MR G IRVINE
SENIOR CORONER
EAST LONDON
East London Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted], Head of National Police Air Service (NPAS) Sent via email: [redacted] **2.** [redacted], Chief Executive Officer and [redacted], Director of Child Social Care, The London Borough of Newham Sent via email: [redacted] and [redacted] **3.** [redacted], Secretary of State for Health & Social Care Sent via Email: [redacted] **4.** [redacted], Chair of the Board, Social Work England Sent via email: [redacted]
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East London
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 30th January 2022, this Court commenced an investigation into the death of Mazeedat Opeyemi Adeoye, aged 2-years. The investigation concluded at the end of the inquest on 29th November 2024. The court returned a narrative conclusion. *Mazeedat Adeoye, a two-year-old girl died on 29/1/22 in the rear garden of domestic premises in Dagenham, East London.*

	Whilst playing alone and inadequately supervised in the garden, Mazeedat fell head first into a plastic refuse bin that contained water. Despite the level of water in the bin being no more than 9cms in depth, Mazeedat drowned. *At the time of her death, Mazeedat had been entrusted into the care of an acquaintance of her mother. Mazeedat's mother had allowed her daughter to be cared for in these circumstances as a matter of last resort. Despite significant efforts, Mazeedat's mother had been unable to secure state assistance for childcare.* *Mazeedat's mother could not care for her daughter on 29/1/22, as she was required to attend hospital with her baby who had undergone heart surgery. Mazeedat was not permitted to accompany her mother into the hospital ward. Mazeedat's mother was a single parent without family or friends to rely upon for support.* *Local authority child services failed to support Mazeedat's family and put in place appropriate support for Mazeedat's care at this time.* *By virtue of her age and the fact that Mazeedat was assessed to be a child in need under s.17 Children's Act 1989 she was obviously in a dependent position and could not maintain her safety herself.* *The combined failures of the local authority and those caring for Mazeedat on 29th January 2022 taken cumulatively, constitute a gross failure. Those aggregated failures, on the balance of probability more than minimally contributed to Mazeedat's death.* *There was a missed opportunity to provide effective care in the form of an offer of a temporary fostering placement which would have probably resulted in the avoidance of Mazeedat's death.* Mazeedat's medical cause of death was determined as; *1.a. Drowning*
4	**CIRCUMSTANCES OF THE DEATH** Mazeedat Adeoye was a 2-year-old girl who was born in Nigeria. Mazeedat's mother brought her to the UK in the spring of 2021 under a visitor visa, the family overstayed in the UK, lacking resources to return to Nigeria. Mazeedat's mother was pregnant when she came to the UK. In September 2021 Mrs Adeoye was referred to Newham social services," no recourse to public funds" team ("NRPF") by an NHS ante-natal care. health visitor. Mazeedat was eventually assessed in mid-October to be a "child in need", at risk of harm and destitution, pursuant to s.17 The Children Act 1989. The family were provided accommodation and subsistence payments. Mrs Adeoye sought temporary foster care for Mazeedat on three occasions when she was temporarily unable to care for her daughter. In October 2021, a request was made when Mrs Adeoye was scheduled to give birth. A second request was made in November 2021 when Mazeedat's baby brother was admitted to hospital for emergency inpatient care. The final request was made on 21st January 2022, when Mrs Adeoye's infant son was required to undergo emergency heart surgery. In all 3 instances, Newham child services failed to facilitate an agreement with Mrs Adeoye to provide temporary foster care. Instead, on each occasion, Mrs Adeoye was asked to find a care solution herself, despite her consistent assertion that she had no family or support network. The result of social service's abrogation of their statutory duties was that Mazeedat was placed at risk of harm whilst, respectively, being cared for by midwives on a labour ward,

	living on a children's ward and finally, being cared for by an unproven volunteer. On 29th January 2022, whilst playing alone and unsupervised in the rear garden of the home of the volunteer carer, Mazeedat fell into a plastic refuse bin containing water and drowned.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – **National Police Air Service** 1. NPAS helicopter resources were utilised in the search for Mazeedat on 29th January 2022. At 16.40, a small circular heat signature was observed by a tactical flight officer within the garden where Mazeedat's body was ultimately located. The shape and size of the object meant that the object was "discounted" in the search and its presence was not communicated to anyone. Mazeedat was discovered 11 minutes later by a police dog unit on the ground. Whereas the delay in locating Mazeedat did not contribute to her tragic death, the decision to discount such a heat signature could, in another case, amount to a risk of fatal harm. **London Borough of Newham** 2. The Adeoye family interactions with the local authority, child services team were characterised by unprofessional behaviour from social workers. A culture existed within the team that tolerated and therefore encouraged overtly antagonistic behaviour towards vulnerable people. Should this hostile environment continue to be enabled, sub-optimal care outcomes will result with an ongoing risk of fatal harm. 3. The NRPF team was poorly managed. Social workers were not adequately supervised, and their caseloads were not periodically reviewed. The absence of leadership allowed a gradual erosion of empathy for the very people the team were employed to support. The absence of proper management left inappropriate behaviour unconstrained and allowed irrational decisions made arbitrarily by junior staff, to stand unchecked. 4. Inadequate standards of note-keeping meant that the rationale for critical decisions made by the NRPF were not properly recorded. The absence of clear records diminished both communication within the team and accountability.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **31st January 2025**. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION**

	I have sent a copy of my report to the Chief Coroner and to the following Interested Persons the family of Mazeedat, to the Child Death Overview Panel (where the deceased was under 18)]. I have also sent it to the local Director of Public Health. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.
9	**[DATE] 05/12/2024 [SIGNED BY CORONER]**