NHS
East London
NHS Foundation Trust

Office of the Chief Medical Officer
Trust Headquarters
Robert Dolan House
5th Floor
9 Alie Street
London E1 8DE

Private & Confidential

[redacted]

Date 17 May 2025

Dear Sir

RE: REGULATION 28 REPORT

1. This is a formal response to your Regulation 28 report issued on 23 March 2024 where you set out concerns relating to the care of late Ms Regina Olufunmilola Ademiluyi at East London NHS Foundation Trust's **(the 'Trust's')** care.

2. I understand that at the inquest into Ms Ademiluyi's death, you heard evidence from the Trust's Serious Incident **(the 'SI')** review author outlining the learning that has taken place because of her death. I understand that you remained concerned about the risk of future deaths in relation to the following areas:

   2.1. From October 2023 until her death in March 2024, Ms Regina Ademiluyi was deprived of the state-funded domiciliary care to which she was entitled. The NHS Trust and Local Authority responsible for her care during this period failed to ensure effective care was provided in the following ways:

      2.1.1. A safeguarding report submitted by NHS district nurses was insufficiently detailed to reflect the concerns that had developed regarding the deceased. The content of the safeguarding report did not trigger the threshold to investigate the matter further.

      2.1.2. When faced with the limited information within the safeguarding report the Local Authority did not seek further information or clarification from the Trust on the basis of the report.

2.1.3. The Trust failed to formally assess Ms Ademiluyi's mental capacity, had they done so it is possible that an Independent Mental Capacity Advocate (IMCA) would have been appointed to act as her voice, over-ruling her daughter's views which may have resulted in effective care being put in place.

2.1.4. Despite the concerns raised regarding the behaviour of Ms Ademiluyi's daughter no effort was made to offer a carer assessment to address whether she was overwhelmed by the task in hand.

3. I wish to assure you and the family of Ms Ademiluyi that the Trust has reviewed the issues highlighted within the Regulation 28 Report and has planned the actions outlined below.

RESPONSE

The safeguarding report

4. I was concerned to hear evidence that the safeguarding report filled out by the Trust's district nurse was insufficiently detailed to reflect concerns and therefore did not trigger the threshold to investigate it further.

5. I asked that this matter be reviewed by the Named Professional for Safeguarding Adults for Newham (**the 'Named Professional'**), and Lead Borough Nurse for Newham Community Health Services (**the 'Lead Nurse'**). They liaised with London Borough of Newham Adult Social Care (**LBN**) to understand more fully what occurred and how this situation can be prevented in the future.

6. According to LBN, the referral was screened according to their own internal safeguarding policy and the Trust was advised that it met threshold for the Section 42 safeguarding enquiry. However, LBN is managing a backlog of such referrals. Therefore, it was not addressed before Ms Ademiluyi's sad death. Please refer to LBN's response to this Regulation 28 report.

7. The Trust recognises that all public bodies are currently under pressure. Therefore, it is more important than ever that they (the public bodies) work together to ensure that vulnerable adults do not slip through the net.

8. The Named Professional, the Lead Nurse and LBN have implemented arrangements to improve collaborative working and developed processes to escalate any drifting delays and/or cases with significant level of risk. These are as follows:

   8.1. A strategic safeguarding meeting, which aims to identify and address any barriers to the safeguarding process, will take place monthly between LBN and Newham Community Health services.

   8.2. A safeguarding forum attended by the Named Professional, the Lead Nurse, Newham Community Health Services' Operational Leads and LBN's Adult Social Care's Neighbourhood Teams will take place monthly to discuss current safeguarding concerns and create escalation plans where necessary.

9. Whilst the detail in the safeguarding referral was not the reason the safeguarding concern was not investigated further; the Named Professional agrees that it provided insufficient information. To ensure this does not occur again, the following training and supervision has been arranged for Community Health Services staff in Newham area:

   9.1. Safeguarding Adults Training will be delivered quarterly to Newham Community Health Services. The first module was delivered in May 2024 and will focus on how to complete good quality safeguarding referrals.

   9.2. Each of the Trust's Named Safeguarding Professionals meets with every single team within the Trust for quarterly supervision. This case has been considered in the most recent supervision.

Further information and joint working

10. The Trust is unable to comment on behalf of LBN. However, it can confirm that the two public organisations have systems in place which help them to work together closely and collaboratively to improve care for service users under both services.

11. Additionally, Newham Community Health Services staff have been reminded of the Trust's internal escalation pathway which they are expected to follow when there are concerns about the safeguarding process between public bodies during supervision. The escalation pathway is a tool to support staff with recognising their

responsibilities in ensuring they follow up referrals made, and escalate any barriers identified without delay. It also ensures that the relevant senior management is aware of concerns. It has been made clear to Newham Community Health Services staff that they should not wait for the monthly safeguarding forum to escalate any barriers or problems related to safeguarding process initiated by them.

Mental Capacity

12. I asked the Trust's Mental Capacity Act Lead to explore issues surrounding Ms Ademiluyi's capacity. They confirmed that in-line with the provisions of the Mental Capacity Act 2005 (the "**MCA**") the Trust is only the decision-maker in relation to decisions pertaining to her health care. The social care provider (LBN) is responsible for assessing capacity in relation to care and support needs.

13. The Trust does recognise that this area of law can be confusing. Therefore, it has agreed with LBN that the forums for collaborative working as described above, will also be used as space for any practitioners to discuss concerns related to service user's capacity.

14. Furthermore, Newham Community Health Services staff have been reminded, during their quarterly safeguarding supervisions, about the support offered by the Trust's Mental Capacity Act Lead (the "**MCA Lead**"). The MCA Lead also supports practitioners with necessary escalations across public bodies.

15. It is unlikely that an IMCA would be appointed in this situation. According to sections 37-39 of the MCA, the statutory requirement for the IMCA to be involved relates to situations when the matter pertains to the serious medical treatment or the care plan involves a new, permanent place of residence.

Carer's Assessment

16. The Named Professional for Safeguarding Adults and Lead Borough Nurse for Community confirmed that staff did not make a separate carer's assessment. Staff believed that LBN would undertake it as part of the safeguarding adult's response.

17. However, anyone can make a carer's assessment referral and should do so if there are concerns. Therefore, all staff were reminded during their

most recent safeguarding supervision to either; 1) discuss with carers about self-referring for the carer's assessment; or 2) to support the carer by making referral on their behalf.

18. I hope this response provides sufficient reassurances to you and to the family of Ms Ademiluyi about the additional learning that has taken place at the Trust because of her sad death.

19. I would like to offer my sincere and heart-felt condolences to the family at this difficult time.

Yours sincerely

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Chief Medical Officer

Cc: