# Waltham Forest safeguarding partners overhaul protocols after year-long death concealment case



A safeguarding partnership in Waltham Forest has committed to improving its protocols following a distressing incident involving a mother found pushing the body of her deceased daughter in a wheelchair. This incident has prompted significant scrutiny and a call for reassessment of case management strategies within the local safeguarding framework.

The Waltham Forest Safeguarding Adults Board (SAB), composed of representatives from Waltham Forest Council, NHS North East London, and the Metropolitan Police, reported on the findings of a review concerning a case that resulted in a police investigation in November 2023. Officers discovered the remains of a woman in her early fifties, referred to as Jodie, while her mother, Janet, in her seventies, was pushing her deceased daughter in the vicinity of 17&Central on Selborne Road.

The inquest revealed that Jodie had been deceased and kept in their shared flat in Leyton for over a year prior to the discovery. Neighbours had previously raised concerns to the housing association about "horrendous smells" and a fly infestation coming from the residence. Despite the circumstances surrounding the death, Janet, who was diagnosed with a brain tumour, was not charged with any crime, although failing to report a death is typically considered illegal. In her statement, she expressed her struggle to cope with the loss, saying, "I couldn’t bear to part with [Jodie]."

This was not an isolated incident regarding the family's dealings with local authorities. Records indicate that the council had become aware of the family in 2013 when they were evicted from their home. Following an assessment in January 2014, safeguarding concerns were noted, but an independent reviewer from the Strategic Partnerships Board (SPB) claimed these were not investigated "rigorously" enough.

In response to the review published in October, the SAB was instructed to swiftly initiate a series of multi-agency audits and to clarify its referral and escalation processes. The SPB emphasised the need for comprehensive understanding across all partner agencies to guarantee that no case is solely understood by one entity, ensuring a "direct line of sight on the front door."

The SAB acknowledged the reviewer’s findings and has committed to implementing the necessary changes to enhance their safeguarding practices. Following comprehensive reviews conducted in November and December, the SAB is expected to provide updates on improvements by June.

The SPB lauded the actions taken by officers involved in the incident, stating: “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.” The review highlighted the unusual nature of the case, describing it as "bizarre and extremely rare," and indicated the importance of ensuring adequate support frameworks for professionals dealing with unexpected and shocking incidents.

Moreover, the SAB has been urged to evaluate its response strategies to cases that may present initially as bizarre or shocking, and to consider the leadership requirements necessary in urgent circumstances.

Source: [Noah Wire Services](https://www.noahwire.com)

## Bibliography

1. <https://www.walthamforest.gov.uk/families-young-people-and-children/child-protection/strategic-partnership-boards/safeguarding-partnership-response-hackney-cspr-child-q> - This page discusses the Waltham Forest Safeguarding Partnership's response to a serious case review, highlighting the importance of professional curiosity and enhanced communication between agencies, which aligns with the findings of the Jodie case review.
2. <https://content.govdelivery.com/accounts/UKWALTHAM/bulletins/3bfe9d3> - This newsletter provides information about Safeguarding Adults Week 2024, including workshops focused on recent Safeguarding Adults Reviews, such as SAR Ivan and Jodie, emphasizing the need for improved safeguarding practices.
3. <https://www.cqc.org.uk/location/1-1226282902/reports> - This Care Quality Commission report evaluates the Independent Living Team in Waltham Forest, noting areas for improvement in safeguarding practices and governance structures, which are relevant to the Jodie case review findings.
4. <https://www.walthamforest.gov.uk/families-young-people-and-children/child-protection/strategic-partnership-boards/statutory-reviews-and-one-panel> - This page outlines the statutory review process in Waltham Forest, detailing how serious incidents are reviewed to improve future practice, similar to the review conducted for the Jodie case.
5. <https://www.londonworld.com/your-london/waltham-forest/several-at-risk-children-suffered-abuse-in-waltham-forest-4162281> - This article reports on multiple incidents of child abuse in Waltham Forest, highlighting systemic issues in safeguarding that the Jodie case review aims to address.
6. <https://safeguardinglewisham.org.uk/lsab/lsab/print> - This document outlines indicators of neglect and self-neglect, providing context for understanding the circumstances surrounding the Jodie case and the importance of comprehensive safeguarding efforts.
7. <https://www.yellowad.co.uk/safeguarding-body-vows-improvement-after-leyton-mum-found-pushing-daughters-body-in-wheelchair/?utm_source=rss&utm_medium=rss&utm_campaign=safeguarding-body-vows-improvement-after-leyton-mum-found-pushing-daughters-body-in-wheelchair> - Please view link - unable to able to access data