg oedema and abdominal distension. Her admission to BHNT (Whipps Cross Hospital) was noted (see 8.12) and that since her discharge she had had abdominal bloating and distension and had been unable to eat solid foods, taking just liquids. Rowena gave staff a handwritten medical history, details of Jasmine's medication and her reason for dialling 111. She said Jasmine had had an adverse reaction to the Aspirin and Clodidogrel prescribed by Whipps Cross Hospital. Doctor liaised with Whipps Cross Hospital and were advised to treat Jasmine for fluid overload.

8.14 On 21 October 2020, BHRUT record that Rowena also expressed concern that Jasmine wasn't given enough time to eat her breakfast or take her medication and that she had difficulty swallowing tablets.

8.15 On 21 October 2020, the NELFT record receipt of a Merlin Report from RAABIT (see 8.11).

8.16 On 22 October 2020, BHRUT record that Jasmine was discharged, having been diagnosed with Hyponatraemia (see Glossary) and Fluid overload, with a discharge plan that included cardiac rehabilitation and follow up by Whipps Cross Hospital, reduced fluid intake, GP to "repeat Urea and Electrolyte blood tests – common blood tests - were

carried out to check sodium in weeks and consider a referral to the community matron if she needs support and a referral to the Outpatient sleep study to rule out Apnoea (see Glossary).

Finding 9:

It was good practice to put in place a discharge plan for Jasmine but of concern that nobody or agency had responsibility to monitor its implementation or its outcome.

8.17 On 28 October 2020, NELFT record receipt and uploading by RAABIT of a Merlin Report but no details of its content, of it being triaged or of any resulting action.

Finding 10:

It is of concern that a Merlin Report is received but no details are recorded of its contents, any resulting action or its outcome.

8.18 On 6 November 2020, BHRUT record that Jasmine missed an appointment for the Sleep Apnoea Diagnostic Test and was discharged from the service back to her GP as per trust Policy.

Finding 11:

It is of concern that BHRUT Did Not Attend Policy doesn't include any attempt to discover the reason for a patient not keeping an appointment but puts the onus on the GP to rerefer if necessary.

8.19 On 7 December 2020, BHRUT record that Rowena rang to book an outpatient appointment for Jasmine with the Cardiac Rehabilitation Clinic. She reported that she was "pushing mother's piles back" four times a night, that Jasmine was doubly incontinent. As a former Red Cross Nurse, she had increased Jasmine's fluid intake from one litre per day to 1.5 – 2 litres a day, that Jasmine's feet were now swollen and she was out of breath. Jasmine had stopped taking her medication and her incontinence and piles had improved. She was advised Jasmine should continue to take the medication and to gradually increase her walking in the flat. A telephone review was arranged for two weeks' time.

Finding 12:

It is of concern that no action was taken over Rowena's neglect of Jasmine by not adhering to the discharge plan (see 8.16).

8.20 On 30 and 31 December 2020 and 4 January 2021, BHRUT record unsuccessful attempts to contact Rowena on her landline and mobile. On 4 January 2021, a letter was sent to Rowena, details of its contents are not known to the Review.

8.21 On 28 January 2021, record BHRUT a discharge summary being sent to the GP advising that they had been unable to complete the home-based cardiac rehabilitation

programme as they had been unable to contact either Jasmine or Rowena by letter or phone. It was pointed out that Jasmine had been advised to continue to take her prescribed medication and to discuss any concerns with her GP. It was requested that Jasmine be added to the cardiovascular disease register and followed up in 12 months' time.

Finding 13:

It is of concern that there is no record of any resulting action from the GP or a referral to HASS at the possible neglect of Jasmine by Rowena.

8.22 On 1 April 2021, NELFT record that the London Ambulance Service (LAS) referred Jasmine to the Community Treatment Team (CTT) after being called twice to the family address due to her being breathless and having headaches and refusing against advice to go to hospital. There is no reference to an assessment of Jasmine's capacity to make this decision.

8.23 On 2 April 2021, NELFT record that Jasmine is admitted to KGH with pain in her upper abdomen and was discharged from the CTT as is standard procedure when the patient is admitted to hospital as the CTT is a short-term intervention team when the patient is unwell in the community.

8.24 On 2 April 2021, BHRUT record that Jasmine was admitted via ambulance, accompanied by Rowena, with shortness of breath and treated for a Pulmonary Embolism, a possible heart attack and low potassium levels. Jasmine refused a CT Pulmonary Angiogram (CPTA) due to her being unable to lie flat and suffering from claustrophobia.

8.25 On 7 April 2021, the Fulwell Cross Medical Centre record that Jasmine was admitted to KGH with suspected heart failure.

8.26 On 7 April 2021, BHRUT record doctors discussing a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) Order on the basis of it being a medical decision with Rowena who did not agree and said she had discussed this with Jasmine and wanted her to be resuscitated.

Finding 14:
It is of concern that the discussion of a 'Do Not Attempt Cardiopulmonary Resuscitation' Order was not with Jasmine herself, but with Rowena,

8.27 On 8 April 2021, BHRUT record that Jasmine was upset and not wanting to go for the CPTA.

8.28 On 9 April 2021, BHRUT record that Jasmine had signed a self-discharge form and insisted on doing so after a doctor spoke to her and Rowena, saying "I want to go home to care for my daughter". Rowena took Jasmine home in a wheelchair.

Finding 15:

It is of concern that no assessment was completed of Jasmine's capacity to discharge herself from KGH.

8.29 On 29 April 2021, BHRUT record that Jasmine didn't attend a Cardiology Outpatient appointment and a new appointment made for six weeks' time. There is no evidence that this appointment was kept.

9. Key Events and Findings

9.1 On 6 January 2023, the Police record that officers attended the Family home in response to a neighbour dispute. They noted "bizarre behaviour and also had to demand to see Jasmine (who is bed-bound)". They considered it evident that Rowena couldn't look after Jasmine and noted Rowena's "MH decline". Neighbours reported "ongoing strange encounters and outbursts with Rowena" and a huge deterioration in her mental health." The Officers had serious concerns for Jasmine and had to insist on seeing her as Rowena prevented them doing so. Jasmine was described as "bedbound, frail but able to talk but found it hard to communicate." Rowena put the latter down to her deafness. Rowena again claimed to being a nurse with medical experience. A Merlin Report supported by a Red BRAG Risk Assessment was completed on 15 January 2023 based on escalating concerns since 6 January 2023 - (see 9.2) and forwarded to HASS on the 18 January 2023.

Finding 16:

While it was good practice to submit a Merlin Report and to complete a BRAG Risk Assessment, it is of concern that it took 12 days to submit them to HASS.

9.2 On 13 January 2023, HASS record a phone call from the Police (PC1) to the FCT to advise them of the concerns first identified on 6 January 2023 (see 9.1). The safeguarding concern was progressed to the Safeguarding Adults process.

Finding 17:

While it was good practice to raise a safeguarding concern without waiting for the completion of the Merlin Report or the BRAG Risk Assessment, it is of concern that there was still a delay of seven days in doing so.

9.3 On 17 January 2023, HASS record that the Fairlop Team (see Glossary) commenced the safeguarding process. A phone call was made to Jasmine but was unsuccessful as Rowena said she was asleep. Rowena asked that a letter be sent as she didn't "want to discuss anything over the phone". Jasmine's GP was advised of the safeguarding concern, asked to provide any relevant information and to undertake a joint welfare visit with a duty worker to ascertain Jasmine's desired outcome. A check with RIO, the NELFT database, which any NELFT clinician can access and record on but to which Local Authority staff in Integrated Teams have only read and record access, showed

Rowena was not known to mental health services. A letter was sent to Jasmine and Rowena asking them to contact the Team.

Finding 18:

It is of concern that the alleged perpetrator was advised of the safeguarding concern, thus putting Jasmine at increased risk of further abuse.

Finding 19:

It was good practice to seek medical background information from Jasmine's GP but information could've been sought from other agencies and it is not clear what benefit was to be gained from joint welfare visit with the GP.

9.4 On 18 January 2023, HASS record receipt of an email acknowledgement from the Medical Centre that the request for information had been passed to the GP.

9.5 On 18 January 2023, HASS record receipt of the Merlin Report (see 9.1) and it was uploaded on 25 January 2023.

9.6 On 25 January 2023, HASS record an unannounced visit by the Fairlop Team's Duty Social Worker; there was no response to the intercom on 4 attempts. Unsuccessful attempts to contact Jasmine via the landline and her mobile were also made.

Finding 20:

It is of concern that there was a delay of 12 days between the initial contact by the Police and a visit to the family.

Finding 21:

It was good practice to both call at the family flat and to attempt phone contact with Jasmine.

9.7 On 25 January 2023, HASS record that the Merlin report was sent to the Mental Health and Wellness Team by the FCT's Wellbeing Officer.

9.8 On 26 January 2023, HASS record an email was sent to the GP to advise them of the unsuccessful welfare visit and to ask that the GP "urgently visit Rowena".

Finding 22:

It was good practice to inform the GP of the unsuccessful welfare visit but of concern that the onus was then put on them to contact Rowena.

Finding 23:

It is of concern that no further attempt was made by HASS to contact Jasmine or Rowena or to establish that Jasmine was safe.

Finding 24:

It is of concern that the safeguarding procedures appear to have been left in limbo, with no managerial overview or monitoring.

9.9 On 6 June 2023, the Police were contacted by the family's neighbours who had not seen either Jasmine or Rowena for several weeks and could see flies in the flat. The Police visited the flat and gained access by forcing the front door, where they found the decomposing bodies of both Jasmine and Rowena.

10. Analysis and Issues to be Addressed

10.1 The Findings identified in the above sections of this report can be grouped under the following six themes:

- Adult Social Care/ Care Act 2014
- Adult Safeguarding Procedures
- Health Services
- Hospital Discharge Planning
- Mental Capacity Act 2005
- Good Practice

These themes aren't mutually exclusive silos but are separated by porous membranes so that the overlap and Findings can fall under more than one theme. They are listed alphabetically – except for Good Practice – not in any order of priority.

10.2.1 **Adult Social Care/Care Act 2014**

Findings: 7, 8, 9, 19, 20, 22 & 24

10.2.1.1 There is no evidence that either Jasmine or Rowena were offered assessments under sections 9 and 10 of the Care Act 2014, despite both stating they were caring for the other.

10.2.1.2 While some form of hospital discharge planning took place for Jasmine, there is no evidence that ASC was involved in that process or that a formal hospital discharge procedure was followed.

10.2.1.3 When a safeguarding concern was raised in January 2023, while it was good practice to seek information from Jasmine's GP to inform the assessment of her care and support needs but information could've been requested from other agencies. Had such requests been made, details of Rowena's mental health issue might have been discovered, raising the level of concern for Jasmine's safeguarding.

10.2.1.4 It was also good practice to visit the family flat to try to see Jasmine and Rowena and to advise the GP of the failure to speak to ether Jasmine or Rowena, however, the failure to persist in trying to speak to them is of concern, as is the placing of responsibility to contact them onto the GP.

10.2.1.5 It is concern that the level of managerial oversight of social work practice failed to challenge the above.

Issues to be Addressed:

- The process for advising the public of their eligibility for and the regular offering of assessments under s9 and s10 of the Care Act 2014
- The lack of a robust multi-agency hospital discharge procedure
- The lack of a robust information gathering procedure to inform Care Act assessments
- The lack of a robust managerial overview of social work practice and professional supervision.

10.2.2 **Adult Safeguarding Procedures**

Findings: 4, 5, 6, 10, 12, 13, 16, 17, 18, 20, 23 & 24

10.2.2.1 There were five occasions on which the Police raised Merlin reports and triaged them internally; on one occasion, the decision from the triage process, quite appropriately, was to not raise a safeguarding concern with HASS as the threshold in the Care Act didn't appear to be met. On the four other occasions, the Police appropriately raised a safeguarding concern with HASS, though on two occasions with a significant delay in so doing – 7 days and 12 days.

10.2.2.2 What is of concern is that HASS doesn't have a record of receiving two of the concerns or therefore of responding to them, receipt of one is recorded but with no recorded response and only responded to the fourth after 12 days.

10.2.2.3 There appears to be no formal process for the acknowledgement of the receipt of a safeguarding concern by HASS, advising the referrer of the outcome of the concern or for escalating the concern if the referrer receives no such acknowledgement. As a result, safeguarding concerns can, in effect, disappear into "a black hole" with no external monitoring of HASS's response.

10.2.2.4 The Independent Reviewer understands that Merlin Reports are not only used by the Police to raise safeguarding concerns, so it may be that some confusion can arise as to the purpose of the Report when it is received by HASS.

10.2.2.5 When HASS did respond to a Merlin Report/safeguarding concern, contact was made with Rowena, the potential abuser, thereby potentially putting Jasmine at greater risk of further abuse or neglect. Having initially failed to make contact with Jasmine or Rowena, the response of HASS was to ask their GP to visit but didn't pursue the concern to establish whether or not Jasmine was safe and the safeguarding concern just disappeared into limbo, with no recorded outcome or conclusion. This raise concerns about the quality and level of managerial oversight of the safeguarding process and the supervision of the staff involved.

10.2.2.6 In December 2020, BHRUT staff were made aware that Rowena had unilaterally changed Jasmine's care routine but took no action to safeguard Jasmine. This was a missed opportunity to a raise a safeguarding concern about potential neglect of Jasmine by Rowena. A month later, Jasmine was discharged by BHRUT as they were unable to contact either her or Rowena to complete the home-based cardiac

rehabilitation programme. The Medical Centre was advised of the above but neither they nor BHRUT raised a safeguarding concern about potential neglect of Jasmine by Rowena, a further missed opportunity to safeguard Jasmine.

Issues to be Addressed:

- The timescales for the triaging of safeguarding concerns within the Police
- The lack of any feedback loop to raisers of safeguarding concerns to monitor the response to them and the lack of any escalating procedure for safeguarding concerns that don't proceed through the multi-agency Safeguarding Procedures
- A potential lack of clarity as to the purpose of any specific Merlin Report
- The implementation of the multi-agency Safeguarding Procedures in accordance with the principles of Making Safeguarding Personal (see Glossary) and without placing the relevant adult at greater potential risk of abuse or neglect
- A lack of recognition of potential neglect/self-neglect situations as requiring the raising of safeguarding concerns
- The lack of an effective monitoring process to oversee the implementation of the multi-agency Safeguarding Procedures

10.2.3 **Health Services**

Findings: 1, 3 &11

10.2.3.1 There were two occasions where either Jasmine or Rowena was referred to specialist health services by the Medical Centre but the referral was not chased up when no outcome followed on from it.

10.2.3.2 This lack of follow-up was echoed in BHRUT's DNA Policy not resulting in any attempt to discover why Jasmine failed to attend an appointment for a Sleep Apnoea Diagnostic Test but simply led to her being discharged from the service. There is no record of the Medical Centre being advised of her non-attendance and subsequent discharge.

10.2.3.3 There were no recorded annual health checks offered to either Jasmine or Rowena. Given Jasmine's age and Rowena's history of mental health issues, this is surprising and of concern.

Issues to be Addressed:

- The lack of follow-up of referrals for specialist services that have no known outcome
- The lack of robust DNA Procedures
- The lack of routine health checks offered to both Jasmine and Rowena

10.2.4 **Hospital Discharge Planning**

Findings: 7, 9, 12 &15

10.2.4.1 On 10 October 2020, referrals and assessments were made for services to support and review Jasmine and Rowena on Jasmine's discharge from BHNT, but these referrals and reviews did not happen and were not chased up. A decision was made that there was "No indication for a package of care" but there is no record of ether Jasmine or Rowena being offered an assessment under the Care Act 2014.

10.2.4.2 On 21 October 2020, when Jasmine was discharged by BHRUT, it was good practice to set up a discharge plan for her support in the community, but of concern that no person or agency was responsible for monitoring its implementation and outcome. This resulted in nobody recognising and responding to Rowena's not complying with the discharge plan.

10.2.4.2 When Jasmine took her own discharge from KGH against medical advice, it is of concern that no package was out in place to support her in the community and services in the community weren't advised of her return home.

Issues to be Addressed

- The lack of a robust multi-agency hospital discharge procedure including a procedure for the monitoring of discharge packages in the community

10.2.5 **Mental Capacity Act 2005**

Findings: 2, 14 &15

10.2.5.1 There is no evidence that either Jasmine or Rowena's capacity was ever queried and no formal assessment of their capacity to make specific decisions was completed.

10.2.5.2 This is not to suggest that either of them lacked capacity at any particular time, but there were three specific situations when the implications of the Mental Capacity Act 2005 were not considered; in the first, Jasmine was discharged from the Continence service by her daughter, who had no right to do so, and this was not challenged by health professionals.

10.2.5.3 On the second occasion, Jasmine was not involved in the discussion about a DNAR Order while she was an inpatient at KGH.

10.2.5.4 The third occasion was when she chose to discharge herself against medical advice from KGH to "look after her daughter" despite her leaving hospital in a wheelchair due to her limited mobility.

Issues to be Addressed:

- A lack of awareness of the implications of the Mental Capacity Act 2005 for patients being discharged from services, including the making of Unwise Decisions or the implementation of DNAR Orders

- A lack of statements/assessments of capacity being an integral part of any assessment

10.2.6 **Good Practice**

Findings: 4, 9, 16, 17, 19, 21 & 22

10.2.6.2 There are some examples of good practice identified in the Review. There is no suggestion that the medical treatment that Jasmine and Rowena received was not of a good quality or was a factor in their tragic deaths. What is apparent is that the examples of good practice do not, with the exception of those of the Police, were not focused in seeking to engage with the two women.

11. Conclusions and Recommendations

11.1 The Terms of Reference (Appendix A) for the Review identified a number of key lines of enquiry; these will not be dealt with individually in this Conclusion, though the issues they cover are picked up. This is due to the fact that, as can be seen from the details of agencies' involvement with Jasmine and Rowena, for most of the Period covered by the Review, the two women kept themselves isolated from services and from Samir, the only member of their family in this country. Specifically, during the Review Period – January 2022 to March 2023 – they had no contact with any agency until January 2023.

11.2 Their accommodation was also unusual as their landlord was a friend of Samir acting, according to him, on his behalf. The Independent Reviewer is not disputing what Samir has told the Review, about the ownership of the flat, it is just impossible to verify.

11.3 The opportunities for services to support Jasmine and Rowena were very limited due to their own choices. Redbridge Council did have a procedure in place to support isolated members of the public during the Covid-19 Pandemic, but neither Jasmine nor Rowena were known to agencies to refer them into the procedure.

11.4 There were opportunities for agencies to seek to engage with both women prior to the Review Period, but these were not taken, as identified in the Analysis above.

Recommendation 1:

That the SAB seek assurance from HASS that they have reviewed and revised as appropriate their multi-agency hospital discharge procedures to meet the Issues to be Addressed identified in 10.2.4

Recommendation 2:

That the SAB seek assurance from the HASS that they have reviewed and revised their policies and procedures as appropriate for the offering and completion of assessments under the Care Act 2014 to meet the Issues to be Addressed identified in 10.2.1

Recommendation3:

That the SAB seek assurance from the ICB that they have reviewed and revised aa appropriate the procedures for monitoring the outcome of specialist health

referrals by Primary Care/GP Practices to meet the Issues to be Addressed identified in 10.2.3

Recommendation 4:

That the SAB seek assurance from the ICB that they have reviewed and revised aa appropriate the procedures for monitoring the offering and uptake of annual health checks by Primary Care/GP Practices to meet the Issues to be Addressed identified in 10.2.3

Recommendation 5:

That the SAB seek assurance from the HASS that it has reviewed and revised as appropriate its internal policies and procedures for the monitoring of Care Act assessments and the multi-agency Safeguarding Procedures to meet the Issues to be Addressed identified in 10.2.1

Recommendation 6:

That the SAB seek assurance from all agencies that they have reviewed as revised as appropriate their policies and procedures for those who do not attend appointments or fail to engage with services

11.5 There were no recorded formal or even informal assessments of Jasmine or Rowena's capacity to make decisions about their health and welfare, despite their grounds for concern about potential self-neglect/neglect

Recommendation 7:

That the SAB seek assurance form all agencies that they have reviewed and revised their internal policies and procedures to ensure they are compliant with the Mental Capacity Act 2005 and its supporting Code of Practice and their implementation monitored to ensure they meet the Issues to be Addressed identified in 10.2.5

11.6 There were missed opportunities to identify potential neglect/self-neglect resulting in failures to raise safeguarding concerns appropriately.

Recommendation 8:

That the SAB seek assurance e from member agencies that they have reviewed and revised as appropriate the staff development opportunities for staff to meet the Issues to be Addressed identified in 10.2.2

11.7 While the Police correctly identified when the thresholds were, or weren't met for raising a safeguarding concern, the triage process to facilitate that decision did cause some delay in the safeguarding concern being raised.

Recommendation 9:

That the SAB seek assurance that the Police have reviewed and revised as appropriate their triage processes for assessing whether Merlin Reports should

trigger a safeguarding concern to meet the Issues to be Addressed identified in 10.2.2

11.8 Current police practice doesn't appear to discriminate between a Merlin Report to raise more general concerns about an individual's situation and one that should be seen as raising a specific safeguarding concern. This could lead to confusion as to the Report's purpose in a multi-agency context, a position that is exacerbated by the lack of a feedback loop from the HASS to those raising a safeguarding concern to advise of the outcome of that concern.

Recommendation 10:

That the SAB seek assurance from the Police and the HASS that they have reviewed and revised as appropriate their procedures for the receipt of safeguarding concerns to meet the Issues to be Addressed identified in 10.2.2

Recommendation 11:

That the SAB seek assurance that the HASS has established a feedback loop to inform those raising a safeguarding concern of its outcome to meet the Issues to be Addressed in 10.2.2

11.9 The multi-agency Safeguarding Procedures were initiated in January 2023 with regard to Jasmine but lapsed into inactivity without being formally closed, resulting in Jasmine not being safeguarded and, potentially the death of one or both of the women.

Recommendation 12:

That the SAB seek assurance from the HASS that they have reviewed and revised as appropriate the management and monitoring processes in place to overview the implementation of the multi-agency Safeguarding Procedures to meet the Issues to be Addressed identified in 10.2.2

11.10 Despite the above, there were some examples of good practice identified in the Review.

Recommendation 13:

That the SAB seek assurance from member agencies that the identified examples of good practice are acknowledged with the relevant members of staff and their line managers and supervisors

11.11 Inconclusion, Jasmine and Rowena had isolated themselves from services and from their family; to what degree this was a conscious decision by Jasmine or one imposed on her by Rowena can only be a matter of conjecture. In reality, it seems likely to have been a combination of both: initially a decision by Jasmine to best support her daughter that she was eventually unable to reverse, possibly because of her own increasing frailty, both physically and mentally or possibly due to coercion by Rowena.

11.12 Whichever was the case, there were opportunities for agencies to seek to engage with both women that weren't taken in the years before their deaths; more culpably, there

was a clear opportunity when the Police raised a safeguarding concern in January 2023, an opportunity that was wasn't so much missed as overlooked by a failure to implement the Safeguarding procedures effectively, a failure caused by ineffective monitoring and managerial and supervisory overview of staff and their practice.

11.12 Given the causes of death identified in their post-mortems, it is likely that Rowena's death may not have been avoidable. Jasmine's may well have been had she been safeguarded effectively. At the same time, it has to be acknowledged that their persistent lack of engagement with services would have limited the degree of support they would have accepted and action under the Mental Capacity Act and/or the Mental Health Act would have been required to impose any support on them and there has to be some doubt whether this would have been possible.

12. Recommendations

Recommendation 1:

That the SAB seek assurance from HASS that they have reviewed and revised as appropriate their multi-agency hospital discharge procedures to meet the Issues to be Addressed identified in 10.2.4

Recommendation 2:

That the SAB seek assurance from the HASS that they have reviewed and revised their policies and procedures as appropriate for the offering and completion of assessments under the Care Act 2014 to meet the Issues to be Addressed identified in 10.2.1

Recommendation 3:

That the SAB seek assurance from the ICB that they have reviewed and revised aa appropriate the procedures for monitoring the outcome of specialist health referrals by Primary Care/GP Practices to meet the Issues to be Addressed identified in 10.2.3

Recommendation 4:

That the SAB seek assurance from the ICB that they have reviewed and revised aa appropriate the procedures for monitoring the offering and uptake of annual health checks by Primary Care/GP Practices to meet the Issues to be Addressed identified in 10.2.3

Recommendation 5:

That the SAB seek assurance from the HASS that it has reviewed and revised as appropriate its internal policies and procedures for the monitoring of Care Act assessments and the multi-agency Safeguarding Procedures to meet the Issues to be Addressed identified in 10.2.1

Recommendation 6:

That the SAB seek assurance from all agencies that they have reviewed as revised as appropriate their policies and procedures for those who do not attend appointments or fail to engage with services

Recommendation 7:

That the SAB seek assurance form all agencies that they have reviewed and revised their internal policies and procedures to ensure they are compliant with the Mental Capacity Act 2005 and its supporting Code of Practice and their implementation monitored to ensure they meet the Issues to be Addressed identified in 10.2.5

Recommendation 8:

That the SAB seek assurance e from member agencies that they have reviewed and revised as appropriate the staff development opportunities for staff to meet the Issues to be Addressed identified in 10.2.2

Recommendation 9:

That the SAB seek assurance that the Police have reviewed and revised as appropriate their triage processes for assessing whether Merlin Reports should trigger a safeguarding concern to meet the Issues to be Addressed identified in 10.2.2

Recommendation 10:

That the SAB seek assurance from the Police and the HASS that they have reviewed and revised as appropriate their procedures for the receipt of safeguarding concerns to meet the Issues to be Addressed identified in 10.2.2

Recommendation 11:

That the SAB seek assurance that the HASS has established a feedback loop to inform those raising a safeguarding concern of its outcome to meet the Issues to be Addressed in 10.2.2

Recommendation 12:

That the SAB seek assurance from the HASS that they have reviewed and revised as appropriate the management and monitoring processes in place to overview the implementation of the multi-agency Safeguarding Procedures to meet the Issues to be Addressed identified in 10.2.2

Recommendation 13:

That the SAB seek assurance from member agencies that the identified examples of good practice are acknowledged with the relevant members of staff and their line managers and supervisors

Appendix A

Terms of Reference

1. Introduction

The Care Act 2014 Section 44 sets out the criteria for when a Safeguarding Adults Board (SAB) must undertake a Safeguarding Adults Review (SAR).

A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if-

a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
b) condition 1 or 2 is met.

Condition 1 is met if-

a) the adult has died, and
b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not if knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if-

a) the adult is still alive, and
b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to:

a) identifying the lessons to be learnt from the adult's case, and
b) applying those lessons to future cases.

The Care and Support Statutory Guidance (updated September 2022), section 14.164, states that the SAB "should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again". In respects of this review, the Redbridge SAB have agreed for this to be considered a 'discretionary' SAR.

All SARs will reflect the six safeguarding principles as set out in the Care Act 2014. In addition, SABs should expect the following principles to be applied to SARs as suggested in the Care and Support Statutory Guidance:

- there should be a culture of continuous learning and improvement across the organisation that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined

- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
- families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively

In addition to this, SARs will:

- focus on learning and not blame, recognising the complexity of circumstances professionals were working within
- develop an understanding of who did what and the underlying reasons that led individuals and organisations to act as they did
- identify what actions are required to develop practice
- lead to sustained improvements in practice and have a positive impact on the outcome for adults

2. Case summary

Mother and daughter were found deceased following a forced entry to their privately rented flat by police. An alert had been raised by a neighbour who had not seen them for some time and had noted an odour and appearance of flies at the windows of their accommodation. The flat evidenced conditions of self-neglect and hoarding.

The post-mortem identified that 'Jasmine' died from pneumonia and abscess of left chest wall and her daughter, 'Rowena' died from high-grade coronary artery atheroma. No inquest was held.

Daughter's behaviour had demonstrated over a period of time that she was suffering from a mental health disorder. Mother had a number of physical health issues. Neither had regular contact with agencies for several years.

3. Commissioning the SAR

The Redbridge 'One Panel' discussed the case referral, submitted by Neighbourhood Policing, East Area (EA) Basic Command Unit (BCU), MPS, at Panel on 17 July 2023 and at an extraordinary meeting on 31 July 2023. Using the decision making tool (Redbridge 'One Panel' Guidance, Appendix C), it was agreed that the case met the threshold for a statutory Safeguarding Adult Review (SAR). A process to identify and appoint an Independent Reviewer/Report Author has been undertaken. The SAR Panel consists of standing members as per the RSAB SAR Protocol and representatives from additional agencies with significant involvement.

4. Scope of the review

The period in scope for the review is from 01 October 2022 to 06 June 2023. Any major incidents that are relevant to the review that took place from 2015 will also be considered within the timeline.

5. Methodology

The Care and Support Statutory Guidance states that the process for undertaking a review should be determined locally and according to the specific circumstances of the case. No one model will be applicable to each case. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

For the purposes of this review, each agency will initially be asked to complete an Information Sharing Return, incorporating a Chronology outlining their agency's involvement with Ms 'N'. Professionals involved will also be invited to attend a learning and reflection workshop where the key lines of enquiry for this review will be discussed. As well as involving professionals, this review will also seek the views of any identified family, friends, or neighbours.

The review will be written up to include analysis of the events that took place with an emphasis on highlighting areas of good practice as well as areas for improvement. There will be recommendations made that will be co-produced by the SAR Panel.

6. Key lines of enquiry (KLOE)

The following key lines of enquiry have been developed by the Independent Reviewer and the SAR Panel:

(i) Which internal procedures were implemented and followed? Examples could include annual landlord checks, annual health checks, fire safety checks etc.
(ii) Which multi-agency procedures were implemented and followed? Examples could include vulnerable adult risk management, multi-agency risk management, safeguarding, Mental Health Assessments, Mental Capacity Assessments, self-neglect etc.
(iii) Were "Did not attend"/"Did Not Engage" procedures in place and implemented appropriately?
(iv) Were escalation procedures in place and implemented appropriately?
(v) Were management/supervision procedures followed to ensure appropriate decision-making including triaging referrals/concerns and staff support?
(vi) Did the Covid-19 pandemic impact on the services offered to Family 'A' and their management?

7. Information Sharing Returns and Chronologies

Information Sharing returns and Chronologies will be requested from the following organisations:

- Adult Mental Health Services - NELFT NHS Trust
- Adult Health & Social Care – LB Redbridge
- Neighbourhood Policing - EA BCU MPS
- GP
- Barts Health NHS Trust
- BHRUT

8. Family, Friends, and Social Network Involvement

The Care and Support Statutory Guidance states that the involvement of family and friends in any SAR is important to ensure that a full picture of the adult is gathered. Any identified family, friends and neighbours will be invited to contribute to the Review.

9. Timetable for Case Review

The Review commenced from 01 November 2023. The final report is due to be presented to the Redbridge SAB in April/July 2024. A detailed timetable has been agreed by the SAR Panel.

Glossary

Apnoea - Sleep apnoea is when your breathing stops and starts whilst you sleep. The most common type is called Obstructive Sleep Apnoea (OSA). Sleep apnoea needs to be treated because it can lead to more serious problems.

BRAG Risk Assessment - a risk assessment scale used by the Metropolitan Police Service (MPS) – blue, red, amber and green.

Cognitive Behavioural Therapy – Cognitive Behavioural Therapy (CBT) is a talking therapy that can help manage problems by changing the way patients think and behave. It's most commonly used to treat anxiety and depression but can be useful for other mental and physical health problems.

Community Treatment Team – works with adults in the community with an acute physical need who could potentially be treated at home, rather than attend accident and emergency (A&E). The aim of the service is to prevent unnecessary hospital admissions.

CT Pulmonary Angiogram - is a medical diagnostic test that employs computed tomography angiography to obtain an image of the pulmonary arteries. Its main use is to diagnose pulmonary embolism (PE). It is a preferred choice of imaging in the diagnosis of PE due to its minimally invasive nature for the patient, whose only requirement for the scan is an intravenous line.

Fairlop Team - The Health & Social Care Team in the Local Authority covering residents living in and around the Fairlop area.

First Contact Team - The First Contact Team in the Local Authority is the 'front door' for referrals for adult health and social care.

Hyponatraemia - is a low concentration of sodium in the blood. Symptoms can be absent, mild or severe. Mild symptoms include a decreased ability to think, headaches, nausea, and poor balance. Severe symptoms include confusion, seizures, and coma; death can ensue.

Making Safeguarding Personal – is a joint initiative between the Local Government Association and the Association of Directors of Adult Social Services that commenced in 2010 and subsequently reviewed and revised to ensure safeguarding practice is person-centred. It is underpinned by the following 6 principles:

- Empowerment – People being supported and encouraged to make their own decisions and informed consent.
- Prevention – It is better to take action before harm occurs.
- Proportionality – The least intrusive response appropriate to the risk presented
- Protection – Support and representation for those in greatest need.

- Partnership – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- Accountability – Accountability and transparency in delivering safeguarding.

Mental Capacity Act 2005 – provides the legal framework to assess whether an adult lacks the capacity, at a specific moment in time, to make a specific decision for themselves and, if they do, for acting and making decisions on their behalf. It is underpinned by the following 6 principles contained in the Act:

1. A person must be assumed to have capacity unless it is established that he/she lacks capacity.

2. A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.

3. A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision.

4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his/ her best interests.

5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

However, the Code of Practice that support the Act identifies that the repeated making of unwise decisions, while not meaning the adult lacks capacity, should lead to an assessment of their capacity to make those decisions.

Mental Health and Wellness Team - provide specialist community mental health services for adults aged 18 and over in the London Borough of Redbridge. This includes an initial mental health assessment to identify needs and signposting or onward referrals if required. Following assessment the team may offer further interventions, including advice and information; further assessment of mental health and social care needs; crisis intervention; psychiatrist medical assessment, medication management and review; recovery and wellbeing approaches including trauma-informed care; individual interventions with service users with severe mental health problems based on recovery and social inclusion; access to psychological therapies; focus on employment, education and training. and; group support or interventions for carers or service users.

Merlin Report - a report prepared by the Metropolitan Police Service (MPS) for the health and social care sector in respect of individuals in need of support or safeguarding.

Redbridge Access, Assessment and Brief intervention Team - is a first point of entry mental health service for adults aged 18-65 in Redbridge. It provides an initial mental health assessment and referral, or signposting to other organisations or services. If appropriate the service can offer medical review and/or brief mental health intervention

for up to one year. In January 2023 it ceased operating and was replaced by Mental Health and Wellness Teams in line with national policy to transform Community Mental Health Services

s9 and s10 of the Care Act 2014 - sets out the rights and responsibilities of local authorities, care providers, and service users in relation to care and support, including safeguarding. S9 and s10 respectively set out the duties to assess the care support needs of adults and their carers.

Wellbeing Officer – is a role within Adult Health and Social Care to support the wellbeing of service users.